



H.B. 325
124th General Assembly
(As Introduced)

Reps. Trakas, Metelsky, Aslanides, Schmidt, Damschroder, White, Schaffer, Kearns, Goodman, Kilbane, Fessler, Lendrum, Webster, Hollister, Krupinski, Allen, Key, Britton, Sullivan, D. Miller

BILL SUMMARY

- Permits two or more health care providers to jointly negotiate contracts with health insuring corporations and sickness and accident insurers.
- Gives the Superintendent of Insurance and the Attorney General enforcement authority.
- Repeals the bill's provisions three years after the bill's effective date and provides for a study of the bill's impact on health care plans.

TABLE OF CONTENTS

OVERVIEW 2

NEGOTIATIONS WITH HEALTH INSURING CORPORATIONS..... 2

Providers may negotiate with health insuring corporations regarding non-fee-related matters that affect patient care..... 2

Providers may negotiate with a health insuring corporation regarding fees and fee-related matters when the corporation has substantial market power..... 4

 The Superintendent of Insurance's role in determining the market power of a health insuring corporation..... 5

Restrictions, conditions, and requirements applicable to the exercise of joint negotiation rights 6

The Attorney General is to approve negotiations prior to their commencement..... 8

Final approval of a contract must be given by the Attorney General 9

NEGOTIATIONS WITH SICKNESS AND ACCIDENT INSURERS 10

Providers may negotiate with sickness and accident insurers regarding non-fee-related matters that affect patient care..... 10

Providers may negotiate with a sickness and accident insurer regarding fees and fee-related matters when the insurer has substantial market power.....	11
The Superintendent of Insurance's role in determining the market power of a sickness and accident insurer	12
Restrictions, conditions, and requirements applicable to the exercise of joint negotiation rights.....	13
The Attorney General is to approve negotiations prior to their commencement....	15
Final approval of a contract must be given by the Attorney General	16
 OTHER PROVISIONS	 17
Repeal of the bill's provisions; study; intent	17

CONTENT AND OPERATION

OVERVIEW

In general, the bill permits two or more health care providers to jointly negotiate contracts with health insuring corporations and sickness and accident insurers. These negotiations may extend to fees and fee-related matters only when the health insuring corporation or insurer has substantial market power over the providers. The bill imposes restrictions, conditions, and requirements on these negotiations and provides a role in the negotiations for the Superintendent of Insurance and the Attorney General. The bill states that "It is the intention of the General Assembly to . . . qualify such joint negotiations and related joint activities for the state-action exemption to the federal antitrust laws"

NEGOTIATIONS WITH HEALTH INSURING CORPORATIONS

Providers may negotiate with health insuring corporations regarding non-fee-related matters that affect patient care

(sec. 1751.132)

The bill permits health care providers to jointly negotiate with a health insuring corporation, and to engage in related joint activity, regarding non-fee-related matters that can affect patient care. The providers' joint negotiations may be related to any health care policy, contract, or agreement offered or administered by the health insuring corporation in which the providers anticipate participating. The joint negotiations may concern, but are not limited to, any of the following:

- (1) The definition of medical necessity and other conditions of coverage under the health insuring corporation's policies, contracts, and agreements;

(2) Utilization review criteria and procedures, consistent with the utilization review provisions of section 1751.77 to 1751.86 of the Health Insuring Corporation Law;

(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, consistent with the formulary provisions found in section 1753.21 of the Revised Code;

(7) Quality assurance programs, consistent with the quality assurance program provisions found in the Health Insuring Corporation Law;

(8) Respective provider and health insuring corporation liability for the treatment or lack of treatment of plan enrollees, consistent with the professional liability and malpractice insurance provisions in division (C) of section 1751.13 of the Revised Code;

(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 providers, consistent with the provisions related to health insuring corporation physicians found in sections 1753.01 to 1753.10 of the Revised Code;

(12) Mechanisms for resolving disputes between the health insuring corporation and providers.

"Provider" is defined, for purposes of the Health Insuring Corporation Law, Chapter 1751. of the Revised Code, to mean (1) any natural person or partnership of natural persons who are licensed, certified, accredited, or otherwise authorized in Ohio to furnish health care services, or (2) any professional association organized under the Professional Association Law, Chapter 1785. of the Revised Code. However, nothing in the Health Insuring Corporation Law or elsewhere in the Revised Code is to be construed to preclude a health insuring corporation, health care practitioner, or organized health care group associated with a health

insuring corporation from employing specified allied health personnel. (Sec. 1751.01(W).)

