CS FOR SENATE BILL NO. 256(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered: 2/24/00
Referred: Finance

Sponsor(s): SENATOR PETE KELLY

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to regulation of managed health care and allowing physicians**
2 **to collectively negotiate with a health benefit plan that has substantial market**
3 **power."**

4 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

5 * **Section 1.** The uncodified law of the State of Alaska is amended by adding a new
6 section to read:
7 FINDINGS AND INTENT FOR SECTION 2. (a) The legislature finds that
8 (1) providing patients and health care providers greater protection in dealing
9 with managed care insurers is in the best interests of residents of the state;
10 (2) the protections contained in sec. 2 of this Act would be beneficial for
11 insurers and for those health care plans offered by businesses that are self-insured;
12 (3) under the Employee Retirement Income Security Act of 1974, health care
13 plans offered by self-insured businesses have largely been exempt from regulation by the state;
14 (4) recently there have been changes recognized by the federal courts regarding

1 the scope of the exemption from state regulation given to health care plans offered by self-
2 insured businesses.
3 (b) It is the intent of the legislature that the provisions of sec. 2 of this Act apply to
4 health care plans offered by self-insured businesses to the maximum extent allowed under
5 federal law.
6 * **Sec. 2.** AS 21.42 is amended by adding a new section to read:
7 **Sec. 21.42.175. Patient and health care provider protection.** (a) A contract
8 between a participating health care provider and a managed care entity that offers a
9 group managed care plan must contain a provision that
10 (1) clearly identifies all health care services to be provided;
11 (2) clearly identifies which health care services are to be provided by
12 a contracting health care provider;
13 (3) clearly identifies and describes each insurance policy used by the
14 group managed care plan to provide identified health care services to a covered person;
15 (4) clearly states the rate and method of compensation for health care
16 services provided by the provider for a covered person;
17 (5) clearly states all ways in which the contract between the health care
18 provider and managed care entity may be terminated; a provision that provides for
19 discretionary termination by either party must apply equitably to both parties;
20 (6) provides that, in the event of a dispute between the parties to the
21 contract, the following procedure must be used before either party may pursue other
22 remedies:
23 (A) an initial meeting at which all parties are present or
24 represented by individuals with full decision-making authority regarding the
25 matters in dispute shall be held within seven days after the plan receives notice
26 of the dispute or gives notice to the provider;
27 (B) if, within 30 days following the initial meeting, the parties
28 have not resolved the dispute, the dispute shall be submitted to mediation
29 directed by a mediator who is mutually agreeable to the parties and who is not
30 regularly under contract to or employed by either of the parties; each party
31 shall bear its proportionate share of the cost of mediation, including the

1 mediator fees;
2 (C) if, after a period of 60 days following commencement of
3 mediation, the parties are unable to resolve the dispute, either party may submit
4 the dispute to binding arbitration in accordance with (E) of this paragraph;
5 (D) the parties shall agree to negotiate in good faith in the
6 initial meeting and in mediation;
7 (E) after 10 days' written notice to the other party, either party
8 may submit the dispute to final and binding arbitration; binding arbitration shall
9 be held in the judicial district in this state where the services at issue in the
10 dispute were or are to be performed; at the request of either party, an
11 arbitration proceeding may be conducted electronically, including by telephone
12 or video conferencing; and
13 (F) binding arbitration shall be conducted under the rules of the
14 National Health Lawyers Association Alternative Dispute Resolution Project;
15 each party shall be responsible for its own costs and expenses related to the
16 arbitration, including attorney fees, and shall bear a proportionate share of the
17 arbitrator fees; the arbitrator shall be selected by mutual agreement between the
18 parties; the arbitrator shall be an attorney and a member of the National
19 Academy of Arbitrators or the National Health Lawyers Association;
20 (7) states that a health care provider may not be penalized or the health
21 care provider's contract terminated by the managed care entity because the health care
22 provider acts as an advocate for a covered person in seeking appropriate, medically
23 necessary health care services;
24 (8) protects the ability of a health care provider to communicate openly
25 with a covered person about all appropriate diagnostic testing and treatment options;
26 (9) clearly identifies the length of time during which the contract is to
27 remain in effect; a contract term may not exceed five years; and
28 (10) defines words in a clear and concise manner.
29 (b) A contract between a participating health care provider and a managed care
30 entity that offers a group managed care plan may not contain a provision that
31 (1) provides financial incentives to the health care provider for

