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## All-products clauses in provider contracts

*By William H. Maruca, Esq.*

**Published June 2000**

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Managed care companies can't sell health insurance without having a sufficient number of physicians under contract. Often, the only power an individual physician has in negotiations with a managed care company is the power to say "no" to contract terms that are unacceptable for clinical or financial reasons. The insurance industry recognizes this power and has begun to implement and enforce "all-products" clauses, a controversial technique to limit physicians' ability to pick and choose whether to participate in the many types of plans each company offers.

The aggressive use of all-products clauses in managed care participation agreements, sometimes referred to as "cram-down," is becoming the focus of increased scrutiny as insurers use them more coercively to build and retain their physician networks across product lines. These clauses, which require physicians to accept all present and future insurance products and payment methods offered by a particular insurer as a condition of participating in any of the insurer's products, have drawn fire on a national scale. A number of states have outlawed them, and authorities have insisted that one national insurer drop the provisions as a condition of settling litigation. As of the date of this article, these clauses have not been declared illegal in Pennsylvania, but physician advocates are urging regulators to take a harder look.

All-products clauses are one of many factors leading to an "uneven playing field" in bargaining power between individual physicians, who are prohibited from acting collectively by the antitrust laws, and large insurers who by sheer numbers of subscribers control patients' access to health care and control health care providers' access to patients. These contractual provisions may be used to compel

physicians to sign up with plans that may be unacceptable on a stand-alone basis, not just because of inadequate reimbursement terms, but also because of unreasonable risk, limited coverage, burdensome referral requirements, limited drug formularies or inappropriate incentives.

Health insurance contracts have routinely included all-products clauses with little attention being directed to their potential anti-competitive effect until recent years. Historically, most insurers offered a limited menu of flavors: traditional fee-for-service/indemnity, preferred provider (discounted fee-for-service) and HMO, and before managed care became widespread many physicians signed up with every plan that came their way. The proliferation of plan options offered by each insurer—including point-of-service plans, Medicare and Medicaid managed care plans and low-cost community based plans—and the increasing polarization of insurance markets mean that insurers need to get new products to market quickly without recruiting and credentialing an entirely new list of physicians. Consequently, these provisions may be used in a coercive manner to force physicians to participate in products that they otherwise may decline to accept if given a free choice.

The problem becomes particularly aggravated in markets in which one or more insurers have a dominant position. A health insurer with a large share of the market may exert what is referred to as "monopsony" power, the mirror image of monopoly power. Monopsony power is the power a dominant purchaser has to artificially drive down prices for the purchase of goods or services when negotiating with sellers that wield less bargaining power. A dominant health insurer may be in a position to set terms of participation for physicians that those physicians would be commercially unable to reject without turning away a large percentage of their patient base.

An insurer may be considered to have monopsony power if it has a large enough share of the market to enable it to coerce physicians to deal with the insurer on a below-market payment basis. If the physicians may be able to continue to operate in the market by simply declining to participate in the insurer's product, monopsony power may not exist. However, a company that can effectively drive physicians out

of business by reason of its size and market share by refusing to deal with them except on an all-or-nothing basis would have monopsony power.

Parts of Pennsylvania are among the most concentrated markets for health insurance in the country. All-products clauses distort the market for physician services and may result in reduced patient access to the health care providers of their choice.

An insurer with monopsony power would violate the federal antitrust laws if it engages in activity that makes it more difficult for physicians to abandon that insurer in favor of providing services to competing insurers, or if it engages in actions that serve to protect and maintain the insurer's monopsony power. Such actions would violate Section 1 of the Sherman Antitrust Act unless the insurer could demonstrate that they resulted in pro-competitive effects or increased efficiencies.

Further, such activities may violate Section 2 of the Sherman Antitrust Act if they constitute predatory conduct, i.e., conduct intended to preserve the monopsony position of the insurer without a legitimate business justification.

When all-products clauses are included in participation agreements for Medicare + Choice managed care plans, the insurer risks violating the Medicare and Medicaid anti-kickback law by demanding a price concession in exchange for access to other lines of business. The anti-kickback law makes it a felony to offer or pay, solicit or receive any remuneration in exchange for referring any business reimbursable under the Medicare or Medicaid systems. The Office of Inspector General (OIG) has warned managed care companies that by forcing physicians to provide services at below-market rates in exchange for access to their other health care programs, those compulsory discounts may be the equivalent of the extortion of prohibited kickbacks which may result in civil and criminal penalties.

In the compliance guidance for Medicare + Choice organizations published on November 15, 1999, the OIG stated: "We are concerned that a managed care organization or contractor may offer (or be offered) a reduced rate for its items or services in the federal

capitated arrangement in order to have the opportunity to participate in other product lines that do not have stringent payment or utilization constraints. This practice is a form of a practice known as 'swapping,' in the case of managed care arrangements, low capitation rates could be traded for access for additional fee-for-service lines of business. We are concerned when these discounts are in exchange for access to fee-for-service lines of business, where there is an incentive to overutilize services provided to Federal health care program beneficiaries."

State regulators and legislatures are beginning to take notice of the impact of all-products clauses. In 1998, Nevada's Commissioner of Insurance declared all-products clauses to be a violation of the state Unfair Trade Practices Act which prohibits acts of boycott, coercion or intimidation that would result in the unreasonable restraint of any business of insurance. According to the commissioner, the coercion occurs when the insurer cancels the provider's PPO contract as a consequence of his not signing an HMO contract. Such termination unfairly prevents the provider from continuing to furnish PPO discounted medical care to the insured marketplace, which restrains the business of insurance.

Kentucky's General Assembly passed legislation outlawing all-products clauses. Virginia's governor recently signed a bill allowing healthcare providers to refuse to participate in an insurer's other products or plans without affecting the provider's status as a member in the plans in which he or she wished to participate, effective July 1, 2000. Responding to efforts from the physician community, including one dermatologist who held a symbolic public burning of his HMO contracts, Maryland's legislature has enacted a similar statute which is awaiting the signature of the governor.

Earlier this year the Texas Attorney General settled a 1998 lawsuit against Aetna U.S. Healthcare for various abusive practices. Among the terms of the settlement is a promise by Aetna U.S. Healthcare to discontinue using an all-products clause and to give physicians the option to care for patients who are enrolled in some or all of Aetna products.

It remains to be seen whether the Pennsylvania

General Assembly will follow the lead of Maryland, Virginia and Kentucky by outlawing all-products clauses or whether the Pennsylvania Department of Health or Department of Insurance will take action similar to Nevada's Insurance Commissioner's ruling. The Pennsylvania Medical Society, with the support of a number of other physician representative organizations, has urged Harrisburg to investigate this practice and its negative effects on the health insurance market. Physicians who wish to preserve their right to "just say no" to unacceptable contracts should contact the Insurance and Health departments and their state legislators.

*William H. Maruca, Esq., is a director with the Pittsburgh law firm of Kabala & Geeseman whose practice is concentrated in healthcare.*

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