H.220

Introduced by Representatives Maier of Middlebury and Milkey of Brattleboro

Referred to Committee on

Date:

Subject: Health; health care providers; contract standards

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

An act relating to health care contract standards

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. 18 V.S.A. § 9412 is amended to read:

§ 9412. ENFORCEMENT

(a) In order to carry out the duties under this chapter, the commissioner, in addition to the powers provided in ~~8 V.S.A. § 72~~ this chapter and in Title 8, may examine the books, accounts, and papers of health insurers, health care providers ~~and~~, health care facilities, health plans, contracting entities, covered entities, and payers, as defined in section 9418 of this title and may administer

oaths and may issue subpoenas to a person to appear and testify or to produce documents or things.

* * *

Sec. 2. 18 V.S.A. § 9418 is amended to read:

§ 9418. PAYMENT FOR HEALTH CARE SERVICES

(a) As used in this ~~section,~~ subchapter:

(1) ~~"Health plan" means a health insurer, disability insurer, health maintenance organization, medical or hospital service corporation or a workers' compensation policy of a casualty insurer licensed to do business in Vermont. "Health plan" also includes a health plan that requires its medical groups, independent practice associations or other independent contractors to pay claims for the provision of health care services.~~ "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.

(2) "Claim" means any claim, bill or request for payment for all or any portion of provided health care services that is submitted by:

(A) A health care provider or a health care facility pursuant to a contract or agreement with the health plan; or

(B) A health care provider, a health care facility or a patient covered by the health plan.

(3) ~~"Contest"~~ "Contested claim" means ~~the circumstance in which the health plan was not provided with~~ a claim submitted to a payer, health plan, or contracting entity that does not include:

(A) Sufficient information needed to determine payer liability; or

(B) Reasonable access to information needed to determine the liability or basis for payment of the claim.

(4) "Contracting entity" means any entity that contracts directly or indirectly with a health care provider for either the delivery of health care services or the selling, leasing, renting, assigning, or granting of access to a contract or terms of a contract. For purposes of this subchapter, the office of Vermont health access, health care providers, physician hospital organizations, health care facilities, and stand-alone dental plans are not contracting entities.

(5)(A) "Covered entity" or "third party" means an entity that has not contracted directly with a health care provider, but that buys, leases, rents, is assigned, or accesses a health care contract or the terms of a health care contract to gain access to a provider network, and includes entities that are responsible for:

(i) the payment or coordination of health care services; or

(ii) the establishment or extension of health care provider networks.

(B) For purposes of this subchapter, the office of Vermont health access is not a covered entity.

~~(4)~~(6) "Denied" or "denial" means the circumstance in which the plan asserts that it has no liability to pay a claim, based on eligibility status of the patient, coverage of a service under the health plan, medical necessity of a service, liability of another payer, or other grounds.

(7) "Edit" or "editing" means a practice or procedure pursuant to which one or more adjustments are made to Current Procedural Terminology (CPT) codes, American Society of Anesthesiologists' (ASA) current procedural terminology, the American Dental Association's (ADA) current dental terminology, or Healthcare Common Procedure Coding System (HCPCS) Level II codes included in a claim that result in:

(A) Payment being made based on some, but not all, of the codes originally billed by a participating health care provider;

(B) Payment being made based on different codes from those originally billed by a participating health care provider;

(C) Payment for one or more of the codes included in the claim originally billed by a participating health care provider being reduced by application of payer's editing software, such as multiple procedure logic software;

(D) Payment for one or more of the codes being denied;

(E) A reduced payment as a result of services provided to an insured that are claimed under more than one procedure code on the same service date; or

(F) Any combination of the subdivisions in this subdivision (7).

(8) "Health care contract" or "contract" means a contract entered into, amended, or renewed between a contracting entity or health plan and a health care provider specifying the rights and responsibilities of the contracting entity and provider for the delivery of health care services to insureds, including primary care health services, preventive health services, chronic care services, and specialty health care services.

(9) "Health plan" means a health insurer, disability insurer, health maintenance organization, medical or hospital service corporation, a workers' compensation policy of a casualty insurer licensed to do business in Vermont, and, to the extent permitted under federal law, any administrator of an insured or self-insured plan. "Health plan" also includes a health plan that requires its medical groups, independent practice associations, or other independent contractors to pay claims for the provision of health care services.

(10) "Health care provider" or "provider" means a person, partnership, or corporation licensed, certified, or otherwise authorized by law to provide professional health care services in this state and shall include a health care provider group, network, independent practice association, or physician

hospital organization that is acting exclusively as an administrator on behalf of a health care provider to facilitate the provider's participation in health care contracts. The term includes a hospital but does not include a pharmacist, pharmacy, nursing home, or a health care provider organization or physician hospital organization that leases its network to a third party or contracts directly with employers or self-insured plans.

(11) "Insured" means any person eligible for health care benefits under a health benefit plan, including an eligible recipient of Medicaid, and includes all of the following terms: enrollee, subscriber, member, insured, dependent, covered individual, and beneficiary.

(12) "Most favored nation clause" means a provision in a health care contract that:

(A) Prohibits, or grants a contracting entity an option to prohibit, a participating provider who contracts with another contracting entity from accepting lower payment for the provision of health care services than the payment specified in the first contracting entity's contract.

