HOUSE DOCKET, NO. 269 FILED ON: 1/13/2011

HOUSE . . . . . No. 279

The Commonwealth of Massachusetts

PRESENTED BY:

Michael A. Costello

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act to enable the formation of accountable care organizations.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
Michael A. Costello	*1st Essex*	*1/13/2011*
Robert L. Hedlund		*2/4/2011*
Thomas P. Kennedy		*1/28/2011*

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HOUSE . . . . . No. 279

By Mr. Costello of Newburyport, a petition (accompanied by bill, House, No. 279) of Michael A. Costello, Robert L. Hedlund and Thomas P. Kennedy for legislation to enable the formation by individual health care providers of accountable care organizations. Financial Services.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act to enable the formation of accountable care organizations.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1.

Chapter 111 of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by inserting at the end of section 204 the following :

(f) The provisions of this section shall apply to any committee formed by an individual health care provider, physician group practice, licensed health care facility or any combination thereof to perform the duties or functions of medical peer review as set forth in section one of this chapter, notwithstanding the fact that the formation of the committee is not required by law or regulation or that the individual, group or facility is not solely affiliated with a public hospital or licensed hospital or nursing home or health maintenance organization.

Section 2.

The General Laws are hereby amended by inserting after chapter 93H the following chapter:

CHAPTER 93I

PROVIDER JOINT NEGOTIATIONS

Section 1. As used in this chapter, the following words shall have the following meanings:

"Attorney General," the attorney general of the commonwealth and individuals designated by him to act on his behalf in carrying out the purposes of this chapter.

"Carrier," an insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a health maintenance organization organized under chapter 176G; and an organization entering into a preferred provider arrangement under chapter 176I. A third party administrator shall be considered a carrier when interacting with health care professionals.

"Carrier affiliate," a carrier that is affiliated with another entity by either the insurer or entity having a five percent or greater, direct or indirect, ownership or investment interest in the other through equity, debt or other means.

"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 professional," a physician or other health care practitioner licensed, accredited or certified to perform specific health services consistent with law, person, acting

alone or acting with other persons through a partnership, professional corporation, organization or association.

"Health care provider" or "provider," a health care professional or a facility.

"Health care services," services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease provided by a health care professional and performed within the lawful scope of practice.

"HMO," a health maintenance organization organized under chapter 176G. The term includes any carrier product that requires enrollees to use health care professionals in a designated provider network to obtain covered services except in limited circumstances such as emergencies.

"Incentive plan," any compensation arrangement between a carrier and a health care professional or health care provider group or organization that employs or utilizes services of one or more health care professionals that may directly or indirectly have the effect of reducing or limiting services furnished to insured's, including but not limited to withholds and risk sharing arrangements.

"Joint negotiation," negotiation with a carrier by two or more health care professionals acting together as part of a formal entity or group or otherwise.

"Joint negotiation representative," a representative selected by a group of health care professionals to be the group's representative in joint negotiations with a carrier under this act.

"Office of Attorney General," the office of attorney general of the commonwealth.

"POS," a point-of-service plan, a variation of an HMO that provides insureds with the choice of obtaining diagnostic and treatment services from a provider of health care services who is not under contract with or is otherwise a participating provider in a carrier's network.

"PPO," a preferred provider organization organized under chapter 176I. The term includes any carrier product, other than an HMO or POS product, that provides financial incentives for enrollees to use health care professionals in a designated provider network for covered services.

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

"Provider network," a grouping of health care providers who contract with a carrier to provide services to insureds covered by any or all of the carrier's plans, policies, contracts or other arrangements.

"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 employer, union or other sponsor.

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

Section 2. Purpose.

(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 carriers engaged in the provision of health care financing services or is otherwise delivered subject to the terms of agreements between carriers and health care professionals.

(3) Carriers are able to control the flow of patients to health care professionals through compelling financial incentives for patient's plans to utilize only the services of health care professionals with whom the carriers have contracted.

(4) Carriers 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 carriers 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) Carriers often are able to virtually dictate the terms of the contracts that they offer health care professionals and commonly offer provider contracts on a take-it-or-leave-it basis.

(7) The power of carriers to unilaterally impose contract terms jeopardizes the ability of physicians and other health care professionals to deliver the superior quality health care services that have been traditionally available in this commonwealth.

(8) Physicians and other health care professionals 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.

(9) Inequitable reimbursement and other unfair payment terms adversely affect quality patient care and access by reducing the resources that health care professionals can devote to patient care and decreasing the time that physicians are able to spend with their patients.

(10) Empowering health care professionals to jointly negotiate with carriers 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 professionals and less dominant carriers.

(11) Allowing health care professionals to jointly negotiate with carriers 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.

(12) Empowering health care professionals who form accountable care organizations to jointly negotiate with carriers is necessary to facilitate the formation of such organizations and provide access to affordable, quality health care.

(13) This chapter 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.

(14) It is the intention of the General Court to authorize health care professionals to jointly negotiate with carriers and other purchasers of health care services, 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, under section 7 of chapter 93 of the General Laws. Section 3. Health care professionals may jointly negotiate with a carrier and engage in related joint activity, as provided in sections 6 and 7, regarding nonfee-related matters which can affect 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 professional and carrier 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) The terms and conditions for amending any agreement between health care professionals and a health insurer, including the amendment of payment methodologies, fee schedules, and payment and claims policies and procedures.

