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LET DOCTORS NEGOTIATE WITH HEALTH CARE PLANS

House Bill 5151
Sponsor: Rep. Paul DeWeese
Committee: Employment Relations, Training and Safety

Complete to 9-11-00

A SUMMARY OF HOUSE BILL 5151 AS INTRODUCED 11-30-99

The bill would create a new act to allow competing physicians within the service area of a comprehensive health benefit plan to jointly negotiate certain terms and conditions of contracts with that plan if the plan had "substantial market power" (as determined by the insurance commissioner) and if those terms and conditions affected (or threatened to adversely affect) the quality and availability of patient care. Except where conformance with the bill's provisions would support a greater or lesser proportion, a joint negotiation could represent no more than ten percent of the physicians in a health benefit plan's defined geographic services area.

Health benefit plans. The act would apply only to health benefit plans that provided for expense-incurred hospital, medical, or surgical benefits, including individual, group, or nongroup policies, certificates, or contracts or individual, group, or nongroup evidence of health coverage or similar coverage document offered by any of the following:

(1) A health insurer operating under the Insurance Code of 1956, including fraternal benefit societies and multiple employer welfare agreements holding certificates of authority under the code;

(2) A health maintenance organization operating under the Public Health Code;

(3) Blue Cross and Blue Shield of Michigan;

(4) A person operating a system of health care delivery and financing (a) that was not a health maintenance organization (HMO) but (b) that was to be offered to individuals, whether or not as members of groups, in exchange for a fixed payment and (c) that was organized so that providers and the organization were in some part at risk for the cost of services in a way similar to HMOs;

(5) a Medicaid managed care plan under the Medicaid managed care delivery system established under state law; or

(6) the MIChild program established under state law.

The proposed act would *not* apply to any of the following:

(1) A plan that provided coverage only for a specified disease or other limited benefit, only for accidental death or dismemberment, for disability payments, as a supplement to liability

insurance, for credit insurance, only for dental or vision care, or only for indemnity for hospital confinement;

(2) Medicare supplemental policies (as defined in federal law),

(3) Worker's compensation insurance coverage,

(4) Medical payment insurance coverage issued as part of a motor vehicle insurance policy, or

(5) Long-term care policies, including nursing home indemnity policies, unless the insurance commissioner determined that the policy provided benefit coverage so comprehensive that the policy were a health benefit plan under the proposed act.

<u>Negotiable items</u>. Under the bill, competing physicians within the service area of a health benefit plan could meet and communicate to jointly negotiate certain terms and conditions of contracts with the health benefit plan. The negotiable contract terms and conditions would include the following:

(1) Practices and procedures to assess and improve the delivery of effective, cost efficient preventive health care services (including childhood immunizations, prenatal care, and mammograms and other cancer screening tests or procedures);

(2) Practices and procedures to encourage early detection and effective, cost efficient management of diseases and illnesses in children;

(3) Practices and procedures to assess and improve the delivery of women's medical and health care, including menopause and osteoporosis;

(4) Clinical criteria for effective, cost efficient disease management programs, including diabetes, asthma, and cardiovascular disease;

(5) Practices and procedures to encourage and promote patient education and treatment compliance, including parental involvement with their children's health care;

(6) Practices and procedures to identify, correct, and prevent potentially fraudulent activities;

(7) Practices and procedures for the effective, cost efficient use of outpatient surgery;

(8) Clinical practice guidelines and coverage criteria;

(9) Administrative procedures, including methods and timing of paying physicians for their services;

(10) Administrative procedures relating to disputes between health benefit plans and physicians;

(11) Patient referral procedures;

(12) Formulation and application of physician reimbursement methodology;

(13) Quality assurance programs;

(14) Health service utilization review procedures;

(15) Health benefit plan physician selection and termination criteria; and

(16) The inclusion or alteration of terms and conditions to the extent that they were the subject of government regulation prohibiting or requiring the particular term or condition in question, so long as such restriction did not limit physicians' rights to jointly petition government to change such a regulation.

Non-negotiable items. The bill generally would prohibit competing physicians from meeting and communicating in order to jointly negotiate fees and prices. More specifically, the bill would prohibit negotiation on all of the following:

(1) The fees or prices for services, including those arrived at by applying any reimbursement methodology procedures;

(2) The conversion factors in a resource-based relative value scale reimbursement methodology (or similar methodologies);

(3) The amount of any discounts on the price of services to be rendered by physicians; and

(4) The dollar amount of capitation or fixed payment for health services rendered by physicians to health benefit plan enrollees.

Physicians' representatives. The bill would define "physicians' representative" and would require physicians' representatives to file certain information with, and obtain the approval of, the insurance commissioner before engaging in any joint negotiation with health benefit plans on behalf of physicians.

A "physicians' representative" would be defined to mean a third party (including a member of the group of physicians that were to engage in joint negotiation) who was authorized by physicians to negotiate on their behalf with health benefit plans over contractual terms and conditions affecting those physicians. Physicians' representatives would be required to file certain information with, pay fees to, and obtain the approval of, the insurance commissioner, before they could engage in any joint negotiations on behalf of physicians with a health benefit plan.

