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THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 575 Session of 2001

INTRODUCED BY TILGHMAN, COSTA, HELFRICK, TOMLINSON, LOGAN, THOMPSON, SCHWARTZ, WOZNIAK AND KITCHEN, MARCH 6, 2001

REFERRED TO PUBLIC HEALTH AND WELFARE, MARCH 6, 2001

AN ACT

Authorizing health care providers to negotiate with health care insurers; and providing for the powers and duties of the Attorney General and the Insurance Commissioner.

The General Assembly hereby finds and declares as follows:

(1) Active, robust and fully competitive markets for health care services provide the best opportunity for residents of this Commonwealth to receive high-quality health care services at an appropriate cost.

(2) A substantial amount of health care services in this Commonwealth is purchased for the benefit of patients by health care insurers engaged in the provision of health care financing services or is otherwise delivered subject to the terms of agreements between health care insurers and providers of the services.

(3) Health care insurers are able to control the flow of patients to providers of health care services through compelling financial incentives for patients in their plans to utilize only the services of providers with whom the

insurers have contracted.

(4) Health care insurers also control the health care services rendered to patients through utilization review programs and other managed care tools and associated coverage and payment policies.

(5) The power of health care insurers in markets of this Commonwealth for health care services has become great enough to create a competitive imbalance, reducing levels of competition and threatening the availability of high-quality, cost-effective health care.

(6) In many areas of this Commonwealth, the health care financing market is dominated by one or two health care insurers, with some insurers controlling over 50% of the market.

(7) Health care insurers often are able to virtually dictate the terms of the provider contracts that they offer physicians and other health care providers and commonly offer provider contracts on a take-it-or-leave-it basis.

(8) The power of health care insurers to unilaterally impose provider contract terms jeopardizes the ability of physicians and other health care providers to deliver the superior quality health care services that have been traditionally available in this Commonwealth.

(9) Physicians and other health care providers do not have sufficient market power to reject unfair provider contract terms that impede their ability to deliver medically appropriate care without undue delay or hassle.

(10) Inequitable reimbursement and other unfair payment terms adversely affect quality patient care and access by reducing the resources that health care providers can devote

to patient care and decreasing the time that physicians are able to spend with their patients.

(11) Inequitable reimbursement and other unfair payment terms also endanger the health care infrastructure and medical advancement by diverting capital needed for reinvestment in the health care delivery system, curtailing the purchase of state-of-the-art technology, the pursuit of medical research and expansion of medical services, all to the detriment of the residents of this Commonwealth.

(12) The inevitable collateral reduction and migration of the health care work force also will have negative consequences for this Commonwealth's economy.

(13) Empowering independent health care providers to jointly negotiate with health care insurers as provided in this act will help restore the competitive balance and improve competition in the markets for health care services in this Commonwealth, thereby providing benefits for consumers, health care providers and less dominant health care insurers.

(14) Allowing independent health care providers to jointly negotiate with health care insurers through a common joint negotiation representative will improve the efficiency and effectiveness of communications between the parties and result in provider contracts that better reflect the mutual areas of agreement.

(15) This act is necessary, proper and constitutes an appropriate exercise of the authority of this Commonwealth to regulate the business of insurance and the delivery of health care services.

(16) The procompetitive and other benefits of the joint

negotiations and related joint activity authorized by this act, including, but not limited to, restoring the competitive balance in the market for health care services, protecting access to quality patient care, promoting the health care infrastructure and medical advancement and improving communications, outweigh any anticompetitive effects.

(17) It is the intention of the General Assembly to authorize independent health care providers to jointly negotiate with health care insurers and to qualify such joint negotiations and related joint activities for the State-action exemption to the Federal antitrust laws through the articulated State policy and active supervision provided in this act.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Short title.

This act shall be known and may be cited as the Health Care Provider Joint Negotiation Act.

Section 2. Definitions.

The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Attorney General." The Attorney General of the Commonwealth.

"Covered lives." The total number of individuals who are entitled to benefits under a health care insurance plan, including, but not limited to, beneficiaries, subscribers and members of the plan.

"Health care insurer." Except as provided in section 14, an entity, subject to the insurance laws of this Commonwealth or

otherwise subject to the jurisdiction of the Insurance Commissioner, which contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including, but not limited to, an entity licensed under any of the following:

(1) The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

(2) The act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

(3) The act of December 14, 1992 (P.L.835, No.134), known as the Fraternal Benefit Societies Code.

