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THE GENERAL ASSEMBLY OF PENNSYLVANIA

# HOUSE BILL

## No. 933 Session of 2007

INTRODUCED BY LENTZ, CALTAGIRONE, COHEN, CREIGHTON, JOSEPHS, KING, KORTZ, MAHONEY, SANTONI, McILVAINE SMITH, K. SMITH AND YOUNGBLOOD, MARCH 29, 2007

REFERRED TO COMMITTEE ON INSURANCE, MARCH 29, 2007

AN ACT

Regulating contracts between managed care plans and participating providers; and providing for an administrative penalty.

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Section 15. Rules and regulations.

Section 16. Effective date.

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 Managed Care Plan and Participating 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 managed care plans 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 managed care plans 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 managed care plans 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 plans and providers.

(4) The General Assembly declares that 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:

"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.

"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 managed care plan subject to this act.

"Health care provider." A physician or other health care professional who is licensed or certified and regulated by the Commonwealth to provide health care services to health care consumers and who enters into contracts with managed care plans. 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 managed care plans.

"Health care service." A covered diagnostic or therapeutic service, surgical procedure, medical supplies, equipment, drugs or biologics, admission to a health care facility or other service, including behavioral health service, that is prescribed, proposed or provided by a health care provider to the enrollee of a managed care plan.

"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 managed care plan;

(2) employs or has contracts with its participating providers;

(3) agrees under its arrangements with the managed care plan to provide or arrange for the provision of a defined set of health care services to the plan's enrollees principally through its participating providers; and

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

"Managed care organization." An entity that operates a managed care plan 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, including section 630, relating to preferred provider organizations, and Article XXIV, relating to fraternal benefit societies.

(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).

The term includes an entity, including a municipality, whether licensed or unlicensed, that contracts with or functions as a managed care plan to provide health care services to enrollees.

"Managed care plan." A health plan that integrates the financing and delivery of health care services to enrollees through contractual agreements with health care providers and may offer financial incentives for enrollees to use certain services within the plan or to use contracted health care providers rather than providers who do not contract with the plan. The term includes a person or organization that contracts with health care providers to render health care services to enrollees of the plan or otherwise act on behalf of the plan, including, but not limited to, a managed care organization that operates the plan and the plan's network administrator. The term does not include an ancillary service plan or an indemnity service plan that is primarily fee for service and does not require prior authorization, mandatory second opinions or does not conduct concurrent or retrospective utilization review.

"Managed care plan contract." A written agreement between a health care provider and a managed care plan or network administrator for a managed care plan that establishes the responsibilities and obligations of the parties to each other and to the enrollees of the plan. The term includes all attachments and appendices to the contract and other documents that are referred to in the agreement that may affect the health care provider's ability to make an informed decision and may prompt the provider to seek additional information or clarification from the health plan before entering into the contract. The term does not include an employment contract between a managed care organization or a managed care plan and health care provider.

"Network administrator." A person or organization that provides a network of participating health care providers to a

managed care plan. 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 that enters into a contract with a managed care plan.

Section 4. Good faith negotiations.

(a) General rule.--A managed care plan shall negotiate the terms of any contract in good faith with any health care provider.

(b) Review period.--A health care provider shall have the right of at least 60 days from receipt to review any managed care plan contract and amendments thereto before execution of the contract or amendments is required and before revisions to an existing contract become effective.

(c) Contract documents.--A managed care plan shall:

(1) Supply copies of every appendix, attachment or other document referred to in the contract to allow the health care provider to make an informed decision whether to enter into the contract.

(2) Send these materials with proposed contracts to health care providers.

(3) In the event any materials are missing or a health care provider requests supplementary information, supply the materials within seven business days of the request.

(d) Proprietary materials.--No managed care plan may be required to give a health care provider any proprietary materials the disclosure of which would harm the plan's competitive or financial position in the marketplace.

(e) Reasonable contract terms.--No managed care plan may

include in any contract terms or conditions to which a reasonable and prudent health care provider would not agree.

(f) Required appendices.--Each managed care plan contract shall include appendices that define:

(1) The managed care plan'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 contract.

(3) The diagnostic and therapeutic services that the plan commonly authorizes.

(4) The prescription drug formularies commonly used by the managed care plan or its pharmacy benefit manager.

Section 5. Contract standards.

A managed care plan contract shall adhere to the following minimum standards to facilitate review by and negotiation with health care providers:

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

(2) The managed care plan 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 managed care plan enrollees.

(3) The managed care plan contract or its cover materials shall clearly and conspicuously disclose to the health care provider the names, telephone numbers, facsimile numbers and e-mail addresses of managed care plan 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) The managed care plan contract shall include an indemnification clause that commits a participating provider to indemnify the plan in the event of any liability claim and shall clearly state that each party is fully responsible and liable for its own actions.

(5) The managed care plan contract shall state that the managed care plan may not use a health care provider's agreement to the contract to represent that provider as a member of any network other than the one committed to in the agreement.

(6) The managed care plan contract shall state that the managed care plan may not compel a health care provider to enter into an exclusive contract that precludes the provider from entering into an agreement with other entities.

(7) The managed care plan contract shall not exceed one year in duration and may be renewed automatically only if the managed care plan notifies the participating provider of the pending renewal 60 days prior to the renewal date. The managed care plan contract may renew automatically under the same terms and conditions if the health care provider does not respond to the managed care plan's reminder notice within the 60-day period.

(8) The managed care plan contract shall include an appeal process for health care providers to seek reconsideration of any decision by the managed care plan to terminate the contract for cause. To ensure appropriate continuity of care for enrollees, the managed care plan contract shall define the obligations of the managed care plan and the health care providers to enrollees after the

termination date of the contract. The managed care plan contract shall notify enrollees of the termination of any contract with a health care provider.