1 withholding covered health care services that are medically necessary;
2 (2) describes the products used by the plan as including all products
3 that are currently offered or that may be offered in the future by the managed care
4 entity; and
5 (3) requires the health care provider to be compensated for health care
6 services performed at the same rate as the health care provider has contracted with
7 another managed care entity.
8 (c) A managed care entity may not enter into a contract with a health care
9 provider that includes an indemnification or hold harmless clause for the acts or
10 conduct of the managed care entity. An indemnification or hold harmless clause
11 entered into in violation of this subsection is void.
12 (d) The standard provisions, other than those specifying the exact
13 compensation, of a contract between a health care provider and a managed care entity
14 must be filed and approved by the director before being used.
15 (e) In this section,
16 (1) "group managed care plan" or "plan" means a group health
17 insurance plan operated by a managed care entity; "group managed care plan" does not
18 include an integrated medical group;
19 (2) "health care provider" means a person licensed in this state or
20 another state of the United States to provide health care services;
21 (3) "health care services" means treatment of an individual for an
22 injury, illness, or disability and includes preventative treatment of an injury or illness;
23 (4) "health insurance" has the meaning given in AS 21.12.050(a);
24 (5) "integrated medical group" means a group of providers who
25 contract with a health care plan for the direct provision of health care services to a
26 person covered by a health care plan;
27 (6) "managed care" means a contract given to an individual, family, or
28 group of individuals under which a member is entitled to receive a defined set of
29 health care benefits through an organized system of health care providers in exchange
30 for defined consideration and that requires the member to use, or creates financial
31 incentives for the member to use, health care providers managed, employed by, or

1 under contract with a managed care entity; "managed care" does not include Medicaid
2 coverage under 42 U.S.C. 1396 - 1396p (Social Security Act);
3 (7) "managed care contractor" means a contractor who establishes,
4 operates, or maintains a network of participating health care providers, conducts or
5 arranges for utilization review activities, and contracts with a managed care entity;
6 (8) "managed care entity" means an insurer, a hospital or medical
7 service corporation, a health maintenance organization, an employer or employee
8 health care organization, or a managed care contractor that operates a group managed
9 care plan;
10 (9) "participating health care provider" means a health care provider
11 who has entered into an agreement with a managed care entity to provide services or
12 supplies to a patient covered by a group managed care plan;
13 (10) "provider" means a health care provider.
14 *** Sec. 3.** AS 23 is amended by adding a new chapter to read:
15 **Chapter 50. Collective Negotiation by Physicians.**
16 **Sec. 23.50.010. Legislative findings.** (a) The legislature finds that permitting
17 competing physicians to engage in collective negotiation of certain terms and
18 conditions of contracts with a health benefit plan will benefit competition, so long as
19 the physicians do not engage in an express or implied threat of retaliatory collective
20 action, including boycotts or strikes.
21 (b) The legislature finds that permitting physicians to engage in collective
22 negotiations over fee-related terms may, in some circumstances, yield anti-competitive
23 effects. There are, however, instances in which a health benefit plan dominates the
24 market to the degree that fair negotiations between physicians and the health benefit
25 plan are not possible in the absence of joint action on behalf of the physicians. In
26 those circumstances, the health benefit plan can virtually dictate the terms of the
27 contracts that it offers to physicians.
28 (c) The legislature finds that it is appropriate and necessary to authorize
29 collective negotiations between competing physicians and health benefit plans on fee-
30 related and other issues when the imbalances in bargaining capacity described in this
31 section exist.

1 **Sec. 23.50.020. Collective action by physicians.** (a) Competing physicians
2 may meet and communicate in order to collectively negotiate with the health benefit
3 plan concerning any of the contract terms and conditions described in this subsection.
4 Competing physicians may not engage in a boycott related to these terms and
5 conditions. Competing physicians may meet and communicate concerning
6 (1) clinical practice guidelines and coverage criteria;
7 (2) the respective liability of physicians and the health benefit plan for
8 the treatment or lack of treatment of insured or enrolled persons;
9 (3) administrative procedures, including methods and timing of the
10 payment of services to physicians;
11 (4) procedures for the resolution of disputes between the health benefit
12 plan and physicians;
13 (5) patient referral procedures;
14 (6) the formulation and application of reimbursement methodology;
15 (7) quality assurance programs;
16 (8) health service utilization review procedures; and
17 (9) criteria to be used by health benefit plans for the selection and
18 termination of physicians, including whether to engage in selective contracting.
19 (b) Except as provided in (c) of this section, competing physicians may not
20 meet and communicate for the purpose of collectively negotiating the following terms
21 and conditions with a health benefit plan:
22 (1) the fees or prices for services, including fees or prices arrived at by
23 applying any reimbursement methodology procedures;
24 (2) the conversion factor in a resource-based relative value scale
25 reimbursement methodology or similar methodologies;
26 (3) the amount of any discount on the price of services to be rendered
27 by the physicians;
28 (4) the dollar amount for capitation or fixed payment for each person
29 covered by the health benefit plan for health services rendered by physicians to a
30 health benefit plan's insureds, beneficiaries, or enrollees; or
31 (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 commissioner receives notice under (f) of this section that an authorized third party intends to negotiate with a health benefit plan, the commissioner shall provide written notice of the intended negotiation to the health benefit plan. A health benefit plan

(1) is rebuttably presumed to have substantial market power; and

(2) has the burden to prove that the health benefit plan does not have substantial market power if the health benefit plan elects not to negotiate under this chapter.