(4) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).

(5) 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

For purposes of this act, a third party administrator shall be considered a health care insurer when interacting with health care providers and enrollees on behalf of a health care insurer.

"Health care insurer affiliate." A health care insurer that is affiliated with another entity by either the insurer or entity having a 5% or greater, direct or indirect, ownership or investment interest in the other through equity, debt or other means.

"Health care provider." A licensed hospital or health care facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide health care services under the laws of this Commonwealth, including, but not limited to, a physician, dentist, podiatrist, optometrist, pharmacist, psychologist, chiropractor, physical therapist, certified nurse practitioner or nurse midwife.

"Health care services." Services for the diagnosis, prevention, treatment, cure or relief of a health condition, injury, disease or illness, including, but not limited to, the professional and technical component of professional services, supplies, drugs and biologicals, diagnostic X-ray, laboratory and other diagnostic tests, preventive screening services and tests, such as pap smears and mammograms, X-ray, radium and radioactive isotope therapy, surgical dressings, devices for the reduction of fractures, durable medical equipment, braces, trusses, artificial limbs and eyes, dialysis services, home health services and hospital and other facility services.

"HMO." A health maintenance organization. The term includes any health care insurer product that requires enrollees to use health care providers in a designated provider network to obtain covered services except in limited circumstances such as emergencies.

"Insurance Commissioner." The Insurance Commissioner of the Commonwealth.

"Joint negotiation." Negotiation with a health care insurer by two or more independent health care providers acting together as part of a formal entity or group or otherwise.

"Joint negotiation representative." A representative selected by a group of independent health care providers to be the group's representative in joint negotiations with a health care insurer under this act.

"Office of Attorney General." The Office of Attorney General of the Commonwealth.

"POS." A point-of-service plan, including, but not limited to, a variation of an HMO that provides limited coverage for certain out-of-network services.

"PPO." A preferred provider organization. The term includes any health care insurer product, other than an HMO or POS product, that provides financial incentives for enrollees to use health care providers in a designated provider network for covered services.

"Provider contract." An agreement between a health care provider and a health care insurer which set forth the terms and conditions under which the provider is to deliver health care services to enrollees of the insurer. The term does not include employment contracts between a health care insurer and a health care professional.

"Provider network." A group of health care providers who have provider contracts with a health care insurer.

"Self-funded health benefit plan." A plan that provides for the assumption of the cost of or spreading the risk of loss resulting from health care services of covered lives by an employer, union or other sponsor, substantially out of the current revenues, assets or any other funds of the sponsor.

"Third party administrator." An entity that provides utilization review, provider network credentialing or other administrative services for a health care insurer or a self-funded health benefit plan.

Section 3. Negotiations regarding nonfee-related terms.

Independent health care providers may jointly negotiate with a health care insurer and engage in related joint activity, as provided in sections 6 and 7, regarding nonfee-related matters which can effect patient care, including, but not limited to any of the following:

(1) The definition of medical necessity and other conditions of coverage.

(2) Utilization review criteria and procedures.

(3) Clinical practice guidelines.

(4) Preventive care and other medical management policies.

(5) Patient referral standards and procedures, including, but not limited to, those applicable to out-of-network referrals.

(6) Drug formularies and standards and procedures for prescribing off-formulary drugs.

(7) Quality assurance programs.

(8) Respective health care provider and health care insurer liability for the treatment or lack of treatment of plan enrollees.

(9) The methods and timing of payments, including, but not limited to, interest and penalties for late payments.

(10) Other administrative procedures, including, but not limited to, enrollee eligibility verification systems and claim documentation requirements.

(11) Credentialing standards and procedures for the selection, retention and termination of participating health care providers.

(12) Mechanisms for resolving disputes between the health care insurer and health care providers, including, but not limited to, the appeals process for utilization review and credentialing determination.

(13) The health insurance plans sold or administered by the insurer in which the health care providers are required to participate.

Section 4. Negotiation regarding fees and fee-related terms.

When a health care insurer has substantial market power over

independent health care providers, the providers may jointly negotiate with the health care insurer and engage in related joint activity, as provided in sections 6 and 7 regarding fees and fee-related matters, including, but not limited to, any of the following:

(1) The amount of payment or the methodology for determining the payment for a health care service.

(2) The conversion factor for a resource-based relative value scale or similar reimbursement methodology for health care services.

