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HOUSE BILL NO. 603

Offered January 9, 2008
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A BILL to amend and reenact §§ 2.2-3705.6 and 38.2-3407.15 of the Code of Virginia and to amend the Code of Virginia by adding sections numbered 32.1-276.5:1 and 38.2-3407.15:1, relating to the disclosure by hospitals of contractual arrangements in certain provider contracts.

Patrons—O'Bannon, Athey, Bell, Carrico, Cole, Cosgrove, Crockett-Stark, Gilbert, Lohr and Sherwood

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-3705.6 and 38.2-3407.15 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding sections numbered 32.1-276.5:1 and 38.2-3407.15:1 as follows:

§ 2.2-3705.6. Exclusions to application of chapter; proprietary records and trade secrets.

The following records are excluded from the provisions of this chapter but may be disclosed by the custodian in his discretion, except where such disclosure is prohibited by law:

1. Proprietary information gathered by or for the Virginia Port Authority as provided in § 62.1-132.4 or 62.1-134.1.

2. Financial statements not publicly available filed with applications for industrial development financings in accordance with Chapter 49 (§ 15.2-4900 et seq.) of Title 15.2.

3. Confidential proprietary records, voluntarily provided by private business pursuant to a promise of confidentiality from the Department of Business Assistance, the Virginia Economic Development Partnership, the Virginia Tourism Authority, the Tobacco Indemnification and Community Revitalization Commission, a nonprofit, nonstock corporation created pursuant to § 2.2-2240.1, or local or regional industrial or economic development authorities or organizations, used by the Department, the Partnership, the Authority, or such entities for business, trade and tourism development; and memoranda, working papers or other records related to businesses that are considering locating or expanding in Virginia, prepared by such entities, where competition or bargaining is involved and where, if such records are made public, the financial interest of the governmental unit would be adversely affected.

4. Information that was filed as confidential under the Toxic Substances Information Act (§ 32.1-239 et seq.), as such Act existed prior to July 1, 1992.

5. Fisheries data that would permit identification of any person or vessel, except when required by court order as specified in § 28.2-204.

6. Confidential financial statements, balance sheets, trade secrets, and revenue and cost projections provided to the Department of Rail and Public Transportation, provided such information is exempt under the federal Freedom of Information Act or the federal Interstate Commerce Act or other laws administered by the Surface Transportation Board or the Federal Railroad Administration with respect to data provided in confidence to the Surface Transportation Board and the Federal Railroad Administration.

7. Confidential proprietary records related to inventory and sales, voluntarily provided by private energy suppliers to the Department of Mines, Minerals and Energy, used by that Department for energy contingency planning purposes or for developing consolidated statistical information on energy supplies.

8. Confidential proprietary information furnished to the Board of Medical Assistance Services or the Medicaid Prior Authorization Advisory Committee pursuant to Article 4 (§ 32.1-331.12 et seq.) of Chapter 10 of Title 32.1.

9. Proprietary, commercial or financial information, balance sheets, trade secrets, and revenue and cost projections provided by a private transportation business to the Virginia Department of Transportation and the Department of Rail and Public Transportation for the purpose of conducting transportation studies needed to obtain grants or other financial assistance under the Transportation Equity Act for the 21st Century (P.L. 105-178) for transportation projects, provided such information is exempt under the federal Freedom of Information Act or the federal Interstate Commerce Act or other laws administered by the Surface Transportation Board or the Federal Railroad Administration with respect to data provided in confidence to the Surface Transportation Board and the Federal Railroad Administration. However, the exemption provided by this subdivision shall not apply to any wholly owned subsidiary of a public body.

10. Confidential information designated as provided in subsection D of § 2.2-4342 as trade secrets or proprietary information by any person who has submitted to a public body an application for

prequalification to bid on public construction projects in accordance with subsection B of § 2.2-4317.

