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Bill Analysis
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BILL SUMMARY

- Prohibits a contracting entity from selling, renting, or giving the entity's rights to a participating provider's services pursuant to the entity's health care contract with the participating provider unless any of specified conditions pertaining to the third party accessing the participating provider's services under the contract applies and requires the contracting entity to provide participating providers access to the listing of certain of those third parties.
- Prohibits a contracting entity from requiring, as a condition of contracting with the entity, that a participating provider provide services for more than one product offered by the entity, specifies that the prohibition is not to be construed to do any of specified actions, and prohibits a contracting entity from requiring, as a condition of contracting with the entity, that the participating provider accept any future product offering that the entity makes.
- Prohibits a contracting entity from requiring, as a condition of contracting with the entity, that a participating provider waive or forego any right or benefit to which the participating provider may be entitled under state or federal law but permits a contracting entity to restrict a participating provider's scope of practice for the services to be provided.
- Prohibits any health care contract from prohibiting any participating provider from entering into a health care contract with any other

- contracting entity or generally precluding the contract's use or disclosure for purposes of enforcing the bill's provisions or state or federal law.
- Requires that, if a health care contract provides for termination of the contract for cause by either party, the contract must state the reasons for termination for cause, which terms must be reasonable.
 - Specifies that disputes that only concern the enforcement of the contract rights conferred by certain provisions in the bill are subject to a mutually agreed upon arbitration mechanism that is binding on all parties, authorizes an arbitrator to award to the prevailing party reasonable attorney's fees and arbitration costs, and prevents a party from simultaneously maintaining an arbitration proceeding and pursuing a complaint with the Superintendent of Insurance to investigate the subject matter of the arbitration proceeding.
 - Requires a contracting entity, upon presentation of a proposed health care contract for a participating provider's consideration, to make available to the participating provider specified information regarding compensation or payment terms for health care services.
 - Requires each health care contract to include, and requires each contracting party to include a summary disclosure form with a health care that includes, the compensation or payment terms and other specified information and to identify any utilization management, quality improvement, or similar program to be used to review or assess the services provided under the contract, and specifies certain statements to be included in the summary disclosure form and other requirements for the form.
 - Replaces existing law's procedures for amending a health care contract with new procedures that, among other requirements, require a contracting entity to provide the proposed amendment in writing and notice of the proposed amendment not later than 60 days prior to the effective date of the proposed amendment, and specifies the circumstances under which the amendment procedures do not apply.
 - Requires the Department of Insurance to prepare and adopt a form that is substantially similar to the credentialing form used by the council on Affordable Quality Healthcare (CAQH) and is the standard credentialing form for physicians, requires the Department to also prepare the standard

credentialing form for all other providers, provides that the credentialing process starts when a provider initially submits a credentialing form upon the oral or written request of a contracting entity, generally requires a contracting entity to complete the credentialing process within 90 days after receiving that form, and imposes a civil penalty on a contracting entity that does not complete the credentialing process within that period.

- Requires that each contracting entity, upon a participating provider's submission of certain information about an enrollee, must make available specified personally identifiable and other information concerning the enrollee that the contracting entity maintains in the ordinary course of business, requires a contracting entity that maintains enrollee information in the ordinary course of business to make that information available electronically or by an internet portal, and provides that these provisions take effect January 1, 2009.
- Requires remittance notices sent by a payer to include the payer's name and the name of the contracting entity through which the payment rate and any discount are claimed if different from the payer.
- Prohibits any health insuring corporation contract with a provider or health care facility from containing any provision that violates the bill's provisions.
- Provides that a series of violations of the bill's provisions (new R.C. Chapter 3963.) by any person regulated by the Department of Insurance under R.C. Title XVII or XXXIX that, taken together, constitute a pattern or practice of violation of that Chapter may be defined as an unfair and deceptive insurance practice under the Insurance Law, and authorizes the Department to conduct a market conduct examination of any person so regulated to determine whether any violation of the Chapter has occurred.
- Requires the Superintendent of Insurance to adopt rules necessary to implement the bill's provisions.
- Specifies certain exclusions from the bill's provisions.
- Applies its provisions only to contracts that are delivered, issued for delivery, or renewed or modified in Ohio on or after the act's effective date.

- Requires the Department of Job and Family Services to allow managed care plans to use providers to render care.
- Precludes any health care contract that includes a most favored nation clause from being entered into, and precludes any health care contract from being amended, modified, or renewed at the instance of a contracting entity to include a most favored nation clause, for a two-year period after the effective date of the act, subject to extension.
- Creates a 15-member Joint Legislative Study Commission on Most Favored Nation Clauses in Health Care Contracts, chaired by the Superintendent of Insurance, and charged with studying specified areas pertaining to most favored nation clauses in health care contracts, and requires the Commission to submit a final report of its findings and recommendations to the General Assembly.

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CONTENT AND OPERATION

Background

R.C. Chapter 1751. (Health Insuring Corporation Law) governs the operations of corporations to which the Superintendent of Insurance has issued a certificate of authority to establish and operate a "health insuring corporation" (see **COMMENT 1**). R.C. Chapter 3923. (Sickness and Accident Insurance Law) governs the issuance of sickness and accident insurance policies by insurers licensed and regulated by the Superintendent of Insurance (see **COMMENT 2**). R.C. 1753.01 to 1753.30 (Physician-Health Plan Partnership Law) contains provisions dealing with health insuring corporations and addressing provider contractual issues and issues relating to patient access to covered health care services, quality assurance programs, and utilization review (see **COMMENT 3**). R.C. 3901.38 and 3901.381 to 3901.3814 contain provisions for the prompt payment by third-party payers of claims submitted by providers.

R.C. 1751.08 and 1753.30 govern the relations among the laws described in the preceding paragraph. R.C. 1751.08(A) provides that, except as otherwise specifically provided in the Health Insuring Corporation Law (R.C. Chapter 1751.) or the Insurance Law (R.C. Title XXXIX), the provisions of the Insurance Law (including the Sickness and Accident Insurance Law and new R.C. Chapter 3963. enacted by the bill) are not applicable to any health insuring corporation holding a certificate of authority under the Health Insuring Corporation Law. However, this nonapplicability provision does not apply to an insurer licensed and regulated pursuant to the Insurance Law except with respect to its health insuring corporation activities authorized and regulated pursuant to the Health Insuring Corporation Law. In other words, except as otherwise specifically provided in the Health Insuring Corporation Law or the Insurance Law, a licensed insurer is

regulated under the Insurance Law with respect to its activities other than its health insuring corporation activities that are authorized and regulated under the Health Insuring Corporation.

