

Model Bill to Address Anticompetitive Terms in Certain Healthcare Contracts

Background and Disclaimer: In 2020, [The Source on Healthcare Price & Competition](#) released a research report entitled “[Preventing Anticompetitive Contracting Practices in Healthcare Markets](#)” that highlights how such contract terms are used. The National Academy for State Health Policy (NASHP) used that report to develop [Model Legislation to address the use of Anticompetitive Terms in Health Insurance Contracts](#). The Cicero Institute supported legislation in Texas ([HB711](#)) based upon this model bill, which was signed into law in 2023.

The Cicero Institute has taken that model legislation and is building upon those efforts to offer state policy menu to ban or limit the use of an array of anticompetitive contract terms and practices used by payers, providers and other market participants. The Cicero Model Legislation uses the NASHP as the basis but also includes additional provisions and modifications. In addition to the language in this model bill, the Cicero institute does have additional language available addressing other anticompetitive behaviors available upon request.

Model Act Summary:

This model legislation primarily targets health insurance contract terms that have been used by health systems and health insurers to impede competition and increase prices and in some cases, limit the availability and mobility of certain clinicians. In particular, this model act prohibits the use of most-favored-nation clauses, anti-steering clauses, anti-tiering clauses, all-or-nothing clauses, gag clauses, and all-products clauses in contracts between health insurers and health care providers. It also limits how non-compete provisions for physicians and health care practitioners can be used. The prohibition on these anticompetitive contract terms would be enforced via administrative penalties from the State Insurance Department, civil penalties and antitrust remedies from the State Attorney General, and a private cause of action under the state’s unfair and deceptive acts or practices statute.

Section 1. [Section 1] is inserted in [State Insurance Code] to read as follows:

(A) Definitions: As used in this section:

- i. “Enrollee” means an individual who is entitled to receive health care services under the terms of a health benefit plan.
- ii. “Health care contract” means a contract, agreement, or understanding, either orally or in writing, entered into, amended, restated, or renewed between a health care provider and a health insurance carrier, health plan administrator, plan sponsor, or its contractors or agents for the delivery of health care services to an enrollee of a health benefit plan.
- iii. “Health care provider” means an entity, corporation, or organization, parent corporation, member, affiliate, subsidiary, or entity under common ownership, whether for-profit or nonprofit, that is or whose members are licensed or otherwise authorized by this state to furnish, bill, or receive payment for health care service delivery in the normal course of business, and includes, without limitation, health systems, hospitals, hospital-based facilities, freestanding emergency facilities, imaging centers, large

physician groups with eight [8] or more physicians, physician staffing organizations, and urgent care clinics.

[Commentary: States may want to define “large physician groups” separately or examine their physician market to define the numeric cutoff for a large physician group. The idea is to exclude the small practices that do not tend to exert market power in their health plan contract negotiations.]

iv. “Health insurance carrier” means an entity subject to the insurance laws and regulations of this state or subject to the jurisdiction of the [Insurance Commissioner] that offers health insurance, health benefits, or contracts for health care services, including prescription drug coverage, to large groups, small groups, or individuals on or outside the [Marketplace].

v. “Health benefit plan” means a plan, policy, contract, certificate, or agreement entered into, offered, or issued by a health insurance carrier or health plan administrator acting on behalf of a plan sponsor to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services and includes nonfederal governmental plans as defined in 29 U.S.C. § 1002(32).

[Commentary: States may already have a definition of “health benefit plan” or “health insurance carrier” in their statutes that can be referenced instead of adopting a new definition here. NASHP recommends defining “health benefit plan” broadly to include third-party administrators working on behalf of a plan sponsor, including self-funded employers and labor unions. States may choose to exclude long-term care plans, disability plans, and dental or vision plans.]

vi. “Health plan administrator” means a third-party administrator who acts on behalf of a plan sponsor to administer a health benefit plan.

vii. “Network plan” means a health benefit plan that either requires enrollees to use, or creates incentives, including financial incentives, for enrollees to use certain health care providers managed, owned, affiliated, under contract with, or employed by a health insurance carrier, a health plan administrator, or plan sponsor. Network plans include health maintenance organization (HMO) plans, preferred provider organization (PPO) plans, and exclusive provider organization (EPO) plans.

viii. “Tiered network plan” means a health benefit plan that sorts some or all types of health care providers into specific groups to which different provider reimbursement, enrollee cost sharing, or provider access requirements, or any combination thereof, are applied for the same services.