Section 6. Determination of eligibility and covered services.

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

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

(c) Erroneous statement of eligibility.--

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

(2) The managed care plan may not bear any financial responsibility for services that the participating provider renders to the nonenrolled person after the date of notification.

(3) The health care provider may bill the former nonenrolled person for these services.

(d) Medical necessity.--A managed care plan shall adopt and maintain a definition of "medical necessity" as health care services or products that a prudent physician would provide to a patient for the purposes of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is

in accordance with generally accepted standards of medical practice and clinically appropriate in terms of type, frequency, extent, site and duration.

Section 7. Health care provider credentialing.

(a) Timing.--

(1) A managed care plan shall complete the credentialing of a health care provider or health care facility within 45 days or less of receipt of a completed application.

(2) The managed care plan shall notify applicants of any discrepancies and omissions in their application and supporting documentation within five business days of receipt of such application and shall expedite consideration of the corrected application upon receipt.

(3) The managed care plan may not recredential health care providers more frequently than is consistent with the standards for health plan credentialing of participating physicians established by the National Committee for Quality Assurance.

(4) The managed care plan shall complete any recredentialing of a health care provider under contract within 45 days.

(b) Claims during credentialing.--

(1) A managed care plan shall agree to make retroactive reimbursement for any claims that a participating provider incurs during the credentialing process when the provider is successfully credentialed by the plan.

(2) During the credentialing process, health care providers may not submit their claims for health care services provided to enrollees until credentialing is completed.

(3) If the health care provider or health care facility does not successfully complete the credentialing process, neither the managed care plan nor its enrollee bear financial responsibility for any pending claims.

Section 8. Health care provider claim submission.

(a) Claim form.--

(1) A managed care plan contract shall require health care providers to submit claims on the Health Care Financing Administration Form 1500 or its successor, as defined by the Centers for Medicare and Medicaid Services.

(2) No managed care plan may require health care providers to submit claims electronically unless the plan offers the appropriate tools and infrastructure to facilitate electronic claims submission.

(b) Erroneous payments.--

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

(2) A managed care plan shall establish, disclose in contracts and include in provider procedure or policy manuals the administrative process by which the plan may challenge and seek to recover potentially erroneous payments to 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 managed care plan that seeks to recoup overpayments made to a health care provider shall complete its administrative procedures and allow the provider to complete available appeal procedures within 90 days of the

date it notifies the provider of its intent to seek remuneration.

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

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

(d) Claim period.--

(1) A managed care plan may 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) The managed care plan and the enrollee shall not be financially responsible for claims that a health care provider does not submit within the claim period.

Section 9. Reimbursement.

(a) Required disclosures.--A managed care plan contract shall disclose the following information about potential reimbursements:

(1) (i) The actuarial assumptions upon which capitated payments to primary health care providers and, if applicable, specialists are calculated and a mechanism for health care providers to challenge or question the assumptions.

(ii) For each capitated health care provider, the health plan shall calculate and make its per-member-per-month reimbursement to the provider for any enrollee who selects that provider.

(iii) The reimbursement shall be based on the day

that the enrollee enrolls in the plan, selects that provider and the member or employer pays premiums to the health plan.

(iv) At no time may a health plan, as part of any capitated agreement with the health care provider, delay per-member-per-month payments to the provider for any enrollee until the enrollee actually begins to utilize health care services.

(2) For health care providers who commonly participate with and are paid by Medicare:

(i) A statement of how the managed care plan's reimbursement compares to Medicare reimbursement for the health care providers.

(ii) A table that contains the ten most commonly submitted evaluation and management current procedural terminology codes, if applicable, and the ten most commonly submitted nonevaluation and management CPT codes, showing Medicare's average reimbursement for that year and the managed care plan's actual reimbursement for those codes, to facilitate a direct comparison.

(3) Upon request, the managed care plan 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 field of practice.

(b) CPT codes.--

(1) A managed care plan shall abide by the CPT codes, modifiers and definitions as established by the American Medical Association or the Centers for Medicare and Medicaid Services.

(2) No managed care plan may arbitrarily alter the CPT

code on a submitted claim or bundle multiple CPT codes into one code to reduce reimbursement.

Section 10. Administrative policies and procedures.

(a) Duty to make available.--Within ten days of execution of a contract with a health care provider, a managed care plan 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.

(b) Managed care plan contracts.--A managed care plan contract shall describe the plan's policies and procedures as they relate to the plan's relationship with its health care providers. The managed care plan shall make available to any health care provider considering a contract copies of procedure or policy manuals typically made available to participating providers.

Section 11. Dispute resolution.

(a) Arbitration.--No managed care plan may compel a health care provider to accept arbitration as the sole or primary means of dispute resolution between the parties. A 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 managed care plan and a health care provider may agree to an informal dispute resolution system for the review and resolution of disputes between the managed care plan and health care provider.

(2) 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.

(3) The informal dispute resolution system shall be set forth in the managed care plan 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.

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

Section 12. Business lines.

No managed care plan may compel a health care provider to participate in all of the managed care plan's business lines. A managed care plan shall differentiate between its business lines in each contract and give health care providers the opportunity to affirmatively choose or defer participation in any particular business line without penalty.

Section 13. HIPAA compliance.

A managed care plan contract shall delineate the obligations of each party to comply with the terms of HIPAA and shall state

that the managed care plan and the health care provider are covered entities under the terms of HIPAA and shall comply with HIPAA or any more restrictive law of this Commonwealth.

Section 14. Penalty.

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

Section 15. Rules and regulations.

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

Section 16. Effective date.

This act shall take effect in 60 days.