11. a. Memoranda, staff evaluations, or other records prepared by the responsible public entity, its staff, outside advisors, or consultants exclusively for the evaluation and negotiation of proposals filed under the Public-Private Transportation Act of 1995 (§ 56-556 et seq.) or the Public Private Education Facilities and Infrastructure Act of 2002 (§ 56-575.1 et seq.), where (i) if such records were made public prior to or after the execution of an interim or a comprehensive agreement, § 56-573.1:1 or 56-575.17 notwithstanding, the financial interest or bargaining position of the public entity would be adversely affected, and (ii) the basis for the determination required in clause (i) is documented in writing by the responsible public entity; and

b. Records provided by a private entity to a responsible public entity, affected jurisdiction, or affected local jurisdiction pursuant to the provisions of the Public-Private Transportation Act of 1995 or the Public-Private Education Facilities and Infrastructure Act of 2002, to the extent that such records contain (i) trade secrets of the private entity as defined in the Uniform Trade Secrets Act (§ 59.1-336 et seq.); (ii) financial records of the private entity, including balance sheets and financial statements, that are not generally available to the public through regulatory disclosure or otherwise; or (iii) other information submitted by the private entity, where, if the records were made public prior to the execution of an interim agreement or a comprehensive agreement, the financial interest or bargaining position of the public or private entity would be adversely affected. In order for the records specified in clauses (i), (ii) and (iii) to be excluded from the provisions of this chapter, the private entity shall make a written request to the responsible public entity:

1. Invoking such exclusion upon submission of the data or other materials for which protection from disclosure is sought;

2. Identifying with specificity the data or other materials for which protection is sought; and

3. Stating the reasons why protection is necessary.

The responsible public entity shall determine whether the requested exclusion from disclosure is necessary to protect the trade secrets or financial records of the private entity. To protect other records submitted by the private entity from disclosure, the responsible public entity shall determine whether public disclosure prior to the execution of an interim agreement or a comprehensive agreement would adversely affect the financial interest or bargaining position of the public or private entity. The responsible public entity shall make a written determination of the nature and scope of the protection to be afforded by the responsible public entity under this subdivision. Once a written determination is made by the responsible public entity, the records afforded protection under this subdivision shall continue to be protected from disclosure when in the possession of any affected jurisdiction or affected local jurisdiction.

Except as specifically provided in subdivision 11 a, nothing in this subdivision shall be construed to authorize the withholding of (a) procurement records as required by § 56-573.1:1 or 56-575.17; (b) information concerning the terms and conditions of any interim or comprehensive agreement, service contract, lease, partnership, or any agreement of any kind entered into by the responsible public entity and the private entity; (c) information concerning the terms and conditions of any financing arrangement that involves the use of any public funds; or (d) information concerning the performance of any private entity developing or operating a qualifying transportation facility or a qualifying project.

For the purposes of this subdivision, the terms "affected jurisdiction," "affected local jurisdiction," "comprehensive agreement," "interim agreement," "qualifying project," "qualifying transportation facility," "responsible public entity," and "private entity" shall mean the same as those terms are defined in the Public-Private Transportation Act of 1995 or in the Public-Private Education Facilities and Infrastructure Act of 2002.

12. Confidential proprietary information or trade secrets, not publicly available, provided by a private person or entity to the Virginia Resources Authority or to a fund administered in connection with financial assistance rendered or to be rendered by the Virginia Resources Authority where, if such information were made public, the financial interest of the private person or entity would be adversely affected, and, after June 30, 1997, where such information was provided pursuant to a promise of confidentiality.

13. Confidential proprietary records that are provided by a franchisee under Article 1.2 (§ 15.2-2108.19 et seq.) of Chapter 21 of Title 15.2 to its franchising authority pursuant to a promise of confidentiality from the franchising authority that relates to the franchisee's potential provision of new services, adoption of new technologies or implementation of improvements, where such new services, technologies or improvements have not been implemented by the franchisee on a nonexperimental scale in the franchise area, and where, if such records were made public, the competitive advantage or financial interests of the franchisee would be adversely affected. In order for confidential proprietary information to be excluded from the provisions of this chapter, the franchisee shall (i) invoke such exclusion upon submission of the data or other materials for which protection from disclosure is sought, (ii) identify the data or other materials for which protection is sought, and (iii) state the reason why

protection is necessary.