Providers may negotiate with a health insuring corporation regarding fees and fee-related matters when the corporation has substantial market power

(secs. 1751.131(A) and 1751.133)

The bill permits providers to jointly negotiate with a health insuring corporation, and to engage in related joint activity, regarding fees and fee-related matters, when a health insuring corporation has "substantial market power" over providers. The bill provides that a health insuring corporation has ***substantial market power*** over providers in either of the following situations:

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

The "comprehensive health care financing market" includes both: (a) all health insuring corporation policies, contracts, and agreements that provide comprehensive coverage, alone or in connection with other policies, contracts, and agreements sold as a package, and (b) self-funded health benefit plans that provide comprehensive coverage. A "relevant segment" in the comprehensive health care financing market is defined for this purpose to include all health insuring corporation policies, contracts, and other agreements, all self-funded health benefit plans, and such other segments as the Ohio Attorney General determines are appropriate for purposes of determining whether a health insuring corporation has substantial market power. A "health insuring corporation affiliate" is defined in the bill as a health insuring corporation that is affiliated with another entity by either the health insuring corporation or entity having a 5% or greater, direct or indirect, ownership or investment interest in the other health insuring corporation or entity through equity, debt, or other means.

(2) The Attorney General determines that the market power of the health insuring corporation 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.

When a health insuring corporation has "substantial market power" over providers, the providers' joint negotiations with the health insuring corporation may concern, but are not limited to:

(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; or

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

The Superintendent of Insurance's role in determining the market power of a health insuring corporation

(sec. 1751.134)

The bill requires the Superintendent of Insurance, not later than March 31 of each year, to calculate the number of enrollees entitled to benefits from each health insuring corporation and its health insuring corporation affiliates in the comprehensive health care financing market and in each relevant segment for each Ohio county. The Superintendent's calculations are to be used in determining the market power of health insuring corporations in the comprehensive health care financing market from the date of the calculation until the next annual calculation. Quarterly data from the preceding year is to be used by the Superintendent in the Superintendent's calculations, unless the Superintendent determines that it would be more appropriate to use other data and information. The Superintendent is also permitted to calculate the number of enrollees entitled to benefits from a health insuring corporation prior to the required annual calculation, if the Superintendent considers such a calculation to be appropriate.

When the necessary information is available to the Superintendent, the bill requires the Superintendent to separately calculate the number of enrollees entitled to benefits who are enrolled in Title XVIII of the "Social Security Act" pursuant to a medicare risk contract or medicare cost contract; in the federal employee health benefits program; in Title XIX of the "Social Security Act," known as the medical assistance program or medicaid, provided by the Ohio Department of Job and Family Services; or in any other federal health care program regulated by a federal regulatory body. The Superintendent also, when the necessary information is available, is required to calculate the number of enrollees entitled to benefits who

are enrolled in any contract, entered into by the Department of Administrative Services, covering Ohio's officers and employees.

The bill provides that when calculating the market power of a health insuring corporation or health insuring corporation affiliate that has third-party-administration products, the enrollees of any health care plan for which the health insuring corporation or health insuring corporation affiliate provides administrative services are to be treated as enrollees of the health insuring corporation or health insuring corporation affiliate. Also, in cases in which the relevant geographic market is in multiple counties, the Superintendent's calculations for those counties are to be aggregated when counting the enrollees of the health insuring corporation whose market power is being evaluated.

The Superintendent is required to adopt rules pertaining to the collection of enrollee information from health insuring corporations and health insuring corporation affiliates as necessary to complete the calculations required by the bill.

Restrictions, conditions, and requirements applicable to the exercise of joint negotiation rights

(sec. 1751.135)

The bill places certain restrictions, conditions, and requirements upon the application of the exercise of joint negotiation rights and related activities, as related to health insuring corporations, under the bill. These restrictions, conditions, and requirements are:

(1) Providers are required to select the members of their joint negotiation group by mutual agreement;

(2) Providers are required to designate a joint negotiation representative as the sole party authorized to negotiate with the health insuring corporation on behalf of the joint negotiation group;

(3) Providers are permitted to communicate with each other and their joint negotiation representative with respect to matters to be negotiated with the health insuring corporation;

(4) Providers are permitted to agree upon a proposal to be presented by their joint negotiation representative to the health insuring corporation;

