HOUSE BILL No. 5151

November 30, 1999, Introduced by Rep. DeWeese and referred to the Committee on Employment Relations, Training and Safety.

A bill to permit and regulate physicians negotiating with certain health benefit plans; to prescribe certain powers and responsibilities of certain state departments and agencies; and to regulate certain persons who negotiate on behalf of physicians.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 1. As used in this act:

(a) "Commissioner" means the state insurance commissioner.

(b) "Health benefit plan" means health coverage as defined in section 3(1).

(c) "Physicians' representative" means a third party, including a member of the physicians who will engage in joint negotiations, who is authorized by physicians to negotiate on their behalf with health benefit plans over contractual terms and conditions affecting those physicians.

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Sec. 3. (1) This act applies only to a health benefit plan that provides for expense-incurred hospital, medical, or surgical benefits, including an individual, group, or nongroup policy, certificate, or contract or individual, group, or nongroup evidence of health coverage or similar coverage document offered by any of the following:

(a) A health insurer operating under the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302, including a fraternal benefit society operating under chapter 81a of the insurance code of 1956, 1956 PA 218, MCL 500.8161 to 500.8199a, and a multiple employer welfare agreement that holds a certificate of authority under chapter 70 of the insurance code of 1956, 1956 PA 218, MCL 500.7001 to 500.7090.

(b) A health maintenance organization operating under part 210 of the public health code, 1978 PA 368, MCL 333.21001 to 333.21098.

(c) A nonprofit health care corporation operating under the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704.

(d) A person operating a system of health care under section 21042 of the public health code, 1978 PA 368, MCL 333.21042.

(e) A medicaid managed care plan under the medicaid managed care delivery system established under state law.

(f) The MIChild program established under state law.

(2) This act does not apply to any of the following:

(a) A plan that provides coverage for any of the following:

(*i*) Only for a specified disease or other limited benefit.

(*ii*) Only for accidental death or dismemberment.

(*iii*) For wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury.

(*iv*) As a supplement to liability insurance.

(*v*) For credit insurance.

(*vi*) Only for dental or vision care.

(*vii*) Only for indemnity for hospital confinement.

(b) A medicare supplemental policy as defined by section 1882(g)(1) of part C of title XVIII of the social security act, 42 U.S.C. 1395ss.

(c) Worker's compensation insurance coverage.

(d) Medical payment insurance coverage issued as part of a motor vehicle insurance policy.

(e) A long-term care policy, including a nursing home indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan under this act.

Sec. 5. Competing physicians within the service area of a health benefit plan may meet and communicate for the purpose of jointly negotiating the following terms and conditions of contracts with the health benefit plan:

(a) 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.

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

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

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

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

(f) Practices and procedures to identify, correct, and prevent potentially fraudulent activities.

(g) Practices and procedures for the effective, cost efficient use of outpatient surgery.

(h) Clinical practice guidelines and coverage criteria.

(i) Administrative procedures, including methods and timing of physician payment for services.

(j) Dispute resolution procedures relating to disputes between health benefit plans and physicians.

(k) Patient referral procedures.

(*l*) Formulation and application of physician reimbursement methodology.

(m) Quality assurance programs.

(n) Health service utilization review procedures.

(o) Health benefit plan physician selection and termination criteria.

(p) The inclusion or alteration of terms and conditions to the extent they are the subject of government regulation prohibiting or requiring the particular term or condition in question, provided, however, that such restriction does not limit physician rights to jointly petition government for a change in this government regulation.

Sec. 7. Except as provided in section 9, competing physicians shall not meet and communicate for the purposes of jointly negotiating the following terms and conditions of contracts with health benefit plans:

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

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

(c) The amount of any discount on the price of services to be rendered by physicians.

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

Sec. 9. (1) Competing physicians within the service area of a health benefit plan may jointly negotiate the terms and conditions specified in section 7 if the health benefit plan has substantial market power and those terms and conditions have already affected or threatened to adversely affect the quality and

availability of patient care. The commissioner shall determine what constitutes substantial market power.

