

AAPPO Provider Contracting Legislation Report

March 11, 2010

****CONNECTICUT S.B. 17 - PROVIDER CONTRACTS**

Sponsor: CT Joint Committee on Insurance and Real Estate

Summary: Requires that internet web site and telephone listings of covered entities be updated at least every ninety days. Prohibits covered entities from granting subsequent access to third parties to health care services, discounted rates or fees established in contracts between health care providers and contracting entities. Specifies that violations are deemed unfair or deceptive insurance practices.

Defines "covered entity" as any entity that has not contracted directly with a health care provider but that buys, leases, rents, is assigned or accesses a contract or terms of a contract with a health care provider, that is responsible for (A) the payment or coordination of health care services, or (B) the establishment or extension of health care provider networks.

<http://www.cga.ct.gov/2010/TOB/S/2010SB-00017-R00-SB.htm>

Status: Introduced and referred to Joint Committee on Insurance and Real Estate February 3, 2010. Hearing held February 18. Passed committee as substituted February 23.

Outlook: The Insurance and Real Estate Committee substituted and passed this measure 15-2. The committee substitute is not currently available online. The bill will now be filed with the Legislative Commissioner's Office to be checked for constitutionality and consistency with other law. It will then be referred to the Office of Fiscal Analysis to estimate the bill's cost. After the Office of Legislative Research adds a "plain English" explanation to the bill, it may be voted on by the House. This measure has been introduced by the Joint Committee on Insurance and Real Estate chaired by Senator Joseph Crisco (D) and Representative Steve Fontana (D).

CONNECTICUT S.B. 429 - PROVIDER CONTRACTS

Sponsor: CT Joint Committee on Public Health

Summary: Provides that "most-favored-nation clause" means a contractual provision that: (1) prohibits, or grants a contracting health organization an option to prohibit, a medical provider from contracting with another payer to provide health care services at a lower rate than the payment or reimbursement rate

specified in the contract with the contracting health organization; (2) requires, or grants a contracting health organization an option to require, a medical provider to accept a lower payment or reimbursement rate if the medical provider agrees to provide health care services to any other payer at a lower rate; (3) requires, or grants a contracting health organization an option to require, termination or renegotiation of an existing health care contract if a medical provider agrees to provide health care services to any other payer at a lower rate; or (4) requires a medical provider to disclose the medical provider's contractual payment or reimbursement rates with other payers.

Provides that no contract between a contracting health organization and a medical provider or hospital shall contain a most-favored-nation clause.

<http://www.cga.ct.gov/2010/TOB/S/2010SB-00429-R00-SB.htm>

Status: Introduced and referred to Joint Committee on Public Health March 5, 2010. Hearing scheduled March 12.

Outlook: The hearing will be open to the public and public testimony will be accepted. A vote is not expected to be taken at the hearing. Connecticut committees typically vote on legislation at a later date. At any point of the legislative process, any committee may choose to hear any legislation. Raised committee bills have a good chance of passing committee as the members collaborated in crafting the legislation. This measure has been introduced by the Joint Committee on Public Health, chaired by Senator Jonathan Harris (D) and Representative Elizabeth Ritter (D).

****FLORIDA H.B. 291 - PPOS, PROVIDER CONTRACTS**

Sponsor: Representative Clay Ford (R)

Summary: Provides that a contract between a health insurer and a health care practitioner for the provision of services to patients may not contain any provision that requires the practitioner to provide services to the policyholders of the health insurer at a fee set by the health insurer unless such services are covered services under the applicable health insurance policy.

Covered services is defined as "services reimbursable under the applicable health insurance policy, subject to any contractual limitations on an insured's benefits that may apply."

Provides that this applies to all contracts entered into or renewed on or after July 1, 2010.

<http://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?FileName->

[=_h0291_.xml&DocumentType=Bill&BillNumber=0291&Session=2010](#)

Status: Prefiled November 2, 2009. Referred to Health Care Regulation Policy Committee November 13.

Outlook: The bill sponsor sits on the committee of referral. If passed out of this committee, the bill will next be referred to the Insurance, Business, and Financial Affairs Policy Committee.

The bill sponsor, Representative Clay Ford (R), is a member of the majority party. The bill is similar to S.B. 302, which has been prefiled in the Senate. The bill lacks an identical majority sponsored companion which is seen as key to moving bills through the Florida Legislature.

****FLORIDA S.B. 302 - PPOS, PROVIDER CONTRACTS**

Sponsor: Senator Dennis Jones (R)

Summary: Provides that a health insurer may not require a contracted health care practitioner to accept the terms of other health care practitioner contracts with the insurer or any other insurer, or health maintenance organization, under common management and control with the insurer except for a practitioner in a group practice as defined in current statute who must accept the terms of a contract negotiated for the practitioner by the group, and a condition of continuation or renewal of the contract.

Prohibits a contract between a health insurer and a health care practitioner from containing any provision that requires the practitioner to provide services to the health insurance subscribers at a fee set by the health insurer unless the services are covered services under the applicable subscriber agreement.

Prohibits a contract between a prepaid limited health service organization and a health care practitioner from containing any provision that requires the practitioner to provide services to subscribers at a fee set by the prepaid limited health service organization unless the services are covered services under the applicable subscriber agreement.

Prohibits a contract between a health maintenance organization and a health care practitioner from containing any provision that requires the practitioner to provide services to the subscribers of the health maintenance organization at a fee set by the health maintenance organization unless the services are covered services under the applicable subscriber agreement.

Defines "covered services" as services reimbursable under the applicable subscriber agreement, subject to such contractual limitations on subscriber

benefits as may apply.

