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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1759 Session of 2009

INTRODUCED BY LENTZ, DePASQUALE, BELFANTI, CALTAGIRONE, CREIGHTON, FRANKEL, GIBBONS, HORNAMAN, JOSEPHS, McILVAINE SMITH, MURT, J. TAYLOR AND YOUNGBLOOD, JUNE 23, 2009

REFERRED TO COMMITTEE ON INSURANCE, JUNE 23, 2009

AN ACT

Relating to health care provider contracts with health insurers, and health insurer utilization review of diagnostic studies.

Table of Contents

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Short title.

This act shall be known and may be cited as the "Fair Health Care Provider Contracting Act."

Section 2. Declaration of policy.

The General Assembly finds and declares as follows:

(1) An equitable and understandable contracting environment is essential to the financial stability of this Commonwealth's health insurers and health care providers and ultimately to the well-being of patients and consumers.

(2) Changes in the last decade in this Commonwealth's health care marketplace have resulted in a shifting balance of power, leaving health insurers with the leverage to drive

the contracting process.

(3) This act is intended to protect the health and welfare of this Commonwealth's health care consumers by ensuring that health insurers enter into contracts with physicians and other health care providers that are equitable and reasonable, provide both parties with clearly articulated and well-defined terms and parameters and assure the long-term financial viability of both the health insurers and the health care providers.

(4) This act is a necessary and proper exercise of the authority of the Commonwealth to protect the public health and to regulate the business of insurance and the practice of medicine and other health professions.

Section 3. Definitions.

The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Clean claim." A claim for payment for a health care service that has no defect or impropriety. The term does not include a claim from a health care provider who is under investigation for fraud or abuse regarding that claim.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"CPT codes." Current Procedural Terminology codes established by the American Medical Association or the Centers for Medicare and Medicaid Services.

"Defect or impropriety." The term includes, but is not limited to, a lack of required substantiating documentation or a particular circumstance requiring special treatment which prevents timely payment from being made on a claim.

"Department." The Insurance Department of the Commonwealth.

"Enrollee." A policyholder, subscriber, covered person, covered dependent or spouse or other person who is entitled to receive health care benefits from a health insurer.

"Exempt plan." A health benefit plan that is exempt, under the Employee Retirement Income Security Act of 1974 (Public Law 93-406, 88 Stat. 829), or otherwise from any provision of this act.

"Fair market value." The most probable price at which a good or service will exchange, expressed in terms of cash or equivalent, in a free market assuming a:

(1) Knowledgeable and willing seller unencumbered by undue pressure to sell and acting in the seller's own best interest.

(2) Knowledgeable and willing buyer unencumbered by undue pressure to buy and acting in the buyer's own best interest.

(3) Reasonable time for exposure in a free and open market.

"Generally accepted standards of medical practice." Standards that are based upon:

(1) credible scientific evidence published in peer-reviewed medical literature and generally recognized by the relevant medical community;

(2) specialty society recommendations;

(3) the views of providers practicing in relevant clinical areas; or

(4) any other relevant factors.

"Health care provider." A physician or other health care professional who is licensed, certified or otherwise regulated

by the Commonwealth to provide health care services to health care consumers. The term includes a physician, podiatrist, optometrist, psychologist, physical therapist, certified nurse practitioner, registered nurse, nurse midwife, physician assistant, chiropractor, dentist, pharmacist and professional who provides behavioral health services. The term also includes an integrated delivery system, in the context of its contractual relations with health insurers and network administrators, and a professional corporation, partnership, and other entity that legally enters into provider contracts on behalf of its health care professional shareholders, partners and employees.

"Health condition." An illness, injury, disease or symptom of an illness, injury or disease.

"Health insurer." An entity that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services in exchange for a premium, including, but not limited to, an entity licensed under any of the following:

(1) The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

(2) The act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

(3) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).

(4) 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

"Health care services." Services for the prevention, diagnosis or treatment of a health condition, including, but not limited to, the professional and technical component of professional services, supplies, drugs and biologicals,

diagnostic X-ray, laboratory and other tests, preventive screening services and tests, including, but not limited to, pap smears, mammograms, X-ray, radium and radioactive isotope therapy, surgical dressings, devices for the reduction of fractures, durable medical equipment, braces, trusses, artificial limbs and eyes, dialysis services, home health services and hospital, ambulatory surgery and other facility services.