(5) Providers may agree to be bound by the terms and conditions negotiated by their joint negotiation representative;

(6) Prior to proceeding with joint negotiations, providers are required to petition the Attorney General, seeking the Attorney General's approval to proceed with the negotiations (*see below*);

(7) The providers' joint negotiation representative may reject a contract proposal made by a health insuring corporation;

(8) The providers' joint negotiation representative is required to advise the providers of the joint negotiation group of the provisions of this bill pertaining to negotiations with health insuring corporations and of the potential for legal action against providers that violate federal antitrust laws; and

(9) At any time during the negotiations, a health insuring corporation may notify the providers' joint negotiation representative that the negotiations are being terminated. If the health insuring corporation notifies the joint negotiation representative that the health insuring corporation desires to resume joint negotiations within 60 days of the termination of the prior negotiations, the providers may renew the previously approved joint negotiations without obtaining a separate approval for the negotiations from the Attorney General.

The bill states that providers may not enter into a joint negotiation pursuant to these provisions with regard to contracts for the provision of health care services under Title XVIII of the "Social Security Act" pursuant to a medicare risk contract or medicare cost contract; under Title XIX of the "Social Security Act," known as the medical assistance program or medicaid, provided by the Ohio Department of Job and Family Services; under the children's health insurance program authorized by Title XXI of the "Social Security Act"; under Chapter 55 of Title X of the United States Code, providing medical and dental care for members and certain former members of the armed forces of the United States; under Chapter 17 of Title XXXVIII of the United States Code, providing veteran's medical benefits; under the federal employee health benefits program; or under Chapter 18 of Title XXV of the United States Code, providing medical care to the American Indian People. Providers are prohibited from negotiating the inclusion or alteration of any restrictions, conditions, or requirements to the extent that these restrictions, conditions, or requirements are in conflict with the federal law or the Health Insuring Corporation Law and any rules adopted thereunder. Nothing in the bill, however, is to be construed to limit the right of providers to jointly petition the government for a change in law or regulation.

The bill provides that if a joint negotiation is terminated, the providers that were involved in the joint negotiation are free to contract individually with the health insuring corporation.

The Attorney General is to approve negotiations prior to their commencement

(sec. 1751.136)

Before engaging in any joint negotiation with a health insuring corporation, those providers wishing to enter into a joint negotiation as set forth in the bill are required to file a petition with the Attorney General seeking approval to proceed with the negotiations. The bill requires this petition to include all of the following:

(1) The name and business address of the providers' joint negotiation representative;

(2) The names and business addresses of the providers petitioning to jointly negotiate;

(3) The name and business address of the health insuring corporation with which the petitioning providers seek to jointly negotiate;

(4) The proposed subject matter of the negotiations;

(5) The proportionate relationship of the providers to the total population of 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 insuring corporation has substantial market power over the providers;

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

(8) The providers' joint negotiation representative's plan of operation and procedures to ensure compliance with the bill's provisions;

(9) Such other data, information, and documents as the petitioners choose to submit in support of the petition.

Providers are required to supplement a petition as new information becomes available that indicates that the subject matter of the proposed negotiations with the health insuring corporation has or will materially change.

Providers are required to obtain the Attorney General's approval of material changes. Providers are required to petition the Attorney General in this regard, and the petition is required to contain all of the following:

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

(2) The proposed new subject matter;

(3) With respect to the new subject matter, a statement of the reasons why the health insuring corporation has substantial market power over the providers and a statement of the procompetitive and other benefits of the proposed negotiations;

(4) Such other data, information, and documents that the petitioners choose to submit in support of the petition.

The Attorney General is required to either approve or disapprove a petition within 30 days after receiving the filing. If the Attorney General disapproves a petition, the Attorney General is required to furnish a written explanation of the deficiencies in the petition along with a statement of specific remedial measures as to how those deficiencies may be corrected.

Final approval of a contract must be given by the Attorney General

(sec. 1751.137)

The bill provides that no terms negotiated in a joint negotiation with a health insuring corporation are effective until those terms are approved by the Attorney General. A petition seeking the Attorney General's approval of the negotiated terms must be jointly submitted by the health insuring corporation and by the providers that are parties to the contract. The bill requires that this petition include all of the following:

(1) The Attorney General's file reference for the original petition seeking the Attorney General's 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 providers or the health insuring corporation choose to submit in support of the petition.