ix. “Anti-steering clause” means a provision of a health care contract that restricts the ability of the health insurance carrier or health plan administrator to encourage an enrollee to obtain a health care service from a competitor of the hospital or health system, including offering incentives to encourage enrollees to utilize specific health care providers.

x. An “anti-tiering clause” means a provision in a health care contract that:

- a. Restricts the ability of the health insurance carrier or health plan administrator to introduce or modify a tiered network plan or assign health care providers into tiers; or
 - b. Requires the health insurance carrier or health plan administrator to place all members of a health care provider in the same tier of a tiered network plan.
- xi. An “all-or-nothing clause” means a provision of a health care contract that:
 - a. Requires the health insurance carrier or health plan administrator to include all members of a health care provider in a network plan; or
 - b. Requires the health insurance carrier or health plan administrator to enter into any additional contracts with an affiliate of the health care provider as a condition of entering into a contract with such health care provider.
- xii. A “most-favored-nations clause” means a provision of a health care contract that:
 - a. Prohibits or grants a health insurance carrier or health plan administrator an option to prohibit a participating health care provider from contracting with another contracting entity to provide health care services at the same or lower price than the payment specified in the health care contract;
 - b. Requires or grants a health insurance carrier or health plan administrator an option to require a participating health care provider to accept a lower payment in the event the participating health care provider agrees to provide health care services to another contracting entity at a lower price;
 - c. Requires or grants a health insurance carrier or health plan administrator an option to require termination or renegotiation of an existing health care contract if a participating health care provider agrees to provide health care services to another contracting entity at the same or lower price; or
 - d. Restricts other health insurance carriers or health plan administrators, not party to the contract, from paying the same or lower rates for items or services than the contracting health insurance carrier or health plan administrator pays for such items or services.
- xiii. A “gag clause” means a provision of a health care contract that:
 - a. Restricts the ability of either the health insurance carrier, health plan administrator, or the provider to disclose any price or quality information, including the allowed amount, negotiated rates or discounts, any fees for services, or any other claim-related financial obligations included in the provider contract, to a governmental entity as authorized by law or its contractors or agents, any enrollee, treating provider of an enrollee, plan sponsor, or potential eligible enrollees and plan sponsors; or
 - b. Restricts the ability of either the health insurance carrier, health plan administrator, or the provider, including a pharmacist, to disclose out-of-pocket

costs or which restricts a provider or pharmacists from disclosing lower cost options to an enrollee.

xiv. "All-products clause" means a provision in a healthcare contract

a. that requires a healthcare provider, as a condition of participation or continuation in a provider network or a health benefit plan, to :

(I) Serve in another provider network utilized by a health insurance carrier, subcontractor, or affiliate with different reimbursement rates and other financial terms for the healthcare provider; or

(II) Provide healthcare services under another health benefit plan or product offered by a health insurance carrier, subcontractor or affiliate with different reimbursement rates and other financial terms for the healthcare provider.;

b. A prohibition on all-products clauses does not prevent a contracting entity from:

(I) Offering a healthcare provider a contract that covers multiple health benefit plans that have the same reimbursement rates and other financial terms for the healthcare provider;

(II) Adding a new health benefit plan to an existing healthcare contract with a healthcare provider under the same reimbursement rates and other financial terms applicable under the original healthcare contract; or

(III) Requiring a healthcare provider to accept multiple health benefit plans that do not differ in reimbursement rates or other financial terms for the healthcare provider.

(IV) offering a healthcare provider a contract for another health benefit plan with different reimbursement rates or financial terms so long as participation in one is not conditional on the other.

c. A healthcare contract may include health benefit plans or coverage options for enrollees within a health benefit plan with different cost-sharing structures, including different deductibles or copayments, so long as the reimbursement rates and other financial terms between the contracting entity and the healthcare provider remain the same for each plan or coverage option included in the healthcare contract.

(B) Limits on Anticompetitive Contract Terms.

i. Except as provided in [subsection 1(B)(iii)], no health insurance carrier, health care provider, health plan administrator, or any agents or other entities that contract on behalf of a health care provider, a health insurance carrier, or a health plan administrator

may offer, solicit, request, amend, renew, or enter into a health care contract that would directly or indirectly include any of the following provisions:

- a. A most-favored-nations clause;
- b. An anti-steering clause;
- c. An anti-tiering clause;
- d. An all-or-nothing clause;
- e. A gag clause;
- f. An all products clause; or
- g. Any other clause that results or intends to result in anticompetitive effects as specified by the [Insurance Commissioner or State Attorney General] through regulation.

ii. Except as provided in [subsection 1(B)(iii)], a violation of this section constitutes an unfair or deceptive act under [insert state consumer protection code section] and be presumptively unlawful under [reference state or federal antitrust laws], subject to enforcement by the State Attorney General.