R.C. 1753.30 provides that nothing in R.C. Chapter 1753. (Physician-Health Plan Partnership Law) prevents or otherwise affects the application to any health care plan of those provisions of R.C. Title XVII (Corporations and Partnerships) or XXXIX (Insurance) that would otherwise apply.

Overview of the bill

The bill enacts a new chapter in the Insurance Law (R.C. Chapter 3963.) that primarily regulates health care contracts entered into by certain health care providers and contracting entities. It includes specific prohibitions applicable to contracting entities and health care contracts. The bill requires specified disclosures regarding compensation or payment terms to be made by contracting entities upon presentation of a proposed health care contract to providers and additional disclosures in a summary disclosure form. It specifies that disputes concerning the enforcement of the contract rights conferred by certain provisions are subject to a mutually agreed upon and binding arbitration mechanism. The bill requires contracting entities, upon a participating provider's submission of certain information regarding an enrollee, to make available electronically or through the internet personally identifiable and other information concerning the enrollee. The bill's standardized provider credentialing procedures replace the credentialing procedures in existing law.

Definitions

The bill defines the following terms for purposes of its provisions (R.C. 3963.02):

"Affiliate" means any person or entity that has ownership or control of a contracting entity, is owned or controlled by a contracting entity, or is under common ownership or control with a contracting entity.

"Basic health care services" has the same meaning as in R.C. 1751.01(A) (see **COMMENT 4**), except that it does not include any services listed in that provision that are provided by a pharmacist or nursing home.

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

"Credentialing" means the process of assessing and validating the qualifications of a provider applying to be approved by a contracting entity to provide basic or supplemental health care services to enrollees.

"Edit" means adjusting one or more procedure codes billed by a participating provider on a claim for payment or a practice that results in: (1) payment for some, but not all of the procedure codes originally billed by a participating provider, (2) payment for a different procedure code than the procedure code originally billed by a participating provider, or (3) a reduced payment as a result of services provided to an enrollee that are claimed under more than one procedure code on the same service date.

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

"Health care contract" means a contract entered into, modified, or renewed between a contracting entity and a participating provider for the delivery of basic or supplemental health care services to enrollees.

"Health care services" means basic health care services and supplemental health care services.

"Participating provider" means a provider that has a health care contract with a contracting entity and is entitled to reimbursement for health care services rendered to an enrollee under the health care contract.

"Payer" means any person that assumes the financial risk for the payment of claims under a health care contract or the reimbursement for health care services provided to enrollees by participating providers pursuant to a health care contract.

"Primary enrollee" means a person who is responsible for making payments for participation in a health care plan or an enrollee whose employment or other status is the basis of eligibility for enrollment in a health care plan.

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

"Product" means a product line for health care services, including, but not limited to a health insuring corporation product or a Medicaid product for which the participating provider may be obligated to provide health care services pursuant to a health care contract.

"Provider" means a physician, podiatrist, dentist, chiropractor, optometrist, psychologist, advanced practice nurse, occupational therapist, massage therapist, physical therapist, professional counselor, professional clinical counselor, hearing aid dealer, orthotist, prosthetist, home medical equipment services provider, hospital, ambulatory surgery center, or medical transportation company. "Provider" does not mean a pharmacist or nursing home.

"Supplemental health care services" has the same meaning as in R.C. 1751.01(B) (see **COMMENT 6**), except that it does not include any services listed in that provision that are provided by a pharmacist or nursing home.

For purposes of this analysis, a defined term is enclosed in quotation marks the first time it is used.

Prohibitions applicable to contracting entities

Selling, renting, or giving contracting entity's rights to participating provider's services

The bill prohibits any "contracting entity" from selling, renting, or giving the entity's rights to a "participating provider's" services pursuant to the contracting entity's "health care contract" with the participating provider unless one of the following applies (R.C. 3963.02(A)(1)):

(A) The third party accessing the participating provider's services under the health care contract is an employer or other entity providing coverage for "health care services" to its employees or members, and that employer or entity has a contract with the contracting entity or its "affiliate" for the administration or processing of claims for payment or service provided pursuant to the health care contract with the participating provider.

(B) The third party accessing the participating provider's services under the health care contract is either: (1) an affiliate or subsidiary of the contracting entity, or (2) providing administrative services to, or receiving administrative services from, the contracting entity or an affiliate or subsidiary of the contracting entity.

(C) 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 provider's services is either: (1) a "payer" or a third party administrator or other entity responsible for administering claims on behalf of the payer, or (2) a preferred provider organization or preferred provider network that receives access

to the participating provider's services pursuant to an arrangement with the preferred provider organization or preferred provider network in a contract with the participating provider that is in compliance with this paragraph (C), and is required to comply with all of 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.

The bill requires the contracting entity that sells, rents, or gives the contracting entity's rights to the participating provider's services pursuant to the contracting entity's health care contract with the participating provider as described above to do both of the following (R.C. 3963.02(A)(2)):

(1) Maintain a web page that contains a listing of third parties described in paragraphs (B)(1) and (C), above, 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 maintain a toll-free telephone number accessible to all participating providers by means of which participating providers may access the same listing of third parties;

(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 of 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 is solely responsible for payment to the participating provider.

The bill provides that any information disclosed to a participating provider under R.C. 3963.02 is considered proprietary and cannot be distributed by the participating provider. Except as described above in paragraphs (A), (B), and (C), the bill prohibits any entity other than a contracting entity from selling, renting, or giving a contracting entity's rights to the participating provider's services pursuant to a health care contract. (R.C. 3963.02(A)(3) and (4).)

