MISSISSIPPI LEGISLATURE REGULAR SESSION 2022

By: Senator(s) Sparks To: Insurance

SENATE BILL NO. 2907

AN ACT TO CREATE NEW SECTIONS 83-9-401 THROUGH 83-9-419, MISSISSIPPI CODE OF 1972, TO ENACT THE HEALTH CARE CONTRACTING SIMPLIFICATION ACT; TO PROVIDE DEFINITIONS FOR THE ACT; TO PROHIBIT THE ALL-PRODUCTS CLAUSE; TO PROHIBIT THE MOST-FAVORED-NATION CLAUSE; TO PROVIDE FURTHER REQUIREMENTS OF HEALTH CARE CONTRACTS; TO PROVIDE THAT THE MISSISSIPPI INSURANCE DEPARTMENT SHALL ENFORCE THIS ACT; AND FOR RELATED PURPOSES.

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

SECTION 1. The following shall be codified as Section 83-9-401, Mississippi Code of 1972:

83-9-401. This article shall be known and may be cited as the "Health Care Contracting Simplification Act."

SECTION 2. The following shall be codified as Section 83-9-403, Mississippi Code of 1972:

83-9-403. (1) "All-products clause" means a provision in a health care contract that requires a health care provider, as a condition of participation or continuation in a provider network or a health benefit plan, to:

(a) Serve in another provider network utilized by the contracting entity or a health care insurer affiliated with the contracting entity; or

(b) Provide health care services under another health benefit plan or product offered by a contracting entity or a health care insurer affiliated with the contracting entity.

(2) "Contracting entity" means a health care insurer or a subcontractor, affiliate, or other entity that contracts directly or indirectly with a health care provider for the delivery of health care services pursuant to any individual or group policy or contract of insurance against loss resulting from bodily injury, including dental care expenses resulting from sickness or bodily injury as defined in Section 83-9-1.

(3) "Enrollee" means an individual who is entitled to receive health care services under the terms of a health benefit plan.

(4) (a) "Health benefit plan" means a plan, policy, contract, certificate, agreement, or other evidence of coverage for health care services offered or issued by a health care insurer in this state and such products as described in Section 83-9-1.

(b) "Health benefit plan" includes nonfederal governmental plans as defined in 29 USC Section 1002(32), as it existed on January 1, 2019.

(c) "Health benefit plan" does not include:

(i) A disability income plan;

(ii) A credit insurance plan;

(iii) Insurance coverage issued as a supplement to liability insurance;

(iv) A medical payment under automobile or homeowners insurance plans;

(v) A health benefit plan provided for workers' compensation;

(vi) A plan that provides only indemnity for hospital confinement;

(vii) An accident-only plan;

(viii) A specified disease plan; and

(ix) A long-term-care-only plan.

(5) "Health care contract" means a contract entered into, materially amended, or renewed between a contracting entity and a health care provider for payment of health care services provided to enrollees and for the purposes of this act shall also include a manual, policy, fee schedule or procedure (including quality improvement and utilization management policies and procedures) document referenced in the contract.

(6) (a) "Health care insurer" means an entity that is subject to state insurance regulation and provides health insurance in this state.

(b) "Health care insurer" includes:

(i) An insurance company;

(ii) A health maintenance organization or managed care organization;

(iii) A hospital and medical service corporation;

(iv) A risk-based provider organization;

(v) A sponsor of a nonfederal self-funded governmental plan;

(vi) A care coordination organization; and

(vii) A provider-sponsored health plan.

(7) "Health care provider" means a person or entity that is licensed, certified, or otherwise authorized by the laws of this state to provide health care services.

(8) "Health care services" means services or goods provided for the purpose of or incidental to the purpose of preventing, diagnosing, treating, alleviating, relieving, curing, or healing human illness, disease, condition, disability or injury.

