SENATE BILL NO. 256

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY SENATOR PETE KELLY

Introduced: 2/8/00
Referred: Health, Education and Social Services, Finance

A BILL

FOR AN ACT ENTITLED

"An Act relating to regulation of managed health care and allowing physicians to collectively negotiate with a health care insurer that has substantial market power."

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

*** Section 1.** AS 21.42 is amended by adding a new section to read:

Sec. 21.42.175. Patient and health care provider protection. (a) A contract between a participating health care provider and a managed care entity that offers a group managed care plan must contain a provision that

(1) clearly identifies all health care services to be provided;

(2) clearly identifies which health care services are to be provided by a contracting health care provider;

(3) clearly identifies and describes each insurance policy used by the group managed care plan to provide identified health care services to a covered person;

(4) clearly states the compensation rates for each provider used by the

group managed care plan to provide health care services;

(5) clearly states all ways in which the contract between the health care provider and managed care entity may be terminated; a provision that provides for discretionary termination by either party must apply equitably to both parties;

(6) provides that, in the event of a dispute between the parties to the contract, the following procedure must be used before either party may pursue other remedies:

(A) an initial meeting at which all parties are present or represented by individuals with full decision-making authority regarding the matters in dispute shall be held within seven days after the plan receives notice of the dispute or gives notice to the provider;

(B) if, within 30 days following the initial meeting, the parties have not resolved the dispute, the dispute shall be submitted to mediation directed by a mediator who is mutually agreeable to the parties and who is not regularly under contract to or employed by either of the parties; each party shall bear its proportionate share of the cost of mediation, including the mediator fees;

(C) if, after a period of 60 days following commencement of mediation, the parties are unable to resolve the dispute, either party may submit the dispute to binding arbitration in accordance with (E) of this paragraph;

(D) the parties shall agree to negotiate in good faith in the initial meeting and in mediation;

(E) after 10 days' written notice to the other party, either party may submit the dispute to final and binding arbitration; binding arbitration shall be held in the judicial district in this state where the services at issue in the dispute were or are to be performed; at the request of either party, an arbitration proceeding may be conducted electronically, including by telephone or video conferencing; and

(F) binding arbitration shall be conducted under the rules of the National Health Lawyers Association Alternative Dispute Resolution Project; each party shall be responsible for its own costs and expenses related to the

arbitration, including attorney fees, and shall bear a proportionate share of the arbitrator fees; the arbitrator shall be selected by mutual agreement between the parties; the arbitrator shall be an attorney and a member of the National Academy of Arbitrators or the National Health Lawyers Association;

(7) states that a health care provider may not be penalized or the health care provider's contract terminated by the managed care entity because the health care provider acts as an advocate for a covered person in seeking appropriate, medically necessary health care services;

(8) protects the ability of a health care provider to communicate openly with a covered person about all appropriate diagnostic testing and treatment options;

(9) clearly identifies the length of time during which the contract is to remain in effect; a contract term may not exceed five years; and

(10) defines words in a clear and concise manner.

(b) A contract between a participating health care provider and a managed care entity that offers a group managed care plan may not contain a provision that

(1) provides financial incentives to the health care provider for withholding covered health care services that are medically necessary;

(2) describes the products used by the plan as including all products that are currently offered by the managed care entity; and

(3) requires the health care provider to be compensated for health care services performed at the same rate as the health care provider has contracted with another managed care entity.

(c) A managed care entity may not enter into a contract with a health care provider that includes an indemnification or hold harmless clause for the acts or conduct of the managed care entity. An indemnification or hold harmless clause entered into in violation of this subsection is void.

(d) The standard provisions, other than those specifying the exact compensation, of a contract between a health care provider and a managed care entity must be filed and approved by the director before being used.