Providing services for more than one product

The bill prohibits any contracting entity from requiring, as a condition of contracting with the contracting entity, that a participating provider provide services for more than one product offered by the contracting entity (R.C. 3963.02(B)(1)). This prohibition is not to be construed to do any of the following (R.C. 3963.02(B)(2)):

(1) Prohibit any participating provider from voluntarily accepting an offer by a contracting entity to provide health care services under more than one of the contracting entity's products;

(2) Prohibit any contracting entity from offering any financial incentive or other form of consideration specified in the health care contract for a participating provider to provide health care services under more than one of the contracting entity's products;

(3) Require any contracting entity to contract with a participating provider to provide health care services under only one of the contracting entity's products if the contracting entity does not wish to do so.

Notwithstanding paragraphs (1), (2), and (3), above, the bill prohibits any contracting entity from requiring, as a condition of contracting with the contracting entity, that the participating provider accept any future product offering that the contracting entity makes (R.C. 3963.02(B)(3)).

Other prohibition

The bill prohibits any contracting entity from requiring, as a condition of contracting with the contracting entity, that a participating provider waive or forego any right or benefit to which the participating provider may be entitled under state or federal law. However, a contracting entity may restrict a participating provider's scope of practice for the services to be provided under the contract. (R.C. 3963.02(C).)

Prohibitions regarding health care contracts

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

(1) Prohibit any participating provider from entering into a health care contract with any other contracting entity;

(2) Preclude its use or disclosure for the purpose of enforcing the bill's provisions (new R.C. Chapter 3963.) or other state or federal law, except that a health care contract may require that appropriate measures be taken to preserve the confidentiality of any proprietary or trade-secret information.

Termination of health care contract

Existing law

The Physician-Health Plan Partnership Law (R.C. 1753.09) provides generally that prior to terminating the participation of a provider on the basis of the participating provider's failure to meet the health insuring corporation's standards for quality or utilization in the delivery of health care services, a health insuring corporation must give the participating provider notice of the reason or reasons for its decision to terminate the provider's participation and an opportunity to take corrective action. The health insuring corporation must develop a performance improvement plan in conjunction with the participating provider. If after being afforded the opportunity to comply with the performance improvement plan, the participating provider fails to do so, the health insuring corporation may terminate the participation of the provider.

Notwithstanding the preceding paragraph, a provider's participation may be immediately terminated if the participating provider's conduct presents an imminent risk of harm to an enrollee or enrollees; or if there has occurred unacceptable quality of care, fraud, patient abuse, loss of clinical privileges, loss of professional liability coverage, incompetence, or loss of authority to practice in the participating provider's field; or if a governmental action has impaired the participating provider's ability to practice.

Nothing in R.C. 1753.09 prohibits a health insuring corporation from rejecting a provider's application for participation, or from terminating a participating provider's contract, if the health insuring corporation determines that the health care needs of its enrollees are being met and no need exists for the provider's or participating provider's services. Nothing in R.C. 1753.09 may be construed as prohibiting a health insuring corporation from terminating a participating provider who does not meet the terms and conditions of the participating provider's contract. (R.C. 1753.09(A), (D), and (F).)

Operation of the bill

The bill provides that in addition to any other lawful reasons for terminating a health care contract, a health care contract may be terminated under the circumstances described below in the first paragraph in "Operation of the bill" under "Amendment of health care contract." If the health care contract provides for termination for cause by either party, the contract must state the reasons that may be used for termination for cause, which terms must be reasonable. Subject to the following paragraph, the health care contract must state the time by which the parties must provide notice of termination for cause and to whom the parties must give the notice.

The bill provides that nothing in the preceding paragraph is to be construed as prohibiting any health insuring corporation from terminating a participating provider's contract for any of the causes described in "Existing law," above. Notwithstanding any provision in a health care contract as described in the preceding paragraph, existing R.C. 1753.09 applies to the termination of a participating provider's contract for any of the causes described in "Existing law," above. (R.C. 3963.02(E).)

The bill further provides that nothing in R.C. 1753.09 may be construed as prohibiting a health insuring corporation from terminating a participating provider's contract pursuant to any provision of the contract providing that it may be terminated for reasons specified in the contract as described in the second preceding paragraph, except that, notwithstanding any such provision of a contract, R.C. 1753.09 applies to the termination of a participating provider's contract for any of the causes described above in "Existing law" (R.C. 1753.09(F)(3)).

Arbitration of disputes

The bill provides that disputes among parties that only concern the enforcement of the contract rights conferred by R.C. 3963.02 (see "Prohibitions applicable to contracting entities," "Prohibitions regarding health care contracts," and "Termination of health care contract," above) and R.C. 3963.04 (see "Amendment of health care contract," below), utilizing the applicable definitions in R.C. 3963.01 (see "Definitions," above) are subject to a mutually agreed upon arbitration mechanism that is binding on all parties. The arbitrator may award reasonable attorney's fees and costs for arbitration relating to the enforcement of this provision to the prevailing party.

A party cannot simultaneously maintain an arbitration proceeding as described in the preceding paragraph and pursue a complaint with the Superintendent of Insurance to investigate the subject matter of the arbitration proceeding. If the Superintendent initiates an investigation into the subject matter of a pending arbitration proceeding, the arbitration proceeding must be stayed at the request of any party pending the outcome of the investigation by the Superintendent. The arbitrator must make the arbitrator's decision in an arbitration proceeding having due regard for any applicable rules, bulletins, rulings, or decisions theretofore issued by the Department of Insurance or any court concerning the enforcement of the contract rights conferred by R.C. 3963.02 and 3963.04, utilizing the applicable definitions in R.C. 3963.01. (R.C. 3963.02(F).)

Contents of health care contract and summary disclosure form

The bill requires each health care contract to include, and requires each contracting entity to include a summary disclosure form with a health care contract that includes, all of the following information (R.C. 3963.03(A) and (B)(1)):

(1)(a) Information sufficient for the participating provider to determine the compensation or payment terms for health care services, including all of the following, subject to paragraph (1)(b), below:

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

(ii) The fee schedule of "procedure codes" reasonably expected to be billed by a participating provider's specialty for services provided pursuant to the health care contract and the associated payment or compensation for each procedure code. A fee schedule may be provided electronically. Upon request, a contracting entity must provide a participating provider with the fee schedule for any other procedure codes requested and a written fee schedule, that cannot be required more frequently than twice per year excluding when it is provided in connection with any change to the schedule. The effect, if any, on payment or compensation if more than one procedure code applies to the service also shall be stated. This requirement may be satisfied by providing a clearly understandable, readily available mechanism, such as a specific web site address, that allows a participating provider to determine the effect of procedure codes on payment or compensation before a service is provided or a claim is submitted.