(11) The terms and conditions for the reconciliation process under incentive plans, including but not limited to risk sharing and withhold arrangements.

(12) The terms and conditions for retroactive termination of covered lives, including but not limited to beneficiaries, subscribers and members of the plan.

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

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

(15) Mechanisms for resolving disputes between the carrier and health care professionals, including, but not limited to, claims payment, and the appeals process for utilization review and credentialing determination.

(16) The carrier plans sold or administered by the insurer in which the health care professionals are required to participate.

Section 4. When a carrier has substantial market power over health care professionals, or when the health care professionals are negotiating through an accountable care organization, the professionals may jointly negotiate with carrier 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. (a) A carrier has substantial market power over health care professionals when either (1) the carrier'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 its carrier affiliates, exceeds either twenty-five percent of the covered lives in the geographic service area of the professionals seeking to jointly negotiate; or (2) the Attorney General determines that the market power of the insurer in the relevant service and geographic markets for the services of the professionals seeking to jointly negotiate significantly exceeds the countervailing market power of the professionals acting individually.

(b) The comprehensive health care financing market includes (1) all carrier 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; and (2) self-funded health benefit plans which provide comprehensive coverage.

(c) Relevant market segments in the comprehensive health care financing market shall include the following: (1) carrier products and self-funded health benefit plans; (2) within the carrier 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; and (4) such other segments as the Attorney General determines are appropriate for purposes of determining whether a carrier has substantial market power.

Section 6. The following requirements shall apply to the exercise of joint negotiation rights and related activity under this act:

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

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

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

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

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

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

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

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

Section 7. (a) Before engaging in any joint negotiation with a carrier, health care professionals not negotiating as part of an accountable care organization shall obtain the Attorney General's approval to proceed with the negotiations. The petition seeking approval shall include the following: (1) the name and business address of the health care professionals' joint negotiation representative; (2) the names and business addresses of the health care professionals petitioning to jointly negotiate; (3) the name and business address of the carrier or insurers with which the petitioning providers seek to jointly negotiate; (4) the proposed subject matter of the negotiations or discussions with the carrier or insurers; (5) the proportionate relationship of the health care professionals to the total population of health care professionals in the relevant geographic service area of the providers by 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 carrier has substantial market power over

the health care professionals; and (7) such other data, information and documents that the petitioners desire to submit in support of their petition.

(b) The petition seeking approval shall include the following: (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) with respect to the proposed new subject matter; and (4) such other data, information and documents that the health care professionals or carrier desire to submit in support of their petition.

(c) No provider contract terms, other than those involving accountable care organizations, 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 professionals and the carrier 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; and (3) such other data, information and documents that the health care professionals or carrier desire to submit in support of their petition.

Section 8. (a) The Office of Attorney General shall either approve or disapprove a petition under section(s) 7(a), (b) or (c) within 30 days after such petition is filed. If any petition is disapproved, the Attorney General shall furnish a written explanation of any deficiencies with such petition along with a statement of specific remedial measures as to how such deficiencies may be corrected.

(b) (1) The Office of Attorney General shall approve a petition under section 7(a) and (b) if (i) the pro-competitive and other benefits of the joint negotiations outweigh its anti-competitive effects, and (ii) in the case of a petition seeking approval to jointly negotiate one or

more fee or fee-related terms, the carrier has substantial market power over the health care professionals.

(2) The pro-competitive 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, and (iii) improved communications between health care professionals and carriers.

(c) 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. 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.

Section 10. Within 180 days from the mailing of a notice of disapproval of a petition under section 8, the petitioners may commence a claim in superior court seeking approval of such petition. The matter shall be tried by the court without a jury. The court shall enter its findings as a judgment of the court and the judgment shall have the same effect and be enforceable as any other judgment of the court in civil cases, subject to the provisions of this chapter. Appeals may be taken to the supreme judicial court under the same conditions and under the same practice as appeals are taken from judgments in civil cases rendered by the superior court.

Section 11. Any petition submitted under section 7 herein and any supplemental submission made under section 8 herein shall be considered confidential, not a public record under the section 7 of chapter 4, and not subject to public disclosure under section 10 of chapter 66.

Section 12. The Attorney General may, in effectuating the purposes of this chapter, engage experts or consultants to assist with the review of the petition. All copies of reports prepared by experts and consultants shall be made available to the petitioners. All costs incurred under this chapter shall be the responsibility of the petitioners in an amount to be determined by the Attorney General. No petition for approval of joint negotiations, petition for approval of modification of joint negotiations, or petition for approval of provider contracts shall be considered complete, unless an agreement has been executed with the Attorney General for the payment of costs incurred pursuant to this chapter.

Section 13. Nothing contained in this act shall be construed (1) to prohibit or restrict activity by health care professionals that is sanctioned under the federal or state laws; (2) to prohibit or require governmental approval of or otherwise restrict activity by health care professionals 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); or, (4) to expand a health care professional's scope of practice or to require a carrier to contract with any type or specialty of health care professionals.

Section 14. If any provision of this chapter or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of

the chapter, which can be given effect without the invalid provision or application, and to this end the provisions of this chapter are declared to be severable.

SECTION 3. This act shall take effect on October 1, 2011.