Provides that this Act applies to all contracts entered into or renewed on or after July 1, 2010.

<http://www.flsenate.gov/data/session/2010/Senate/bills/billtext/pdf/s0302.pdf>

Status: Prefiled October 5, 2009. Referred to Banking and Insurance Committee December 9.

Outlook: The bill sponsor does not sit on the committee of referral, the Banking and Insurance Committee. If passed out of this committee, the bill would go to the Health Regulation Committee. The Banking and Insurance Committee has not scheduled any meetings on the bill.

The bill sponsor, Senator Dennis Jones (R), is a member of the majority party. This measure lacks majority sponsored companion legislation. Majority sponsored companion legislation is seen as key to moving bills through the Florida Legislature.

****GEORGIA S.B. 50 - PPOS, PROVIDER CONTRACTS**

Sponsor: Senator Ralph Hudgens (R)

Summary: Current version (February 17) prohibits access to a provider's health care services and contractual discounts by certain contracting entities under certain circumstances.

Provides that this legislation does not apply to: 1) provider network contracts for services provided to Medicaid, Medicare or the State Children's Health Insurance Program; 2) in circumstances where access to the provider network contract is granted to an entity operating under the same brand licensee program as the contracting entity; and 3) to a contract between a contracting entity and a discount medical plan organization.

Defines a "contracting entity" as any person or entity that enters into direct contracts with providers for the delivery of health care services in the ordinary course of business.

Provides that a contracting entity shall not lease, rent or otherwise grant to a third party access to a provider network contract unless the third party accessing the contract is: 1) a payer or third party administrator or another entity that administers or processes claims on behalf of a payer; 2) a preferred provider organization or preferred provider network, including a physician organization or physician hospital organization; or 3) an entity engaged in the electronic claims

transport between the contracting entity and the payer that does not provide access to the provider's services and discounts to any other third party.

Provides that any person who begins business as a contracting entity shall register with the Commonwealth within 30 days of beginning business unless a person is licensed by the Commissioner as an insurer. Requires that each person not licensed by the Commissioner as a contracting entity shall be required to register with the Commissioner within 90 days following July 1, 2010.

Provides that a contracting entity shall not grant access to a provider's health care services and contractual discounts in a provider network contract unless: 1) the contract specifically states that the contracting entity may enter into an agreement with a third party allowing the third party to obtain the contracting entity's rights and responsibilities under the provider network contracts as if the third party were the contracting entity; 2) the provider network contract, and all agreements between a contracting entity and any third party, prohibits such third party from increasing the contractual discount or otherwise reducing the compensation to a provider to an amount below that which the provider was entitled from the contracting entity for health care services at the time the third party was granted access to the provider network unless such third party becomes a contracting entity; and 3) the third party accessing the provider network contract is contractually obligated to comply with the terms, limitations and conditions of the provider network contract.

Provides that a contracting entity that grants access to a provider's health care services and contractual discounts shall: 1) give to the provider a written or electronic list of all third parties known at the time of contracting to which the contracting entity has or will grant access to the provider's health care services and contractual discounts under a provider network contract; 2) maintain a website or toll free number for which the provider can obtain a listing of third parties which the contracting entity or a third party has executed contracts for access to a provider's health care services and contractual discounts; 3) provide the third party that contracts with the contracting entity to gain access to the provider network contract with information that enables the third party to comply with the terms, limitations, and conditions of the contract; 4) require that the third party who contracts with the contracting entity to gain access to the provider network contract identify the source of the contractual discount on each remittance advice or explanation of payment form; 5) notify the third party who contracts with the contracting entity to gain access to the provider network contract of the termination of the contract no later than 30 days after receipt of notice of the termination of the contract and require those that are contract eligible to claim the right of access to a provider's discounted rate for services rendered after termination of the provider network contract.

Provides that a third party's right to access a providers health care services and

discounts ends on the date the provider network contract is terminated and that claims for health care services performed after the termination shall not be eligible for processing and payment. Claims performed before the date of termination, but processed after the termination date are eligible for processing and payment.

Provides that a third party that has been granted access to a provider's health care services or contractual discounts that grants access to another third party or enters into a contract with another third party to access a provider's health care services and discounts are obligated to comply with the proposed provisions of this Act.

Provides that a violation of this Act is an unfair trade practice. Provides that the monetary penalty for a violation shall not be more than \$25,000 for each and every act or violation, unless the person knew or reasonably knew or reasonably should have known that they were in violation, in which case the penalty shall not be more than \$50,000 for each and every act or violation. Allows any person to file a civil action for damages arising from a violation of the Act.

Current version: http://www.legis.state.ga.us/legis/2009_10/versions/sb50_As_-_passed_Senate_7.htm

February 2 version: http://www.legis.state.ga.us/legis/2009_10/versions/sb5-0_Committee_sub_LC_37_1005S_4.htm

Introduced version: http://www.legis.state.ga.us/legis/2009_10/versions/sb5-0_As_introduced_LC_28_4416_2.htm

Status: Introduced and referred to Insurance and Labor Committee January 27, 2009. Failed to meet crossover deadline March 12. Carried over to 2010 session April 3. Discussion session held November 4. Hearing held, passed committee with substitute February 2, 2010. Amended and passed Senate February 17. Received in House and referred to Insurance Committee February 18.

Outlook: The House Insurance Committee has not scheduled any hearings on the bill.

The Senate amended and passed the bill by a vote of 51-1. The amendments added provisions about monetary penalties for violations under the Act and allowing a person to file a civil action for damages arising from violations of the Act.