(b) If the contracting entity is unable to include the information described in the preceding paragraph, the contracting entity must include both of the following types of information instead:

(i) The methodology used to calculate any fee schedule, such as relative value unit system and conversion factor or percentage of billed charges. If applicable, the methodology disclosure must include the name of any relative value unit system, its version, edition, or publication date, any applicable conversion or geographic factor, and any date by which compensation or fee schedules may be changed by the methodology as anticipated at the time of contract.

(ii) The identity of any internal processing edits, including the publisher, product name, version, and version update of any editing software.

(2) Any product or network for which the participating provider is to provide services;

(3) The term of the health care contract;

(4) A specific web site address that contains the identity of the contracting entity or payer responsible for the processing of the participating provider's compensation or payment;

(5) Any internal mechanism provided by the contracting entity to resolve disputes concerning the interpretation or application of the terms and conditions of the contract. A contracting entity may satisfy this requirement by providing a clearly understandable, readily available mechanism, such as a specific web site address or an appendix, that allows a participating provider to determine the procedures for the internal mechanism to resolve those disputes.

(6) A list of addenda, if any, to the contract.

Other requirements for summary disclosure form

The information in the summary disclosure form must refer to the location in the health care contract, whether a page number, section of the contract, appendix, or other identifiable location, that specifies the provisions in the contract to which the information in the form refers. (R.C. 3963.03(B)(1).)

The summary disclosure form must include all of the following statements (R.C. 3963.03(B)(2)):

(1) That the form is a guide to the health care contract and that the terms and conditions of the contract constitute the contract rights of the parties;

(2) That reading the form is not a substitute for reading the entire health care contract;

(3) That by signing the health care contract, the participating provider will be bound by the contract's terms and conditions;

(4) That the terms and conditions of the health care contract may be amended pursuant to R.C. 3963.04 and the participating provider is encouraged to carefully read any proposed amendments sent after execution of the contract;

(5) That nothing in the summary disclosure form creates any additional rights or causes of action in favor of either party.

The bill provides that no contracting entity that includes any information in the summary disclosure form with the reasonable belief that the information is truthful or accurate is subject to a civil action for damages or to binding arbitration based on the summary disclosure form. This provision does not impair or affect any power of the Department of Insurance to enforce any applicable law. (R.C. 3963.03(B)(3).)

The bill requires the summary disclosure form to be in substantially the form specified in R.C. 3963.03(B)(4) (see **Attachment**).

Information on compensation or payment terms

When a contracting entity presents a proposed health care contract for consideration by a participating provider, the bill requires the contracting entity to provide in writing or make reasonably available the information on compensation or payment terms required as described in paragraph (1) under "**Contents of health care contract and summary disclosure form**," above. If the information is not disclosed in writing, it must be disclosed in a manner that allows the participating provider to evaluate the participating provider's payment or compensation for services under the health care contract. The contracting entity need not provide such information to the participating provider in written format more than twice a year. (R.C. 3963.03(C).)

Disclosure of program used to review services

The bill requires a contracting entity to identify any utilization management, quality improvement, or a similar program the contracting entity uses to review, monitor, evaluate, or assess the services provided pursuant to a health care contract. The contracting entity must disclose the policies, procedures, or guidelines of such a program applicable to a participating provider upon request by the participating provider within 14 days after the date of the request. (R.C. 3963.03(D).)

Disclosures under the Physician-Health Plan Partnership Law

Prior to entering into a participation contract with a provider under the existing Physician-Health Plan Partnership Law, a health insuring corporation must disclose basic information regarding its programs and procedures to the provider, *upon the provider's request*. The information includes all of the following (R.C. 1753.07(A)):

(1) How a participating provider is reimbursed for the participating provider's services, including the range and structure of any financial risk sharing arrangements, a description of any incentive plans, and, if reimbursed according to a type of fee-for-service arrangement, the level of reimbursement for the participating provider's services;

(2) How referrals to other participating providers or to nonparticipating providers are made;

(3) The availability of dispute resolution procedures and the potential for cost to be incurred;

(4) How a participating provider's name and address will be used in marketing materials.

The bill modifies existing law by requiring that a health insuring corporation disclose the information described in paragraph (1), above, without a provider requesting the information. It further provides that insofar as the information on compensation or payment terms described in paragraphs (1)(a) and (b) under "*Contents of health care contract and summary disclosure form,*" above, applies, all of that described information that is not included in paragraph (1) in existing law, above, must be disclosed by a health insuring corporation without a provider requesting the information. (R.C. 1753.07(A)(1)(b).)

The existing Physician-Health Plan Partnership Law requires a health insuring corporation to provide all of the following to a participating provider: (1) any material incorporated by reference into the participation contract, that is not otherwise available as a public record, if such material affects the participating provider, (2) administrative manuals related to provider participation, if any, and (3) a signed and dated copy of the final participation contract (R.C. 1753.07(B)).

The bill provides that insofar as the bill's provisions on the summary disclosure form are applicable, a health insuring corporation must provide to a participating provider the summary disclosure form with the disclosures required under the bill (R.C. 1753.07(B)(3)). It further provides that nothing in R.C. 3963.03 is to be construed as preventing or affecting the application of R.C. 1753.07 that would otherwise apply to a contract with a participating provider (R.C. 3963.03(E)).

Amendment of health care contract

Existing law

The Physician-Health Plan Partnership Law requires a health insuring corporation (see **COMMENT 1**) that amends a participation contract to notify the participating provider of the amendment prior to the effective date of the amendment. A health insuring corporation must also notify a participating provider prior to the effective date of an amendment to any document incorporated by reference into such a contract if the amendment directly and materially affects the participating provider. These amendments are not to be effective with regard to the participating provider until the participating provider has had reasonable time, as defined in the contract, to exercise the participating provider's right to terminate the provider's participation status in accordance with the terms and conditions of the contract. These provisions pertaining to the amendment of a participating provider's contract do not apply to amendments that are required by state or federal law, rule, or regulation, and they do not apply if a delay caused by

compliance with the provisions could result in imminent harm to an enrollee.¹ (R.C. 1753.08.)