(B) 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 for any other contracting entity at a lower price.

(C) 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 for any other contracting entity at a lower price.

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

(13) "National Correct Coding Initiative," or "NCCI" means the Centers for Medicare and Medicaid Services' (CMS) published list of edits and adjustments that are made to health care providers' claims submitted for services or supplies provided to patients insured under the federal Medicare program and other federal insurance programs.

(14) "Participating provider" means a health care provider that has a health care contract with a contracting entity and is entitled to reimbursement for health care services rendered to an insured under the health care contract. The term includes a hospital, but does not include a pharmacist, pharmacy, or nursing home, or a health care practitioner organization or physician-hospital organization that leases the health care practitioner organization's or physician-hospital organization's network to a third party or contracts directly with employers or self-insured plans.

(15) "Payer" means any person or entity that assumes the financial risk for the payment of claims under a health care contract or the reimbursement for

health care services rendered to an insured by a participating provider under the health care contract. The term "payer" does not include:

(A) the office of Vermont health access; or

(B) reinsurers that neither pay claims directly nor act as contracting entities.

(16) "Procedure codes" means a set of descriptive codes indicating the procedure performed by a health care provider and includes the American Medical Association's Current Procedural Terminology codes (CPT), the Healthcare Common Procedure Coding System Level II Codes (HCPCS), the American Society of Anesthesiologists' (ASA) current procedural terminology, and the American Dental Association's current dental terminology.

(17) "Product" means, to the extent permitted by state and federal law, one of the following types of categories of coverage for which a participating provider may be obligated to provide health care services pursuant to a health care contract:

(A) Health maintenance organization;

(B) Preferred provider organization;

(C) Fee-for-service or indemnity plan;

(D) Medicare Advantage HMO plan;

(E) Medicare Advantage private fee-for-service plan;

(F) Medicare Advantage special needs plan;

(G) Medicare Advantage PPO;

(H) Medicare supplement plan;

(I) Workers compensation plan;

(J) Medicaid, the Vermont health access plan (VHAP), or Dr. Dynasaur;

(K) the state children's health insurance plan (SCHIP);

(L) Catamount Health; or

(M) any other commercial health coverage plan or product.

(b) No later than ~~45~~ 30 days following receipt of a claim, a health plan, contracting entity, or payer shall do one of the following:

(1) Pay or reimburse the claim.

(2) Notify the claimant in writing that the claim is contested or denied. The notice shall include specific reasons supporting the contest or denial and a description of any additional information required for the health plan, contracting entity, or payer to determine liability for the claim.

(c) ~~If the claim submitted is to a health plan that is a workers' compensation insurance policy,~~

~~(1) The health plan shall within 45 days following receipt of the claim:~~

~~(A) pay or reimburse the claim; or~~

~~(B) notify in writing the claimant and the commissioner of labor that the claim is contested or denied. The notice shall include specific reasons supporting the contest or denial and a description of any additional information required for the health plan to determine liability for the claim.~~

~~(2) Disputes regarding any claims under this subsection shall be resolved pursuant to the provisions of chapters 9 and 11 of Title 21.~~

~~(3) The commissioner of labor may assess interest and penalties as provided in subsections (e) and (f) of this section against a health plan that fails to comply with the provisions of this section or any order of the commissioner. These remedies are in addition to any other penalties available under Title 8 and chapters 9 and 11 of Title 21.~~

~~(d)~~ If a claim is contested because the health plan, contracting entity, or payer was not provided with sufficient information to determine payer liability and for which written notice has been provided as required by subdivision (b)(2) of this section, then the health plan shall have ~~45~~ 30 days after receipt of the additional information to complete consideration of the claim.

(d) A health plan, contracting entity or payer shall acknowledge receipt of an electronic claim to the submitting party within 24 hours after the beginning of the next business day following receipt of the claim. For purposes of this section, the term “submitting party” means:

(1) a health care provider or insured submitting a claim to a contracting entity, health plan, or payer; or

(2) a clearinghouse submitting a claim on behalf of a health care provider to a contracting entity, health plan, or payer.

(e) Interest shall accrue on a claim at the rate of 12 percent per annum calculated as follows:

(1) For a claim that is uncontested, from the first calendar day following the ~~45-day~~ 30-day period following the date the claim is received by the health plan, contracting entity, or payer.

(2) For a nonelectronic contested claim~~,~~ for which notice was provided as required by subdivision (b)(2) of this section, or for an electronic contested claim for which notice and acknowledgment were provided as required in subdivision (b)(2) and subsection (c) of this section, from the first calendar day after the ~~45-day~~ 30-day period following the date that sufficient additional information is received.

(3) For a nonelectronic contested claim for which notice was not provided as required by subdivision (b)(2) of this section or for which notice was provided later than the ~~45~~ 30 days required by subdivision (b)(2) of this section, from the first calendar day after the ~~45-day~~ 30-day period following the date the original claim was received by the health plan, contracting entity, or payer.

