By Representative Lawson

A bill to be entitled

An act relating to joint negotiations by health care providers with health care insurers; providing a short title; providing legislative findings; providing application; providing definitions; providing exclusions; providing for negotiations relating to nonfee-related terms; providing for negotiations relating to fees and fee-related terms; providing procedures and requirements; providing for determinations of substantial market power; providing duties and responsibilities of the Insurance Commissioner; providing for conduct of negotiations; providing requirements and limitations; providing duties and responsibilities of the Attorney General relating to oversight, approval or disapproval of negotiations and contracts, notice and hearings, proceedings and appellate review, and rulemaking authority; requiring good faith negotiations; providing for arbitration; providing requirements and procedures; providing for fees; providing for severability; providing for immunity from antitrust liability; providing construction; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Short title.--This act may be cited as the "Health Care Provider Joint Negotiation Act."

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

Section 2. Legislative findings.--The Legislature finds and determines that:

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

(2) A substantial amount of health care services in this state 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 health care providers.

(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 state 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 state, the health care financing market is dominated by one or two health care insurers, with some insurers controlling over 50 percent of the market.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

(7) Health care insurers are often able to virtually dictate the terms of the provider contracts 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 state.

(9) Physicians and other health care providers do not have sufficient economic 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 and curtailing the purchase of state-of-the-art technology, the pursuit of medical research, and the expansion of medical services, all to the detriment of the residents of this state.

(12) The inevitable collateral reduction and migration of the health care workforce will also have negative consequences for this state'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

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

competition in the markets for health care services in this state, thereby providing benefits for consumers.

(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 and proper and constitutes an appropriate exercise of the authority of this state to regulate the business of insurance and the delivery of health care services.

(16) Joint negotiation by certain competing health care providers of certain terms and conditions of contracts with health plans will result in procompetitive effects.

(17) The procompetitive effects 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.

(18) Although the Legislature finds that joint negotiation over fee-related terms may, under some circumstances, yield anticompetitive effects, the Legislature also recognizes that there are instances in which health plans dominate the market to such a degree that fair negotiations between health care providers and the plan are unobtainable absent any joint action on behalf of health care providers.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

(19) It is the intention of the Legislature 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.

Section 3. Scope.--This act applies solely to any health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document, that is offered by a health care insurer and the health care insurer's affiliates.

Section 4. Definitions.--As used in this act, unless the context clearly indicates otherwise:

(1) "Covered lives" means 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.

(2) "Health care insurer" means any entity licensed under the Florida Insurance Code, subject to the insurance laws of this state, 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, except as provided in section 5. For purposes of this act, a third party administrator shall be considered a health care insurer when

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

interacting with health care providers and enrollees on behalf of a health care insurer.

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

(4) "Health care provider" means a person who is licensed, certified, or otherwise regulated to provide health care services under the laws of this state, including, but not limited to, a physician, dentist, podiatrist, optometrist, pharmacist, psychologist, chiropractor, physical therapist, certified nurse practitioner, or nurse midwife. The term does not include hospitals, health care facilities, or medical equipment suppliers.

(5) "Health care services" means 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.

(6) "Health maintenance organization" has the same meaning as that provided in s. 641.19, Florida Statutes, and 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, including, but not limited to, emergencies.

(7) "Joint negotiation" means 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.

(8) "Joint negotiation representative" means 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.

(9) "Point-of-service plan" includes, but is not limited to, a variation of a health maintenance organization contract that provides limited coverage for certain out-of-network services.

(10) "Preferred provider" has the same meaning as that provided in s. 627.6471, Florida Statutes, and includes any health care insurer product, other than a health maintenance organization or point-of-service product, that provides financial incentives for enrollees to use health care providers in a designated provider network for covered services.

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

(12) "Provider network" means a group of health care providers who have provider contracts with a health care insurer.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

(13) "Self-funded health benefit plan" means 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.

(14) "Third party administrator" means 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 5. Exclusions.--Nothing in this act authorizes joint negotiations regarding health care services covered under the following insurance policies or coverage programs:

(1) Workers' compensation.

(2) Disability insurance, including policies that specify payments be provided in lieu of wages for a period during which an employee is absent from work because of sickness or injury.