Operation of the bill

The bill outright repeals the above provisions in the Physician-Health Plan Partnership Law and replaces them with the following provisions. An amendment of a health care contract occurs only if the contracting entity provides to the participating provider the proposed amendment in writing and notice of the proposed amendment not later than 60 days prior to the effective date of the amendment. Subject to the following paragraph, if within 30 days after receiving the proposed amendment and notice the participating provider objects in writing to the proposed amendment, and there is no resolution of the objection, either party may terminate the health care contract upon written notice of termination provided to the other party not later than 30 days prior to the effective date of the proposed amendment. If the participating provider does not object to the proposed amendment in the manner described above, the amendment becomes effective as specified in the notice of the proposed amendment.

If a proposed amendment is the addition of a new category of coverage under the health care contract, the participating provider objects to that proposed amendment in the manner described in the preceding paragraph, and there is no resolution of the objection, the amendment is not effective as to the participating provider, and the objection cannot be a basis upon which the contracting entity may terminate the contract as described in the preceding paragraph. (R.C. 3963.04(A).)

The provisions described in the preceding paragraphs do not apply if the delay caused by compliance with those provisions could result in imminent harm to an "enrollee" or if the amendment of a health care contract is required by state or federal law, rule, or regulation. R.C. 3963.04 does not apply under any of the following circumstances (R.C. 3963.04(B)):

(1) The participating provider's payment or compensation is based on the current Medicaid or Medicare physician fee, and the change in payment or compensation results solely from a change in that physician fee schedule.

(2) A routine change or update of the health care contract is made in response to any addition, deletion, or revision of any service code, procedure code,

¹ R.C. 1753.01(B) (not in the bill), by reference to R.C. 1751.01(J), defines "enrollee" as any natural person who is entitled to receive health care benefits provided by a health insuring corporation.

or reporting code, or a pricing change is made by any third party source. For purposes of this provision: (a) "service code, procedure code, or reporting code" means the current procedural terminology (CPT), the healthcare common procedure coding system (HCPCS), the international classification of diseases (ICD), or the drug topics redbook average wholesale price (AWP), and (b) "third party source" means the American Medical Association, the Centers for Medicare and Medicaid services, the National Center for Health Statistics, the Department of Health and Human Services Office of the Inspector General, the Ohio Department of Insurance, or the Ohio Department of Job and Family Services.

Notwithstanding the above provisions, a health care contract may be modified, without the need for an amendment as described above, by operation of law as required by any applicable state or federal law, rule, or regulation. Nothing in R.C. 3963.04 is to be construed to require the renegotiation of a health care contract that is in existence before the effective date of that section, until the time that the contract is renewed or modified. (R.C. 3963.04(C).)

Credentialing

Existing law

The Physician-Health Plan Partnership Law requires the Superintendent of Insurance to prescribe a standard credentialing form to be used by all health insuring corporations when initially credentialing or recredentialing providers in connection with policies, contracts, and agreements providing basic health care services. The Director of Health may make recommendations to the Superintendent for such a standard credentialing form, and the Superintendent must consider those recommendations in prescribing a standard credentialing form. If the Director makes such recommendations, the Director is required to take into consideration the standard credentialing forms developed by the National Association of Insurance Commissioners, the American Medical Association, the American Association of Health Plans, and any other national organization that has developed such a form. The Superintendent may amend or revise the prescribed standard credentialing form as necessary, and a health insuring corporation must use the amended or revised form to credential or recredential providers. A health insuring corporation may request information from a provider, in addition to that information provided from the standard credentialing form, as necessitated by the health insuring corporation's credentialing standards. (R.C. 1753.03 and 1753.04.)

Existing law permits a health insuring corporation to use "economic profiling" as a factor in credentialing a provider, if the economic profiling takes into consideration the case mix, severity of illness, and age of patients. "Economic profiling" means a health insuring corporation's use of economic

performance data and economic information in determining whether to contract with a provider for the provision of health care services to enrollees as a participating provider.

A health insuring corporation may request the information necessary to perform an economic profile with regard to an initial applicant. If the health insuring corporation requests information on case mix, severity of illness, and age of patients, but the information is not produced by the applicant, the health insuring corporation is not required to take these factors into consideration in its economic profile of the provider. The Law states that it does not prohibit a health insuring corporation from taking into consideration the quality and appropriateness of care given by a provider when deciding whether to employ, contract with, or terminate the provider. (R.C. 1753.01(A) and 1753.05.)

Operation of the bill

The bill outright repeals the above credentialing provisions in existing law and replaces them with the following provisions regarding "credentialing." It eliminates the definition of "economic profiling" (R.C. 1753.01(A)) and the existing provisions (R.C. 1753.05) on economic profiling as a factor in credentialing providers. The bill requires the Department of Insurance to prepare and adopt a form, in electronic or paper format, that is substantially similar to the credentialing form used by the Council for Affordable Quality Healthcare (CAQH), and that form must be the standard credentialing form for physicians. The Department of Insurance also must prepare the standard credentialing form for all other providers. (R.C. 3963.05(A).)

The bill prohibits any contracting entity from doing either of the following (R.C. 3963.05(B) and (C)):

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

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

If a provider, upon the oral or written request of a contracting entity to submit a credentialing form, submits a credentialing form that is not complete, the contracting entity that receives the form must notify the provider of the deficiency electronically or by certified mail, return receipt requested, not later than 21 days after the contracting entity receives the form. If a contracting entity receives any

information that is inconsistent with the information given by the provider in the credentialing form, the contracting entity may request the provider to submit a written clarification of the inconsistency and must send this request electronically or by certified mail, return receipt requested. (R.C. 3963.06(A) and (B).)

