CS FOR SENATE BILL NO. 256(RLS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY THE SENATE RULES COMMITTEE

Offered: 4/19/00
Referred: Today's Calendar

Sponsor(s): SENATOR PETE KELLY

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to allowing physicians to collectively negotiate with a health
2 benefit plan that has substantial market power."

3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

4 * Section 1. AS 23 is amended by adding a new chapter to read:
5
6 Chapter 50. Collective Negotiation by Physicians.

7 Sec. 23.50.010. Legislative findings. (a) The legislature finds that permitting
8 competing physicians to engage in collective negotiation of certain terms and
9 conditions of contracts with a health benefit plan will benefit competition, so long as
10 the physicians do not engage in an express or implied threat of retaliatory collective
11 action, including boycotts or strikes.
12
13 (b) The legislature finds that permitting physicians to engage in collective
14 negotiations over fee-related terms may, in some circumstances, yield anti-competitive
15 effects. There are, however, instances in which a health benefit plan dominates the
16 market to the degree that fair negotiations between physicians and the health benefit
plan are not possible in the absence of joint action on behalf of the physicians. In those circumstances, the health benefit plan can virtually dictate the terms of the contracts that it offers to physicians.

(c) The legislature finds that it is appropriate and necessary to authorize collective negotiations between competing physicians and health benefit plans on fee-related and other issues when the imbalances in bargaining capacity described in this section exist.

Sec. 23.50.020. Collective action by physicians. (a) Competing physicians may meet and communicate in order to collectively negotiate with the health benefit plan concerning any of the contract terms and conditions described in this subsection. Competing physicians may not engage in a boycott related to these terms and conditions. Competing physicians may meet and communicate concerning

(1) clinical practice guidelines and coverage criteria;
(2) the respective liability of physicians and the health benefit plan for the treatment or lack of treatment of insured or enrolled persons;
(3) administrative procedures, including methods and timing of the payment of services to physicians;
(4) procedures for the resolution of disputes between the health benefit plan and physicians;
(5) patient referral procedures;
(6) the formulation and application of reimbursement methodology;
(7) quality assurance programs;
(8) health service utilization review procedures; and
(9) criteria to be used by health benefit plans for the selection and termination of physicians, including whether to engage in selective contracting.

(b) Except as provided in (c) of this section, competing physicians may not meet and communicate for the purpose of collectively negotiating the following terms and conditions with a health benefit plan:

(1) the fees or prices for services, including fees or prices arrived at by applying any reimbursement methodology procedures;
(2) the conversion factor in a resource-based relative value scale
reimbursement methodology or similar methodologies;

(3) the amount of any discount on the price of services to be rendered
by the physicians;

(4) the dollar amount for capitation or fixed payment for each person
covered by the health benefit plan for health services rendered by physicians to a
health benefit plan's insureds, beneficiaries, or enrollees; or

(5) the inclusion or alteration of terms and conditions to the extent that
they are prohibited or required by law; however, this paragraph does not limit
physician rights to collectively petition the government for a change in the law.

(c) Competing physicians within the service area of a health benefit plan may
collectively negotiate the terms and conditions of contracts described in (b) of this
section if the health benefit plan has substantial market power. If the attorney general
receives notice under (f) of this section that an authorized third party intends to
negotiate with a health benefit plan, the attorney general shall provide written notice
of the intended negotiation to the health benefit plan. A health benefit plan is
rebuttably presumed to have substantial market power.

(d) A health benefit plan may rebut the presumption of substantial market
power described under (c) of this section by providing proof satisfactory to the
attorney general that the health benefit plan's market share does not exceed 15 percent

(1) as measured by the number of covered lives at the end of the most
recently completed calendar year or by the actual number of consumers of prepaid
comprehensive health services at the end of the most recently completed calendar
quarter divided by the total population of the geographic service area as of the most
recent census; or

(2) within a particular geographic service area when its market
segments are added together for all types of health insurance insureds, beneficiaries,
or enrollees and for Medicare and Medicaid beneficiaries.

(e) In exercising the collective rights granted by (a) and (c) of this section,

(1) physicians may communicate with each other with respect to the
contractual terms and conditions to be negotiated with a health benefit plan;

(2) physicians may communicate with an authorized third party
regarding the terms and conditions of contracts allowed under this section;

(3) the authorized third party is the sole party authorized to negotiate with a health benefit plan on behalf of a defined group of physicians;

(4) physicians can be bound by the terms and conditions negotiated by the authorized third party that represents their interests;

(5) a health benefit plan communicating or negotiating with the authorized third party may contract with, or offer different contract terms and conditions to, individual competing physicians;

(6) an authorized third party may not represent more than 30 percent of the market of practicing physicians for the provision of services in the geographic service area or proposed geographic service area, if the health benefit plan has less than a five percent market share as determined by the number of covered lives as reported by the director of insurance for the most recently completed calendar year or by the actual number of consumers of prepaid comprehensive health services;

(7) the attorney general may limit the percentage of practicing physicians represented by an authorized third party; however, the limitation may not be less than 30 percent of the market of practicing physicians in the geographic service area or proposed geographic service area; when determining whether to impose a limitation described under this paragraph, the attorney general shall consider the provisions described under (h), (i), and (j) of this section; this paragraph does not apply if the market of practicing physicians in the geographic service area or proposed geographic service area consists of 40 or fewer individuals; and

(8) the authorized third party shall comply with the provisions of (f) of this section.

