

SENATE BILL NO. 412

INTRODUCED BY J. COBB

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A BILL FOR AN ACT ENTITLED: "AN ACT AUTHORIZING JOINT NEGOTIATIONS BY COMPETING PHYSICIANS OF CERTAIN TERMS AND CONDITIONS OF CONTRACTS WITH HEALTH BENEFIT PLANS THAT DOMINATE THE MARKET; PROVIDING DEFINITIONS; AUTHORIZING THE INSURANCE COMMISSIONER TO ADOPT RULES; AND PROVIDING AN EFFECTIVE DATE."

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

NEW SECTION. **Section 1. Legislative findings -- purpose.** (1) The legislature finds that:

(a) joint negotiation by competing physicians of certain terms and conditions of contracts with health benefit plans will result in procompetitive effects in the absence of any express or implied threat of retaliatory joint action, such as a boycott or strike, by physicians; and

(b) although joint negotiations over fee-related terms may in some circumstances yield anticompetitive effects, there are instances in which health benefit plans dominate the market to such a degree that fair negotiations between physicians and the health benefit plan are unobtainable without joint action on behalf of physicians.

(2) The legislature finds it appropriate and necessary to authorize joint negotiations on fee-related and other issues in instances in which health benefit plans have the ability to dictate the terms of contracts offered to physicians.

NEW SECTION. **Section 2. Definitions.** As used in [sections 1 through 8], the following definitions apply:

(1) "Health benefit plan" means a plan described in [section 3].

(2) "Person" means an individual, association, corporation, or other legal entity.

(3) "Physicians' representative" means a third party, including a physician engaging in joint negotiations, who is authorized by physicians to negotiate on their behalf with a health benefit plan over contractual terms and conditions affecting those physicians.



1            NEW SECTION. **Section 3. Scope.** (1) [Sections 1 through 8] apply only to a health benefit plan  
2 that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident,  
3 or illness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a  
4 group hospital service contract, or an individual or group evidence of coverage or similar coverage  
5 document that is offered by:

6            (a) an insurance company;  
7            (b) a group hospital service corporation operating under Title 33, chapters 22 and 30;  
8            (c) a fraternal benefit society as defined in 33-7-105;  
9            (d) a stipulated premium insurance company operating under Title 33;  
10           (e) a reciprocal exchange operating under Title 33;  
11           (f) a health maintenance organization defined in 33-31-102; and  
12           (g) a multiple employer welfare arrangement as defined in 33-35-103.

13           (2) [Sections 1 through 8] do not apply to:

14           (a) a plan that provides coverage:

15                (i) only for a specified disease or other limited benefit;  
16                (ii) only for accidental death or dismemberment;  
17                (iii) for wages or payments in lieu of wages for a period during which an employee is absent from  
18 work because of illness or injury;

19                (iv) as a supplement to liability insurance;  
20                (v) for credit insurance;  
21                (vi) only for dental or vision care;  
22                (vii) only for hospital expenses; or  
23                (viii) only for indemnity for hospital confinement;

24           (b) a small employer health benefit plan written under Title 33, chapter 22, part 18;  
25           (c) a medicare supplemental policy as defined by section 1882(g)(1) of the Social Security Act,  
26 42 U.S.C. 1395ss(g)(1), as amended;  
27           (d) workers' compensation insurance coverage;  
28           (e) medical payment insurance coverage issued as part of a motor vehicle insurance policy; or  
29           (f) a long-term care policy, including a nursing home indemnity policy, unless the attorney general  
30 determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit

1 plan as described in subsection (1).

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3 NEW SECTION. **Section 4. Joint negotiation authorized -- requirements.** (1) Competing  
4 physicians within the service area of a health benefit plan may meet and communicate for the purpose of  
5 jointly negotiating the following terms and conditions of contracts with the health benefit plan:

6 (a) practices and procedures to assess and improve the delivery of effective, cost-efficient  
7 preventive health care services, including childhood immunizations, prenatal care, and mammography or  
8 other cancer screening tests or procedures;

9 (b) practices and procedures to encourage early detection and effective, cost-efficient  
10 management of diseases and illnesses in children;

11 (c) practices and procedures to assess and improve the delivery of women's medical and health  
12 care, including menopause and osteoporosis;

13 (d) clinical criteria for effective, cost-efficient disease management programs, including diabetes,  
14 asthma, and cardiovascular disease;

15 (e) practices and procedures to encourage and promote patient education and treatment  
16 compliance, including parental involvement with their children's health care;

17 (f) practices and procedures to identify, correct, and prevent potentially fraudulent activities;

18 (g) practices and procedures for the effective, cost-efficient use of outpatient surgery;

19 (h) clinical practice guidelines and coverage criteria;

20 (i) administrative procedures, including methods and timing of physician payment for services;

21 (j) dispute resolution procedures relating to disputes between health benefit plans and physicians;

22 (k) patient referral procedures;

23 (l) formulation and application of physician reimbursement methodology;

24 (m) quality assurance programs;

25 (n) health service utilization review procedures;

26 (o) health benefit plan physician selection and termination; and

27 (p) the inclusion or alteration of terms and conditions to the extent that they are subject to  
28 government regulation prohibiting or requiring the particular term or condition in question if the restriction  
29 does not limit a physician's right to jointly petition government for a change in the regulation.

