
OLR Bill Analysis

HB 5345

AN ACT CONCERNING COOPERATIVE HEALTH CARE ARRANGEMENTS.

SUMMARY:

This bill permits health care practitioners from two or more firms to form a health care collaborative (“collaborative”) to negotiate as a group with insurers, managed care organizations (MCO), or other similar groups for compensation, prices, and conditions of service. It defines practitioners as licensed (1) physicians, (2) chiropractors, (3) podiatrists, (4) naturopaths, and (5) optometrists. A collaborative must apply to the Office of Healthcare Advocate (OHA) for approval to (1) negotiate an agreement and (2) implement any final agreement.

The bill exempts collaboratives from state antitrust law if they operate under the bill’s provisions (see BACKGROUND). It is not clear whether, despite being exempted from state antitrust law, collaboratives would be considered a violation of federal antitrust law.

Under the bill, when negotiations stall between a collaborative and an insurer or MCO, the healthcare advocate must take steps to help the parties reach an agreement. If there is an impasse, the advocate must order a resolution, which is presumably binding on both parties. An insurer or MCO can face civil penalties for refusing to negotiate with a collaborative.

The bill authorizes OHA to issue certificates of public advantage (CPAs) that permit collaboratives to negotiate. It requires OHA to regulate collaboratives and gives it authority to revoke their certificates for failing to comply with their application or terms of approval.

The bill exempts all applications, reports, records, documents, and other information obtained by the advocate due to activities under the bill from the Freedom of Information Act.

The bill also includes provisions addressing (1) appealing the advocate's decisions to Superior Court, (2) charging prospective collaboratives an administrative fee, (3) requiring the advocate to report annually to the governor and General Assembly, and (4) adopting regulations.

EFFECTIVE DATE: October 1, 2014

§ 2 — HEALTH CARE COLLABORATIVE AUTHORITY TO NEGOTIATE

The bill permits a prospective collaborative or a collaborative to negotiate on behalf of itself and its practitioners and enter into agreements with health plans to provide health care items and services under the plans, provided the healthcare advocate determines the prospective collaborative or collaborative complies with the bill's requirements (see "Certificate Process" below regarding authority to negotiate).

It defines "prospective health care collaborative" as an entity comprised of health care practitioners who practice in two or more separate firms that (1) is seeking recognition as a health care collaborative, or (2) has received preliminary CPA from OHA. A "health care collaborative" is an entity comprised of practitioners who practice in two or more separate firms and that has:

1. entered or plans to enter into a compensation agreement with a health plan to incentivize quality over volume and place practitioners at risk for some or all of the costs of inefficient care delivery, or
2. arranged to implement an ongoing program to evaluate and modify practitioner practice patterns and create interdependence and cooperation among practitioners to ensure efficient delivery of care.

The bill does not define phrases such as "incentivize quality over volume" and "place practitioners at risk for some of all of the costs of inefficient care delivery." Presumably, they refer to methods to

financially reward efficient care delivery.

It defines a “health plan” as an entity that pays for health care services, including commercial health insurance plans, self-insurance plans, health maintenance organizations (HMOs), MCOs, or any insurer or corporation under state insurance law. It is not clear whether the bill’s provisions could apply to self-insured plans because a federal law, the Employee Retirement Income Security Act (ERISA), exempts self-insured plans from state regulations (see BACKGROUND).

The bill specifies that it does not limit a practitioner from exercising his or her rights under the National Labor Relations Act (29 USC 151 et seq.) or any other applicable federal or state law.

§ 3 — CERTIFICATE PROCESS

Preliminary Certificates of Public Advantage (CPA)

Before any negotiations take place, OHA must (1) grant the collaborative a preliminary CPA and (2) determine it is a health care collaborative. The collaborative must apply to OHA for a preliminary certificate.

The bill requires the application to include:

1. the prospective collaborative’s name,
2. the names of the practitioners included,
3. the health plan’s name,
4. the expected effects of the contract on the quality and price of practitioner services,
5. either the collaborative's (a) proposed method of health plan payment designed to incentivize quality over volume and place practitioners at risk for some or all of any inefficient health care delivery or (b) arrangements to evaluate and modify practitioner practice and create practitioner interdependence and cooperation in order to efficiently deliver care, and

6. any other information the advocate requests.