The bill provides that the credentialing process starts when a provider initially submits a credentialing form upon the oral or written request of a contracting entity. Subject to the last sentence in this paragraph a contracting entity must complete the credentialing process not later than 90 days after the contracting entity receives that credentialing form from the provider. A contracting entity that does not complete the credentialing process within that 90-day period is liable for a civil penalty payable to the provider in the amount of \$500 per day, including weekend days, starting at the expiration of that 90-day period until the provider's application for the health care contract is granted or denied. The requirement that the credentialing process be completed within the 90-day period specified in this paragraph does not apply to a contracting entity if a provider that submits a credentialing form to the contracting entity under that division is a home medical equipment services provider, hospital, ambulatory surgery center, or medical transportation company. (R.C. 3963.06(C).)

Enrollee information; remittance notices

The bill requires that upon a participating provider's submission of an enrollee's name, the enrollee's relationship to the "primary enrollee," the enrollee's birth date, or the enrollee's social security number, each contracting entity shall make available information maintained in the ordinary course of business that is sufficient for the participating provider to determine at the time of the enrollee's visit all of the following: (1) the enrollee's identification number assigned by the contracting entity, (2) the birth date and gender of the primary enrollee, (3) the names, birth dates, and gender of all covered dependents, (4) the current enrollment and eligibility status of the enrollee, (5) whether a specific type or category of service is a covered benefit for the enrollee, (6) the enrollee's excluded benefits or limitations, whether group or individual, (7) the enrollee's copayment requirements, and (8) the unmet amount of the enrollee's deductible or the enrollee's financial responsibility. A contracting entity that maintains enrollee information in the ordinary course of business make must available the information described in this paragraph electronically or by an internet portal and must maintain the flexibility to determine the manner described in this paragraph by which the participating provider must access the information specified in this paragraph. The information required in this paragraph must include a statement to the effect that the information made available is not necessarily the final indication of the eligibility status of the enrollee due to changes that may have occurred prior to or after that date of which the contracting entity is unaware, and that the

information was obtained from sources that the contracting entity reasonably believes to be accurate. Any information specified in this paragraph that is provided in good faith by the contracting entity cannot be used in any enforcement action under R.C. Chapter 3963. The bill prohibits any contracting entity from directly or indirectly charging a participating provider any fee for the above information the contracting entity makes available.

Notwithstanding the above requirement for a contracting entity to make available the described information regarding an enrollee, a contracting entity is not permitted to make that information available to any person except to a participating provider or the participating provider's agent or to any person or governmental entity that is authorized under state and federal law to receive personally identifiable information concerning an enrollee or an enrollee's dependent.

A contracting entity is considered as having complied with the above provisions if the specified information is updated once a month and the date on which the information is updated is included with the information that is made available electronically or by internet portal. The above provisions take effect January 1, 2009. (R.C. 3963.07(A) and (C) and Section 4.)

The bill requires all remittance notices sent by a payer, whether written or electronic, to include both the name of the payer issuing the payment to the participating provider and the name of the contracting entity through which the payment rate and any discount are claimed if the contracting entity is different from the payer (R.C. 3963.07(B)).

Rules

The bill requires the Superintendent of Insurance to adopt any rules necessary for the implementation of R.C. Chapter 3963. (R.C. 3963.08).

Enforcement

The bill provides that a series of violations of R.C. Chapter 3963. by any person regulated by the Department of Insurance under R.C. Title XVII (Corporations and Partnerships) or R.C. Title XXXIX (Insurance) that, taken together, constitute a pattern or practice of violating R.C. Chapter 3963. may be defined as an unfair and deceptive insurance practice under R.C. 3901.19 to 3901.26.

The bill specifically authorizes the Superintendent of Insurance to conduct a market conduct examination of any person regulated by the Department of Insurance under R.C. Title XVII or R.C. Title XXXIX to determine whether any

violation of R.C. Chapter 3963. has occurred. When conducting that type of examination, the Superintendent may assess the costs of the examination against the person examined. The Superintendent may enter into a consent agreement to impose any administrative assessment or fine for conduct discovered that may be a violation of R.C. Chapter 3963. All costs, assessments, and fines collected under this provision must be deposited to the credit of the Department of Insurance Operating Fund. (R.C. 3963.09.)

Exclusions

The bill provides that R.C. Chapter 3963. does not apply with respect to any of the following (R.C. 3963.10)):

(1) Payments made to providers for rendering health care services to Medicaid recipients pursuant to the reimbursement system referred to by the Department of Job and Family Services as the fee-for-service system;

(2) Payments made to providers for rendering health care services to claimants pursuant to claims made under R.C. Chapter 4121. (Industrial Commission), 4123. (Workers' Compensation), 4127. (Public Works Relief Compensation), or 4131. (Separate Compensation Funds);

(3) Payments made to providers for rendering health care services to beneficiaries of the Medicare program established under Title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended;

(4) An exclusive contract between a health insuring corporation and a single group of providers in a specific geographic area to provide or arrange for the provision of health care services.

Prohibited contents of health insuring corporation contract with provider or health care facility

The current Health Insuring Corporation Law precludes any health insuring corporation contract with a provider or health care facility from containing provisions that do any of the following: (1) directly or indirectly offer an inducement to the provider or health care facility to reduce or limit medically necessary health care services to a covered enrollee, (2) penalize a provider or health care facility that assists an enrollee in seeking reconsideration of a health insuring corporation's decision to deny or limit benefits, (3) limit or otherwise restrict the provider's or health care facility's ethical and legal responsibility to fully advise enrollees about their medical condition and about medically appropriate treatment options, (4) penalize a provider or health care facility for principally advocating for medically necessary health care services, or (5) penalize

a provider or health care facility for providing information or testimony to a legislative or regulatory body or agency if the information or testimony is not libelous or slanderous or does not disclose trade secrets that the provider or health care facility has no privilege or permission to disclose. (R.C. 1751.13(D)(1)(a) to (e).)

The bill additionally precludes any health insuring corporation contract with a provider or health care facility from containing any provision that violates the bill's provisions (R.C. 1751.13(D)(1)(f)).

Applicability

The bill states that its provisions (R.C. 3963.01 to 3963.10) apply only to contracts that are delivered, issued for delivery, or renewed or modified in Ohio on or after the effective date of the act. A health insuring corporation having fewer than 15,000 enrollees must comply with the "provisions of this section" within 12 months after the act's effective date. (Section 3.)