The committee passed this legislation with a substitute by a unanimous vote.

The bill sponsor, Senator Ralph Hudgens (R) held a discussion session on this

legislation. According to the sponsor's staff, the meeting was a public forum for all interested parties to work through the bill toward an agreeable compromise to bring to the Legislature.

The bill sponsor is a member of the majority party. The bill has two additional cosponsors, Senator Lee Hawkins (R) and Senator Jim Butterworth (R).

Effective Date: July 1, 2010

****ILLINOIS H.B. 5250 - PPOS, PROVIDER CONTRACTS**

Sponsor: Representative Linda Chapa LaVia (D)

Summary: Sets provisions concerning restrictions on payment and reimbursement. Provides that a contracting entity, insurer, or third-party administrator may not grant access to a provider's health care services and contractual discounts pursuant to a provider on a discounted fee basis for covered services that are provided to an insured unless certain conditions are met. Provides that a party to a preferred provider contract may not sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of the contract without notification to and the authority of the other contracting parties. Sets requirements for a contracting entity, insurer, or third-party administrator that grants access to a provider's health care services and contractual discounts pursuant to a provider network contract. Provides that the Department of Insurance shall enforce the provisions concerning restrictions on payment and reimbursement. Creates penalties for violations of this law.

<http://www.ilga.gov/legislation/fulltext.asp?DocName=09600HB5250lv&;SessionID=76&GA=96&DocTypeID=HB&DocNum=5250&;print=true>

Status: Introduced and referred to House Rules Committee February 3, 2010. Referred to Insurance Committee February 16. Hearing held February 23. Hearing held March 2. Hearing scheduled March 9.

Outlook: Public testimony will be accepted and a vote is likely to be taken as this measure must pass the committee before the March 12 deadline. No action was taken on the measure at the March 2 hearing. According to staff, this measure was not taken up at the February 23 hearing. The bill sponsor is a member of the majority party and does not sit on the committee of referral. The bill currently has no cosponsors. Cosponsorship is important for bill passage in the Illinois General Assembly.

****KANSAS S.B. 136 - PROVIDER CONTRACTS**

Sponsor: KS Senate Financial Institutions and Insurance Committee

Summary: Prohibits a health insurer from including a provision in an agreement with any provider that: 1) prohibits or grants a health insurer the option to prohibit a provider from contracting with another health insurer to accept a lower reimbursement than the payment specified in the agreement; 2) requires or grants the health insurer an option to require the provider to accept a lesser reimbursement from the health insurer if the provider agrees with another carrier to accept the lower reimbursement for services; 3) terminates, renegotiates, or grants the health insurer an option to terminate or renegotiate the agreement, if the provider agrees to accept a lower payment from a different carrier for services; or 4) requires the provider to disclose such provider's contracted reimbursement rates with other health insurers.

<http://www.kslegislature.org/bills/2010/136.pdf>

Status: Introduced January 28, 2009. Referred to Financial Institutions and Insurance Committee January 29. Withdrawn from committee, referred to Ways and Means February 17. Withdrawn from committee, referred to Financial Institutions and Insurance February 18. Carried over June 4. Withdrawn from committee and referred to Public Health and Welfare Committee February 2, 2010. Hearing held February 17.

Outlook: The committee held an informational meeting on the bill, but did not vote on it. A vote has not been scheduled by the committee. The bill was withdrawn from the Financial Institutions and Insurance Committee and referred to the Public Health and Welfare Committee. The bill is sponsored by the Financial Institutions and Insurance Committee. Bills that are sponsored by committee typically have a vast amount of support.

MASSACHUSETTS H.B. 1012 - MANAGED CARE, PROVIDER CONTRACTS

Sponsor: Representative Vincent Pedone (D)

Summary: Provides regulations to ensure fair and equitable managed care contracting standards. Establishes provider contract requirements. Requires contract modifications to obtain written consent by all parties.

<http://www.mass.gov/legis/bills/house/186/ht01pdf/ht01012.pdf>

Status: Filed in House March 5, 2009. Referred to Joint Committee on Financial Services March 6. Hearing held December 2.

Outlook: During the hearing, the Massachusetts Association of Health Plans

and the Massachusetts Medical Society testified in support of the measure. No opposition testimony was offered, nor was a vote held during the hearing. The committee will schedule an executive session to consider testimony and issue a recommendation on the measure at a later date.

The bill sponsor is a member of the majority party in the highly Democratic General Court. This bill was originally filed as H.D. 3060. The bill is also a refile of H.B. 1055 from the 2007-2008 legislative session, which was referred to a study.

MASSACHUSETTS H.B. 3563 - MANAGED CARE, PPOS, PROVIDER CONTRACTS

Sponsor: Representative Christopher Speranzo (D)

Summary: Requires any provision in a contract between: (a) a health insurance carrier or HMO; and (b) any provider that purports to adjust or vary the reimbursement payable to such a provider on the basis of quality of care measurements or other performance factors to reflect nationally recognized standards and measures of care that are created by independent health care improvement organizations or agencies. Requires the standard of care definitions, performance measurements and methodologies for analyzing data utilized in contract provisions to be those utilized by health care improvement organizations or agencies, except to the extent that the parties to the contract have expressly agreed in writing otherwise. Prohibits contractual changes except: (a) by express written agreement of the parties; or (b) as such health care improvement organizations or agencies adjust their standards, definitions, measurements or methodologies. Requires health insurance carriers proposing to make a reimbursement adjustment or variation based upon a measurement of quality of care or other performance factor to first give the affected provided at least 60 days advanced written notice, together with full and complete disclosure of the basis and calculation justifying such adjustment or variation.