The Attorney General is required to either approve or disapprove the petition within 30 days after receiving the filing. The Attorney General is not permitted to approve a petition if the negotiated provider contract terms prohibit or restrict the performance of health care services by contracting providers, which

health care services are within the recognized scope of practice of that category of provider. If the Attorney General disapproves a petition, the Attorney General is required to furnish a written explanation of the deficiencies in the petition along with a statement of specific remedial measures as to how those deficiencies may be corrected.

NEGOTIATIONS WITH SICKNESS AND ACCIDENT INSURERS

Providers may negotiate with sickness and accident insurers regarding non-fee-related matters that affect patient care

(secs. 3923.35(C) and (D) and 3923.351)

The bill permits health care providers to jointly negotiate with a sickness and accident insurer that offers an open panel plan, and to engage in related joint activity, regarding non-fee-related matters that can affect patient care. An "open panel plan," for purposes of the bill, means a sickness and accident insurer's health care plan that provides incentives for its insureds to use participating providers and that also allows its insureds to use non-participating providers. An open panel plan does not include a health care plan whose participating providers receive compensation from any other insurer. The providers' joint negotiations may be related to any health care policy offered or administered by the insurer in which the providers anticipate participating. The joint negotiations may concern, but are not limited to, any of the following:

- (1) The definition of medical necessity and other conditions of coverage under the insurer's policies;
- (2) Clinical practice guidelines;
- (3) Preventive care and other medical management policies;
- (4) Patient referral standards and procedures;
- (5) Drug formularies and standards and procedures for prescribing off-formulary drugs;
- (6) Respective provider and insurer liability for the treatment or lack of treatment of insureds;
- (7) The methods and timing of payments, including, but not limited to, interest and penalties for late payments;
- (8) Other administrative procedures, including, but not limited to, benefit eligibility verification systems and claim documentation requirements;

(9) Credentialing standards and procedures for the selection, retention, and termination of participating providers;

(10) Mechanisms for resolving disputes between the insurer and providers.

As used in connection with joint negotiations with sickness and accident insurers, "provider" means any natural person or partnership of natural persons, or any professional association organized under Chapter 1785. of the Revised Code, which person, partnership, or association is licensed, certified, accredited, or otherwise authorized in Ohio to furnish health care services.

Providers may negotiate with a sickness and accident insurer regarding fees and fee-related matters when the insurer has substantial market power

(secs. 3923.35(E) and 3923.352)

The bill permits providers to jointly negotiate with a sickness and accident insurer, and to engage in related joint activity, regarding fees and fee-related matters, when an insurer has "substantial market power" over providers. The bill provides that an insurer has "**substantial market power**" over providers in either of the following situations:

(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 share of its "sickness and accident insurer affiliates," exceeds either 15% of the insureds covered under sickness and accident insurance policies in the geographic service area of the providers seeking to jointly negotiate or 25,000 covered lives.

The "comprehensive health care financing market" includes both: (a) all policies of sickness and accident insurance that provide comprehensive coverage, alone or in combination with other policies of sickness and accident insurance sold as a package, and (b) self-funded health benefit plans that provide comprehensive coverage. A "relevant segment" of the comprehensive health care financing market is defined for this purpose to include all policies of sickness and accident insurance, all self-funded health benefit plans, and such other segments as the Ohio Attorney General determines are appropriate for purposes of determining whether a sickness and accident insurer has substantial market power. A "sickness and accident insurer affiliate" is defined in the bill as a sickness and accident 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.

(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.

When a sickness and accident insurer has "substantial market power" over providers, the providers' joint negotiations with the insurer may concern, but are not limited to:

(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; or

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

The Superintendent of Insurance's role in determining the market power of a sickness and accident insurer

(sec. 3923.353)

The bill requires the Superintendent of Insurance, not later than March 31 of each year, to calculate the number of insureds entitled to benefits from each sickness and accident insurer and its sickness and accident insurer affiliates in the comprehensive health care financing market and in each relevant segment for each Ohio county. The Superintendent's calculations are to be used in determining the market power of sickness and accident insurers in the comprehensive health care financing market from the date of the calculation until the next annual calculation. Quarterly data from the preceding year is to be used by the Superintendent in the Superintendent's calculations, unless the Superintendent determines that it would be more appropriate to use other data and information. The Superintendent is also permitted to calculate the number of insureds entitled to benefits from an insurer prior to the required annual calculation, if the Superintendent considers such a calculation to be appropriate.