(3) Motor vehicle insurance that includes payments issued for medical coverage.

(4) Medicare Supplemental, as defined by s. 1882(g)(1) of the Social Security Act, 42 U.S.C. s. 1395ss, as amended.

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

(6) Accident only, including death and dismemberment.

(7) Specified disease only, or other such limited benefits.

(8) Long-term care, including a nursing home indemnity policy, unless the Attorney General determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described in section 3.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

(9) Credit insurance.

(10) Policies or programs supplemental to liability insurance.

Section 6. Negotiations regarding nonfee-related terms.--Competing health care providers may meet and communicate with each other for the purpose of jointly negotiating terms and conditions of contracts and may jointly negotiate with a health care insurer and engage in related joint activity, as provided in section 9 and subsection (1) of section 10, regarding nonfee-related matters which can affect patient care, including, but not limited to:

(1) The definition of medical necessity and other conditions of coverage insofar as such terms are not defined by other provisions of law.

(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 and out-of-region care sites.

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

(7) Quality assurance programs.

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

(9) Fiscally oriented administrative procedures, including, but not limited to, the methods and timing of payments, including, but not limited to, interest and penalties for late payments.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

(10) Nonfiscally oriented 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) Whether and the extent to which the health care providers are required to participate in other health insurance plans sold or administered by the health care insurer.

(14) Practices and procedures to encourage and promote patient education and treatment compliance.

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

(16) Procedures by which expanded access to care may be achieved.

(17) Procedures by which inclusion or alteration of contractual terms and conditions may occur, to the extent they are the subject of government regulation prohibiting or requiring their existence, provided that such restriction does not limit health care providers' rights to jointly petition government to change such regulation.

Section 7. Negotiation regarding fees and fee-related terms.--If a health care insurer has substantial market power over independent health care providers, competing health care providers may meet and communicate with each other for the purpose of jointly negotiating terms and conditions of

contracts and may jointly negotiate with the health care insurer, and engage in related joint activity, as provided in section 9 and subsection (1) of section 10 regarding fees and fee-related matters, including, but 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.

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

(7) The amount of capitation or fixed payment for health care services rendered by health care providers to enrollees of the health care insurer.

Section 8. Substantial market power.--

(1) For purposes of this section:

(a) A health care insurer has substantial market power over health care providers if:

1. The comprehensive health care financing market or a relevant segment of that market reflects a market concentration of 1800 or greater as calculated by the Herfindahl-Hirschman Index, and the health care insurer, alone or in combination with the market shares of health care

insurer affiliates, has one of the five highest market shares in that market or relevant segment; or

2. The Attorney General determines that the market power of the health care insurer in the relevant product and geographic markets for the services of the health care providers seeking to jointly negotiate significantly exceeds the countervailing market power of the health care providers acting individually.

(b) 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, health maintenance organization, preferred provider, and point-of-service products and packages.

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

(c) Relevant market segments in the comprehensive health care financing market include:

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

2. Within the health care insurer product category, private health insurance, Medicare health maintenance organizations, Medicare preferred provider organizations, Medicare point-of-service plans, and Medicaid health maintenance organizations.

3. Within the private health insurance category, indemnity, health maintenance organization, preferred provider, and point-of-service products.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

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

(2)(a) By March 31 of each year, the Insurance Commissioner shall calculate the number of covered lives of each health care insurer and its health care insurer affiliates in the comprehensive health care financing market and in each relevant market segment for each county in this state. The Insurance Commissioner shall make these calculations by averaging quarterly data from the preceding year unless the Insurance Commissioner determines that using other data and information would be more appropriate. The Insurance Commissioner may recalculate covered lives determinations earlier than the required annual recalculation when the Insurance Commissioner deems appropriate.

(b) 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 a health maintenance organization or another health care insurer product.

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

(d) The Insurance Commissioner's covered lives calculations shall be used for purposes of determining the market share of health care insurers in the comprehensive health care financing market from the date of the

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

determination until the next annual determination or until the Insurance Commissioner recalculates the determination, whichever is earlier.

(e) In cases in which the relevant geographic market consists of 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.