(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 commissioner that the health benefit plan's market share does not exceed 15 percent

(1) as measured 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; or

(2) within a particular 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

1 authorized third party may contract with, or offer different contract terms and
2 conditions to, individual competing physicians;
3 (6) an authorized third party may not represent more than 30 percent
4 of the market of practicing physicians for the provision of services, or a particular
5 physician type or specialty in the service area or proposed service area, if the health
6 benefit plan has less than a five percent market share as determined by the number of
7 covered lives as reported by the director of insurance for the most recently completed
8 calendar year or by the actual number of consumers of prepaid comprehensive health
9 services; and
10 (7) the authorized third party shall comply with the provisions of (f)
11 of this section.
12 (f) A person acting or proposing to act as an authorized third party under this
13 section shall,
14 (1) before engaging in collective negotiations with a health benefit plan,
15 (A) file with the commissioner the information that identifies
16 the authorized third party, the authorized third party's plan of operation, and the
17 authorized third party's procedures to ensure compliance with this section;
18 (B) furnish to the commissioner, for the commissioner's
19 approval, a brief report that identifies the proposed subject matter of the
20 negotiations or discussions with a health benefit plan and that contains an
21 explanation of the efficiencies or benefits that are expected to be achieved
22 through the collective negotiations; the commissioner may not approve the
23 report if the proposed negotiations exceed the authority granted in this chapter
24 and, if they do, shall enter an order prohibiting the collective negotiations from
25 proceeding; the authorized third party shall provide supplemental information
26 to the commissioner as new information becomes available that indicates that
27 the subject matter of negotiations with the health benefit plan has changed or
28 will change;
29 (2) within 14 days after receiving a health benefit plan's decision to
30 decline to negotiate or to terminate negotiations, or within 14 days after requesting
31 negotiations with a health benefit plan who fails to respond within that time, report to

1 the commissioner that negotiations have ended or have been declined;
2 (3) before reporting the results of negotiations with a health benefit
3 plan and before giving physicians an evaluation of any offer made by a health benefit
4 plan, provide to the commissioner, for the commissioner's approval, a copy of all
5 communications to be made to physicians related to the negotiations, discussions, and
6 health benefit plan offers.
7 (g) With the advice of the attorney general, the commissioner shall either
8 approve or disapprove the collective negotiation subject to the reporting required in (f)
9 of this section within 30 days after receiving the reports. If disapproved, the
10 commissioner shall furnish a written explanation of any deficiencies along with a
11 statement of specific remedial measures that would correct any identified deficiencies.
12 An authorized third party who fails to obtain the commissioner's approval is
13 considered to be acting outside the authority of this section.
14 (h) This section does not authorize competing physicians to act in concert in
15 response to a report issued by an authorized third party related to the authorized third
16 party's discussion or negotiations with a health benefit plan. The authorized third party
17 shall advise the physicians of the provisions of this subsection and shall warn them of
18 the potential for legal action against those who violate state or federal anti-trust laws
19 by exceeding the authority granted under this section.
20 (i) A contract allowed under this section may not exceed a term of five years.
21 (j) The documents relating to a collective negotiation described under this
22 section that are in the possession of the department are confidential and not open to
23 public inspection.
24 **Sec. 23.50.030. Fee for registration of authorized third parties.** (a) The
25 commissioner shall adopt regulations that establish the amount and manner of payment
26 of a registration fee for authorized third parties. The commissioner shall establish the
27 fee level so that the total amount of fees collected from authorized third parties
28 approximately equals the actual regulatory costs for the oversight of joint negotiations
29 between physicians and health benefit plans. The commissioner shall annually review
30 the fee level to determine whether the regulatory costs are approximately equal to fee
31 collections. If the review indicates that the fee collections and regulatory costs are not

1 approximately equal, the commissioner shall calculate fee adjustments and adopt
2 regulations under this subsection to implement the adjustments. In January of each
3 year, the commissioner shall report on the fee level and revisions for the previous year
4 under this subsection to the office of management and budget.
5 (b) In this section, "regulatory costs" means costs of the department that are
6 attributable to oversight of joint negotiations between physicians and health benefit
7 plans.
8 **Sec. 23.50.040. Voluntary negotiation by health benefit plan.** A health
9 benefit plan that is not required to negotiate under this chapter may voluntarily comply
10 with the provisions of this chapter and negotiate with an authorized third party.
11 **Sec. 23.50.050. Regulations.** The commissioner may adopt regulations
12 necessary to implement this chapter.
13 **Sec. 23.50.099. Definitions.** In this chapter,
14 (1) "authorized third party" means a person authorized by the
15 physicians to negotiate on their behalf with a health benefit plan under this chapter;
16 (2) "commissioner" means the commissioner of labor and workforce
17 development;
18 (3) "health benefit plan" has the meaning given in AS 21.54.500.
19 *** Sec. 4.** AS 45.50.572 is amended by adding a new subsection to read:
20 (k) AS 45.50.562 - 45.50.596 do not forbid the existence or operation of
21 organizations of physicians acting in accordance with AS 23.50, or forbid or restrain
22 members of those organizations from lawfully carrying out the legitimate objectives
23 of them; nor are these organizations or members illegal combinations or conspiracies
24 in restraint of trade under the provisions of AS 45.50.562 - 45.50.596.