(f) A person acting or proposing to act as an authorized third party under this section shall,

(1) before engaging in collective negotiations with a health benefit plan,

(A) file with the attorney general the information that identifies the authorized third party, the authorized third party’s plan of operation, and the authorized third party’s procedures to ensure compliance with this section;

(B) furnish to the attorney general, for the attorney general's
approval, a brief report that identifies the proposed subject matter of the negotiations or discussions with a health benefit plan and that contains an explanation of the efficiencies or benefits that are expected to be achieved through the collective negotiations; the attorney general may not approve the report if the proposed negotiations exceed the authority granted in this chapter and, if they do, shall enter an order prohibiting the collective negotiations from proceeding; the authorized third party shall provide supplemental information to the attorney general as new information becomes available that indicates that the subject matter of negotiations with the health benefit plan has changed or will change;

(2) within 14 days after receiving a health benefit plan's decision to decline to negotiate or to terminate negotiations, or within 14 days after requesting negotiations with a health benefit plan who fails to respond within that time, report to the attorney general that negotiations have ended or have been declined;

(3) before reporting the results of negotiations with a health benefit plan and before giving physicians an evaluation of any offer made by a health benefit plan, provide to the attorney general, for the attorney general’s approval, a copy of all communications to be made to physicians related to the negotiations, discussions, and health benefit plan offers.

(g) The attorney general shall either approve or disapprove the contract that was the subject of the collective negotiation within 30 days after receiving the reports required under (f) of this section. If the contract is disapproved, the attorney general shall furnish a written explanation of any deficiencies along with a statement of specific remedial measures that would correct any identified deficiencies. An authorized third party who fails to obtain the attorney general’s approval is considered to be acting outside the authority of this section.

(h) The attorney general shall approve a collective negotiation if

(1) the competitive and other benefits of the contract terms outweigh any anticompetitive effects; and

(2) the contract terms are consistent with other applicable laws and regulations.
(i) The competitive and other benefits of joint negotiations or negotiated provider contract terms may include

(1) restoration of the competitive balance in the market for health care services;
(2) protections for access to quality patient care;
(3) promotion of health care infrastructure and medical advancement;
or
(4) improved communications between health care providers and health care insurers.

(j) When weighing the anticompetitive effects of contract terms, the attorney general may consider whether the terms

(1) provide for excessive payments; or
(2) contribute to the escalation of the cost of providing health care services.

(k) This section does not authorize competing physicians to act in concert in response to a report issued by an authorized third party related to the authorized third party's discussion or negotiations with a health benefit plan. The authorized third party shall advise the physicians of the provisions of this subsection and shall warn them of the potential for legal action against those who violate state or federal anti-trust laws by exceeding the authority granted under this section.

(l) A contract allowed under this section may not exceed a term of five years.

(m) The documents relating to a collective negotiation described under this section that are in the possession of the Department of Law are confidential and not open to public inspection.

Sec. 23.50.030. Fee for registration of authorized third parties. (a) The attorney general shall adopt regulations that establish the amount and manner of payment of a registration fee for authorized third parties. The attorney general shall establish the fee level so that the total amount of fees collected from authorized third parties approximately equals the actual regulatory costs for the oversight of joint negotiations between physicians and health benefit plans. The attorney general shall annually review the fee level to determine whether the regulatory costs are
approximately equal to fee collections. If the review indicates that the fee collections
and regulatory costs are not approximately equal, the attorney general shall calculate
fee adjustments and adopt regulations under this subsection to implement the
adjustments. In January of each year, the attorney general shall report on the fee level
and revisions for the previous year under this subsection to the office of management
and budget.

(b) In this section, "regulatory costs" means costs of the Department of Law
that are attributable to oversight of joint negotiations between physicians and health
benefit plans.

Sec. 23.50.040. Regulations. The attorney general may adopt regulations
necessary to implement this chapter.

Sec. 23.50.099. Definitions. In this chapter,
(1) "authorized third party" means a person authorized by the
physicians to negotiate on their behalf with a health benefit plan under this chapter;
(2) "covered lives" means the total number of individuals who are
entitled to benefits under the health benefit plan;
(3) "geographic service area" means the geographic area of the
physicians seeking to jointly negotiate;
(4) "health benefit plan" has the meaning given in AS 21.54.500.

* Sec. 2. AS 45.50.572 is amended by adding a new subsection to read:
(k) AS 45.50.562 - 45.50.596 do not forbid the existence or operation of
organizations of physicians acting in accordance with AS 23.50, or forbid or restrain
members of those organizations from lawfully carrying out the legitimate objectives
of them; nor are these organizations or members illegal combinations or conspiracies
in restraint of trade under the provisions of AS 45.50.562 - 45.50.596.

* Sec. 3. AS 23.50.010, 23.50.020, 23.50.030, 23.50.040, 23.50.099; and AS 45.50.572(k)
are repealed July 1, 2005.