(9) "Material amendment" means a change in a health care contract that results in:

(a) A decrease in fees, payments, or reimbursement to a participating health care provider;

(b) A change in the payment methodology for determining fees, payments, or reimbursement to a participating health care provider;

(c) A new or revised coding guideline;

(d) A new or revised payment rule; or

(e) A change of procedures that may reasonably be expected to significantly increase a health care provider's administrative expenses.

(10) "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 health care provider from contracting with another contracting entity to provide health care services at a lower price than the payment specified in the health care contract;

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

(c) Requires or grants a contracting entity an option to require termination or renegotiation of an existing health care contract if a participating health care provider agrees to provide health care services to another contracting entity at a lower price; or

(d) Requires a participating health care provider to disclose the participating health care provider's contractual reimbursement rates with other contracting entities.

(11) "Participating health care provider" means a health care provider that has a health care contract with a contracting

entity to receive payment for the provision of health care services to enrollees from the contracting entity or a health care insurer affiliated with the contracting entity.

(12) "Provider network" means a group of participating health care providers that are contracted to be paid for the provision of health care services to enrollees at contracted rates.

SECTION 3. The following shall be codified as Section 83-9-405, Mississippi Code of 1972:

83-9-405. (1) Except as provided in subsections (2) and (4) of this section, a contracting entity shall not:

(a) Offer to a health care provider a health care contract that includes an all-products clause;

(b) Enter into a health care contract with a health care provider that includes an all-products clause; or

(c) Amend or renew an existing health care contract previously entered into with a health care provider so that the health care contract as amended or renewed adds or continues to include an all-products clause.

(2) (a) This section does not prohibit a contracting entity from:

(i) Offering a health care provider a contract that covers multiple health benefit plans that have the same reimbursement rates and other financial terms for the health care

provider, as long as the health care provider has the option to opt out of any health benefit plan offered; or

(ii) Adding a new health benefit plan to an existing health care contract with a health care provider under the same reimbursement rates and other financial terms applicable under the original health care contract, as long as the health care provider has the option to opt out of any health benefit plan to be added.

(b) A health care contract may include health benefit plans or coverage options for enrollees within a health benefit plan with different cost-sharing structures, including different deductibles or copayments, as long as the reimbursement rates and other financial terms between the contracting entity and the health care provider remain the same for each plan or coverage option included in the health care contract and the details of the various plans and coverage options are made available to the health care provider in writing.

(c) This section does not authorize a health care provider to:

(i) Opt out of providing services to an enrollee of a particular health benefit plan after the health care provider has entered into a valid contract under this section to provide the services; or

(ii) Refuse to disclose the provider networks or health benefit plans in which the health care provider participates.

(3) If a health care contract contains a provision that violates this section, the violating provision in the health care contract is void.

SECTION 4. The following shall be codified as Section 83-9-407, Mississippi Code of 1972:

83-9-407. (1) A contracting entity shall not:

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

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

(c) Amend or renew an existing health care contract previously entered into with a health care provider so that the contract as amended or renewed adds or continues to include a most-favored-nation clause.

(2) If a health care contract contains a provision that violates this section, the violating provision of the health care contract is void.

SECTION 5. The following shall be codified as Section 83-9-409, Mississippi Code of 1972:

83-9-409. (1) (a) A material amendment to a health care contract is not allowed unless a contracting entity provides to a participating health care provider the material amendment at least

ninety (90) days before the proposed effective date of the material amendment and in writing and the material amendment shall not become effective unless either the amendment has first been negotiated, agreed to and executed by the health care provider or the amendment is required to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization, unless the accreditation organization is affiliated with the contracting entity.

(b) The notice required under paragraph (a) of this subsection shall specify the precise health care contract or health care contracts to which the material amendment applies and be conspicuously labeled as follows: "Notice of Material Amendment to Health Care Contract."

(c) The notice shall contain sufficient information about the amendment, including the specific language of the proposed amendment, to allow a health care provider to assess the financial and operational impact, if any, of the amendment.