Department of Job and Family Services functions

Existing law authorizes the Department of Job and Family Services (ODJFS) to enter into contracts with managed care organizations, including health insuring corporations, under which the organizations are authorized to provide, or arrange for the provision of, health care services to medical assistance recipients who are required or permitted to obtain health care services through managed care organizations as part of the care management system established under R.C. 5111.16. The bill requires ODJFS to allow managed care plans to use providers to render care upon completion of the managed care plan's credentialing process. (R.C. 5111.17(A) and (C).)

Joint Legislative Study Commission on Most Favored Nation Clauses in Health Care Contracts

Definitions

The bill defines the following terms for purposes of the Joint Legislative Study Commission on Most Favored Nation Clauses in Health Care Contracts that it creates (Section 5(A)):

"Most favored nation clause" means a provision in a health care contract that does any of the following:

(1) Prohibits, or grants a contracting entity an option to prohibit, the participating provider from contracting with another contracting entity to provide health care services at a lower price than the payment specified in the contract;

(2) Requires, or grants a contracting entity an option to require, the participating provider to accept a lower payment in the event the participating provider agrees to provide health care services to any other contracting entity at a lower price;

(3) Requires, or grants a contracting entity an option to require, termination or renegotiation of the existing health care contract in the event the participating provider agrees to provide health care services to any other contracting entity at a lower price;

(4) Requires the participating provider to disclose the participating provider's contractual reimbursement rates with other contracting entities.

"Contracting entity," "health care contract," "health care services," "participating provider," and "provider" have the same meanings as described above under "Definitions."

Moratorium

The bill precludes any health care contract that includes a most favored nation clause from being entered into, and precludes any health care contract from being amended, modified, or renewed at the instance of a contracting entity to include a most favored nation clause, for a period of two years after the effective date of the act, subject to extension as described below (Section 5(B)).

Composition; appointment; meetings

The bill creates the Joint Legislative Study Commission on Most Favored Nation Clauses in Health Care Contracts consisting of 15 members as follows: (1) the Superintendent of Insurance, (2) two members of the House of Representatives, one representing the majority party and one representing the minority party, (3) two members of the Senate, one representing the majority party and one representing the minority party, (4) three providers who are individuals, (5) two representatives of hospitals, (6) two representatives of contracting entities regulated by the Department of Insurance under R.C. Title XVII, (7) two representatives of contracting entities regulated by the Department of Insurance under R.C. Title XXXIX, and (8) one representative of an employer that pays for the health insurance coverage of its employees. (Section 6(A).)

The members of the Commission are appointed as follows (Section 6(B)):

(1) The Speaker of the House of Representatives appoints the two members of the House specified in (2) in the preceding paragraph.

(2) The President of the Senate appoints the two members of the Senate specified in (3) in the preceding paragraph.

(3) The Speaker of the House and the President of the Senate jointly appoint the remaining members specified in (4) to (8) in the preceding paragraph.

Initial appointments to the Commission must be made within 30 days after the effective date of the act. The appointments are for the term of the Commission as described below. Vacancies are to be filled in the same manner provided for original appointments. (Section 6(C).)

The Superintendent of Insurance is the Chairperson of the Commission. Meetings of the Commission are at the call of the Chairperson and must be held pursuant to R.C. 121.22 (Open Meetings Law). All of the members of the Commission are voting members. The Department of Insurance must provide office space or other facilities, any administrative or other technical, professional, or clerical employees, and any necessary supplies for the work of the Commission. The Chairperson must keep the records of the Commission. Upon submission of the Commission's final report to the General Assembly, the Chairperson must deliver all of the Commission's records to the General Assembly. (Section 6(D).)

Duties; report

The bill requires the Commission to study the following areas pertaining to health care contracts and authorizes the Commission to take testimony from experts or interested parties on the areas of study: (1) the procompetitive and anticompetitive aspects of most favored nation clauses, (2) the impact of most favored nation clauses on health care costs and on the availability of and accessibility to quality health care, (3) the costs associated with the enforcement of most favored nation clauses, (4) other state laws and rules pertaining to most favored nation clauses in their health care contracts, (5) matters determined by the Department of Insurance as relevant to the study of most favored nation clauses, and (6) any other matters that the Commission considers appropriate to determine the effectiveness of most favored nation clauses. (Section 6(E).)

Not less than 90 days prior to the expiration of the two-year period described above in "Moratorium," the Commission must report its preliminary findings to the General Assembly and a recommendation of whether to extend that two-year period for one additional year. If the General Assembly does not grant the extension, the Commission must submit its final report to the General Assembly not later than three months after the expiration of the two-year period. If the General Assembly grants the extension, the extension must be for not more than one year after the expiration of the two-year period, and the Commission must submit its final report to the General Assembly not later than six months

prior to the expiration of the one-year extension. The final report of the Commission must include its findings and recommendations on whether state law should prohibit or restrict most favored nation clauses in health care contracts. The Commission ceases to exist upon the submission of its final report to the General Assembly. (Section 6(F).)

COMMENT

1. R.C. 1751.01(O), not in the bill, defines "health insuring corporation" as a corporation that, pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services, supplemental health care services, or specialty health care services, or a combination of basic health care services and either supplemental health care services or specialty health care services, through either an "open panel plan" or a "closed panel plan" (see below).

"Health insuring corporation" does not include a limited liability company formed pursuant to R.C. Chapter 1705., *an insurer licensed under R.C. Title XXXIX (Insurance Law) if that insurer offers only open panel plans under which all providers and health care facilities participating receive their compensation directly from the insurer*, a corporation formed by or on behalf of a political subdivision or a department, office, or institution of the state, or a public entity formed by or on behalf of a board of county commissioners, a county board of mental retardation and developmental disabilities, an alcohol and drug addiction services board, a board of alcohol, drug addiction, and mental health services, or a community mental health board, as those terms are used in R.C. Chapters 340. and 5126.