[Commentary: Some states have a code section in their insurance or business codes defining unfair and deceptive acts or practices (UDAP) in the business of insurance, but NASHP recommends that states declare violations of this section as a violation of general UDAP laws so as not to limit enforcement actions to the Insurance Department and enable enforcement against health care providers and health systems for violations of this section by the State Attorney General.]

iii. Application for a waiver:

a. A party to a health care contract, which contains a provision specified in [subsection 1(B)(i)], may submit the health care contract to the [Attorney General or Insurance Commissioner] for a waiver. The health care contract must be accompanied by the following information:

- I. The name and business address of each party to the health care contract;
- II. An identification of each location at which any party to the agreement or policy provides health care services; and
- III. Any information required to demonstrate that the proposed agreement or policy results in an increase in the welfare of consumers in this State that could not have been accomplished through alternative means that are less restrictive.

b. The [Attorney General or Insurance Commissioner] shall approve or deny any waiver application in writing within 60 days.

c. The [Attorney General or Insurance Commissioner] may approve a waiver to allow a contract to include a provision specified in [subsection 1(B)(i)] only if the [Attorney General or Insurance Commissioner] determines:

I. The agreement or policy will result in an increase in the welfare of consumers in this State such that the procompetitive benefits of including the provision outweigh the harms to competition;

II. Such increase in the welfare could not have been accomplished through alternative means that are less restrictive; and

III. The agreement or policy does not otherwise constitute a contract, combination or conspiracy in restraint of trade under [state or federal antitrust laws].

d. The [Attorney General or Insurance Commissioner] may promulgate rules under this section to identify allowable conduct, agreements, or arrangements for which waivers may be granted.

iv. Except for contracts granted a waiver under [Section 1(B)(iii)] by the [Attorney General or Insurance Commissioner], any provision of a health care contract described in [Section 1(B)] in violation of this section is null and void and unenforceable. The remaining provisions of the health care contract, excluding any provision in violation of this section, remain in effect and are enforceable.

[Commentary: This section allows the State Attorney General or Insurance Commissioner to review and approve contracts with a provision specified in [subsection 1(B)(i)] if the contract increases the public welfare, e.g., if the procompetitive benefits outweigh the anticompetitive harms. It also allows the State Attorney General or Insurance Commissioner to promulgate rules to define specific conditions under which the agency finds health care contracts are procompetitive, e.g., in specific types of accountable care organizations or other advanced payment models.]

(C) Enforcement.

i. Enforcement by State Attorney General

a. The Attorney General may subpoena any records necessary to enforce any provisions of [this Act] or to investigate suspected violations of any provisions of [this Act].

b. The Attorney General may institute proceedings on behalf of [the state, its agencies or municipal corporations] or as *parens patriae* of the persons residing in the state for:

I. Injunctive relief to prevent and restrain a violation of any provision of this chapter including, without limitation, a temporary restraining order, preliminary injunction, or permanent injunction;

II. Civil penalties for violations of the provisions of [Section 1(B)];

III. Criminal penalties for violations of the provisions of [Section 1(B)]; or

IV. Other equitable relief for violations of the provisions of [this Act] including, without limitation, disgorgement or restitution.

ii. Enforcement by Insurance Commissioner

a. All records and papers of health insurance carriers pertaining to health benefit plans or negotiations between the health insurance carrier and any health care provider shall be subject to inspection by the [Insurance Commissioner] or by any agent he or she may designate for that purpose. The Insurance Commissioner may require any health insurance carrier to produce a list of all health care contracts, transactions, or pricing arrangements entered into within the preceding twelve (12) months.

b. Except for contracts granted a waiver under [Section 1(B)(iii)], the Insurance Commissioner may impose an administrative penalty of up to \$5,000 per day upon a health insurance carrier for each day that a contract in violation of [Section 1(B)] is in effect.

c. The Insurance Commissioner may, under section [state rate review section] deny the sale of any health insurance plan where the contract between the health insurance carrier and any health care provider is in violation of [Section 1(B)].

d. The Insurance Commissioner may refer any health care contract subject to this section to the Attorney General to review for compliance with this Act. The referral of any health care contract by the Insurance Commissioner to the Attorney General does not constitute a violation of any confidentiality agreement between the health insurance carrier and the Insurance Commissioner that may exist under [state rate filing laws]. The authority of the Attorney General to prosecute violations of antitrust or consumer protection requirements shall not be narrowed, abrogated, or otherwise altered by this section.

iii. Private right of action.

a. Any party that suffers a loss as a result of the violation of [this Act] shall be entitled to initiate an action pursuant to [reference to state UDAP law] and seek all remedies, damages, costs, and fees available under [reference to state UDAP law].