When the necessary information is available to the Superintendent, the bill requires the Superintendent to separately calculate the number of insureds entitled to benefits who are enrolled in Title XVIII of the "Social Security Act" pursuant to a medicare risk contract or medicare cost contract; in the federal employee health benefits program; in Title XIX of the "Social Security Act," known as the medical assistance program or medicaid, provided by the Ohio Department of Job and Family Services; or in any other federal health care program regulated by a federal regulatory body. The Superintendent also, when the necessary information is available, is required to calculate the number of insureds entitled to benefits who are enrolled in any contract, entered into by the Department of Administrative Services, covering Ohio's officers and employees.

The bill provides that when calculating the market power of a sickness and accident insurer or sickness and accident insurer affiliate that has third-party-administration products, the insureds of any health care plan for which the insurer or sickness and accident insurer affiliate provides administrative services are to be treated as insureds of the insurer or sickness and accident insurer affiliate. Also, in cases in which the relevant geographic market is in multiple counties, the Superintendent's calculations for those counties are to be aggregated when counting the insureds of the insurer whose market power is being evaluated.

The Superintendent is required to adopt rules pertaining to the collection of insured information from sickness and accident insurers and sickness and accident insurer affiliates as necessary to complete the calculations required by the bill.

Restrictions, conditions, and requirements applicable to the exercise of joint negotiation rights

(sec. 3923.354)

The bill places certain restrictions, conditions, and requirements upon the application of the exercise of joint negotiation rights and related activities, as related to sickness and accident insurers, under the bill. These restrictions, conditions, and requirements are:

- (1) Providers are required to select the members of their joint negotiation group by mutual agreement;
- (2) Providers are required to designate a joint negotiation representative as the sole party authorized to negotiate with the insurer on behalf of the joint negotiation group;
- (3) Providers are permitted to communicate with each other and their joint negotiation representative with respect to matters to be negotiated with the insurer;

(4) Providers are permitted to agree upon a proposal to be presented by their joint negotiation representative to the insurer;

(5) Providers may agree to be bound by the terms and conditions negotiated by their joint negotiation representative;

(6) Prior to proceeding with joint negotiations, providers are required to petition the Attorney General, seeking the Attorney General's approval to proceed with the negotiations (*see below*);

(7) The providers' joint negotiation representative may reject a contract proposal made by an insurer;

(8) The providers' joint negotiation representative is required to advise the providers of the joint negotiation group of the provisions of this bill pertaining to negotiations with insurers and of the potential for legal action against providers that violate federal antitrust laws; and

(9) At any time during the negotiations, an insurer may notify the providers' joint negotiation representative that the negotiations are being terminated. If the insurer notifies the joint negotiation representative that the insurer desires to resume joint negotiations within 60 days of the termination of the prior negotiations, the providers may renew the previously approved joint negotiations without obtaining a separate approval for the negotiations from the Attorney General.

The bill states that providers may not enter into a joint negotiation pursuant to these provisions with regard to contracts for the provision of health care services under Title XVIII of the "Social Security Act" pursuant to a medicare risk contract or medicare cost contract; under Title XIX of the "Social Security Act," known as the medical assistance program or medicaid, provided by the Ohio Department of Job and Family Services; under the children's health insurance program authorized by Title XXI of the "Social Security Act"; under Chapter 55 of Title X of the United States Code, providing medical and dental care for members and certain former members of the armed forces of the United States; under Chapter 17 of Title XXXVIII of the United States Code, providing veteran's medical benefits; under the federal employee health benefits program; or under Chapter 18 of Title XXV of the United States Code, providing medical care to the American Indian People. Providers are prohibited from negotiating the inclusion or alteration of any restrictions, conditions, or requirements to the extent that these restrictions, conditions, or requirements are in conflict with the federal law or the Sickness and Accident Insurance Law, Chapter 3923. of the Revised Code, and any rules adopted thereunder. Nothing in the bill, however, is to be construed to

limit the right of providers to jointly petition the government for a change in law or regulation.

The bill provides that if a joint negotiation is terminated, the providers that were involved in the joint negotiation are free to contract individually with the insurer.