"HIPAA." The Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936).

"Integrated delivery system" or "IDS." A partnership, association, corporation or other legal entity that:

(1) Enters into a contractual arrangement with a health insurer or network administrator.

(2) Employs or has contracts with its participating providers.

(3) Agrees under its arrangements with the health insurer or network administrator to provide or arrange for the provision of a defined set of health care services to enrollees principally through its participating providers.

(4) Assumes some responsibility for disease management programs, quality assurance, utilization review, credentialing, provider relations or related functions.

"Network administrator." An entity that provides a network of participating health care providers to a health insurer. The term includes an integrated delivery system in the context of a contractual relationship between the integrated delivery system and its participating health care providers.

"Participating provider." A health care provider who enters into a provider contract with a health insurer, integrated

delivery system or network administrator.

"Provider contract." An agreement between a health care provider and a health care insurer, integrated delivery system or network administrator that states the terms and conditions under which the provider will deliver health care services to enrollees. The term includes all attachments and appendices to the contract and other documents that are referred to in the agreement that may affect the provider's ability to make an informed decision and may prompt the provider to seek additional information or clarification before entering into the contract. The term does not include an employment contract.

Section 4. Provider contract standards.

A provider contract shall comply with the following minimum standards to facilitate review by and negotiation with health care providers:

(1) A provider contract shall be in plain English and readily understandable to the average reasonable physician or other health care provider.

(2) A provider contract shall explicitly define the managed care plan's responsibilities to the health care provider, the provider's responsibilities to the plan and their joint responsibilities to health insurer enrollees.

(3) A provider contract or its cover materials shall clearly and conspicuously disclose to the health care provider the names, telephone numbers, fax numbers and e-mail addresses of health insurer officials who can supply the materials necessary to answer any questions in order to make an informed decision about whether to enter into the contract.

(4) (i) No provider contract may include an

indemnification clause that commits a participating provider to indemnify the plan in the event of a liability claim.

(ii) A provider contract shall clearly state that each party is fully responsible and liable for its own actions.

(5) No health insurer may compel a health care provider to enter into an exclusive contract that precludes the health care provider from entering into an agreement with any other entity.

(6) (i) No provider contract may exceed one year in duration.

(ii) A provider contract may renew automatically only if the managed care plan notifies the participating provider of the pending renewal 60 days prior to the renewal date. The provider contract may renew automatically under the same terms and conditions if the health care provider does not respond to the health insurer's reminder notice within the 60-day period.

(7) (i) A provider contract shall include an appeal process for a health care provider to seek reconsideration of any decision by the health insurer to terminate the provider contract for cause.

(ii) To ensure appropriate continuity of care for enrollees, a provider contract shall define the obligations of the health insurer and the health care provider to enrollees after the termination date of the provider contract.

(iii) The health insurer shall notify enrollees of the termination of the provider contract with a health

care provider.

Section 5. Determination of eligibility and covered services.

(a) General rule.--A health insurer shall quickly and efficiently determine an enrollee's eligibility for coverage and reimbursement of health care services by the plan.

(b) Eligibility information systems.--A health insurer shall provide information systems that allow participating providers to determine an enrollee's eligibility for services, which systems shall include either a toll-free hotline or a secure Internet website.

(c) Erroneous statement of eligibility.--

(1) If a health insurer erroneously informs a participating provider that a person is enrolled and eligible for services when in fact the person is not, the health insurer shall reimburse the provider for all covered services rendered up to the time that the health insurer notifies the provider and nonenrolled person of the error.

(2) No health insurer shall bear any financial responsibility for services that the participating provider renders to the nonenrolled person after the time of notification. The health care provider may bill the former nonenrolled person for these services.

Section 6. Definition of "medically necessary."

A health insurer shall adopt the following definition of "medically necessary" health services: Health care services that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an injury, illness, disease or its symptoms and that are:

(1) In accordance with generally accepted standards of

medical practice.

(2) Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease.

(3) Not primarily for the convenience of the patient or provider and not more costly than an alternative service or sequence of services at least likely to produce an equivalent therapeutic or diagnostic result.