"Closed panel plan" means a health care plan that requires enrollees to use participating providers. "Open panel plan" means a health care plan that provides incentives for enrollees to use participating providers and that also allows enrollees to use providers that are not participating providers. (R.C. 1751.01(E) and (S)(1), not in the bill.) No health insuring corporation may offer an open panel plan, unless the health insuring corporation is also licensed as an insurer under the Insurance Law, the health insuring corporation, on June 4, 1997, holds a certificate of authority or license to operate under R.C. Chapter 1736. or 1740. (both chapters have been repealed), or an insurer licensed under the Insurance Law is responsible for the out-of-network risk as evidenced by both an evidence of coverage filing under R.C. 1751.11 (evidence of subscriber's coverage for health care plan under which health care benefits are provided) and a policy and certificate filing under R.C. 3923.02 (sickness and accident insurance policy or certificate). (R.C. 1751.01(S)(2), not in the bill.)

2. "Policy of sickness and accident insurance" includes any policy, contract, or certificate of insurance against loss or expense resulting from the sickness of the insured or from bodily injury or death of the insured by accident, or both (R.C. 3923.01, not in the bill).

3. The provisions of the Physician-Health Plan Partnership Law addressing contractual issues generally: (a) require the Superintendent of Insurance to prescribe a standard credentialing form to be used by health insuring corporations in credentialing providers, (b) require a health insuring corporation to give participating providers an opportunity to take corrective action prior to terminating the provider's participation in the health insuring corporation, (c) prohibit the inclusion of certain provisions in a health insuring corporation's contract with a provider or health care facility, including "gag" clauses, and (d) require a health insuring corporation to make certain disclosures to participating providers and provider applicants.

4. R.C. 1751.01(A)(1) generally defines "basic health care services" as the following services when medically necessary: (a) physician's services, except when such services are supplemental as defined below, (b) inpatient hospital services, (c) outpatient medical services, (d) emergency health services, (e) urgent care services, (f) diagnostic laboratory services and diagnostic and therapeutic radiologic services, (g) diagnostic and treatment services, other than prescription drug services, for biologically based mental illnesses, and (h) preventive health care services, including, but not limited to, voluntary family planning services, infertility services, periodic physical examinations, prenatal obstetrical care, and well-child care. "Basic health care services" does not include experimental procedures.

5. The definition of "enrollee" in the bill includes all of the following: (a) "enrollee" and "subscriber" as defined in R.C. 1751.01(J) and (AA) ("enrollee" means any natural person who is entitled to receive health care benefits provided by a health insuring corporation; "subscriber" means a person who is responsible for making payments to a health insuring corporation for participation in a health care plan, or an enrollee whose employment or other status is the basis of eligibility for enrollment in a health insuring corporation), (b) "member" as defined by R.C. 1739.01(E) ("member" means an individual or an employer that is a member of an organization sponsoring a "multiple employer welfare arrangement," defined as an employee welfare benefit plan, trust, or any other arrangement, whether such plan, trust, or arrangement is subject to the "Employee Retirement Income Security Act of 1974," 29 U.S.C.A. 1001, that is established or maintained for the purpose of offering or providing, through group insurance or group self-insurance programs, medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, or death, to the employees,

and their dependents, of two or more employers, or to two or more self-employed individuals and their dependents (R.C. 1739.01(F))), (c) insured and plan member pursuant to R.C. Chapter 3923. (Sickness and Accident Insurance), (d) "beneficiary" as defined by R.C. 3901.38(A) ("beneficiary" means any policyholder, subscriber, member, employee, or other person who is eligible for benefits under a "benefits contract," which means a sickness and accident insurance policy providing hospital, surgical, or medical expense coverage, or a health insuring corporation contract or other policy or agreement under which a third-party payer agrees to reimburse for covered health care or dental services rendered to beneficiaries, up to the limits and exclusions contained in the benefits contract), and (e) claimant pursuant to R.C. Chapter 4121. (Industrial Commission; Bureau of Workers' Compensation), 4123. (Workers' Compensation), 4127. (Public Works Relief Compensation), or 4131. (Separate Compensation Funds).

6. R.C. 1751.01(B)(1) defines "supplemental health care services" as any health care services other than basic health care services that a health insuring corporation may offer, alone or in combination with either basic health care services or other supplemental health care services, and includes: (a) services of facilities for intermediate or long-term care, or both, (b) dental care services, (c) vision care and optometric services including lenses and frames, (d) podiatric care or foot care services, (e) mental health services, excluding diagnostic and treatment services for biologically based mental illnesses, (f) short-term outpatient evaluative and crisis-intervention mental health services, (g) medical or psychological treatment and referral services for alcohol and drug abuse or addiction, (h) home health services, (i) prescription drug services, (j) nursing services, (k) services of a dietitian licensed under R.C. Chapter 4759., (l) physical therapy services, (m) chiropractic services, and (n) any other category of services approved by the Superintendent of Insurance.

HISTORY

ACTION	DATE
Introduced	03-22-07
Reported, H. Civil & Commercial Law	10-09-07
Passed House (91-5)	10-09-07

h0125-ph-127.doc/kl

Attachment

SUMMARY DISCLOSURE FORM

- (1) Compensation terms
 - (a) Manner of payment
 - Fee for service
 - Capitation
 - Risk
 - Other _____ See _____
 - (b) Fee schedule available at _____
 - (c) Fee calculation schedule available at _____
 - (d) Identity of internal processing edits available at _____
 - (e) Information in (c) and (d) is not required if information in (b) is provided.
- (2) List of products or networks covered by this contract
 - _____
 - _____
 - _____
 - _____
 - _____
- (3) Term of this contract _____
- (4) Contracting entity or payer responsible for processing payment available at _____
- (5) Internal mechanism for resolving disputes regarding contract terms available at _____
- (6) Addenda to contract

	Title	Subject
(a)		
(b)		
(c)		
(d)		

IMPORTANT INFORMATION – PLEASE READ CAREFULLY

The information provided in this Summary Disclosure Form is a guide to the attached Health Care Contract as defined in section 3963.01(G) of the Ohio Revised Code. The terms and conditions of the attached Health Care Contract constitute the contract rights of the parties.

Reading this Summary Disclosure Form is not a substitute for reading the entire Health Care Contract. When you sign the Health Care Contract, you will be bound by its terms and conditions. These terms and conditions may be amended over time pursuant to section 3963.04 of the Ohio Revised Code. You are encouraged to read any proposed amendments that are sent to you after execution of the Health Care Contract.

Nothing in this Summary Disclosure Form creates any additional rights or causes of action in favor of either party.