More specifically, before engaging in any joint negotiations with health benefit plans on behalf of physicians, any person or organization proposing to act (or acting) as a physicians' representative would have to furnish a report for the insurance commissioner's approval that included all of the following information:

(1) The representative's name and business address;

(2) The names and addresses of the physicians who would be represented by the identified representative;

(3) The relationship of the physicians requesting joint representation to the total population of physicians in a geographic service area;

(4) The health benefit plans with which the physicians' representative intended to negotiate on behalf of the identified physicians;

(5) The proposed subject matter of the negotiations or discussion with the identified health benefit plan;

(6) The representative's plan of operation and procedures to ensure compliance with the bill;

(7) The expected impact of the negotiations on the quality of patient care; and

(8) The benefits of a contract between the identified health benefit plan and physicians.

A physicians' representative who failed to obtain the insurance commissioner's approval of a report required to be filed (whether "initial filing" or "supplemental filing") or a proposed contract would be considered to be acting outside the authority granted under the bill.

The physicians' representative also would be required to advise physicians of the bill's provisions and warn physicians of the potential for legal action against physicians who violated state or federal antitrust laws when acting outside the bill's authority.

Fees. Each party who acted as the representative of negotiating parties under the bill would be required to pay to the insurance commissioner a fee, set by the commissioner, to act as a representative. The commissioner would be required to set fees in amounts reasonable and necessary to cover the costs incurred by the state in administering the bill. Fees collected under the bill would be deposited in the state treasury to the credit of the operating fund from which the expense was incurred.

Insurance commissioner's approval or disapproval. The insurance commissioner would be required to either approve or disapprove "initial" and "subsequent" filings and proposed contracts filed with him or her by physicians' representatives. If the commissioner disapproved an "initial filing" or "supplemental filing" or a proposed contract, he or she would have to furnish a written explanation of any deficiencies, along with a statement of specific remedial measures as to how the deficiencies could be corrected.

The commissioner would be required to approve a request to enter into joint negotiations or a proposed contract if he or she determined that the applicants had demonstrated that the likely benefits resulting from the joint negotiation or proposed contract outweighed the disadvantages

attributable to a reduction in competition that could result from the joint negotiation or proposed contract.

If the insurance commissioner did not issue a written approval or rejection of an initial filing, supplemental filing, or proposed contract, the applicant would have the right to petition a district court for a mandamus order requiring the insurance commissioner to approve or disapprove the contents of the filing immediately.

The insurance commissioner's approval or disapproval of an initial filing would be effective for all subsequent negotiations between the parties specified in the initial filing.

Criteria for negotiation. Competing physicians' exercise of their joint negotiation rights under the bill would have to conform to criteria set out in the bill as follows:

(1) Physicians could communicate with each other with respect to the contractual terms and conditions to be negotiated with a health benefit plan, and with the third party who was authorized to negotiate on their behalf with health benefit plans over these contractual terms and conditions;

(2) The third party would be the sole party authorized to negotiate with health benefit plans on behalf of the physicians as a group;

(3) At the option of each physician, the physicians could agree to be bound by the terms and conditions negotiated by the third party authorized to represent their interests; and

(4) Health benefit plans communicating or negotiating with the physicians' representative would remain free to contract with or offer different contract terms and conditions to individual competing physicians.

In addition, the joint negotiation would have to represent no more than ten percent of the physicians in a health benefit plan's defined geographic service area. However, the insurance commissioner could approve a greater or lesser percentage if the applicants demonstrated that the likely benefits resulting from the joint negotiation outweighed the disadvantages attributable to a reduction in competition that could result from the joint negotiation.

Proposed contracts, termination of negotiations. After the parties identified in the initial filing (by the physicians' representative with the insurance commissioner) had reached an agreement, any person or organization proposing to act or acting as a physicians' representative would be required to furnish a copy of the proposed contract and plan of action for the insurance commissioner's approval.

If a health benefit plan decided not to negotiate, terminated negotiation, or failed to respond to a request to negotiate, the physicians' representative would have 14 days to report the end of negotiations to the insurance commissioner. If negotiations resumed within 60 days of the representative's notification to the insurance commissioner, the physicians' representative would be allowed to renew the previously filed report without submitting a new report for approval.

Limitations. The bill would specify that it could not be construed either (a) to enable physicians to jointly coordinate any cessation, reduction, or limitation of health care services or (b) to prohibit physicians from negotiating the terms and conditions of contracts as allowed by other states or by federal law.

Annual determination. The insurance commissioner, in conjunction with the Departments of Community Health and Consumer and Industry Services, could collect and investigate information necessary to determine annually both (1) the average number of covered lives per month per county by every health benefit plan in the state and (b) the annual impact of the bill on average physician fees in the state.

Effective date. If enacted, the bill would take effect on October 1, 2000.

Analyst: S. Ekstrom

■ This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.