<http://www.mass.gov/legis/bills/house/186/ht03pdf/ht03563.pdf>

Status: Introduced in House and referred to Joint Committee on Financial Services March 18, 2009. Hearing held December 2.

Outlook: No action was taken during the hearing. The committee will schedule an executive session to consider testimony and issue a recommendation on the measure at a later date.

The bill sponsor is a member of the majority party in the highly Democratic General Court. This bill was originally filed as H.D. 2256.

****MISSOURI H.B. 1495 - PPOS, PROVIDER CONTRACTS**

Sponsor: Representative Robert Schaaf (R)

Summary: Requires that the Department of Insurance, Financial Institutions, and Professional Registration shall establish after due consultation with accident and sickness insurers, health services corporations, health maintenance organizations, insurance producers, and after a public hearing, uniform application forms for applicants.

Provides that an agreement between a health carrier and a participating provider shall not contain a provision that: 1) prohibits or grants the health carrier an option to prohibit, the participating provider from contracting with another health carrier to accept lower payment for health care services than the payment specified in the agreement; 2) requires or grants the health carrier an option or require, the participating provider to accept a lower payment from the health carrier if the participating provider agrees with another health carrier to accept lower payment for health care services; 3) requires or grants the health carrier an option of, termination or renegotiation of the agreement if the participating provider agrees with another health carrier to accept lower payment for health care services; or 4) requires the participating provider to disclose the participating provider's reimbursement rates under contracts with other health carriers.

<http://www.house.mo.gov/billtracking/bills101/biltxt/intro/HB1495I.htm>

Status: Prefiled January 4, 2010. Referred to Healthcare Transformation Committee February 25. Hearing cancelled March 2. Hearing scheduled March 16.

Outlook: The hearing is open to the public and testimony will be accepted. An Executive Session, where a vote may occur on the bill, may follow the hearing. The bill sponsor serves as the chair of the committee of referral. The bill sponsor, Representative Robert Schaaf (R), is a member of the majority party. The bill has no additional cosponsors.

MISSOURI H.B. 2160 - PPOS, PROVIDER CONTRACTS

Sponsor: Representative John Diehl (R)

Summary: Prohibits a contracting entity from selling, renting, or giving a third party the contracting entity's rights to a participating provider's services unless one of the following applies: 1) the third party accessing the participating provider's services under the contract is an employer or other entity providing coverage for health care services to its employees or members, and such employer or entity has a contract with the contracting entity or its affiliate for the

administration or processing of claims for payment for services under a health care contract with the participating provider; 2) 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; or 3) the health care contract specifically provides that it applies to network rental arrangements and states that one purpose of the contract is selling, renting, or giving the contracting entity's rights to the services of the participating provider, including other preferred provider organizations, and the third party accessing the participating provider's services is any one of the following: a) a payer or third party administrator or other entity responsible for administering claims on behalf of the payer; b) a preferred provider organization or network that receives access to the participating provider's services under an arrangement with the preferred provider organization or network in a contract with the participating provider which complies with all 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 steering and the timeliness and manner of reimbursement; or c) 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 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 steering and manner of reimbursement.

Requires that the contracting entity that sells, rents, or gives the contracting entity's rights to the participating provider's services under the contracting entity's health care contract with the participating provider do all of the following: 1) maintain a webpage that contains a listing of third parties 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 maintains a toll free telephone number accessible to all participating providers by means of which participating providers may access the same listing of third parties; and 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 the applicable terms and conditions of the contract, including but not limited to the products for which the participating provider has agreed to provide services; except that, a payer receiving administrative services from the contracting entity or its affiliate shall be solely responsible for payment to participating provider.

Provides that except as provided, no entity shall sell, rent, or give a contracting entity's rights to the participating provider's services under a health care contract.

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

<http://www.house.mo.gov/billtracking/bills101/biltxt/intro/HB2160I.htm>

Status: Introduced February 15, 2010.

Outlook: The bill sponsor, Representative John Diehl (R), is a member of the majority party, but does not sit on the likely committee of referral, the Health Care Policy Committee. Committee referrals do not guarantee that a bill will receive a hearing. The bill has no additional cosponsors.

MISSOURI S.B. 925 - PPOS, PROVIDER CONTRACTS

Sponsor: Senator Tom Dempsey (R)

Summary: Prohibits agreements between a health carrier and a participating provider from containing a provision that requires the participating provider to disclose the participating provider's reimbursement rates under contracts with other health carriers.

<http://www.senate.mo.gov/10info/pdf-bill/intro/SB925.pdf>

Status: Introduced February 8, 2010. Referred to Judiciary and Civil and Criminal Jurisprudence Committee February 11.

Outlook: The bill sponsor does not sit on the committee of referral. Committee referrals do not guarantee that a bill will receive a hearing. The bill sponsor, Senator Tom Dempsey (R), is a member of the majority party.

NEW JERSEY A.B. 372 - PPOS, PROVIDER CONTRACTS

Sponsor: Assemblymember Gary Schaer (D)

Summary: Establishes requirements for granting access to physician discounts under a provider network contract, in order to prevent the improper selling or leasing of these contractual discounts under a silent PPO (preferred provider organization) arrangement. Imposes a registration requirement on contracting entities as defined in the bill, and allows them to grant to third parties access to the network discounts that they have negotiated with physicians and certain other health care providers, only under certain circumstances and with certain disclosures.