(4) For a contested electronic claim, for which notice and acknowledgment were not provided as required by subdivision (b)(2) and subsection (c) of this section, or for which notice or acknowledgment were provided later than the time required by subdivision (b)(2) and subsection (c) of this section, from the first calendar day after the 30-day period following the date the original claim was received by the health plan, contracting entity, or payer.

(5) For a claim that was denied or for which notice of denial was provided as required by subdivision (b)(2) of this section, from the first calendar day after the ~~45-day~~ 30-day period following the date of a final arbitration award, judgment, or administrative order that found a plan, contracting entity, or payer to be liable for payment of the claim.

(6) For a claim that was denied, for which notice of denial was not provided as required by subdivision (b)(2) of this section, or for which notice was provided later than the 30 days required by subdivision (b)(2) of this section, from the first calendar day after the 30-day period following the date the original claim was received by the health plan, contracting entity, or payer.

(f) The commissioner may suspend the accrual of interest under subsection (e) of this section if the commissioner determines that the health plan's failure to pay a claim within the applicable time limit is the result of a major disaster,

act-of-God or unanticipated major computer system failure or that the action is necessary to protect the solvency of the health plan.

(g) All payments shall be made within the time periods provided by this section unless otherwise specified in the contract between the health plan and the health care provider or the health care facility. The health plan shall provide notice as required by subsection (b) of this section and pay interest on uncontested and contested claims as required in subsection ~~(d)~~ (e) of this section from the day following the contract payment period, unless otherwise specified in the contract.

(h) ~~Any dispute concerning payment of a claim or interest on a claim, arising out of or relating to the provisions of this section shall, at the option of either party, be settled by arbitration in accordance with the Commercial Rules of the American Arbitration Association, and judgment upon the arbitrator's award may be entered in any court having jurisdiction.~~

~~(i) In addition to any other remedy provided by law, if the commissioner finds that a health plan has engaged in a pattern and practice of violating this section, the commissioner may impose an administrative penalty against the health plan of no more than $500.00 for each violation, and may order the health plan to cease and desist from further violations and order the health plan to remediate the violation. In determining the amount of penalty to be assessed, the commissioner shall consider the following factors:~~

~~(1) The appropriateness of the penalty with respect to the financial resources and good faith of the health plan.~~

~~(2) The gravity of the violation or practice.~~

~~(3) The history of previous violations or practices of a similar nature.~~

~~(4) The economic benefit derived by the health plan and the economic impact on the health care facility or health care provider resulting from the violation.~~

~~(5) Any other relevant factors.~~

~~(j)~~ A health plan in this state shall not impose on any provider any retrospective denial of a previously paid claim or any part of that previously paid claim, unless:

(1) The health plan has provided at least 30 days' notice of any retrospective denial or overpayment recovery or both in writing to the provider. The notice must include:

(A) the patient's name;

(B) the service date;

(C) the payment amount;

(D) the proposed adjustment; and

(E) a reasonably specific explanation of the proposed adjustment.

(2) The time that has elapsed since the date of payment of the previously paid claim does not exceed 12 months.

~~(k)~~(i) The retrospective denial of a previously paid claim shall be permitted beyond 12 months from the date of payment for any of the following reasons:

(1) The plan has a reasonable belief that fraud or other intentional misconduct has occurred;

(2) The claim payment was incorrect because the provider of the insured was already paid for the health services identified in the claim;

(3) The health care services identified in the claim were not delivered by the provider;

(4) The claim payment is the subject of adjustment with another health insurer; or

(5) The claim payment is the subject of legal action.

~~(l)~~(j) Notwithstanding this section, a health plan may not retroactively deny or recoup a pharmacy point-of-sale payment except in the circumstances of fraud, intentional misconduct, a member not receiving the prescription, or error in the processing of the claim.

~~(m)~~(k) Nothing in this section shall be construed to prohibit a health plan from applying payment policies that are consistent with applicable federal or state laws and regulations, or to relieve a health plan from complying with payment standards established by federal or state laws and regulations, including rules adopted by the commissioner pursuant to section 9408 of this title relating to claims administration and adjudication standards, and rules

adopted by the commissioner pursuant to section 9414 of this title and section 4088f of Title 8 relating to pay for performance or other payment methodology standards.

~~(n)~~(l) The provisions of this section shall not apply to stand-alone dental plans or to a workers' compensation policy of a casualty insurer licensed to do business in Vermont.

Sec. 3. 18 V.S.A. § 9418a is amended to read:

§ 9418a. PROCESSING CLAIMS, DOWNCODING, AND ADHERENCE TO CODING RULES

* * *

(b) Health plans, contracting entities, covered entities, and payers shall accept and initiate the processing of all health care claims submitted by a health care provider pursuant to and consistent with the current version of the American Medical Association's ~~current procedural terminology~~ Current Procedural Terminology (CPT) codes, reporting guidelines, and conventions; the Centers for Medicare and Medicaid Services ~~health care common procedure coding system~~ Healthcare Common Procedure Coding System (HCPCS); American Society of Anesthesiologists; the National Correct Coding Initiative (NCCI); the National Council for Prescription Drug Programs coding; or other appropriate standards, guidelines, or conventions approved by the commissioner.