Section 7. Medically necessary health care services and estoppel for precertification.

(a) Precertification decisions.--

(1) A health insurer shall honor any precertification decision based on medically necessary health care services when the health insurer certifies or precertifies a proposed service as being medically necessary.

(2) No health insurer may include a contractual disclaimer that can change a precertification decision at a later date, with the effect of depriving a health care provider of reimbursement.

(b) Applicability.--This section shall not apply if a medically necessary determination is made fraudulently or the information submitted is materially erroneous or incomplete.

Section 8. Medically necessary dispute procedures.

In the event of a treatment denial by a health insurer based on a determination that the treatment is not medically necessary, a challenge to the denial shall be permitted, subject to the following standards:

(1) The definition of "medically necessary" as enumerated in this act shall be used in any medical necessity adverse determination.

(2) If the denial is based on a decision that the service or treatment was experimental or investigational, the health insurer must utilize credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, the views of practicing physicians, individual clinical circumstances, the views of the treating health care provider and any other relevant factors.

(3) (i) Only a physician in the same specialty as the treating health care provider may make the denial.

(ii) For purposes of this paragraph, "same specialty" means a physician with similar credentials and licensure as those physicians who typically treat the health condition in question or a health care provider who has experience treating the same health condition as that in question in an appeal.

(4) Any challenge to the health insurer's medically necessary determination adverse to the provider may be initiated in a court of competent jurisdiction.

Section 9. Mandated disclosure of contract information.

(a) Duty to provide copies of documents.--A health insurer shall supply a health care provider with a copy of each appendix, attachment or other document referred to in a provider contract. A health insurer shall send the materials with proposed provider contracts to health care providers. In the event any materials are missing or a health care provider requests supplementary information, the health insurer shall supply the materials within seven business days of the request.

(b) Required appendices.--A health insurer shall include in

a provider contract appendices that define:

(1) The health insurer's responsibilities under the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

(2) Key terms and phrases in the provider contract.

(3) The diagnostic and therapeutic services to which the health insurer commonly gives prior authorization.

(4) The prescription drug formularies commonly used by the health insurer or its pharmacy benefit manager.

Section 10. Mandated reimbursement disclosures and requirements.

(a) General rule.--A health insurer shall disclose in a provider contract the following information about potential reimbursements:

(1) For a health care provider who commonly participates with and is paid by Medicare, a table that contains the ten most commonly submitted evaluation and management CPT codes, if applicable, and the ten most commonly submitted nonevaluation and management CPT codes, showing the applicable Pennsylvania area Medicare reimbursement for that year and the health insurer's actual reimbursement for those codes under the provider contract, to facilitate a direct comparison.

(2) Upon request, a health insurer shall disclose to a health care provider its range of payments for the 100 CPT codes most commonly submitted in the health care provider's designated specialty of practice.

(b) Time period for payment.--A health insurer shall pay within 30 days a clean claim submitted from a participating health care provider.

Section 11. Mandated disclosure of administrative policies and procedures.

Within ten days of execution of a provider contract with a health care provider, a health insurer shall make available all of its administrative policy and procedure manuals, including, but not limited to:

(1) Coverage policies and technology assessments of specific diagnostic or therapeutic services, drugs or biologics, devices or medical supplies or equipment.

(2) Mechanisms for resolving administrative or clinical disputes and opportunities for participating in plan governance by participating providers.

(3) Health care provider peer review, quality assurance and credentialing programs. The provider contract shall describe the plan's policies and procedures as they relate to the plan's relationship with its health care providers. The health insurer shall make available to the health care provider considering a contract, copies of procedure or policy manuals typically made available to participating providers.

Section 12. Medical policy standards.

(a) General rule.--A health insurer shall provide 90 days' notice before a medical policy is changed or implemented after the execution of a provider contract with a health care provider.

(b) Criteria.--When formulating and adopting medical policies, health insurers shall rely on each of the following criteria:

(1) Credible scientific evidence published in peer-reviewed medical literature generally recognized by the

relevant medical community.

(2) National physician specialty society recommendations.

(3) The views of prudent physicians practicing in relevant clinical areas.

(4) Any other clinically relevant factors.