Provides that a contracting entity that grants to a third party access to a provider's health care services and contractual discounts pursuant to a provider

network contract shall, in situations in which the provider network contract is terminated, provide certain notices to the third party of the termination of the provider network.

http://www.njleg.state.nj.us/2010/Bills/A0500/372_11.PDF

Status: Introduced in Assembly and referred to Financial Institutions and Insurance Committee January 12, 2010.

Outlook: The bill sponsor is a member of the majority party in the Democratically-controlled Legislature. The bill is also a refile of A.B. 4002 from the 2008-2009 legislative session, which failed to receive consideration in the Financial Institutions and Insurance Committee.

NEW JERSEY A.B. 589 - MANAGED CARE, PPOS, PROMPT PAYMENT, PROVIDER CONTRACTS

Sponsor: Assemblymember Joseph Cryan (D)

Summary: Makes several changes relating to carriers and health care providers. Requires the issuance of a health benefits plan identification card to at least the primary covered person under the health benefits plan. Requires the Commissioner of Banking and Insurance, in consultation with representatives of managed care plans and health care providers, to establish by regulation a universal contract for participation form, for use by any carrier which offers a managed care plan for the purpose of establishing and renewing health care provider participation in that plan.

Requires contracts between carriers and the participating health care providers to include certain protections for the health care providers. Requires a carrier which offers a managed care plan to only contract with a participating health care provider after: (1) the health care provider submits, and the carrier accepts, the universal physician application for participation form or renewal form; and (2) the health care provider is given an opportunity to review the proposed contract for participation, presented on the universal contract form, as well as a summary disclosure form for that contract.

Requires a carrier to furnish a fee schedule, showing the specifically defined compensation terms, or generally recognized method of payment or mode of classification for determining fees, and the fees for all codes and in-network services. Regulates the disclosure and use of privately negotiated in-network fees and reimbursement rates agreed to between health care providers and carriers and other payers, for use by these parties, and their third party administrators and billing services.

http://www.njleg.state.nj.us/2010/Bills/A1000/589_I1.PDF

Status: Introduced in Assembly and referred to Health and Senior Services Committee January 12, 2010.

Outlook: The bill sponsor is a member of the majority party in the Democratically-controlled Legislature. The measure has garnered one additional cosponsors. The bill is a refile of A.B. 4162 from the 2008-2009 legislative session, which failed to receive consideration in the Health and Senior Services Committee.

****NEW JERSEY S.B. 375 - MANAGED CARE, PPOS, PROVIDER CONTRACTS**

Sponsor: Senator Loretta Weinberg (D)

Summary: Current version (March 4) requires at least four public hearings on any proposed conversion. Expands the scope of the health impact study to include reviews of particular health insurance markets, provider contracts, networks, and compensation, claims processing and payment. Requires additional public participation and health impact "fairness analysis" as conditions of the conversion of health service corporations to domestic stock insurers.

Current version (March 4): http://www.njleg.state.nj.us/2010/Bills/S0500/375_R1a.PDF

Introduced version: http://www.njleg.state.nj.us/2010/Bills/S0500/375_I1.PDF

Status: Introduced in Senate and referred to Health, Human Services and Senior Citizens Committee January 12, 2010. Transferred to Commerce Committee February 1. Passed committee as amended March 4.

Outlook: After passing the Commerce Committee with amendments, the measure awaits consideration on the Senate floor. The Senate clerk could not indicate the likelihood of the measure's passage. A vote count is unavailable at this time.

The bill sponsor is a member of the majority party in the Democratically-controlled Legislature. The measure has garnered six additional cosponsors. The bill is also a refile of S.B. 2532 from the 2008-2009 legislative session, which failed to receive consideration in the Health, Human Services and Senior Citizens Committee.

NEW YORK A.B. 3341 - HEALTH SAVINGS ACCOUNTS, MANAGED CARE, MEDICAL MALPRACTICE, PPOS, PROMPT PAYMENT, PROVIDER

CONTRACTS

Sponsor: Assemblymember Adam T. Bradley (D)

Summary: Prohibits insurers from leasing or conveying their rights under a health care contract with providers to third parties. The definition of 'insurer' and contract include entities offering PPO products.

Requires insurers to pay valid claims within 15 days if such claim is submitted electronically and claims submitted on paper shall be paid within 30 days. Requires an insurer electing not to renew its contract with a health care provider to provide advance written notice within 150 days prior to the intended date of expiration. Insurers intending to change provisions of its current policies shall provide health care providers with a written notice explaining such provisions at least 90 days prior to the proposed implementation of such changes.

No insurer at any time during the duration of a contract, shall assign, lease or convey such contract or any of its rights to an unrelated party without the advanced written consent of the health care provider to such assignment, lease or conveyance. Provides indemnification for health care providers for any damages for medical liability resulting from compliance with insurer's utilization review decisions. Requires insurers who offer a health savings account to create and maintain an internet web site containing a listing of the individual costs of particular medical services and procedures.

<http://www.assembly.state.ny.us/leg/?bn=A03341&sh=t>

Status: Introduced and referred to Assembly Insurance Committee January 27, 2009.

Outlook: The bill sponsor, Assemblymember Adam T. Bradley (D), is a member of the majority party, and is a member of the committee of referral, the Insurance Committee. The bill sponsor introduced identical legislation last session, A.B. 7591, which was not heard in committee. This bill lacks majority sponsored companion legislation. Majority sponsored companion legislation is considered important in the Democrat controlled New York Legislature.

NEW YORK A.B. 726 - MANAGED CARE, PROVIDER CONTRACTS

Sponsor: Assemblymember Richard Gottfried (D)

Summary: Current version (January 19) prohibits clauses that entitle reimbursement at the lowest price or rate. Prohibits contracts which restrict

referral of patients based solely upon a health care provider's status with a managed care product. Prohibits disclosure of an enrollee's diagnosis as a condition for authorizing coverage for payment or dispensing of a prescription, and prohibits contracts which allow for the substitution of a pharmaceutical drug or agent by any person other than the prescribing health care professional.