(3) The amount of any discount on the price of a health care service.

(4) The procedure code or other description of the health care service or services covered by a payment.

(5) The amount of a bonus related to the provision of health care services or a withhold from the payment due for a health care service.

(6) The amount of any other component of the reimbursement methodology for a health care service.

Section 5. Substantial market power.

(a) Standard.--A health care insurer has substantial market power over health care providers when:

(1) the insurer's market share in the comprehensive health care financing market or a relevant segment of that market, alone or in combination with the market shares of affiliates, exceeds either 15% of the covered lives in the geographic service area of the providers seeking to jointly negotiate or 25,000 covered lives; or

(2) the Attorney General determines that the market power of the insurer in the relevant product and geographic

markets for the services of the providers seeking to jointly negotiate significantly exceeds the countervailing market power of the providers acting individually.

(b) Comprehensive health care financing market.--The comprehensive health care financing market includes:

(1) All health care insurer products which provide comprehensive coverage, alone or in combination with other products sold together as a package, including, but not limited to, indemnity, HMO, PPO and POS products and packages.

(2) Self-funded health benefit plans which provide comprehensive coverage.

(c) Relevant market segments.--Relevant market segments in the comprehensive health care financing market shall include the following:

(1) Health care insurer products and self-funded health benefit plans.

(2) Within the health care insurer product category, private health insurance, Medicare HMO, PPO and POS and Medicaid HMO.

(3) Within the private health insurance category, indemnity, HMO, PPO and POS products.

(4) Such other segments as the Attorney General determines are appropriate for purposes of determining whether a health care insurer has substantial market power.

(d) Annual calculation by Insurance Commissioner.--

(1) By March 31 of each year, the Insurance Commissioner shall calculate the number of covered lives of each health care insurer and its affiliates in the comprehensive health care financing market and in each relevant market segment for

each county of the Commonwealth. The Insurance Commissioner shall make these calculations by averaging quarterly data from the preceding year unless the Insurance Commissioner determines that it would be more appropriate to use other data and information. The Insurance Commissioner may recalculate covered lives determinations earlier than the required annual recalculation when the Insurance Commissioner deems appropriate.

(2) Recipients of Medicare, Medicaid and other governmental programs shall not be counted as covered lives in the health care financing market unless they receive their governmental program coverage through an HMO or another health care insurer product.

(3) When calculating the market power of a health care insurer or affiliate that has third party administration products, the covered lives of the health care insurers and self-funded health benefit plans for whom the insurer or affiliate provides administrative services shall be treated as the covered lives of the insurer or affiliate.

(4) The Insurance Commissioner's covered lives calculations shall be used for purposes of determining the market power of health care insurers in the comprehensive health care financing market from the date of the determination until the next annual determination or until the Insurance Commissioner recalculates the determination, whichever is earlier.

(5) In cases where the relevant geographic market is multiple counties, the Insurance Commissioner's calculations for those counties shall be aggregated when counting the covered lives of the health care insurer whose market power

is being evaluated.

(6) The Insurance Commissioner shall collect and investigate information necessary to calculate the covered lives of health care insurers and their affiliates.

Section 6. Conduct of negotiations.

The following requirements shall apply to the exercise of joint negotiation rights and related activity under this act:

(1) Health care providers shall select the members of their joint negotiation group by mutual agreement.

(2) Health care providers shall designate a joint negotiation representative as the sole party authorized to negotiate with the health care insurer on behalf of the health care providers as a group.

(3) Health care providers may communicate with each other and their joint negotiation representative with respect to the matters to be negotiated with the health care insurer.

(4) Health care providers may agree upon a proposal to be presented by their joint negotiation representative to the health care insurer.

(5) Health care providers may agree to be bound by the terms and conditions negotiated by their joint negotiation representative.

(6) The health care providers' joint negotiation representative may provide the health care providers with the results of negotiations with the health care insurer and an evaluation of any offer made by the health care insurer.

(7) The health care providers' joint negotiation representative may reject a contract proposal by a health care insurer on behalf of the health care providers as long as the health care providers remain free to individually

contract with the health care insurer.

(8) The health care providers' joint negotiation representative shall advise the health care providers of the provisions of this act and shall inform the health care providers of the potential for legal action against health care providers who violate the Federal antitrust laws.