Section 13. Restrictions on all products clauses, most favored nation clauses and open practice requirements.

(a) General rule.--A health insurer shall comply with the following provisions:

(1) No health insurer may compel a participating provider to participate in all of its lines of business nor penalize a participating provider for not participating in all lines of business.

(2) A health insurer shall differentiate between its lines of business in the provider contract and give participating providers the opportunity to affirmatively choose or defer participation in any particular line without penalty.

(b) Lines of business.--

(1) Lines of business differ if the contracting provider's rights and responsibilities are materially different or if there is any other difference in the features that would be material to the contracting provider when determining whether to participate in the lines of business on a line-by-line basis.

(2) The following also shall be considered a separate line of business:

(i) The provision of insurance or a network for workers' compensation medical benefits.

(ii) The provision of insurance or a network for motor vehicle medical benefits.

(iii) The provision of a network for another insurer or network administrator.

(iv) The provision of a network for an exempt plan.

(3) Nothing in this section shall be construed as prohibiting a health insurer or network from using a single provider contract for multiple lines of business as long as the provider has the right to opt in or out of each line of business on a line-by-line basis.

(c) Prohibited contractual provisions.--

(1) No health insurer may use a most favored nation clause in a provider contract.

(2) No health care insurer may use a clause in a provider contract to prohibit a participating provider from limiting the number of individuals covered by the insurer who are accepted as new patients of the provider.

Section 14. Prohibition on silent preferred provider organizations.

A health insurer shall explicitly identify in its provider contract each network in which the health care provider agrees to participate and the health or other insurers who are authorized to access the network. A health insurer shall not agree nor represent that a participating provider will participate in the network of another health insurer, other insurer or network administrator without the provider's explicit written agreement.

Section 15. Standardization of CPT coding nomenclature.

(a) General rule.--A health insurer shall abide by the CPT codes, modifiers and definitions as established by the American

Medical Association or the Centers for Medicare and Medicaid Services. No health insurer may arbitrarily or automatically alter, reassign or downcode the CPT code on a submitted claim or bundle multiple CPT codes into one code to reduce reimbursement.

(b) Patient billing for denied reimbursement.--In the event that a health insurer denies reimbursement for a billed code on a basis other than that the service or product was not medically necessary, the health insurer may not prohibit the physician or other provider who rendered the service or product from billing the patient for the service as if the service or product were a noncovered service.

(c) Global surgical periods.--No health insurer may create a global surgical period longer than exists under standards of the Centers for Medicare and Medicaid Services.

(d) Separately payable services.--CPT codes for supervision and interpretation or radiologic guidance shall be separately payable health care services.

Section 16. Fair valuation of physician services.

(a) General rule.--A health insurer shall provide reimbursement for physician services at fair market valuation.

(b) Contesting reimbursement rates.--A physician shall have standing to contest the adequacy of the reimbursement rates paid by a health insurer for physician services if the rates apply to the services of the physician or a competitor of the physician.

Section 17. Utilization review of diagnostic studies.

(a) Conditions for prior authorization in studies.--No health insurer may require prior authorization for a diagnostic imaging or other diagnostic study unless:

(1) the proposed study falls outside of clinical practice guidelines that are nationally recognized or are

adopted by the insurer in consultation with physicians who are in active clinical practice and experts in the field;

(2) the ordering physician does not meet specialized training, education or skill qualifications for the ordered study that is nationally recognized or adopted by the insurer in consultation with physicians who are in active clinical practice and experts in the field;

(3) there is a reasonable basis for imposing the prior authorization requirement based upon an assessment of the ordering physician's prior utilization record through a retrospective utilization review program adopted by the insurer in consultation with the physicians who are in active clinical practice and experts in the field; or

(4) the ordering physician does not agree to a retrospective audit of the medical appropriateness of the ordered study in accordance with a retrospective utilization program adopted by the insurer in consultation with physicians who are in active clinical practice and experts in the field.

(b) Documentation of medical necessity.--A health insurer shall permit a physician seeking to document the medical necessity of diagnostic imaging or another study proposed or performed by the physician to provide a written explanation and may not require the physician to speak personally with the insurer's review personnel.

Section 18. Dispute resolution.