(c) When editing claims, health plans, contracting entities, covered entities, and payers shall adhere to edit standards that are no more restrictive than the following, except as provided in subsection (d) of this section:

(1) The CPT, HCPCS, and NCCI;

(2) National specialty society edit standards; or

(3) Other appropriate edit standards, guidelines, or conventions approved by the commissioner.

(d) Adherence to the edit standards in subdivision (c)(1) or (2) of this section is not required:

(1) When necessary to comply with state or federal laws, rules, regulations, or coverage mandates; or

(2) For services not addressed by NCCI standards or national specialty society edit standards.

~~(c)~~(e) Nothing in this section shall preclude a health plan, contracting entity, covered entity, or payer from determining that any such claim is not eligible for payment in full or in part, based on a determination that:

(1) The claim is contested as defined in subdivision 9418(a)(3) of this title;

(2) The service provided is not a covered benefit under the contract, including a determination that such service is not medically necessary or is experimental or investigational;

(3) The insured did not obtain a referral, prior authorization, or precertification, or satisfy any other condition precedent to receiving covered benefits from the health care provider;

(4) The covered benefit exceeds the benefit limits of the contract;

(5) The person is not eligible for coverage or is otherwise not compliant with the terms and conditions of his or her coverage agreement;

(6) The health plan has a reasonable belief that fraud or other intentional misconduct has occurred; or

(7) The health plan, contracting entity, covered entity, or payer determines through coordination of benefits that another health ~~insurer~~ entity is liable for the claim.

~~(d)~~(f) Nothing in this section shall be deemed to require a health plan, contracting entity, covered entity, or payer to pay or reimburse a claim, in full or in part, or to dictate the amount of a claim to be paid by a health plan, contracting entity, covered entity, or payer to a health care provider.

~~(e)~~(g) No health plan, contracting entity, covered entity, or payer shall automatically reassign or reduce the code level of evaluation and management codes billed for covered services (downcoding), except that a health plan, contracting entity, covered entity, or payer may reassign a new patient visit code to an established patient visit code based solely on CPT codes, CPT guidelines, and CPT conventions.

~~(f)~~(h) Notwithstanding the provisions of subsection ~~(c)~~(e) of this section, and other than the edits contained in the conventions in ~~subsection (b)~~ subsections (b) and (c) of this section, health plans, contracting entities, covered entities, and payers shall continue to have the right to deny, pend, or adjust claims for covered services on other bases and shall have the right to reassign or reduce the code level for selected claims for covered services based on a review of the clinical information provided at the time the service was rendered for the particular claim or a review of the information derived from a health plan's fraud or abuse billing detection programs that create a reasonable belief of fraudulent or abusive billing practices, provided that the decision to reassign or reduce is based primarily on a review of clinical information.

~~(g)~~(i) Every health plan, contracting entity, covered entity, and payer shall publish on its provider website and in its provider newsletter ~~the~~:

(1) The name of the commercially available claims editing software product that the health plan, contracting entity, covered entity, or payer utilizes;

(2) The standard or standards, pursuant to subsection (c) of this section, that the entity uses for claim edits;

(3) The payment percentages for modifiers; and

(4) ~~any~~ Any significant proprietary edits, as determined by the health plan, contracting entity, covered entity, or payer, added to the claims software

product after the effective date of this section, which are made at the request of the health plan, contracting entity, covered entity, or payer.

(j) ~~The~~ Upon written request, the health plan, contracting entity, covered entity, or payer shall also directly provide ~~such~~ the information ~~upon written request of~~ in subsection (i) of this section to a health care provider who is a participating member in the health plan's, contracting entity's, covered entity's, or payer's provider network.

~~(h) In addition to any other remedy provided by law, if the commissioner finds that a health plan has engaged in a pattern and practice of violating this section, the commissioner may impose an administrative penalty against the health plan of no more than $500.00 for each violation, and may order the health plan to cease and desist from further violations and order the health plan to remediate the violation. In determining the amount of penalty to be assessed, the commissioner shall consider the following factors:~~

~~(1) The appropriateness of the penalty with respect to the financial resources and good faith of the health plan.~~

~~(2) The gravity of the violation or practice.~~

~~(3) The history of previous violations or practices of a similar nature.~~

~~(4) The economic benefit derived by the health plan and the economic impact on the health care facility or health care provider resulting from the violation.~~

~~(5) Any other relevant factors.~~

~~(i) Nothing in this section shall be construed to prohibit a health plan from applying payment policies that are consistent with applicable federal or state laws and regulations, or to relieve a health plan from complying with payment standards established by federal or state laws and regulations, including rules adopted by the commissioner pursuant to section 9408 of this title relating to claims administration and adjudication standards, and rules adopted by the commissioner pursuant to section 9414 of this title and section 4088f of Title 8 relating to pay for performance or other payment methodology standards.~~

Sec. 4. 18 V.S.A. § 9418c is added to read:

§ 9418c. FAIR CONTRACT STANDARDS

(a) Required information.