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

Section 9. 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 a 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 the 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 the joint negotiation representative to the health care insurer.

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

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

(6) The 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 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 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 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 subsection shall not be construed to limit the right of health care providers to jointly petition government for a change in such regulation.

Section 10. Attorney General; oversight; determinations; notice and hearings; proceedings and appellate review; rules.--

(1)(a) Before engaging in any joint negotiation with a health care insurer, health care providers shall petition the Attorney General for 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 health care 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 by health care 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 the health care insurer has substantial market power over the health care providers.

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

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

9. Such other data, information, and documents the health care providers desire to submit in support of the petition.

(b) The health care providers shall supplement a petition under paragraph (a) 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 shall petition the Attorney General for approval of modification of the subject matter of the joint negotiations. The petition seeking approval of modification shall include:

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

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

2. The proposed new subject matter.

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

4. Such other data, information, and documents the health care providers desire to submit in support of the petition.

(c) No provider contract terms negotiated under this act shall be effective until the terms are approved by the Attorney General. The petition seeking approval of provider contract terms shall be jointly submitted to the Attorney General by the health care providers and the health care insurer who are parties to the contract. The petition seeking approval of provider contract terms 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 the health care providers desire to submit in support of the petition.

(d) Joint negotiations approved under this act may continue until the health care insurer notifies the joint negotiation representative that the health care insurer declines to negotiate or is terminating negotiations. If the health care insurer notifies the joint negotiation representative that the health care insurer desires to resume negotiations within 60 days after 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.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

(2)(a) The Office of Attorney General shall either approve or disapprove a petition under subsection (1) 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)1. The Office of Attorney General shall approve a petition under paragraph (1)(a) or paragraph (1)(b) if:

a. The petition meets the requirements set forth in such paragraphs, as applicable.

b. The anticompetitive effects, if any, do not outweigh the procompetitive effects and other benefits of the joint negotiations.

c. 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 as determined pursuant to section 8.

2. The Office of Attorney General shall approve a petition under paragraph (1)(c) if:

a. The petition meets the requirements set forth in such paragraph.

b. The anticompetitive effects, if any, do not outweigh the procompetitive effects and other benefits of the contract terms.

c. The contract terms are consistent with other applicable laws and regulations.

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

a. Restoration of the competitive balance in the market for health care services.

b. Protections for access to quality patient care.

c. Promotion of the health care infrastructure and medical advancement.

d. 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:

a. Provide for excessive payments; or

b. Contribute to the escalation of the cost of providing health care services.

5. A petition may be denied only if the petition does not meet the requirements of this subsection.

(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 the Attorney General may deem necessary or proper to enable him or her to reach a determination.

(3)(a) In the case of a petition under paragraph (1)(a) or paragraph (1)(b), the Attorney General shall notify the health care insurer of the petition and provide the health care insurer with the opportunity to submit written comments within a specified timeframe that does not extend beyond the date on which the Attorney General is required to act on the petition.

(b)1. Except as provided in paragraph (a), the Attorney General shall not be required to provide public notice of a petition under paragraph (1)(a), paragraph (1)(b), or paragraph (1)(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 or her discretion, publish notice of a petition for approval of provider contract terms in the Florida Administrative Weekly 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.

(4)(a) Within 30 days after the mailing of a notice of disapproval of a petition under subsection (2), the petitioners may make a written application to the Attorney General for a hearing.

(b) Upon receipt of a timely written application for a hearing, the Attorney General shall schedule and conduct a hearing as provided for in chapter 120, Florida Statutes. The hearing shall be held within 30 days after the application unless the petitioners seek an extension.

(c) If the Attorney General does not issue a written approval or disapproval of a petition under subsection (2) within the required time period, the parties to the petition shall have the right to petition a court for a mandamus order requiring the Attorney General to approve or disapprove the petition.

(d) The sole parties with respect to any petition under subsection (2) shall be the petitioners and the Attorney General, and notwithstanding any otherwise applicable provision of law, 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.

(5) The Attorney General may adopt any rules reasonably necessary to implement the purposes of this act.