(2) A notice described under subsection (1)(a) of this section is not required for a material amendment resulting solely from a change in a fee schedule or code set if:

(a) The fee schedule or code set is published by the federal government, or another third party and adopted by the federal government; and

(b) The terms of the health care contract expressly states that the health care provider's compensation or claims submission is based on the fee schedule or code set.

(3) (a) Within ten (10) business days of a health care provider's request, a contracting entity shall provide to the health care provider a full and complete written copy of each health care contract between the contracting entity and the health care provider.

(b) A full and complete copy of the health care contract shall include any amendments to the health care contract.

(4) (a) (i) A health care contract shall open for renegotiation and revision at least one time every three (3) years.

(ii) Under subparagraph (i) of this paragraph (a), a party to the health care contract is not required to terminate the health care contract in order to open the health care contract for renegotiation of the terms.

(b) This section does not prohibit a renegotiation of a health care contract at any time during the term of the health care contract.

(c) In the event that the contracting entity and the health care provider cannot agree to a change in the health care contract, the health care provider may terminate the health care contract prior to the implementation of any proposed change.

(5) If a health care contract contains a provision that violates this section, the violating provision of the health care contract is void.

SECTION 6. The following shall be codified as Section 83-9-411, Mississippi Code of 1972:

83-9-411. (1) A contracting entity shall not condition payment to a health care provider based upon the actions or omissions of another health care provider.

(2) If a health care contract contains a provision that violates this section, the violating provision of the health care contract is void.

SECTION 7. The following shall be codified as Section 83-9-413, Mississippi Code of 1972:

83-9-413. (1) A contracting entity shall contract with any health care provider unless that health care provider has a significant history of malpractice claims, licensure or accreditation violations, license suspension or terminations, or has been barred from participation in a federal or state health care program and shall not, directly or indirectly, offer or enter into a health care contract that:

(a) Prohibits a participating health care provider from entering into a health care contract with another contracting entity; or

(b) Prohibits a contracting entity from entering into a health care contract with another health care provider.

(2) If a health care provider owns or operates multiple health care facilities or employs other health care providers, a contracting entity must offer a master health care contract to the health care provider that encompasses all such facilities or providers. Nothing in this section requires a contracting entity to, or prohibits a contracting entity from, offering the same terms to all facilities or health care providers encompassed in the master health care contract.

(3) If a health care contract contains a provision that violates this section, the violating provision of the health care contract is void.

SECTION 8. The following shall be codified as Section 83-9-415, Mississippi Code of 1972:

83-9-415. (1) A contracting entity shall not include a provision in a health benefit plan that would impose a monetary advantage or penalty under a health benefit plan that would affect an enrollee's choice among participating health care providers. "Monetary advantage or penalty" includes:

(a) A higher co-payment, co-insurance or deductible;

(b) A lower co-payment, co-insurance or deductible;

(c) A reduction in reimbursement for services;

(d) An increase in reimbursement for services; and

(e) Promotion of one (1) participating health care provider over another by these methods.

(2) If a health care contract contains a provision that violates this section, the violating provision of the health care contract is void.

SECTION 9. The following shall be codified as Section 83-9-417, Mississippi Code of 1972:

83-9-417. The Commissioner of Insurance may, after notice and hearing, revoke the authority of a contracting entity or impose an administrative fine, or both, if the contracting entity violates or neglects to comply with any provision in this act. Such administrative fine shall not exceed Five Thousand Dollars ($5,000.00) per violation.

SECTION 10. The following shall be codified as Section 83-9-419, Mississippi Code of 1972:

83-9-419. (1) The Commissioner of Insurance shall promulgate rules necessary to ensure compliance with this article.

(2) When adopting the initial rules to ensure compliance with this article, the final rule shall be filed with the Secretary of State for adoption under the Administrative Procedures Law on or before December 31, 2022.

SECTION 11. This act shall take effect and be in force from and after July 1, 2023, except for Section 10 of this act which shall take effect and be in force from and after July 1, 2022.