Criteria and Decision on Applications

The bill requires that, for OHA to find that a prospective collaborative is a collaborative (i.e., no longer just “prospective”), it must meet one of two criteria intended to control costs while maintaining patient care.

A collaborative must either:

1. place or plan to place its practitioners at risk for some or all of their inefficient health-care delivery through methods, including pay-for-performance, capitation, shared savings and costs, bundled payment arrangements, or other financial incentives or risk assumption mechanisms based in whole or in part on per-episode, per-population, or per-procedure costs, outcomes, patient satisfaction, education, or welfare activities; or
2. implement a program to modify practitioner practice patterns and create interdependence and cooperation among the practitioners to ensure quality. The latter includes (a) cost control and quality-of-care mechanisms to monitor and control utilization of health care services, (b) selecting network health compensations intended to further the efficiency aims, or (c) investing monetary and human capital in the necessary infrastructure and capability to achieve the efficiencies.

The bill does not define these terms or concepts. It also does not detail how OHA is to evaluate these cost-control mechanisms or programs to create cooperation and monitor utilization or promote efficiency.

The bill requires OHA to decide on a prospective collaborative’s application within 20 days of receiving it. OHA must notify the collaborative in writing of the decision to approve or reject. If it rejects an application, OHA must furnish a written explanation of any deficiencies, along with specific proposals for remedial measures to address them.

The bill gives OHA the option of conducting a hearing, after giving notice to the parties, to obtain information necessary to decide on the application.

§4 — NEGOTIATIONS

Notification to OHA

Under the bill, once the collaborative receives a preliminary certificate, it must notify OHA no later than 14 days after any of the following events occur:

1. negotiations begin;
2. negotiations conclude;
3. negotiations reach an impasse; or
4. a health plan's refusal to negotiate, cancellation of negotiations, or failure to respond to a negotiation request.

Impasse or Failure to Negotiate

Under the bill, several situations require OHA to act. If (1) the advocate determines that negotiations are at an impasse or (2) a health plan declines to negotiate, cancels negotiations, or fails to respond to a request for negotiation, the advocate must designate a mediator to assist the parties in starting or continuing negotiations and in reaching a settlement of the issues presented in negotiation.

The mediator designated must be experienced in health care mediation and selected from a list of mediators maintained by the advocate, the American Arbitration Association, or the Federal Mediation and Conciliation Service. Both parties must agree on the mediator.

If, after a reasonable period of mediation (not defined), the parties are unable to agree, the advocate must appoint a fact-finding board of not more than three members drawn from the list of mediators she maintains, the American Arbitration Association, or the Federal Mediation and Conciliation Service. A majority of board's members

may vote to make recommendations for the resolution of the negotiations.

Advocate Order to End Impasse

The fact-finding board must also, no later than 60 days after the members are appointed, submit its findings and recommendations in writing to the advocate, the collaborative, and the health plan. If the impasse continues longer than 20 days after the date of submission, the advocate must order a resolution to the negotiations based on the board's findings of fact and recommendations. (It appears that the resolution is binding on both parties, but the bill does not specify this.)

Refusal to Negotiate and Penalty

The bill prohibits a health plan from refusing to negotiate in good faith with a collaborative. Whenever, in the advocate's judgment, a plan has refused to negotiate in good faith in violation of the bill or any regulation adopted or order issued related to the bill, the advocate can ask the attorney general to bring an action in the New Britain Superior Court for an order directing the plan to comply.

The advocate has the discretion to observe the good faith negotiations between the plan and the collaborative.

A plan that refuses to negotiate is subject to a civil penalty of up to \$25,000, to be fixed by the court, for each day of each violation. The bill requires each violation be a separate and distinct offense and, in the case of a continuing violation, each day's continuance is considered a separate and distinct offense. At the advocate's request, the attorney general must institute a civil action in the New Britain Superior Court to recover the penalty.

§5 — REVIEW OF AGREEMENTS AND CERTIFICATE OF PUBLIC ADVANTAGE

All agreements negotiated under the bill must be submitted to the advocate for review and either approved or rejected.