(1) Each contracting entity shall provide and each health care contract shall obligate the contracting entity to provide participating health care providers information sufficient for the participating provider to determine the compensation or payment terms for health care services, including all of the following:

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

(B) On request, the fee-for-service dollar amount allowable for each CPT code for those CPT codes that a provider in the same specialty typically

uses or that the requesting provider actually bills. Fee schedule information may be provided by CD-ROM or electronically, at the election of the contracting entity, but a provider may elect to receive a hard copy of the fee schedule information instead of the CD-ROM or electronic version.

(C) A clearly understandable, readily available mechanism, such as a specific website address, that includes the following information:

(i) the name of the commercially available claims editing software product that the health plan, contracting entity, covered entity, or payer uses;

(ii) the standard or standards from subsection 9418a(c) of this title that the entity uses for claim edits;

(iii) payment percentages for modifiers; and

(iv) any significant proprietary edits, as determined by the health plan, contracting entity, covered entity, or payer, added to the claims software product, which are made at the request of the health plan, contracting entity, covered entity, or payer, and which have been approved by the commissioner pursuant to subsection 9418a(b) or (c) of this title.

(2) Contracting entities shall provide the information described in subdivisions (a)(1)(A) and (B) of this section to health care providers who are actively engaged in the process of determining whether to become a participating provider in the contracting entity's network.

(3) Contracting entities may require health care providers to execute written confidentiality agreements with respect to fee schedule and claim edit information received from contracting entities.

(4) Each health care contract shall include the following information:

(A) Any product, company, or network for which the participating provider has agreed to provide services;

(B) For each product or network, reimbursement terms and methodologies, unless the terms are identical for multiple products or networks;

(C) The term of the health care contract;

(D) Termination notice period and reasons for termination;

(E) Language that identifies the contracting entity or payer responsible for the processing of the participating provider's compensation or payment, including contact information, including telephone, fax, and e-mail. This requirement may be satisfied by providing a specific web address that contains the necessary information.

(F) 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 website address or an appendix, that allows a participating provider to determine the procedures for the internal mechanism to resolve those disputes.

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

(b) Summary disclosure form.

(1) Each contracting entity shall include a summary disclosure form with a health care contract that includes all of the information specified in subsection (a) of this section. The information in the summary disclosure form shall refer to the location in the health care contract, whether a page number, section of the contract, appendix, or other identifier, that specifies the provisions in the contract to which the information in the form refers.

(2) The summary disclosure form shall include all of the following information:

(A) That the form is merely a guide to the health care contract and that the terms and conditions of the health care contract constitute the actual contract rights of the parties.

(B) That reading the form is not a substitute for reading the entire health care contract.

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

(D) That the terms and conditions of the health care contract may be amended pursuant to section 9418d of this title, and the participating provider

is encouraged to carefully read any proposed amendments sent after execution of the contract.

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

(3) No contracting entity that includes any information in the summary disclosure form with the reasonable belief that the information is truthful or accurate shall be subject to a civil action for damages or to binding arbitration based on information included in the summary disclosure form. Inclusion of intentional misstatements or intentional misrepresentations in the summary disclosure form shall be considered a violation of this chapter subject to enforcement under section 9418h of this title. This section does not impair or affect any power of the department of banking, insurance, securities, and health care administration to enforce any applicable law.

(4) The summary disclosure form described in subdivisions (1) and (2) of this subsection shall be in substantially the following form:

"SUMMARY DISCLOSURE FORM

Compensation terms

Manner of payment:

[ ] Fee for service

[ ] Capitation

[ ] Risk

[ ] Other ..... See .....

Reimbursement schedule available at ……

Claim edit information available at …….

List of products or networks covered by this contract (fill in names as applicable):

[ ] .....

[ ] .....

[ ] .....

[ ] .....

[ ] .....

Term of this contract ……

Termination notice period …….

Contracting entity, covered entity, or payer responsible for processing payment available at ……

Internal mechanism for resolving disputes regarding contract terms available at …….

Addenda to contract (list addenda, if any)

Telephone number to access a readily available mechanism, such as a specific website address, to allow a participating provider to receive the information listed above from the payer: ……

Rental network information

……

……

IMPORTANT INFORMATION - PLEASE READ CAREFULLY

The information provided in this Summary Disclosure Form is a guide to the attached Health Care Contract. 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 18 V.S.A. § 9418d. 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."

(5) Upon request, contracting entities shall provide the summary disclosure form to a participating provider or a provider who is actively engaged in the process of determining whether to become a participating provider within 60 days of the request.

(c) When a contracting entity presents a proposed health care contract for consideration by a provider, the contracting entity shall provide in writing or

make reasonably available the information required in subdivision (a)(1) of this section.

(d) Upon request, the contracting entity shall identify any utilization management, quality improvement, price or quality transparency program, or a similar program that the contracting entity uses to review, monitor, evaluate, or assess the services provided pursuant to a health care contract. The contracting entity shall disclose the policies, procedures, or guidelines of such a program upon request by the participating provider who is subject to or is participating in the program within 14 days after the date of the request.

(e) The requirements of subdivision (b)(5) of this section do not prohibit a contracting entity from requiring a reasonable confidentiality agreement between the provider and the contracting entity regarding the terms of the proposed health care contract. If either party violates the confidentiality agreement, a party to the confidentiality agreement may bring a civil action to enjoin the other party from continuing any act that is in violation of the confidentiality agreement, to recover damages, to terminate the contract, or to obtain any combination of relief.