Current version: <http://www.assembly.state.ny.us/leg/?bn=A00726&sh=t>

Status: Prefiled and referred to Assembly Health Committee December 31, 2008. Hearing held, passed Committee February 24, 2009. Passed Assembly, sent to Senate and referred to Health Committee March 2. Returned to Assembly January 6, 2010. Amended on third reading January 19. Passed Assembly; referred to Senate Health Committee February 9.

Outlook: This measure passed the Assembly 108-2 and has been referred to the Senate Health Committee for consideration. The January 19 amendment changed how this measure will be codified into statute. The bill passed the Health Committee with one member voting against it. The bill sponsor, Assemblymember Richard Gottfried (D), is a member of the majority party. The bill sponsor introduced similar legislation last session, A.B. 4607, which passed the Assembly but was not heard in the Senate. Majority sponsored companion legislation has been introduced in the Senate, S.B. 4112. Majority sponsored companion legislation is considered important to moving bills through the legislative process.

Companion Bill: 2009 S.B. 4112

Effective Date: Effective 180 days after enactment.

NEW YORK A.B. 3688 - PROVIDER CONTRACTS

Sponsor: Assemblymember Adam T. Bradley (D)

Summary: Prohibits providers of health care plans from substantially altering health care plans after the contract has been entered into.

<http://www.assembly.state.ny.us/leg/?bn=A03688&sh=t>

Status: Introduced and referred to Assembly Insurance Committee January 28, 2009.

Outlook: The bill sponsor, Assemblymember Adam T. Bradley (D), is a member of the majority party and sits on the committee of referral, the Insurance Committee. The bill sponsor introduced identical legislation last session, A.B.

6508, which did not move in committee. This bill lacks majority sponsored companion legislation. Majority sponsored companion legislation is considered important in the Democrat controlled New York Legislature.

OHIO H.B. 185 - PROVIDER CONTRACTS

Sponsor: Representative Timothy DeGeeter (D)

Summary: Specifies that a material amendment to a health care contract does not become part of the contract if: 1) there is no resolution between the two contracting parties; 2) neither party terminates the contract more than 60 days prior to the effective date of the amendment; and 3) the participating provider objects to the material amendment within 15 days of receiving notice of the amendment. Current law requires that health care providers be notified and provided with material amendments at least 90 days prior to the effective date of the amendments.

http://www.legislature.state.oh.us/bills.cfm?ID=128_HB_185

Status: Introduced in House May 19, 2009. Referred to Civil and Commercial Law Committee May 20. Hearing held June 2. Hearing held June 9. Hearing held June 16. Hearing held June 23. Passed committee June 30. Passed House October 21. Referred to Insurance, Commerce and Labor Committee October 28. Hearing cancelled December 15. Hearing held January 12, 2010. Hearing held February 2. Hearing held February 9.

Outlook: During the hearing, the Ohio Association of Health Plans, United HealthCare and Delta Dental of Ohio testified in opposition to the measure, arguing the bill would increase administrative burdens and costs for insurers. Support testimony was not accepted, nor was a vote taken. Rather, the committee will schedule additional hearings at a later date to consider further testimony and vote on the bill.

During the February 2 hearing, the Ohio State Medical Association testified in support of the measure. The bill sponsor testified in support of the measure during the January 12 hearing. The measure passed the House 85-14. All 14 who voted against the bill are members of the minority party in the House. The bill passed the Civil and Commercial Law Committee with two members of the minority party voting in opposition. It is unclear whether the Republican-controlled Senate will consider this legislation. During the June 16 hearing, Anthem Blue Cross Blue Shield, Delta Dental of Ohio and the Ohio Association of Health Plans testified in opposition to this legislation, citing unnecessary increases in costs and paperwork that would impact patients' access to affordable and timely care. During the June 9 hearing, the Ohio State Medical Association, the Ohio Hospital Association, the Ohio Health Care Provider Coalition and TRG-Rubicon testified

in support of this legislation. The bill sponsor is a member of the majority party in the highly partisan Ohio Legislature.

Effective Date: 91 days after enactment.

RHODE ISLAND H.B. 7500 - PROMPT PAYMENT, PROVIDER CONTRACTS

Sponsor: Representative Brian Kennedy (D)

Summary: Requires insurers to file any provider contract with the health insurance commissioner within 30 days after the health insurer and hospital have reached an agreement on such terms and conditions. Grants the commissioner the authority to review a provider contract, hold a hearing to determine the contract's fairness, and either accept, deny or modify such agreements.

<http://www.rilin.state.ri.us/BillText10/HouseText10/H7500.pdf>

Status: Introduced in House and referred to Corporations Committee February 23, 2010. Held for further study March 3.

Outlook: The committee recommended the measure be held for further study.

A similar measure has been introduced in the Senate, S.B. 2540, by a member of the majority party. The bill sponsor is a member of the majority party and chairs the committee of referral in the Democratically-controlled General Assembly. The measure has garnered four cosponsors, including one additional member of the committee of referral, increasing the likelihood of consideration.

Companion Bill: 2010 S.B. 2540

RHODE ISLAND S.B. 2540 - PROMPT PAYMENT, PROVIDER CONTRACTS

Sponsor: Senator Joshua Miller (D)

Summary: Requires insurers to file any provider contract with the health insurance commissioner within 30 days after the health insurer and hospital have reached an agreement on such terms and conditions. Grants the commissioner the authority to review a provider contract, hold a hearing to determine the contract's fairness, and either accept, deny or modify such agreements.