(9) Health care providers may not negotiate the inclusion or alteration of terms and conditions to the extent the terms or conditions are required or prohibited by government regulation. This paragraph shall not be construed to limit the right of health care providers to jointly petition government for a change in such regulation.

Section 7. Attorney General oversight.

(a) Petition for approval of joint negotiations.--Before engaging in any joint negotiation with a health care insurer, health care providers shall obtain the Attorney General's approval to proceed with the negotiations. The petition seeking approval shall include:

(1) The name and business address of the health care providers' joint negotiation representative.

(2) The names and business addresses of the health care providers petitioning to jointly negotiate.

(3) The name and business address of the health care insurer or insurers with which the petitioning providers seek to jointly negotiate.

(4) The proposed subject matter of the negotiations or discussions with the health care insurer or insurers.

(5) The proportionate relationship of the health care providers to the total population of health care providers in the relevant geographic service area of the providers by

provider type and specialty.

(6) In the case of a petition seeking approval of joint negotiations regarding one or more fee or fee-related terms, a statement of the reasons why the health care insurer has substantial market power over the health care providers.

(7) A statement of the procompetitive and other benefits of the proposed negotiations.

(8) The health care provider's joint negotiation representative's plan of operation and procedures to ensure compliance with this act.

(9) Such other data, information and documents that the petitioners desire to submit in support of their petition.

(b) Petition for approval of modification of joint negotiations.--The health care providers shall supplement a petition under section 7(a) or (b) as new information becomes available that indicates that the subject matter of the proposed negotiations with the health care insurer has or will materially change and must obtain the Attorney General's approval of material changes. The petition seeking approval shall include:

(1) The Attorney General's file reference for the original petition for approval of joint negotiations.

(2) The proposed new subject matter.

(3) The information required by subsection (a)(6) and (7) with respect to the proposed new subject matter.

(4) Such other data, information and documents that the health care providers or health care insurer desire to submit in support of their petition.

(c) Petition for approval of provider contract terms.--No provider contract terms negotiated under this act shall be effective until the terms are approved by the Attorney General.

The petition seeking approval shall be jointly submitted by the health care providers and the health care insurer who are parties to the contract. The petition shall include:

(1) The Attorney General's file reference for the original petition for approval of joint negotiations.

(2) The negotiated provider contract terms.

(3) A statement of the procompetitive and other benefits of the negotiated provider contract terms.

(4) Such other data, information and documents that the health care providers or health care insurer desire to submit in support of their petition.

(d) Resumption of negotiations.--Joint negotiations approved under this act may continue until the health care insurer notifies the joint negotiation representative for the health care providers that it declines to negotiate or is terminating negotiations. If the health care insurer notifies the joint negotiation representative for health care providers that it desires to resume negotiations within 60 days of the end of prior negotiations, the health care providers may renew the previously approved negotiations without obtaining a separate approval of the renewal from the Attorney General.

Section 8. Attorney General determinations.

(a) Time period for review.--The Office of Attorney General shall either approve or disapprove a petition under section 7 within 30 days after the filing. If disapproved, the Attorney General shall furnish a written explanation of any deficiencies along with a statement of specific remedial measures as to how such deficiencies may be corrected.

(b) Standards for reviewing petitions.--

(1) The Office of Attorney General shall approve a

petition under section 7(a) and (b) if:

(i) The procompetitive and other benefits of the joint negotiations outweigh any anticompetitive effects.

(ii) In the case of a petition seeking approval to jointly negotiate one or more fee or fee-related terms, the health care insurer has substantial market power over the health care providers.

(2) The Office of Attorney General shall approve a petition under section 7(c) if:

(i) The procompetitive and other benefits of the contract terms outweigh any anticompetitive effects.

(ii) The contract terms are consistent with other applicable laws and regulations.

(3) The procompetitive and other benefits of joint negotiations or negotiated provider contract terms may include, but shall not be limited to:

(i) Restoration of the competitive balance in the market for health care services.

(ii) Protections for access to quality patient care.

(iii) Promotion of the health care infrastructure and medical advancement.

(iv) Improved communications between health care providers and health care insurers.

(4) When weighing the anticompetitive effects of provider contract terms, the Attorney General may consider whether the terms:

(i) provide for excessive payments; or

(ii) contribute to the escalation of the cost of providing health care services.

(c) Supplemental information.--For the purpose of enabling

the Attorney General to make the findings and determinations required by this section, the Attorney General may require the submission of such supplemental information as it may deem necessary or proper to enable him to reach a determination.