Sec. 5. 18 V.S.A. § 9418d is added to read:

§ 9418d. CONTRACT AMENDMENTS

(a) A health care contract may be amended by mutual agreement of the parties.

(b) Absent mutual agreement of the parties, a health care contract may be amended only as follows:

(1) The contracting entity shall provide to the participating provider notice of the amendment and the amendment in writing not later than 60 days prior to the effective date of the amendment. The notice shall be conspicuously entitled "Notice of Amendment to Contract" and shall include a summary of the amendment as described in subdivision (4) of this subsection. The notice period may be extended by mutual agreement of the parties.

(2) The participating provider shall have 60 days after receiving the amendment, notice, and summary pursuant to subdivision (1) of this subsection to object, in writing, to the proposed amendment. If the participating provider objects to the amendment and there is no resolution of the objection within 60 days following the contracting entity's receipt of the written objection, either party may terminate the contract upon written notice of termination provided to the other party. Termination shall become effective in the time period specified in the health care contract. If no termination period is specified in the health care contract, the termination shall become effective 90 days after the notice of termination is provided. The terms of the underlying contract shall remain in effect through the termination period and shall be unaffected by the proposed amendment.

(3) If the participating provider does not object to the amendment in the manner specified in subdivision (2) of this subsection, the amendment shall be effective as specified in the notice described in subdivision (1) of this subsection; provided, however, that if the amendment is the addition of a new product and the health care provider objects to the amendment, the addition shall not be effective as to that health care provider, and the objection shall not be a basis upon which the contracting entity may terminate the contract.

(4) The notice of amendment shall include a summary cover sheet that shall include the following information:

(A) a brief explanation of the amendment;

(B) the date the amendment will become effective;

(C) a notice of right to object in writing to the amendment;

(D) the time frame for objection;

(E) the address to send an objection;

(F) Contact information for the person to call to discuss the amendment for further information, or to resolve an objection;

(G) the effect of an objection;

(H) the right to terminate the contract if the objection is not resolved;

(I) the time period for the effective date of any such termination; and

(J) the address to send a notice of termination.

(c) Subsection (b) of this section shall not apply in the following circumstances:

(1) The delay caused by compliance with the 60-day notice period in subdivision (b)(1) of this section could result in imminent harm to an insured.

(2) The amendment of a health care contract is required by a state or federal law, rule, or regulation that includes an effective date for the amendment.

(3) The provider affirmatively accepts the amendment in writing and agrees to an earlier effective date than that specified in the notice required by subdivision (b)(1) of this section.

(4) The participating provider's payment or compensation is based on the current Medicaid or Medicare physician reimbursement schedule, and the amendment reflects a change in payment or compensation resulting solely from a change in that physician reimbursement schedule.

(5) The amendment is a routine change or update of the health care contract made in response to any addition, deletion, or revision of any service code, procedure code, or reporting code, or a pricing change is made by a third party source. For purposes of this subdivision.

(A) "Service code, procedure code, or reporting code" means the American Medical Association's Current Procedural Terminology, the American Dental Association's Current Dental Terminology, the Centers for

Medicare and Medicaid Services' Healthcare Common Procedure Coding System, the World Health Organization's International Classification of Diseases, or the Drug Topics Red Book average wholesale price; and

(B) "Third party source" means the American Medical Association; the American Society of Anesthesiologists; the American Dental Association; the Centers for Medicare and Medicaid Services; the National Center for Health Statistics; the U.S. Department of Health and Human Services Office of the Inspector General; the Vermont department of banking, insurance, securities, and health care administration; or the Vermont agency of human services.

(d) Notwithstanding subsections (a), (b) and (c) of this section, a health care contract may be amended by operation of law as required by any applicable state or federal law, rule, or regulation.

(e) Subsection (b) of this section shall not apply to amendments of health care contracts with hospitals.

Sec. 6. 18 V.S.A. § 9418e is added to read:

§ 9418e. MOST FAVORED NATION CLAUSES PROHIBITED

No later than 180 days after the effective date of this section, no contracting entity shall do any of the following:

(1) Offer to a provider or hospital a health care contract that includes a most favored nation clause;

(2) Enter into a health care contract with a provider or hospital that includes a most favored nation clause; or

(3) Amend an existing health care contract previously entered into with a provider or hospital to include a most favored nation clause.

Sec. 7. 18 V.S.A. § 9418f is added to read:

§ 9418f. RENTAL NETWORKS

(a) Registration. The commissioner of banking, insurance, securities, and health care administration shall establish a registration process for all contracting entities not otherwise licensed by the commissioner, and shall have jurisdiction to oversee compliance of contracting entities and covered entities with the provisions of this subchapter. The commissioner may adopt rules for the collection of a reasonable fee for the purpose of administering the registration process.

(b) Contracts. A contracting entity's health care contract shall:

(1) State that entities that are not authorized by subdivision (c)(1) of this section may not apply or transfer rights under a health care contract, or the terms of a health care contract including a health care provider's reimbursement rate under an agreement with a contracting entity.