30 (2) Competing health care physicians' exercise of joint negotiation rights authorized under [section

1 5(2)] and this section must conform as follows:

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

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

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

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

10 (e) A health benefit plan communicating or negotiating with the physicians' representative is free  
11 to contract with or offer different contract terms and conditions to individual competing physicians.

12 (f) The physicians' representative shall comply with the provisions of [section 6].

13

14 **NEW SECTION. Section 5. Limit on joint negotiation -- exceptions.** (1) Except as provided in  
15 subsection (2), competing physicians may not meet and communicate to jointly negotiate the following  
16 terms or conditions of contracts with a health benefit plan:

17 (a) the fees or prices for services, including those arrived at by applying any reimbursement  
18 methodology procedures;

19 (b) the conversion factors in a resource-based relative value scale reimbursement methodology  
20 or similar methodologies;

21 (c) the amount of any discount on the price of services to be rendered by physicians; and

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

24 (2) Competing physicians within the service area of a health benefit plan may jointly negotiate the  
25 terms and conditions specified in subsection (1) where the health benefit plan has substantial market  
26 power and those terms and conditions have already adversely affected or threaten to adversely affect the  
27 quality and availability of patient care.

28 (3) The commissioner may collect information and investigate as necessary to determine on an  
29 annual basis:

30 (a) the average number of covered individuals per month per county by every health care entity

1 in the state; and

2 (b) the annual impact, if any, of [sections 1 through 8] on average physician fees in the state.

3 (4) Subsection (2) does not apply to:

4 (a) a medicaid managed care plan under the medicaid managed delivery system; or

5 (b) a child health plan:

6 (i) for certain low-income children issued under Title 53; or

7 (ii) designed under section 2101 of the Social Security Act, 42 U.S.C. 1397aa.

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9 NEW SECTION. **Section 6. Requirements for physicians' representative.** (1) A physicians'  
10 representative shall:

11 (a) before engaging in any joint negotiations with health benefit plans on behalf of physicians,  
12 furnish to the commissioner a report identifying:

13 (i) the representative's name and business address;

14 (ii) the names and addresses of the physicians who will be represented by the identified  
15 representative;

16 (iii) the relationship of the physicians requesting joint representation to the total population of  
17 physicians in a geographic service area;

18 (iv) the health benefit plans with which the representative intends to negotiate on behalf of the  
19 identified physicians;

20 (v) the proposed subject matter of the negotiations or discussions with the identified health benefit  
21 plans;

22 (vi) the representative's plan of operation and procedures to ensure compliance with this section;

23 (vii) the expected impact of the negotiations on the quality of patient care; and

24 (viii) the benefits of a contract between the identified health benefit plan and physicians;

25 (b) after the parties identified in the initial filing have reached an agreement, submit to the  
26 commissioner for approval a copy of the proposed contract and plan of action; and

27 (c) within 14 days of a health benefit plan decision declining negotiation, terminating negotiation,  
28 or failing to respond to a request for negotiation, report to the commissioner that negotiations have ended.

29 If negotiations resume within 60 days of notifying the commissioner, the applicant may renew the  
30 previously filed report without submitting a new report for approval.

1           (2) The commissioner shall approve a request to enter into joint negotiations or a proposed  
2 contract upon determining that a health benefit plan controls at least 25% of the market.

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4           NEW SECTION. Section 7. Joint action prohibited. (1) [Sections 1 through 8] may not be  
5 construed to enable physicians to jointly coordinate any cessation, reduction, or limitation of health care  
6 services.

7           (2) Physicians may not:

8           (a) as a condition of the physicians' participation or group of physicians' participation in a health  
9 benefit plan, require that all physicians or group of physicians participate in all the products within the  
10 same health benefit plan; or

11           (b) negotiate to exclude, limit, or otherwise restrict nonphysician health care providers from  
12 participating in a health benefit plan based substantially on the fact that the health care provider is not a  
13 licensed physician unless the restriction, exclusion, or limitation is permitted by law.

14           (3) The physicians' representative shall advise physicians of the provisions of [sections 1 through  
15 8] and shall warn physicians of the potential for legal action against physicians who violate the provisions  
16 of [sections 1 through 8] or federal antitrust law.

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18           NEW SECTION. Section 8. Rulemaking authority. The commissioner may adopt rules necessary  
19 to implement [sections 1 through 8], including but not limited to:

20           (1) procedures for approving joint negotiation contracts; and

21           (2) procedures for determining market share of a particular health benefit plan.

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23           NEW SECTION. Section 9. Codification instruction. [Sections 1 through 8] are intended to be  
24 codified as an integral part of Title 33, and the provisions of Title 33 apply to [sections 1 through 8].

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26           NEW SECTION. Section 10. Effective date. [This act] is effective July 1, 2001.

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