By: Stevens To: Insurance

HOUSE BILL NO. 1379

AN ACT TO CREATE THE "PARTICIPATING PROVIDER PROTECTION ACT"; TO PROHIBIT INAPPROPRIATELY DISCOUNTED CLAIMS BY SILENT PREFERRED PROVIDER ORGANIZATIONS AND PENALIZE THE PAYERS THAT ENGAGE IN SUCH PROHIBITED PRACTICE; TO REQUIRE HEALTH INSURERS TO PROVIDE CERTAIN INFORMATION ON MEMBER IDENTIFICATION CARDS; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. This article shall be known and may be cited as the "Participating Provider Protection Act."

SECTION 2. As used in this article:

(a) "Alternative rates of payment" means the rate at which or sum for which the provider agrees to perform specified health care services. The rate shall be negotiated between purchaser and provider and shall be in effect for a fixed term. It may, but need not, include a discount from the provider’s customary fee.

(b) "Group purchaser" means an organization or entity which contracts with providers for the purpose of establishing a preferred provider organization. "Group purchaser" may include:

(i) Entities which contract for the benefit of their insureds, employees or members such as insurers, self-funded organizations, medical service plans, trusts or employers who establish or participate in self-funded trusts or programs.

(ii) Entities which serve as brokers for the formation of such contracts, including health care financiers, third party administrators, providers or other intermediaries.

(c) "Participating provider" means a provider who has agreed to provide health care services to members of a group

purchaser with an expectation of receiving payment directly or indirectly from the preferred provider organization.

(d) "Preferred provider organization (PPO)" means a contractual agreement or agreements between a provider or providers and a group purchaser or purchasers to provide for alternative rates of payment specified in advance for a defined period of time in which the provider agrees to accept the alternative rates of payment offered by group purchasers to their members whenever a member chooses to use the provider's services during the defined period of time; and there is a tangible benefit to the provider in offering such alternative rates of payment to the group purchaser.

Preferred provider organization agreements should include, but not be limited to, the following components:

(i) Incentives which encourage the member to utilize the participating providers;

(ii) Procedures to provide the participating provider with a means to determine whether the patient qualifies for alternative rates of payment;

(iii) Participation in a resource monitoring component to insure quality control both for patient care and cost effectiveness; and

(iv) Procedures to encourage prompt payment for services rendered.

(e) "Provider" means any physician, hospital or other natural or artificial person licensed or otherwise authorized to furnish health care services.

(f) "Tangible benefit" means, but is not limited to:

(i) Any reasonable expectation of a demonstrable increase in or maintenance of usage of the provider's services;

(ii) Contractual provisions requiring quality control of patient care and participation in resource monitoring procedures; and

(iii) Any reasonable expectation of prompt payment for services rendered.

SECTION 3. (1) Except as otherwise provided in this section, the requirement of this section shall apply to all

preferred provider organization agreements that are applicable to health care services rendered in this state and to group purchasers as defined in this article. The provisions of this section shall not apply to a group purchaser when providing health care benefits through its own network or direct provider agreements or to such agreements of a group purchaser.

(2) A preferred provider organization's alternative rates of payment shall not be enforceable or binding upon any provider unless such organization is clearly identified on the benefit card issued to the member by the group purchaser or other entity accessing a group purchaser's contractual agreement or agreements and presented to the participating provider when health care services are provided. When more than one preferred provider organization is shown on the benefit card of a group purchaser or other entity, the applicable contractual agreement that shall be binding on a provider shall be determined as follows:

(a) The first preferred provider organization domiciled in this state, listed on the benefit card, beginning on the front of the card, reading from left to right, line by line, from top to bottom, that is applicable to a provider on the date health care services are rendered, shall establish the contractual agreement for payment that shall apply.

(b) If there is no preferred provider organization domiciled in this state listed on the benefit card, the first preferred provider organization domiciled outside this state listed on the benefit card, following the same process outlined in paragraph (a) of this subsection shall establish the contractual agreement for payment that shall apply.

(c) The side of the benefit card that prominently identifies the name of the carrier, insurer, or plan sponsor and beneficiary shall be deemed to be the front of the card.

(d) When no preferred provider organization is listed, the carrier, insurer or plan sponsor identified by the benefit

card shall be deemed to be the group purchaser for purposes of this section.

(e) When no benefit card is issued or utilized by a group purchaser or other entity, written notification shall be required of any entity accessing an existing group purchaser's contractual agreement or agreements, at least thirty (30) days before accessing health care services through a participating provider under such agreement or agreements.

(3) A preferred provider organization agreement shall not be applied or used on a retroactive basis unless all providers of health care services that are affected by the application of alternative rates of payment receive written notification from the entity that seeks such an arrangement and agree in writing to be reimbursed at the alternative rates of payment.

(4) In no instance shall any provider be bound by the terms of a preferred provider organization agreement that is in violation of this section.

(5) Any claim submitted by a provider for health care services provided to a person identified by the provider and a group purchaser as eligible for alternative rates of payment in a preferred provider organization agreement shall be subject to the standards for claims submission and timely payment set forth in Section 83-9-5.

(6) Failure to comply with the provisions of this section shall subject a group purchaser to damages payable to the provider of double the fair market value of the health care services provided, but in no event less than the greater of Fifty Dollars ($50.00) per day of noncompliance or Two Thousand Dollars ($2,000.00), together with attorney's fees to be determined by the court. A provider may institute this action in any court of competent jurisdiction.

SECTION 4. Whenever any hospital or other provider is a party to a preferred provider organization agreement, there shall

be a rebuttable presumption that such hospital or other provider contracted with the expectation of receiving a tangible benefit. Unless clearly indicated otherwise in a preferred provider organization contractual arrangement, it shall be presumed that the hospital or other provider negotiated the contract with the knowledge that such agreement would result in a tangible benefit to the hospital or other provider.

SECTION 5. (1) Every health insurer authorized to write health and accident policies of insurance in this state who issues a member identification card, membership card, identification card, benefit card, insurance coverage card or other documentation of coverage to any policy holder or health plan participant shall, in issuing such card or cards, satisfy the requirements of this section.

(2) No health insurer acting as the administrator for a health benefit plan which plan is not fully insured shall issue any member identification card, membership card, identification card, benefit card, insurance coverage card or other documentation of coverage on which the name of the health insurer is prominently displayed on the face of such card or documentation. The name of the health benefit plan’s sponsor shall be prominently displayed on the face of such card or documentation with an annotation that the plan’s benefits are being administered by the health insurance insurer.

(3) The Commissioner of Insurance may promulgate rules and regulations implementing the provisions of this section.

(4) This section shall apply to any health and accident member identification card, membership card, identification card, benefit card, insurance coverage card or other documentation of coverage issued, reissued, or replaced on or after July 1, 2000, and any such card or other documentation issued before July 1, 2000, shall be replaced to conform to the provisions of this section on or before its renewal date, but in no event later than

July 1, 2001.

SECTION 6. This act shall take effect and be in force from and after July 1, 2000.