Within 60 days after receiving an agreement, the advocate must provide a tentative approval or rejection. Before issuing a decision, the

advocate must issue a public notice and allow a 30-day public comment period regarding the opinion. The advocate's tentative decision must be accompanied by a written opinion on the agreement's expected effects on the reasonableness of fees and the quality and price of services. It is not clear whether the tentative decision and opinion are to be issued (1) in time to be commented on during the 30-day comment period or (2) after the comment period.

No agreement can become final and effective unless and until, following the comment period, the advocate approves the agreement and issues a CPA on the basis that the agreement fosters reasonably priced, quality practitioner services. The bill permits the advocate to collect information from any person to assist in evaluating the impact of the proposed agreement on the health care marketplace.

In determining the reasonableness of service fees and quality, the advocate must consider whether the collaborative's proposed fees:

1. are consistent with fees in similar practitioner communities,
2. ensure reasonable access to care,
3. improve the collaborative's ability to provide services efficiently,
4. provide for the collaborative's financial stability, and
5. encourage innovative approaches to medical care that could improve patient outcomes and lower costs.

§6 — CERTIFICATE REVOCATION

The advocate must actively monitor agreements approved under the bill to ensure that a health care collaborative's performance remains in compliance with the approval conditions. Upon request and at least annually, each health plan and collaborative operating under a CPA must submit a written report regarding agreement compliance to the advocate, who can prescribe the report's form.

The advocate can revoke a CPA upon a finding that performance under the agreement is not in substantial compliance with the terms of

the application or the conditions of CPA approval.

§7 — APPEAL OF ADVOCATE’S DECISIONS

Under the bill, any person aggrieved by the advocate’s final decision can appeal the decision to Superior Court according to state law. The bill defines “person” as an individual, association, corporation, or any other legal entity.

§9 — ADMINISTRATIVE FEE

The advocate must charge each prospective collaborative a \$1,000 administrative fee for determining whether the collaborative can engage in negotiations with a health plan within the bill’s parameters. The advocate must set fees in amounts deemed reasonable and necessary for determining whether the agreement between the prospective collaborative and a health plan will be approved or disapproved. The language requiring a \$1,000 fee appears to conflict with the language that gives the advocate some leeway to set fees that are “deemed reasonable and necessary” which may not be \$1,000.

§10 — ANNUAL REPORT TO GENERAL ASSEMBLY AND GOVERNOR

By October 1, 2015, and every following year, the advocate must submit an annual report on the advocate’s operations and activities under the bill to the governor and the Labor and Public Employees Committee.

§ 12 — REGULATIONS

The advocate must adopt rules and regulations establishing application and review procedures, methods for determining whether to issue a CPA, and any other procedures or standards needed to administer the bill’s provisions.

BACKGROUND

Related Bill

sSB 35, favorably reported by the Public Health Committee, requires health care providers and hospitals to notify the attorney general when provider practices of eight or more physicians are purchased or

merged.

Antitrust Law

With limited exceptions, state and federal law prohibit restraint of any part of trade or commerce, including contracts intended to, or that have the effect of:

1. price fixing;
2. fixing, controlling, maintaining, limiting, or discontinuing the production, manufacture, mining, sale, or supply of any part of trade or commerce;
3. allocating or dividing customers or markets, either functionally or geographically, in any part of trade or commerce; or
4. refusing to deal or coercing, persuading, or inducing third parties to refuse to deal with another person.

The attorney general is authorized to litigate state and federal antitrust cases. Persons, including consumers, are also entitled to file suit and may recover treble damages for the injury to their business or property, plus reasonable attorney's fees.

ERISA

Generally, a state insurance law does not apply to a company's self-insured benefit plan because the federal ERISA preempts state law for self-insured plans (29 USC Chapter 18).

ERISA prohibits states from "deeming" self-funded plans to be subject to state insurance requirements. As a result, the Connecticut Insurance Department does not have jurisdiction over self-insured plans. Such plans are under the U.S. Department of Labor's jurisdiction.

COMMITTEE ACTION

Labor and Public Employees Committee

Joint Favorable

Yea 8 Nay 2 (03/18/2014)