(a) Arbitration.--No health insurer may compel a health care provider to accept arbitration as the sole or primary means of dispute resolution between the parties. A provider contract may provide for arbitration as an option for dispute resolution

available to the parties only when there is joint consent and the contract describes all of the following:

(1) The circumstances in which arbitration is an option.

(2) The procedures to seek an arbitration.

(3) The process for selecting a certified arbitrator.

(4) How the parties would share the costs of the arbitration.

(b) Informal dispute resolution.--

(1) A health insurer and a health care provider may agree to an informal dispute resolution system for the review and resolution of disputes between the health care provider and the plan. Disputes that may be handled informally include denials based on procedural errors and administrative denials involving the level or types of health care service provided.

(2) The informal dispute resolution system shall be stated in the provider contract and shall be impartial, include specific and reasonable time frames in which to initiate appeals, receive written information, conduct hearings, render decisions and provide for final review and determination of disputes.

(3) An alternative dispute resolution system may not be used for any external grievance filed by an enrollee.

(c) Judicial review.--A provider contract shall not preclude a participating provider from seeking judicial review of a dispute with the health insurer.

Section 19. Health care provider claim submission.

(a) Claim form.--—

(1) A provider contract shall require the health care provider to submit claims on the CMS Form 1500 or its successor, as defined by the Centers for Medicare and

Medicaid Services.

(2) No health insurer may require a health care provider to submit claims electronically unless the health insurer offers the appropriate tools and infrastructure to facilitate electronic claims submission.

(b) Erroneous payments.--

(1) No health insurer may withhold future reimbursement as a means to recoup payments believed to have been made in error.

(2) A health insurer shall establish, disclose in contracts and include in provider procedure or policy manuals, the administrative process by which the plan can challenge and seek to recover potentially erroneous payments to the health care providers.

(3) A managed care plan shall disclose its intent to challenge a potentially erroneous payment within 180 days of the date of the payment.

(4) A health insurer that seeks to recoup overpayments made to a health care provider shall complete its administrative procedures and allow the health care provider to complete available appeal procedures within 90 days of the date it notifies the health care provider of its intent to seek remuneration.

(5) For any amount in excess of $10,000, a health insurer shall allow the health care provider to reimburse the plan in installments over not more than three years.

(6) In a situation where the health insurer has identified provider medical record documentation substantiating that a service was performed that should have been legitimately reimbursed at a higher level if properly

coded, the health insurer shall make payment to the provider equivalent to the difference between what was originally paid for the billed service and the amount that would have been paid had the service been coded and billed accurately.

(7) A corrected payment shall be made by the health insurer to the health care provider within 90 days of discovery.

(c) Fraud.--Subsections (a) and (b) shall not apply where the health insurer reasonably suspects fraud, illegality or other malfeasance regarding claims submitted and payments made.

(d) Claim period.--

(1) Health insurers shall not compel health care providers to submit claims or encounter data to the plan within not less than 180 days nor more than 360 days from the date of service.

(2) No health insurer or plan enrollee shall be required to bear any financial responsibility for claims that a health care provider does not submit within the claim period.

Section 20. Responsibility for compliance.

(a) Health insurer.--A health insurer remains responsible for complying with the requirements of this act, regardless of whether the insurer arranges for claims to be processed or paid by another entity.

(b) Network administrators.--A network administrator shall make the disclosures required of health insurers under sections 7, 8 and 9 for each health insurer who is able to access the network and shall comply with all sections of this act as if it is a health insurer.

Section 21. HIPAA compliance.

A provider contract shall:

(1) Delineate the obligations of each party to comply with the terms of HIPAA.

(2) State that the health insurer and the health care provider, if applicable, are covered entities under the terms of HIPAA and shall comply with HIPAA or any more restrictive privacy law of this Commonwealth.

Section 22. Penalties.

In addition to any other remedy available at law or in equity, the department may assess an administrative penalty on a health insurer that violates a provision of this act. The penalty may not exceed $5,000 per violation.

Section 23. Severability.

The provisions of this act are severable. If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions of applications of this act which can be given effect without the invalid provision or application.

Section 24. Rules and regulations.

The department may promulgate rules and regulations to administer and enforce this act.

Section 25. Effective date.

This act shall take effect in 60 days.