14. Documents and other information of a proprietary nature furnished by a supplier of charitable gaming supplies to the Department of Charitable Gaming pursuant to subsection E of § 18.2-340.34.

15. Records and reports related to Virginia apple producer sales provided to the Virginia State Apple Board pursuant to §§ 3.1-622 and 3.1-624.

16. Trade secrets, as defined in the Uniform Trade Secrets Act (§ 59.1-336 et seq.) of Title 59.1, submitted by CMRS providers as defined in § 56-484.12 to the Wireless Carrier E-911 Cost Recovery Subcommittee created pursuant to § 56-484.15, relating to the provision of wireless E-911 service.

17. Records submitted as a grant application, or accompanying a grant application, to the Commonwealth Health Research Board pursuant to Chapter 22 (§ 23-277 et seq.) of Title 23 to the extent such records contain proprietary business or research-related information produced or collected by the applicant in the conduct of or as a result of study or research on medical, rehabilitative, scientific, technical, or scholarly issues, when such information has not been publicly released, published, copyrighted, or patented, if the disclosure of such information would be harmful to the competitive position of the applicant.

18. Confidential proprietary records and trade secrets developed and held by a local public body (i) providing telecommunication services pursuant to § 56-265.4:4 and (ii) providing cable television services pursuant to Article 1.1 (§ 15.2-2108.2 et seq.) of Chapter 21 of Title 15.2, to the extent that disclosure of such records would be harmful to the competitive position of the locality. In order for confidential proprietary information or trade secrets to be excluded from the provisions of this chapter, the locality in writing shall (i) invoke the protections of this subdivision, (ii) identify with specificity the records or portions thereof for which protection is sought, and (iii) state the reasons why protection is necessary.

19. Confidential proprietary records and trade secrets developed by or for a local authority created in accordance with the Virginia Wireless Service Authorities Act (§ 15.2-5431.1 et seq.) to provide qualifying communications services as authorized by Article 5.1 (§ 56-484.7:1 et seq.) of Chapter 15 of Title 56, where disclosure of such information would be harmful to the competitive position of the authority, except that records required to be maintained in accordance with § 15.2-2160 shall be released.

20. Trade secrets as defined in the Uniform Trade Secrets Act (§ 59.1-336 et seq.) or financial records of a business, including balance sheets and financial statements, that are not generally available to the public through regulatory disclosure or otherwise, provided to the Department of Minority Business Enterprise as part of an application for (i) certification as a small, women- or minority-owned business in accordance with Chapter 14 (§ 2.2-1400 et seq.) of this title or (ii) a claim made by a disadvantaged business or an economically disadvantaged individual against the Capital Access Fund for Disadvantaged Businesses created pursuant to § 2.2-2311. In order for such trade secrets or financial records to be excluded from the provisions of this chapter, the business shall (a) invoke such exclusion upon submission of the data or other materials for which protection from disclosure is sought, (b) identify the data or other materials for which protection is sought, and (c) state the reasons why protection is necessary.

21. Documents and other information of a proprietary or confidential nature disclosed by a carrier to the State Health Commissioner pursuant to § 38.2-3407.15:1.

§ 32.1-276.5:1. Carrier disclosures of contractual arrangements to be made publicly available.

A. The Commissioner shall compile the information regarding contractual arrangements in provider contracts that is disclosed by carriers pursuant to § 38.2-3407.15:1 and make such information, or such portions or aggregations thereof that the Board determines may be disclosed without compromising the identities of the carrier and provider to a specific provider contract, available to the public through an Internet website. Such information shall be made available to the public in a manner that provides access on the average amount that a provider is compensated by carriers for specific health care services. Information about a specific health care service may be withheld if the Board determines that its disclosure for specific providers would compromise requirements for confidentiality. The Commissioner shall negotiate and contract with a nonprofit organization authorized under § 32.1-276.4 for compiling, storing, and making such information available to the public.