(e) In this section,

(1) "group managed care plan" or "plan" means a group health

insurance plan operated by a managed care entity; "group managed care plan" does not include an integrated medical group;

(2) "health care provider" means a person licensed in this state or another state of the United States to provide health care services;

(3) "health care services" means treatment of an individual for an injury, illness, or disability and includes preventative treatment of an injury or illness;

(4) "health insurance" has the meaning given in AS 21.12.050(a);

(5) "integrated medical group" means a group of providers who contract with a health care plan for the direct provision of health care services to a person covered by a health care plan;

(6) "managed care" means a contract given to an individual, family, or group of individuals under which a member is entitled to receive a defined set of health care benefits through an organized system of health care providers in exchange for defined consideration and that requires the member to use, or creates financial incentives for the member to use, health care providers managed, employed by, or under contract with a managed care entity; "managed care" does not include Medicaid coverage under 42 U.S.C. 1396 - 1396p (Social Security Act);

(7) "managed care contractor" means a contractor who establishes, operates, or maintains a network of participating health care providers, conducts or arranges for utilization review activities, and contracts with a managed care entity;

(8) "managed care entity" means an insurer, a hospital or medical service corporation, a health maintenance organization, an employer or employee health care organization, or a managed care contractor that operates a group managed care plan;

(9) "participating health care provider" means a health care provider who has entered into an agreement with a managed care entity to provide services or supplies to a patient covered by a group managed care plan;

(10) "provider" means a health care provider.

*** Sec. 2.** AS 23 is amended by adding a new chapter to read:

Chapter 50. Collective Negotiation by Physicians.

Sec. 23.50.010. Legislative findings. (a) The legislature finds that permitting

competing physicians to engage in collective negotiation of certain terms and conditions of contracts with health care insurers will benefit competition, so long as the physicians do not engage in an express or implied threat of retaliatory collective action, including boycotts or strikes.

(b) The legislature finds that permitting physicians to engage in collective negotiations over fee-related terms may, in some circumstances, yield anti-competitive effects. There are, however, instances in which health care insurers dominate the market to the degree that fair negotiations between physicians and the health care insurers are not possible in the absence of joint action on behalf of the physicians. In those circumstances, health care insurers can virtually dictate the terms of the contracts that they offer to physicians.

(c) The legislature finds that it is appropriate and necessary to authorize collective negotiations between competing physicians and health care insurers 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 care insurer 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 health care insurers 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 health care insurers 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 care insurers 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 care insurer:

(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 care insurer for health services rendered by physicians to a health care insurer's insureds 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 insurer may collectively negotiate the terms and conditions of contracts described in (b) of this section if the health care insurer has substantial market power. A health care insurer has substantial market power under this section if the health care insurer's market share exceeds 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 or enrollees and for Medicare and Medicaid beneficiaries.

(d) 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 care insurer;

(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 health care insurers 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 care insurer 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, or a particular physician type or specialty in the service area or proposed service area, if the health care insurer 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; and

(7) the authorized third party shall comply with the provisions of (e) of this section.

(e) 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 care insurer,

(A) file with the commissioner 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 commissioner, for the commissioner’s approval, a brief report that identifies the proposed subject matter of the negotiations or discussions with a health care insurer and that contains an explanation of the efficiencies or benefits that are expected to be achieved through the collective negotiations; the commissioner 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 commissioner as new information becomes available that indicates that the subject matter of negotiations with the health care insurer has changed or will change;

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

(3) before reporting the results of negotiations with a health care insurer and before giving physicians an evaluation of any offer made by a health care insurer, provide to the commissioner, for the commissioner's approval, a copy of all communications to be made to physicians related to the negotiations, discussions, and health care insurer offers.

(f) With the advice of the attorney general, the commissioner shall either approve or disapprove the collective negotiation subject to the reporting required in (e) of this section within 30 days after receiving the reports. If disapproved, the commissioner 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 commissioner's approval is considered to be acting outside the authority of this section.

(g) 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 care insurer. 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.

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

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

Sec. 23.50.030. Fee for registration of authorized third parties. The

commissioner shall adopt regulations that establish the amount and manner of payment of a registration fee for authorized third parties. The commissioner 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 care insurers. The commissioner 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 commissioner shall calculate fee adjustments and adopt regulations under this section to implement the adjustments. In January of each year, the commissioner shall report on the fee level and revisions for the previous year under this section to the office of management and budget. In this section, "regulatory costs" means costs of the department that are attributable to oversight of joint negotiations between physicians and health care insurers.

Sec. 23.50.040. Regulations. The commissioner 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 care insurer under this chapter;

(2) "commissioner" means the commissioner of labor and workforce development;

(3) "health care insurer" has the meaning given in AS 21.54.500.

*** Sec. 3.** 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.