(D) Construction

i. Nothing in this section shall modify, reduce, or eliminate the existing privacy protections and standards provided by reason of State and Federal law, including the federal Health Insurance Portability and Accountability Act (HIPAA) (Pub. L.104-191), the federal Genetic Information Nondiscrimination Act of 2008 (GINA) (Pub. L. 110-233), and

required confidentiality provisions of the Americans with Disabilities Act of 1990 (ADA) (P.L. 110-325).

ii. Nothing in this section shall be construed to limit network design or cost or quality initiatives by a group health plan, health insurance carrier, or administrators working on behalf of a plan sponsor, including accountable care organizations, exclusive provider organizations, networks that tier providers by cost or quality or steer enrollees to centers of excellence, or other pay-for-performance programs.

[Commentary: The data privacy provision is included to ensure that the ban on gag clauses does not allow data protected by HIPAA or other privacy laws to be disclosed to employers or plan sponsors. The network provision provides assurances that the anti-steering and anti-tiering provisions do not limit insurers or administrators working on behalf of a plan sponsor from using other methods to direct patients to higher-value care. The network provision also expresses the intent of the legislature to allow health systems to create accountable care organizations or use other risk-based payment models to control costs.]

(E) Regulatory Authorization. The [Insurance Commissioner] and the [State Attorney General] may promulgate regulations necessary to implement, impose penalties, and ensure compliance with this section.

(F) Effective Date. This section shall apply to any contract entered into or amended after the date of enactment of [this Act].

Section 2 Protecting the Healthcare Workforce

[Commentary: Non-compete agreements are often used for physicians, and sometimes other healthcare workers. There should be some ability for employers to recoup investments by requiring employees to pay back or reimburse sign on bonuses or retention incentives (i.e. student loan payments made for retention') if agreed upon conditions are not met. However, sweeping non-compete agreements in the healthcare sector negatively impact an already insufficient workforce and reduce patient access to care. This is bad public policy. Legislation banning non-compete agreements could target physicians, lower wage healthcare workers, or all healthcare workers.

Some states have passed laws to ban or limit such negative covenants. This can range from outright bans on non-compete agreements virtually across the board (CA, ND, OK, MN), to bans on physicians (Massachusetts, Colorado, Delaware), or putting parameters on the scope of such covenants, such as duration or geography). For example, New Mexico law disallows non-competes for a practitioner who provides "clinical health care services." In Colorado, non-compete provisions are void when used with physicians (with some exceptions with some exception for reasonable damages.

The model language below gives two options that can be used individually or together. The first section addresses non-compete provisions used on physicians, while the subsequent section addresses non-compete provisions used for all healthcare clinicians.]

[Section 2] is inserted in [Business and Commerce Code] to read as follows

(A) Limitations on non-compete provisions for physicians:

i. Except as provided in paragraph (C) of this section, a covenant not to compete relating to the practice of medicine is enforceable against a person licensed as a physician by the [State Medical Board] if such covenant complies with the following requirements:

(a) the covenant must:

(1) not deny the physician access to a list of the patients whom the physician had seen or treated within one year of termination of the contract or employment;

(2) provide access to medical records of the physician's patients upon authorization of the patient and any copies of medical records for a reasonable fee as established by the [State] Medical Board; and

(3) provide that any access to a list of patients or to patients' medical records after termination of the contract or employment shall not require such list or records to be provided in a format different than that by which such records are maintained except by mutual consent of the parties to the contract;

(b) the covenant must provide for a buyout of the covenant by the physician in an amount not greater than the physician's total annual salary and wages at the time of termination of the contract or employment;

(c) The covenant must provide that the physician will not be prohibited from providing continuing care and treatment to a specific patient or patients during the course of an acute illness even after the contract or employment has been terminated; and

(d) the covenant must provide that:

(1) it expires within one year of termination of the contract or employment; and

(2) the radius of the geographical area subject to the covenant is not greater than five miles.