(2) State the following in clear terms in the body of the health care contract or amendment if the contract authorizes renting, leasing or otherwise providing access to the provider's services:

(A) That a purpose of the contract or amendment is to rent or lease the provider network to other preferred provider networks, payers, and other covered entities.

(B) That Vermont laws and regulations applicable to such rental, lease, or other access will apply to the contract or amendment.

(C) That health care providers who believe that the contract or amendment terms are being inappropriately applied will have access to the enforcement process identified in this subchapter and all applicable state remedies.

(3) Ensure that all covered entities to which the contracting entity has sold, rented, assigned, or otherwise given access to the health care provider's discounted rate comply with all terms of the health care contract, including all requirements designed to encourage patient access to the contracted health care provider and requirements to pay the health care provider pursuant to the rates of payment and methodology set forth in that contract without further reduction.

(4) Require the contracting entity to obligate any covered entity through contract to not further sell, rent, or give its right to access the health care provider's discounted rate to any other entity, unless such entity is specifically approved by the contracting entity and complies with all requirements of this subchapter.

(5) Require that upon termination of the contracting entity's health care contract, the contracting entity shall notify each covered entity that it must immediately cease taking the health care provider's discounted rate or exercising any other contractual right.

(c) Sale, lease, rental, or gift to third party.

(1) No contracting entity shall sell, lease, rent, or give a third party access to the contracting 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:

(A) The covered entity 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 for services provided pursuant to the health care contract with the participating provider.

(B) The health care contract expressly states that it applies to network rental arrangements and further states that one purpose of the contract is selling, renting, or giving the contracting entity's rights under the health care contract, and the covered entity accessing the participating provider's services is any of the following:

(i) a payer or a third-party administrator or other entity responsible for administering claims on behalf of the payer;

(ii) a covered entity that receives access to the participating provider's services pursuant to an arrangement with the contracting entity, provided that the covered entity complies with all of the terms, conditions, and affirmative obligations to which the original contracting entity is bound under its contract with the participating provider, including obligations concerning patient steerage and the prompt payment requirements of section 9418 of this title, compliance with state and federal laws, and reimbursement terms specified by the participating providers' contract with the contracting entity.

(iii) an entity that is engaged in the business of providing electronic claims transport between the contracting entity and the payer or third-party administrator and complies with all of the applicable terms, conditions, and affirmative obligations of the contracting entity's contract with the participating provider, including obligations concerning patient steerage and the prompt payment requirements of section 9418 of this title, compliance with state and federal laws, and reimbursement terms specified by the participating providers' contract with the contracting entity.

(2) A contracting entity that sells, leases, rents, gives, or otherwise grants access to its rights to the participating provider's services pursuant to

the contracting entity's health care contract with the participating provider as provided in this section shall do all of the following:

(A) Maintain a web page that is updated at least monthly, is accessible to all participating providers, and contains a listing of covered entities described in subdivisions (1)(B) and (C) of this subsection with whom the contracting entity contracts for the purpose of selling, renting, or giving the contracting entity's rights to the services of 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.

(B) Where the contracting entity or covered entity issues member or subscriber identification cards, the cards shall identify, in a clear and legible manner, the entity responsible for paying claims and the contracting entity whose contracts with the health care providers control the reimbursement for claims pursuant to the subscriber contract.

(C) Require that any covered entity accessing the participating provider's services through the participating provider's health care contract with a contracting entity is obligated to comply with all of the applicable terms and conditions of the contract, including the products for which the participating provider has agreed to provide services, except that a payer receiving administrative services from the contracting entity or its affiliate shall be solely responsible for payment to the participating provider under the

direct and specific oversight of the contracting entity, including accuracy of reimbursement and problem resolution.

(3) Information provided to health care providers by contracting entities, covered entities, and their agents, including eligibility verification information, prior authorization information, and payment information, shall be binding on all contracting entities, covered entities, their affiliates, and their agents.

(4) Each contracting entity or covered entity shall include in each response to an eligibility verification request the name of the contracting entity through which the reimbursement for the claim will be made.

(5) On and after January 1, 2010, all remittance advices, whether written or electronic, shall clearly identify the following:

(A) The name of the covered entity responsible for payment to the health care provider; and

(B) The name of the contracting entity through which the payment rate and any discounts are claimed.

(6) Subject to any applicable continuity of care requirements, agreements, or contractual provisions with a health care provider, a covered entity's right to exercise a contracting entity's rights and responsibilities under a contract with a health care provider shall terminate on the date such contracting entity's contract with such participating provider is terminated.

(7) A contracting entity shall establish a process for participating providers to use to communicate violations of this section. Within 30 days following receipt of information from a participating health care provider that a covered entity is not complying with the terms of the underlying contract; has violated this section; has failed to comply with timely payment requirements; has further rented, sold, or given its right to a physician's discounted rates to other entities in violation of subdivision (b)(4) of this section; or has continued to exercise contract rights and discount after termination of the contracting entity's contract with the participating provider, the contracting entity shall do at least one of the following:

(A) Ensure that the covered entity corrects the violation, complies with the terms of the underlying contract, and causes correct payment to be made; or

(B) Terminate the contracting entity's arrangement with the covered entity.