Section 9. Notice and comment.

(a) Notice to health insurer.--In the case of a petition under section 7(a) or (b), the Attorney General shall notify the health insurer of the petition and provide the insurer with the opportunity to submit written comments within a specified time frame that does not extend beyond the date on which the Attorney General is required to act on the petition.

(b) Public notice not required.--

(1) Except as provided in subsection (a), the Attorney General shall not be required to provide public notice of a petition under section 7(a), (b) or (c) to hold a public hearing on the petition or to otherwise accept public comment on the petition.

(2) The Attorney General may, at his discretion, publish notice of a petition for approval of provider contract terms in the Pennsylvania Bulletin and receive written comment from interested persons, so long as the opportunity for public comment does not prevent the Attorney General from acting on the petition within the time period set forth in this act.

Section 10. Attorney General proceedings and appellate review.

(a) Request for hearing.--Within 30 days from the mailing of a notice of disapproval of a petition under section 7, the petitioners may make a written application to the Attorney General for a hearing.

(b) Hearing to be conducted.--Upon receipt of a timely written application for a hearing, the Attorney General shall

schedule and conduct a hearing as provided for in 2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of Commonwealth agencies) and Ch. 7 Subch. A (relating to judicial review of Commonwealth agency action). The hearing shall be held within 30 days of the application unless the petitioner seeks an extension.

(c) Mandamus action.--If the Attorney General does not issue a written approval or disapproval of a petition under section 7 within the required time period, the parties to the petition shall have the right to petition the Commonwealth Court for a mandamus order requiring the Attorney General to approve or disapprove the petition.

(d) Parties to proceedings.--The sole parties with respect to any petition under section 7 shall be the petitioners and the Attorney General. Notwithstanding any otherwise applicable provision of 2 Pa.C.S. Ch. 5 Subch. A and Ch. 7 Subch. A, the Attorney General shall not be required to treat any other person as a party and no other person shall be entitled to appeal the Attorney General's determination.

Section 11. Confidentiality and disclosure.

(a) General rule.--All information, documents and copies thereof obtained by or disclosed to the Attorney General or any other person in a petition under section 7 or pursuant to a request for supplemental information under section 8(c) shall be given confidential treatment, shall not be subject to subpoena and shall not be made public or otherwise disclosed by the Attorney General or any other person without the written consent of the petitioners to whom the information pertains, except as provided in subsection (b).

(b) Exceptions.--

(1) In the case of a petition under section 7(a) or (b), the Attorney General may disclose the information required to be submitted pursuant to section 7(a)(1) through (4) and (b)(1) and (2).

(2) The Attorney General may disclose provider contracts negotiated under this act provided that the Attorney General removes or redacts those provider contract provisions that contain payment rates and fees. The Attorney General may disclose payment rates and fees to the Insurance Commissioner, the insurance department of another state, a law enforcement official of this Commonwealth or any other state or agency of the Federal Government, so long as the agency or office receiving the information agrees in writing to hold it confidential and in a manner consistent with this act.

Section 12. Good faith negotiations.

A health care insurer shall negotiate in good faith with health care providers regarding the terms of provider contracts.

Section 13. Construction.

Nothing contained in this act shall be construed:

(1) To prohibit or restrict activity by health care providers that is sanctioned under the Federal or State laws.

(2) To prohibit or require governmental approval of or otherwise restrict activity by health care providers that is not prohibited under the Federal antitrust laws.

(3) To require approval of provider contracts terms to the extent that the terms are exempt from State regulation under section 514 of the Employee Retirement Income Security Act of 1974 (Public Law (93-406, 88 Stat. 829).

(4) To expand a health care provider's scope of practice

or to require a health care insurer to contract with any type or specialty of health care providers.

Section 14. Exclusions.

Nothing contained in this act shall authorize joint negotiations regarding health care services covered under the following insurance policies or coverage programs:

(1) Workers' compensation.

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

(3) Medicare supplemental.

(4) Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

(5) Accident only.

(6) Specified disease.

(7) Long-term care insurance.

(8) Disability insurance.

(9) Credit insurance.

Section 15. Regulations.

The Attorney General may promulgate such regulations as are reasonably necessary to implement the purposes of this act.

Section 16. Repeals.

All acts and parts of acts are repealed insofar as they are inconsistent with this act.

Section 17. Effective date.

This act shall take effect in 60 days.