(e) A non-compete covenant in an employment agreement for clinical health care services to be rendered in this state by a physicians is void, unenforceable and against public policy if the provision:

(1) makes the agreement subject to the laws of another state; or

(2) requires any litigation arising out of the agreement to be conducted in another state.

(B) Limitations on non-compete provisions for health care practitioners:

(i) In this section, "health care practitioner" means a person licensed in this state as a dentist, nurse, or physician assistant. *[drafter's note: This could be expanded to other clinicians or even non-clinician healthcare workers].*

(ii) Except as provided in paragraph (C) of this section, employer may not require a health care practitioner to enter into a covenant not to compete unless the covenant:

(a) provides for a buyout of the covenant by the health care practitioner in an amount not greater than the employers quantifiable economic damages related to onboarding expenses (to include signing bonuses), training expenses, or retention incentives (retention bonus, student loan payments) but shall not include salary or wages paid.

(2) provides that it expires within one year of the date of termination of the contract or employment; and

(3) provides that the radius of the geographical area subject to the covenant is not greater than five miles.

(c) A covenant not to compete entered into by a health care practitioner that fails to comply with Subsection (b) is void and unenforceable.

(iii) A provision in an employment agreement for clinical health care services to be rendered in this state by a health care practitioner is void, unenforceable and against public policy if the provision:

(a) makes the agreement subject to the laws of another state; or

(b) requires any litigation arising out of the agreement to be conducted in another state.

(C) Non-compete provisions associated with the sale of a business or practice owned by a physicians or health care practitioner.

(i) Any physician or health care practitioner who sells the goodwill of a business, or any owner of a business entity selling or otherwise disposing of all of his or her ownership interest in the business entity, or any owner of a business entity that sells

(a) all or substantially all of its operating assets together with the goodwill of the business entity,

(b) all or substantially all of the operating assets of a division or a subsidiary of the business entity together with the goodwill of that division or subsidiary, or

(c) all of the ownership interest of any subsidiary, may agree with the buyer to refrain from carrying on a similar business within a specified geographic area in which the business so sold, or that of the business entity, division, or subsidiary has been carried on, so long as the buyer, or any person deriving title to the goodwill or ownership interest from the buyer, carries on a like business therein.

(ii) For the purposes of this section, "business entity" means any partnership (including a limited partnership or a limited liability partnership), limited liability company (including a series of a limited liability company formed under the laws of a jurisdiction that recognizes such a series), or corporation.

(iii) For the purposes of this section, "owner of a business entity" means any partner, in the case of a business entity that is a partnership (including a limited partnership or a limited liability partnership), or any member, in the case of a business entity that is a limited liability company (including a series of a limited liability company formed under the laws of a jurisdiction that recognizes such a series), or any owner of capital stock, in the case of a business entity that is a corporation.

(iv) For the purposes of this section, "ownership interest" means a partnership interest, in the case of a business entity that is a partnership (including a limited partnership a limited liability partnership), a membership interest, in the case of a business entity that is a limited liability company (including a series of a limited liability company formed under the laws of a jurisdiction that recognizes such a series), or a capital stockholder, in the case of a business entity that is a corporation.

(v) For the purposes of this section, "subsidiary" means any business entity over which the selling business entity has voting control or from which the selling business entity has a right to receive a majority share of distributions upon dissolution or other liquidation of the business entity (or has both voting control and a right to receive these distributions.)

(d) A covenant not to compete entered into or renewed before the effective date of this Act is governed by the law in effect on the date the covenant was entered into or renewed, and the former law is continued in effect for that purpose.

Section 3. Severability and Savings-Construction Clauses

(A) Every provision in [this Act] and every application of the provisions in [this Act] are severable from each other as a matter of state law. If any application of any provision in [this Act] to any person or group of persons or circumstances is found by a court to be invalid, the remainder of [this Act] and the application of the Act's provisions to all other persons and circumstances may not be affected. All constitutionally valid applications of [this Act] shall be severed from any applications that a court finds to be invalid, leaving the valid applications in force, because it is the legislature's intent and priority that the valid applications be allowed to stand alone. Even if a reviewing court finds a provision of [this Act] invalid in a large or substantial fraction of relevant cases, the remaining valid applications shall be severed and allowed to remain in force.

(B) [This Act] shall be construed, as a matter of state law, to be enforceable up to but no further than the maximum possible extent consistent with federal law and constitutional requirements, even if that construction is not readily apparent, as such constructions are authorized only to the extent necessary to save the statute from judicial invalidation.

Section 4. The requirements set forth in this bill shall take effect on xx/xx/xxxx unless otherwise specified.