(d) The provisions of this section shall not apply in circumstances where access to the provider network is granted to an entity operating under the same brand licensee program as the contracting entity.

Sec. 8. 18 V.S.A. § 9418g is added to read:

§ 9418g. ALL PRODUCT CLAUSES

(a)(1) No contracting entity shall require, as a condition of entering into a contract with it, that a participating provider provide services for all of the products offered by the contracting entity.

(2) Subdivision (1) of this subsection shall not be construed to do either of the following:

(A) Prohibit any participating provider from voluntarily accepting an offer by a contracting entity to provide health care services under all of the contracting entity's products; or

(B) 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 all of the contracting entity's products.

(b)(1) A participating provider may decline to participate in products on an annual basis and at any time that a new product is introduced.

(2) If a participating provider refuses to accept any future product offering that the contracting entity makes, the addition of the future product shall not be effective as to the health care provider, and the refusal shall not be a basis upon which the contracting entity may terminate the contract.

(3) Notwithstanding the provisions of subdivision (a)(2) of this section, no contracting entity shall require, as a condition of entering into a contract with it, that the participating provider accept any future product offering that the contracting entity makes.

(c) This section shall apply to all contracts entered into or renewed after the effective date of this section and shall apply to all other existing contracts no later than five years after the effective date of this section.

Sec. 9. 18 V.S.A. § 9418h is added to read:

§ 9418h. ENFORCEMENT

For a violation of any provision of this subchapter:

(1) In addition to any other remedy provided by law, the commissioner shall have the power to examine and investigate any health plan, contracting entity, covered entity, or payer to determine if the health plan, contracting entity, covered entity, or payer has violated the provisions of this subchapter.

(2) If the commissioner finds that a health plan, contracting entity, covered entity, or payer has violated this subchapter, the commissioner may order the health plan, contracting entity, covered entity, or payer to cease and desist from further violations and may order the health plan, contracting entity, covered entity, or payer to remediate the violation.

(3) If the commissioner finds that a health plan, contracting entity, covered entity, or payer has engaged in a pattern or practice of violating this

subchapter, the commissioner may impose an administrative penalty against the health plan, contracting entity, covered entity, or payer of no more than $500.00 for each violation. In determining the amount of the penalty to be assessed, the commissioner shall consider the following factors:

(A) The appropriateness of the penalty with respect to the financial resources and good faith of the health plan, contracting entity, covered entity, or payer.

(B) The gravity of the violation or practice.

(C) The history of previous violations or practices of a similar nature.

(D) The economic benefit derived by the health plan, contracting entity, covered entity, or payer and the economic impact on the health care facility or health care provider resulting from the violation.

(E) Any other relevant factors.

(4) This subchapter may also be enforced by a health care provider under contract with a health plan or contracting entity through a private cause of action in a court of competent jurisdiction for damages and for injunctive relief to enjoin, restrain, or prevent a violation of this subchapter. The court may award costs and reasonable attorney's fees to the health care provider who prevails in an action under this section.

(5) Any dispute arising out of or relating to the provisions of this subchapter shall, at the option of either party, be settled by arbitration in

accordance with the commercial rules of the American Arbitration Association or the rules or procedures of another mutually agreed upon alternative dispute resolution forum, such as the American Health Lawyers Association. Judgment upon the arbitrator's award may be entered in any court having jurisdiction, and the arbitrator's award shall be binding on both parties.

(6) Nothing in this subchapter shall be construed to prohibit a health plan, contracting entity, covered entity, or payer from applying payment policies that are consistent with applicable federal or state laws and regulations, or to relieve a health plan, contracting entity, covered entity, or payer from complying with payment standards established by federal or state laws and regulations, including rules adopted by the commissioner.

Sec. 10. STATUTORY REVISION

Sections 9418 through 9418h of Title 18 shall be recodified as subchapter 2 (Claims Processing and Contract Standards) of chapter 221 of Title 18.

Sec. 11. EFFECTIVE DATES

(a) Health plans, contracting entities and payers shall comply with the amendments to subsections (b), (c), (d), and (e) of 18 V.S.A. § 9418 (payment for health care services) no later than July 1, 2010.

(b) Subdivisions (a)(1) through (4) of 18 V.S.A. § 9418c (disclosure of payment information), with the exception of subdivision (a)(1)(C) (disclosure of claim edit information), shall take effect as follows:

(1) Contracting entities shall provide the information required in subdivisions (a)(1) through (3) beginning on July 1, 2009.

(2) Contracts shall obligate contracting entities to provide the information required in subdivision (a)(1), with the exception of subdivision (a)(1)(C), upon request beginning no later than September 1, 2009, and for all participating health care providers no later than January 1, 2010.

(3) Contracting entities and contracts shall comply with the provisions of subdivision (a)(1)(C) no later than July 1, 2010.

(c) The summary disclosure form required by subsection 9418c(d) of Title 18 shall be included in all contracts entered into or renewed on or after July 1, 2009 and shall be provided for all other existing contracts no later than July 1, 2014.

(d) Contracting entities and covered entities shall comply with the provisions of 18 V.S.A. § 9418f (rental networks) no later than January 1, 2010.

(e) The remaining sections of this act shall take effect July 1, 2009.