<http://www.rilin.state.ri.us//BillText10/SenateText10/S2540.pdf>

Status: Introduced in Senate and referred to Health and Human Services Committee February 11, 2010.

Outlook: The measure has been backdated to coincide with the Senate introduction deadline. The bill sponsor is a member of the majority party and sits on the committee of referral in the Democratically-controlled General Assembly. The measure has garnered four additional cosponsors, including the chair and one additional member of the committee of referral, increasing the likelihood of consideration. A similar measure has been introduced in the House, H.B. 7500, by a member of the majority party.

Companion Bill: 2010 H.B. 7500

RHODE ISLAND S.B. 2632 - PPOS, PROVIDER CONTRACTS

Sponsor: Senator James Sheehan (D)

Summary: Establishes standards for discount medical plan organizations. Establishes contract requirements. Protects consumers from unfair and deceptive marketing practices.

<http://www.rilin.state.ri.us/BillText10/SenateText10/S2632.pdf>

Status: Introduced in Senate and referred to Health and Human Services Committee March 4, 2010.

Outlook: The bill sponsor is a member of the majority party and is the vice chair of the committee of referral in the Democratically-controlled General Assembly. The measure has garnered four additional cosponsors, including the chair of the committee of referral, increasing the likelihood of consideration. An identical measure has been introduced in the House, H.B. 7606, by a member of the majority party.

Companion Bill: 2010 H.B. 7606

TENNESSEE H.B. 857 - PROVIDER CONTRACTS

Sponsor: Representative Jason Mumpower (R)

Summary: Provides that any lower fees paid for medical services furnished on or after January 1, 2010, must be made pursuant to a contract or agreement negotiated and signed directly between the health care provider and the employer, trust, pool, insurer or PPO Network. Provides that under no conditions shall negotiated rates for workers' compensation services be assigned to or accessible to any other party than the employer, trust, pool, or insurer who

signed the contract or agreement.

<http://www.capitol.tn.gov/Bills/106/Bill/HB0857.pdf>

Status: Introduced February 11, 2009. Referred to Consumer & Employee Affairs Committee; assigned to subcommittee on Employee Affairs February 18. Hearing held; deferred April 28. Hearing held; passed subcommittee May 5. Deferred in Consumer & Employee Affairs Committee to last calendar May 13. Carried over to 2010 session June 18.

Outlook: The bill sponsor is a member of the majority party, but does not sit on the committee of referral, the Consumer and Employee Affairs Committee. There is majority sponsored companion legislation in the Senate, S.B. 1297. Majority sponsored companion legislation is important due to the partisan nature of the Tennessee Legislature.

Companion Bill: 2009 S.B. 1297

TENNESSEE H.B. 1584 - PROVIDER CONTRACTS

Sponsor: Representative Charles Curtiss (D)

Summary: Enacts the "Rental Network Contract Arrangements Act." Provides that a contracting entity may not grant access to a provider's health care services and contractual discounts pursuant to a provider network contract unless: (1) the provider network contract specifically states that the contracting entity may enter into an agreement with a third party allowing the third party to obtain the contracting entity's rights and responsibilities under the provider network contract as if the third party were the contracting entity; and (2) the third party accessing the provider network contract is contractually obligated to comply with all applicable terms, limitations, and conditions of the provider network contract. Requires that contracting entities that grant access to a provider's health care services and contractual discounts pursuant to a provider network contract: (1) identify and provide to the provider, upon request at the time a provider network contract is entered into with a provider, a written or electronic list of all third parties known at the time of contracting, to which the contracting entity has or will grant access to the provider's health care services and contractual discounts pursuant to a provider network contract; (2) maintain an Internet web site or other readily available mechanism, such as a toll-free telephone number, through which a provider may obtain a listing, updated at least every 90 days, of the third parties to which the contracting entity or another third party has executed contracts to grant access to such provider's health care services and contractual discounts pursuant to a provider network contract; (3) provide the third party who contracts with the contracting entity to gain access to the provider network contract with sufficient information regarding the provider network contract to

enable the third party to comply with all relevant terms, limitations, and conditions of the provider network contract; (4) require that the third party who contracts with the contracting entity to gain access to the provider network contract identify the source of the contractual discount taken by the third party on each remittance advice (RA) or explanation of payment (EOP) form furnished to a provider when such discount is pursuant to the contracting entity's provider network contract; and (5) notify the third party who contracts with the contracting entity to gain access to the provider network contract of the termination of the provider network contract no later than the date established by rule by the department, which date shall be prior to the effective date of the final termination of the provider network contract; and require any third party that is eligible to access a provider's discounted rate pursuant to the contract to be terminated to cease claiming entitlement to the discounted rate or other contracted rights or obligations for services rendered pursuant to such contract after termination of the provider network contract.

<http://www.capitol.tn.gov/Bills/106/Bill/HB1584.pdf>

Status: Introduced February 19, 2009. Referred to Commerce and Government Operations Committee February 23. Assigned to Subcommittee on Industrial Impact February 26. Carried over to 2010 session June 18.

Outlook: The bill sponsor is a member of the minority party, but sits on one of the committees of referral, the House Commerce Committee. There is majority sponsored companion legislation in the Senate, S.B. 694. Majority sponsored companion legislation is important due to the partisan nature of the Tennessee Legislature.