B. The information provided to the Commissioner pursuant to § 38.2-3407.15:1 and this section shall be confidential and shall be excluded from the Virginia Freedom of Information Act (§ 2.2-3700 et seq.) pursuant to subdivision 21 of § 2.2-3705.6.

C. The Board shall promulgate regulations to implement the provisions of this section.

D. The Board shall evaluate biennially the impact and effectiveness of such data collection.

§ 38.2-3407.15. Ethics and fairness in carrier business practices.

A. As used in this section:

"Carrier," "enrollee" and "provider" shall have the meanings set forth in § 38.2-3407.10; however, a

"carrier" shall also include any person required to be licensed under this title which offers or operates a managed care health insurance plan subject to Chapter 58 (§ 38.2-5800 et seq.) of this title or which provides or arranges for the provision of health care services, health plans, networks or provider panels which are subject to regulation as the business of insurance under this title.

"Claim" means any bill, claim, or proof of loss made by or on behalf of an enrollee or a provider to a carrier (or its intermediary, administrator or representative) with which the provider has a provider contract for payment for health care services under any health plan; however, a "claim" shall not include a request for payment of a capitation or a withhold.

"Clean claim" means a claim (i) that has no material defect or impropriety (including any lack of any reasonably required substantiation documentation) which substantially prevents timely payment from being made on the claim or (ii) with respect to which a carrier has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with this section.

"Health care services" means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.

"Health plan" means any individual or group health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, managed care health insurance plan, or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, to cover all or a portion of the cost of persons receiving covered health care services, which is subject to state regulation and which is required to be offered, arranged or issued in the Commonwealth by a carrier licensed under this title. Health plan does not mean (i) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. or Title XX of the Social Security Act, 42 U.S.C. § 1397 et seq. (Medicaid), 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. (CHAMPUS); or (ii) accident only, credit or disability insurance, long-term care insurance, CHAMPUS supplement, Medicare supplement, or workers' compensation coverages.

"Provider contract" means any contract between a provider and a carrier (or a carrier's network, provider panel, intermediary or representative) relating to the provision of health care services.

"Retroactive denial of a previously paid claim" or "retroactive denial of payment" means any attempt by a carrier retroactively to collect payments already made to a provider with respect to a claim by reducing other payments currently owed to the provider, by withholding or setting off against future payments, or in any other manner reducing or affecting the future claim payments to the provider.

B. Subject to subsection H, every provider contract entered into by a carrier shall contain specific provisions which shall require the carrier to adhere to and comply with the following minimum fair business standards in the processing and payment of claims for health care services:

1. A carrier shall pay any claim within 40 days of receipt of the claim except where the obligation of the carrier to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by specific information available for review by the person submitting the claim that:

a. The claim is determined by the carrier not to be a clean claim due to a good faith determination or dispute regarding (i) the manner in which the claim form was completed or submitted, (ii) the eligibility of a person for coverage, (iii) the responsibility of another carrier for all or part of the claim, (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which services were accessed or provided; or

b. The claim was submitted fraudulently.

Each carrier shall maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim shall be entitled to inspect such record on request and to rely on that record or on any other admissible evidence as proof of the fact of receipt of the claim, including without limitation electronic or facsimile confirmation of receipt of a claim.

2. A carrier shall, within 30 days after receipt of a claim, request electronically or in writing from the person submitting the claim the information and documentation that the carrier reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim. Upon receipt of the additional information requested under this subsection necessary to make the original claim a clean claim, a carrier shall make the payment of the claim in compliance with this section. No carrier may refuse to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits if the carrier fails timely to notify or attempt to notify the person submitting the claim of the matters identified above unless such failure was caused in material part by the person submitting the claims; however, nothing herein shall preclude such a carrier from imposing a retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim would violate subdivision 6 of this subsection. Nothing in this subsection shall require a carrier to pay a claim which is not a clean claim.

3. Any interest owing or accruing on a claim under § 38.2-3407.1 or 38.2-4306.1 of this title, under any provider contract or under any other applicable law, shall, if not sooner paid or required to be paid, be paid, without necessity of demand, at the time the claim is paid or within 60 days thereafter.