The Attorney General is to approve negotiations prior to their commencement

(sec. 3923.355)

Before engaging in any joint negotiation with a sickness and accident insurer, those providers wishing to enter into a joint negotiation as set forth in the bill are required to file a petition with the Attorney General seeking approval to proceed with the negotiations. The bill requires this petition to include all of the following:

(1) The name and business address of the providers' joint negotiation representative;

(2) The names and business addresses of the providers petitioning to jointly negotiate;

(3) The name and business address of the insurer with which the petitioning providers seek to jointly negotiate;

(4) The proposed subject matter of the negotiations;

(5) The proportionate relationship of the providers to the total population of 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 insurer has substantial market power over the providers;

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

(8) The providers' joint negotiation representative's plan of operation and procedures to ensure compliance with the bill's provisions;

(9) Such other data, information, and documents as the petitioners choose to submit in support of the petition.

Providers are required to supplement a petition as new information becomes available that indicates that the subject matter of the proposed negotiations with the insurer has or will materially change.

Providers are required to obtain the Attorney General's approval of material changes. Providers are required to petition the Attorney General in this regard, and the petition is required to contain all of the following:

- (1) The Attorney General's file reference for the original petition seeking approval of joint negotiations;
- (2) The proposed new subject matter;
- (3) With respect to the new subject matter, a statement of the reasons why the insurer has substantial market power over the providers and a statement of the procompetitive and other benefits of the proposed negotiations;
- (4) Such other data, information, and documents that the petitioners choose to submit in support of the petition.

The Attorney General is required to either approve or disapprove a petition within 30 days after receiving the filing. If the Attorney General disapproves a petition, the Attorney General is required to furnish a written explanation of the deficiencies in the petition along with a statement of specific remedial measures as to how those deficiencies may be corrected.

Final approval of a contract must be given by the Attorney General

(sec. 3923.356)

The bill provides that no terms negotiated in a joint negotiation with a sickness and accident insurer are effective until those terms are approved by the Attorney General. A petition seeking the Attorney General's approval of the negotiated terms must be jointly submitted by the insurer and by the providers that are parties to the contract. The bill requires that this petition include all of the following:

- (1) The Attorney General's file reference for the original petition seeking the Attorney General's 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 providers or the insurer choose to submit in support of the petition.

The Attorney General is required to either approve or disapprove the petition within 30 days after receiving the filing. The Attorney General is not permitted to approve a petition if the negotiated provider contract terms prohibit or restrict the performance of health care services by contracting providers, which health care services are within the recognized scope of practice of that category of provider. If the Attorney General disapproves a petition, the Attorney General is required to furnish a written explanation of the deficiencies in the petition along with a statement of specific remedial measures as to how those deficiencies may be corrected.

OTHER PROVISIONS

Repeal of the bill's provisions; study; intent

(Sections 2, 3, 4, and 5)

Uncodified language in the bill provides for the repeal of its provisions three years after its effective date. During this period, ending three years after the bill's effective date, health insuring corporations and sickness and accident insurers may enter into contract negotiations with two or more providers acting together pursuant to the bill's provisions to jointly negotiate the terms of a contract for the provision of health care services, and may enter into a contract with these providers. The bill provides that a contract entered into pursuant to its provisions may not be in force more than one year after the effective date of the bill's repeal.

Uncodified language provides that the Superintendent of Insurance is to conduct a study on the bill's impact on health care plans, including changes in the cost of health care, results of patient care, and satisfaction of providers regarding their relationship with health care plans. The Superintendent is to commence this study two years after the bill's effective date, and is to complete the study within six months. Upon the study's completion, the Superintendent is to submit a report of findings to the Governor, the Speaker and Minority Leader of the House of Representatives, the President and Minority Leader of the Senate, and the chairperson and ranking minority member of each House of Representatives and Senate committee with jurisdiction over health and insurance issues. The report must include the Superintendent's recommendation on whether to repeal the scheduled termination of the act's provisions, thereby extending the act. If the Superintendent recommends such an extension of the act, the report is to include the Superintendent's recommendation for any amendments to the act and the length of the period of the extension.

The bill provides this statement of its intention: "It is the intention of the General Assembly to authorize health care providers to jointly negotiate with health insuring corporations and sickness and accident insurers and to qualify such joint negotiations and related joint activities for the state-action exemption to the federal antitrust laws through the articulated policy and active supervision provided for in this act."

HISTORY

ACTION	DATE	JOURNAL ENTRY
Introduced	07-03-01	p. 798

h0325-i.124/jc