Companion Bill: 2009 S.B. 694

TENNESSEE S.B. 3162 - PROVIDER CONTRACTS

Sponsor: Senator Jack Johnson (R)

Summary: Requires every contracting agent that sells, leases, assigns, transfers, or conveys its list of contracted medical providers and their contracted reimbursement rates to, upon entering or renewing a medical provider contract, do all of the following: (1) disclose to the medical provider whether the list of contracted medical providers may be sold, leased, transferred, or conveyed to other payors or agents, including workers' compensation insurers or self insureds. Provides that the disclosure of the ability to sell, lease, transfer or convey the list or network of medical providers shall be in a section of a contract titled "assignment" or "assignability" or similar title; (2) disclose whether workers' compensation payors to whom the list of contracted medical providers may be

sold, leased, transferred, or conveyed may be permitted to pay a medical provider's contracted rate if less than the workers' compensation fee schedule. The disclosure of the ability to pay a medical provider's contracted rate, if less than the workers' compensation fee schedule, shall be in a section of a contract titled "assignment" or "assignability" or similar title; (3) allow medical providers, upon the initial signing or renewal of a medical provider contract, to decline to participate in networks solely to serve workers' compensation payors that are sold, leased, transferred, or conveyed to workers' compensation payors; and (4) maintain a web page that contains a complete listing of customers to whom the network is sold, leased, transferred or conveyed that is accessible to all contracted medical providers and updated at least twice a year, as well as maintain a toll-free telephone number accessible to all contracted medical providers whereby medical providers may access workers' compensation payor summary information and a list of lessees of the network.

Defines "contracting agent" as any person that is in direct privity of contract with a medical provider to reimburse the medical provider for medical services provided to an injured worker pursuant to this chapter at rates other than those provided under the workers' compensation medical fee schedule. Provides that nothing contained within this section shall be construed to permit the creation of preferred provider organization networks that permit payments above the medical fee schedule adopted by the department.

<http://www.capitol.tn.gov/Bills/106/Bill/SB3162.pdf>

Status: Introduced January 27, 2010. Referred to Commerce, Labor and Agriculture Committee January 28.

Outlook: The bill sponsor is a member of the majority party and chairs the committee of referral, the Commerce, Labor and Agriculture Committee. Currently, this measure lacks companion legislation. Companion legislation, while not necessary for passage, streamlines the legislative process and enables bills to pass more easily through the chambers.

****VERMONT H.B. 220 - PPOS, PROVIDER CONTRACTS**

Sponsor: Representative Steven Maier (D)

Summary: Establishes standards for processing claims for health care services submitted to health plans by health care providers and to establish standards for disclosure of payment methodologies, regulation of rental networks, and prohibitions on the use of "most favored nation" and "all-products" clauses in health care provider contracts.

<http://www.leg.state.vt.us/docs/2010/bills/Intro/H-220.pdf>

Status: Introduced and referred to the Committee on Health Care February 17, 2009. Hearing held March 19. Hearing held March 27. Hearing held March 31. Carried over May 9.

Outlook: Hearings were held on this legislation during the 2009 legislative session but a vote was not taken. A vote has not been scheduled. The bill sponsor is a member of the majority party and is the chairman of the committee of referral, the House Health Care Committee. This bill has one cosponsor, Representative Virginia Milkey (D), who is the vice-chairman of the committee of referral.

VERMONT H.B. 278 - PROVIDER CONTRACTS

Sponsor: Representative Virginia Milkey (D)

Summary: Provides that any person that commences business as a contracting entity shall register with the department within 30 days of commencing business unless such person is licensed by the department as an insurer. Provides that each person not licensed by the department as a contracting entity shall have 90 days within which to register with the department.

Provides that a contracting entity may not grant access to a provider's health care services and contractual discounts pursuant to a provider network contract unless: (1) the provider network contract specifically states that the contracting entity may enter into an agreement with a third party, allowing the third party to obtain the contracting entity's rights and responsibilities under the provider network contract as if the third party were the contracting entity; and (2) the third party accessing the provider network contract is contractually obligated to comply with all applicable terms, limitations and conditions of the provider network contract.

<http://www.leg.state.vt.us/docs/2010/bills/Intro/H-278.pdf>

Status: Introduced and referred to the House Committee on Health Care February 24, 2009. Carried over May 9.

Outlook: The bill sponsor is a member of the majority party and is the vice-chairman of the committee of referral, the House Committee on Health Care. Currently, this bill lacks cosponsorship. This measure was not heard in committee during the 2009 legislative session.

WASHINGTON H.B. 2213 - PROVIDER CONTRACTS

Sponsor: Representative Tami Green (D)

Summary: Provides that, effective January 1, 2010, a person or entity that contracts with a health care provider shall comply with specified provisions. Requires each contract have provided with it a summary disclosure form disclosing, in plain language, the following: (i) the terms governing compensation and payment; (ii) any category of coverage for which the health care provider is to provide service; (iii) the duration of the contract and how the contract may be terminated; (iv) the identity of the person or entity responsible for the processing of the health care provider's claims for compensation or payment; (v) any internal mechanism required by the person or entity to resolve disputes that arise under the terms or conditions of the contract; and (vi) the subject and order of addenda, if any, to the contract.

<http://apps.leg.wa.gov/documents/billdocs/2009-10/Pdf/Bills/House%20Bills/2-213.pdf>

Status: Introduced and referred to Health Care and Wellness Committee February 13, 2009. Carried over to 2010 session April 27.

Outlook: Currently, this legislation lacks cosponsorship. Majority party cosponsorship is seen as beneficial for a bill's movement through the Democratically-controlled Legislature. The sponsor is a member of the majority party and serves on the committee of referral.