Section 11. Good faith negotiations.--

(1) Both health care insurers and health care providers shall negotiate in good faith regarding the terms of insurer-provider contracts.

(2) Health care providers may not propose a plan to exclude, limit, or otherwise restrict any other health care provider from participation in a health benefit plan.

(3) The joint negotiation representative shall advise health care providers of the provisions herein and shall warn health care providers of the potential for legal action against health care providers who violate state or federal antitrust laws when acting outside the authority granted in this act.

Section 12. Arbitration.--

(1) Health care providers within the coverage of this act shall have the right to jointly negotiate with health care insurers and the right to invoke a dispute resolution process.

(2) Health care providers within the coverage of this act shall exert every reasonable effort to settle all disputes by engaging in joint negotiations in good faith and by achieving written agreements.

(3) Joint negotiations shall begin at least 6 months before the termination of a contract and any request for arbitration shall be made at least 3 months before termination of a contract.

(4)(a) Either the health care insurer or the health care provider may request appointment of a board of arbitration by providing written notice to the other party containing specifications of each disputed issue causing the impasse.

(b) Such request shall be filed with the Attorney General and shall lead to the appointment of a board of

arbitration composed of three persons; one each shall be appointed by the health care insurer and health care provider, and these two shall mutually concur as to appointment of the third.

(c) Such appointments shall be made within 5 days after filing. If, after 10 additional days, the third person has not been chosen, the American Arbitration Association, or its successor in function, shall be requested by the Attorney General to furnish a list of three members of said association from which the third arbitrator shall be selected. Within 5 days thereafter, the already-appointed arbitrators shall sequentially delete one name from the three-person list, with the first deletion made by the arbitrator appointed by the non-requesting party.

(d) The arbitrator who has not been appointed by either disputing party shall serve as the chair of the board of arbitrators.

(e) The board of arbitrators thus established shall commence the arbitration proceedings within 10 days after the third arbitrator has been selected and the board shall make its determination within 30 days after the appointment of the third arbitrator.

(f) Each of the arbitrators shall have the power to administer oaths, to compel the attendance of witnesses, and to subpoena provision of physical evidence.

(g) The determination of the majority of the board of arbitration shall be final on each disputed issue and shall be binding on all parties, such determination shall be provided in writing to all parties, and no appeal from such determination shall be allowed to any court.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

(5) Fees incurred through the arbitration process shall be split equally between the parties.

(6) Nothing contained in this act shall be construed to permit health care providers within the coverage of this act to jointly coordinate any cessation, reduction, or limitation of health care services.

(7) If subsection (1), paragraph (4)(a), or paragraph (4)(g), or the application of such provisions to any person or circumstances, shall, for any reason, be adjudged by a court of competent jurisdiction to be invalid, such judgment shall have the effect of also invalidating subsection (6).

Section 13. Immunity from antitrust liability.--Any actions by health care providers or their representatives pursuant to this act shall be exempt from all federal and state antitrust laws and shall not give rise to any legal cause of action or liability against health care providers whose conduct is consistent with this act.

Section 14. Construction.--Nothing contained in this act shall be construed to:

(1) Prohibit or restrict activity by health care providers that is sanctioned under federal or state laws.

(2) Prohibit or require governmental approval of or otherwise restrict activity by health care providers that is not prohibited under federal antitrust laws.

(3) Require approval of provider contract terms to the extent that the terms are exempt from state regulation under section 514 of the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406.

(4) Expand a health care provider's scope of practice under current law or to require a health care insurer to contract with any type or specialty of health care providers.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

Section 15. This act shall take effect October 1, 2000.

****

HOUSE SUMMARY

Creates the Health Care Provider Joint Negotiation Act to authorize health care providers to meet and communicate for purposes of jointly negotiating, through a joint negotiation representative, with health care insurers to restore competitive balance and improve competition in markets for health care services. Distinguishes between negotiations relating to nonfee-related and fee-related terms. Establishes the concepts of substantial market power and market share relating to health care services and products. Specifies procedures for conducting negotiations. Provides duties and responsibilities of the Attorney General in overseeing, reviewing, and approving negotiations. Provides for arbitration. Provides for immunity from antitrust liability. See bill for details.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.