(2) The commissioner in conjunction with the department of community health and the department of consumer and industry services may collect and investigate information necessary to determine, on an annual basis, both of the following:

(a) The average number of covered lives per month per county by every health benefit plan in the state.

(b) The annual impact of this act on average physician fees in this state.

Sec. 11. Competing health care physicians' exercise of joint negotiation rights under sections 5 and 9 shall conform to the following criteria:

(a) Physicians may communicate with each other with respect to the contractual terms and conditions to be negotiated with a health benefit plan.

(b) Physicians may communicate with the third party who is authorized to negotiate on their behalf with health benefit plans over these contractual terms and conditions.

(c) The third party is the sole party authorized to negotiate with health benefit plans on behalf of the physicians as a group.

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

(e) Health benefit plans communicating or negotiating with the physicians' representative shall remain free to contract with

or offer different contract terms and conditions to individual competing physicians.

(f) The physicians' representative shall comply with section 13.

Sec. 13. (1) 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 representative of physicians under this act shall furnish, for the commissioner's approval, a report identifying all of the following:

(a) The representative's name and business address.

(b) The names and addresses of the physicians who will be represented by the identified representative.

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

(d) The health benefit plans with which the representative intends to negotiate on behalf of the identified physicians.

(e) The proposed subject matter of the negotiations or discussions with the identified health benefit plans.

(f) The representative's plan of operation and procedures to ensure compliance with this section.

(g) The expected impact of the negotiations on the quality of patient care.

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

(2) After the parties identified in the initial filing have reached an agreement, any person or organization proposing to act

or acting as a representative of physicians under this act shall furnish, for the commissioner's approval, a copy of the proposed contract and plan of action. Within 14 days of a health benefit plan decision declining negotiation, terminating negotiation, or failing to respond to a request for negotiation, the representative shall report to the commissioner the end of negotiations. If negotiations resume within 60 days of this notification to the commissioner, the representative shall be permitted to renew the previously filed report without submitting a new report for approval.

Sec. 15. (1) The commissioner shall either approve or disapprove an initial filing, supplemental filing, or a proposed contract within 30 days of each filing. If disapproved, the commissioner shall furnish a written explanation of any deficiencies along with a statement of specific remedial measures as to how the deficiencies could be corrected. A representative who fails to obtain the commissioner's approval is considered to act outside the authority granted under this act.

(2) The commissioner shall approve a request to enter into joint negotiations or a proposed contract if the commissioner determines that the applicants have demonstrated that the likely benefits resulting from the joint negotiation or proposed contract outweigh the disadvantages attributable to a reduction in competition that may result from the joint negotiation or proposed contract. The joint negotiation shall represent no more than 10% of the physicians in a health benefit plan's defined geographic service area except in cases where in conformance with

this subsection conditions support the approval of a greater or lesser percentage.

(3) An approval of the initial filing by the commissioner is effective for all subsequent negotiations between the parties specified in the initial filing.

(4) If the commissioner does not issue a written approval or rejection of an initial filing, supplemental filing, or proposed contract as provided in subsection (1), the applicant shall have the right to petition a district court for a mandamus order requiring the commissioner to approve or disapprove the contents of the filing immediately.

Sec. 17. (1) This act shall not be construed to enable physicians to jointly coordinate any cessation, reduction, or limitation of health care services. The representative of the physicians shall advise physicians of the provisions of this act and shall warn physicians of the potential for legal action against physicians who violate state or federal antitrust laws when acting outside the authority of this act.

(2) This act shall not be construed to prohibit physicians from negotiating the terms and conditions of contracts as permitted by other state or federal law.

Sec. 19. Each person who acts as the representative of negotiating parties under this act shall pay to the insurance commissioner a fee to act as a representative. The commissioner, by rule established under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, shall set fees in amounts reasonable and necessary to cover the costs incurred by

the state in administering this act. A fee collected under this act shall be deposited in the state treasury to the credit of the operating fund from which the expense was incurred.

Sec. 21. This act takes effect October 1, 2000.