4. a. Every carrier shall establish and implement reasonable policies to permit any provider with which there is a provider contract (i) to confirm in advance during normal business hours by free telephone or electronic means if available whether the health care services to be provided are medically necessary and a covered benefit and (ii) to determine the carrier's requirements applicable to the provider (or to the type of health care services which the provider has contracted to deliver under the provider contract) for (a) pre-certification or authorization of coverage decisions, (b) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim, (c) provider-specific payment and reimbursement methodology, coding levels and methodology, downcoding, and bundling of claims, and (d) other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract, including determining whether a claim is a clean claim. If a carrier routinely, as a matter of policy, bundles or downcodes claims submitted by a provider, the carrier shall clearly disclose that practice in each provider contract. Further, such carrier shall either (i) disclose in its provider contracts or on its website the specific bundling and downcoding policies that the carrier reasonably expects to be applied to the provider or provider's services on a routine basis as a matter of policy or (ii) disclose in each provider contract a telephone or facsimile number or e-mail address that a provider can use to request the specific bundling and downcoding policies that the carrier reasonably expects to be applied to that provider or provider's services on a routine basis as a matter of policy. If such request is made by or on behalf of a provider, a carrier shall provide the requesting provider with such policies within 10 business days following the date the request is received.

b. Every carrier shall make available to such providers within 10 business days of receipt of a request, copies of or reasonable electronic access to all such policies which are applicable to the particular provider or to particular health care services identified by the provider. In the event the provision of the entire policy would violate any applicable copyright law, the carrier may instead comply with this subsection by timely delivering to the provider a clear explanation of the policy as it applies to the provider and to any health care services identified by the provider.

5. Every carrier shall pay a claim if the carrier has previously authorized the health care service or has advised the provider or enrollee in advance of the provision of health care services that the health care services are medically necessary and a covered benefit, unless:

a. The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized; or

b. The carrier's refusal is because (i) another payor is responsible for the payment, (ii) the provider has already been paid for the health care services identified on the claim, (iii) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to the carrier by the provider, enrollee, or other person not related to the carrier, or (iv) the person receiving the health care services was not eligible to receive them on the date of service and the carrier did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status.

6. No carrier may impose any retroactive denial of a previously paid claim unless the carrier has provided the reason for the retroactive denial and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by the provider, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed the lesser of (a) 12 months or (b) the number of days within which the carrier requires under its provider contract that a claim be submitted by the provider following the date on which a health care service is provided. Effective July 1, 2000, a carrier shall notify a provider at least 30 days in advance of any retroactive denial of a claim.

7. Notwithstanding subdivision 6 of this subsection, with respect to provider contracts entered into, amended, extended, or renewed on or after July 1, 2004, no carrier shall impose any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought. The written communication shall also contain an explanation of why the claim is being retroactively adjusted.

8. No provider contract may fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis and (ii) all material addenda, schedules and exhibits thereto and any policies (including those referred to in subdivision 4 of this subsection) applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract.

9. No amendment to any provider contract or to any addenda, schedule, exhibit or policy thereto (or

new addenda, schedule, exhibit, or policy) applicable to the provider (or to the range of health care services reasonably expected to be delivered by that type of provider) shall be effective as to the provider, unless the provider has been provided with the applicable portion of the proposed amendment (or of the proposed new addenda, schedule, exhibit, or policy) at least 60 calendar days before the effective date and the provider has failed to notify the carrier within 30 calendar days of receipt of the documentation of the provider's intention to terminate the provider contract at the earliest date thereafter permitted under the provider contract.

10. In the event that the carrier's provision of a policy required to be provided under subdivision 8 or 9 of this subsection would violate any applicable copyright law, the carrier may instead comply with this section by providing a clear, written explanation of the policy as it applies to the provider.

11. All carriers shall establish, in writing, their claims payment dispute mechanism and shall make this information available to providers.

12. A carrier shall not prohibit or restrict a hospital from making any disclosure required or permitted pursuant to § 38.2-3407.15:1.

C. Without limiting the foregoing, in the processing of any payment of claims for health care services rendered by providers under provider contracts and in performing under its provider contracts, every carrier subject to regulation by this title shall adhere to and comply with the minimum fair business standards required under subsection B, and the Commission shall have the jurisdiction to determine if a carrier has violated the standards set forth in subsection B by failing to include the requisite provisions in its provider contracts and shall have jurisdiction to determine if the carrier has failed to implement the minimum fair business standards set out in subdivisions B 1 and B 2 in the performance of its provider contracts.

D. No carrier shall be in violation of this section if its failure to comply with this section is caused in material part by the person submitting the claim or if the carrier's compliance is rendered impossible due to matters beyond the carrier's reasonable control (such as an act of God, insurrection, strike, fire, or power outages) which are not caused in material part by the carrier.

E. Any provider who suffers loss as the result of a carrier's violation of this section or a carrier's breach of any provider contract provision required by this section shall be entitled to initiate an action to recover actual damages. If the trier of fact finds that the violation or breach resulted from a carrier's gross negligence and willful conduct, it may increase damages to an amount not exceeding three times the actual damages sustained. Notwithstanding any other provision of law to the contrary, in addition to any damages awarded, such provider also may be awarded reasonable attorney's fees and court costs. Each claim for payment which is paid or processed in violation of this section or with respect to which a violation of this section exists shall constitute a separate violation. The Commission shall not be deemed to be a "trier of fact" for purposes of this subsection.

F. No carrier (or its network, provider panel or intermediary) shall terminate or fail to renew the employment or other contractual relationship with a provider, or any provider contract, or otherwise penalize any provider, for invoking any of the provider's rights under this section or under the provider contract.

G. This section shall apply only to carriers subject to regulation under this title.

H. This section shall apply with respect to provider contracts entered into, amended, extended or renewed on or after July 1, 1999.

I. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to implement this section.

J. If any provision of this section, or the application thereof to any person or circumstance, is held invalid or unenforceable, such determination shall not affect the provisions or applications of this section which can be given effect without the invalid or unenforceable provision or application, and to that end the provisions of this section are severable.

K. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.

§ 38.2-3407.15:1. Carrier disclosure of contractual arrangements in provider contracts.

A. As used in this section:

"Carrier" means (i) any insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis; (ii) any corporation providing individual or group accident and sickness subscription contracts; (iii) any health maintenance organization providing health care plans for health care services; (iv) any other person or organization that provides health benefit plans subject to state regulation, and includes an entity that arranges a provider panel for compensation; (v) any person required to be licensed under this title who offers or operates a managed care health insurance plan subject to Chapter 58 (§ 38.2-5800 et seq.) or who provides or arranges for the provision of health care services, health plans, networks or provider panels that are subject to regulation as the business of insurance under this title; or (vi) any entity described in any of clauses (i) through (v) that is acting as

a third party administrator for an entity that funds a self-insurance program for health care services for employees of the entity.

"Commissioner" means the State Health Commissioner.

"Contractual arrangements" means the terms of a provider contract that establish the amount that the carrier is required to pay to the provider, including amounts of any negotiated discounts, volume adjustments, incentives, and any other provision that effects the actual amount that the provider is contractually entitled to receive from the carrier and the carrier is contractually obligated to remit to the provider, for each health care service that may be provided to individuals covered by the provider contract, in such form and in such detail as is required pursuant to regulations promulgated pursuant to § 32.1-276.5:1.

"Health care services" means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.

"Provider" means a public or private institution licensed pursuant to Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 or Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2.

"Provider contract" means any contract between a provider and a carrier relating to the provision of health care services.

B. On or before March 1 of each year, each carrier shall disclose to the Commissioner the carrier's contractual arrangements under each provider contract with each provider as of the preceding January 1. The disclosures shall be filed on a form and in such detail as is prescribed by the Board of Health. The Commissioner shall make the information available to the public as provided in § 32.1-276.5:1.

C. Each provider shall make its provider contracts available for inspection by the Commissioner in order to permit the Commissioner to confirm the information disclosed to the Commissioner by a carrier regarding its provider contracts.