

ALASKA STATE LEGISLATURE
SENATE LABOR & COMMERCE COMMITTEE

March 13, 2001
1:30 pm

MEMBERS PRESENT

Senator Randy Phillips, Chair
Senator Alan Austerman
Senator Loren Leman
Senator John Torgerson
Senator Bettye Davis

MEMBERS ABSENT

All Members Present

COMMITTEE CALENDAR

CS FOR SENATE BILL NO. 37(JUD)

"An Act relating to collective negotiation by physicians with health benefit plans, to health benefit plan contracts with individual competing physicians, and to the application of state antitrust laws to agreements involving providers and groups of providers affected by collective negotiations."

MOVED CSSB 37 (L&C) OUT OF COMMITTEE

PREVIOUS COMMITTEE ACTION

SB 37 - See Judiciary minutes dated 1/22/01 and 2/21/01.

WITNESS REGISTER

Mr. George Rhymeer
Alaska Physicians and Surgeons Member
3340 Providence Dr.
Anchorage AK 99508

POSITION STATEMENT: Supported SB 37.

Dr. Mike Carroll
No address provided
Fairbanks AK

POSITION STATEMENT: Supported SB 37.

Mr. Mike Haugen, Executive Director
Alaska Physicians and Surgeons

3340 Providence Dr.
Anchorage AK 99508

POSITION STATEMENT: Supported SB 37.

Mr. Clyde Sniffen, Assistant Attorney General
Department of Law
1031 W 4th, #200
Anchorage AK 99501

POSITION STATEMENT: Commented on SB 37.

Ms. Laura Sarcone
Alaska Nurses Association
Alaska Nurse Practitioners Association
Alaska Chapter, American College of Nurse Midwives
1444 Hillcrest
Anchorage AK 99503

POSITION STATEMENT: Commented on SB 37.

ACTION NARRATIVE

TAPE 01-10, SIDE A

Number 001
#SB37

SB 37-PHYSICIAN NEGOTIATIONS WITH HEALTH INSURE

CHAIRMAN RANDY PHILLIPS called the Senate Labor & Commerce Committee meeting to order at 1:30 pm and announced SB 37 to be up for consideration.

SENATOR KELLY, sponsor of SB 37, said that this bill does not include nurses and it was never his intent to include them. He said the nurses' associations were satisfied with the language that removes them.

MR. GEORGE RHYMEER, Alaskan Physicians and Surgeons Board member, said he is a cardiologist from Anchorage and strongly supported SB 37. He said:

The physician community is very keen on this bill for a number of reasons, one of which is that it allows physicians in the state to talk with one another about medical concerns, about clinical practices, about what is best medical care for their patients without being afraid of being attacked by the Federal Trade Commission.

He said participation is voluntary and the bill has a sunset clause.

DR. MIKE CARROLL, Fairbanks physician, supported SB 37. He said

that recently the Alaska Health Care Network was investigated by the federal government for price fixing. He wanted to clarify that they have never dealt with financial aspects in regards to the cost of health care. They have spent more than \$100,000 to try and set up an organization that would avoid price fixing. They, then, had to spend \$75,000 to deal with the federal government because more than 30 percent of Fairbanks physicians were involved in their network. "They did not have an appreciation for the practice of medicine, the isolation, the way specialties are directed in some of our communities."

He thought that patients and businesses in Fairbanks suffer because competition on the insurance side of things went away when the Network was asked to stop trying to direct the contracts.

Small insurers have elected to not come to Fairbanks at this point, because they have no means of directing some of their queries to an organized group of physicians. That left just the large insurance companies and it's to their advantage not to have any competition. I don't think health care costs for the State of Alaska or other organizations in the Fairbanks area have gone down over the last year as a result of the limits the federal government put on the physicians in Fairbanks.

MR. MIKE HAUGEN, Executive Director, Alaska Physicians and Surgeons, explained what are in the contracts that could be negotiated between physicians and health insurers:

There is some confusion about would a list of potential covered services be allowed to be negotiated by doctors. In other words, would the doctors be able to tell the insurers that you must provide a certain list of benefits or covered areas to your patients before the doctors will consider doing a contract with you. And I wanted to clarify that those are not terms that would be negotiated. Terms that would be negotiated would be things like what is the medical necessity - the definition of it. What are covered services. Often in these contracts, the doctors don't even know what the complete list is. We're not talking about defining what the list is, just they would like to know what the list is. What's the appeals process. Is mutual written consent required on both parties parts before the contract can be amended? In many of these contracts that's not the case. The insurance carrier can unilaterally change the terms of the contracts with some sort of notice, but the doctors' only option at that point is to try to terminate the contract, going through that process or live with the

changes. That's just a short list of some of the types of things that may be negotiated, but we're certainly not in any way trying to lead you to conclude that the doctors are trying to define for the health care insurers what their list of covered services would be.

Number 700

SENATOR DAVIS asked how this bill would increase competition and efficiencies.

MR. HAUGEN answered that, "In two areas, it may. That's why there is a five-year sunset and I view it as an experiment, particularly in the State of Alaska.

It might increase competition, because right now this state has difficulty in attracting outside health insurance carriers. We have a relatively small population base and we're separated from the rest of the country by a great distance. It is attractive to health care insurers to be able to get an instant panel of doctors if they can arrive at a contract with the doctors. In other words, it's very expensive for the carriers to come up and do it one doctor at a time and try to build a network. If we were in a position where we could go to a carrier and say, "If we can come to a contract that is acceptable to the doctors, you will instantly have a panel of 150 or 200 doctors." That automatically makes that new carrier a player up here. That can't help, but I think, increase competition, because right now there are really only two large ones.

The second issue, and Dr. Rhymeer touched on it, was that there are many areas where doctors see inefficiencies in the system. They don't feel comfortable, because of what happened in Fairbanks and the general climate, in discussing those inefficiencies.

MR. HAUGEN continued to explain:

If they were in a position as a group to say, "Look, what you're doing here is crazy. You're wasting all kinds of money. Try this. That may lower costs."

SENATOR DAVIS asked if it had been 30 percent of the doctors in Fairbanks, not 60 percent, would they have been targeted.

MR. RHYMEER answered that he really didn't know the answer to that. Part of the problem is that they have never been able to get the

guidelines and rules from the FTC about what they can do and how to do them. "Physicians are basically operating in the dark when it comes to talking with one another about anything more than what you had for lunch, basically."

MR. RHYMEER said that the rules could change along with the administration in Washington D.C. at this point.

SENATOR DAVIS asked him to point out some of the inefficiencies that he envisions would be corrected.

MR. RHYMEER answered:

There are numerous instances of duplication of services, because physicians are dealing with different insurance companies with different carriers and if there was a more business orientation and a greater business association between physicians, there would be a greater incentive and a much easier time to do things that are less duplicative. Information transfer would be better. I see people all the time who've had a chest x-ray three days ahead of time, but it's unavailable for one reason or another... There are many instances of that. Plus the fact that a large amount of money is spent in the emergency room now, physicians think unnecessarily. Part of the reason is because of the way medicine is paid for. We think physicians working together with people who pay the bills is distinctly the way to go to get efficiencies. The physicians' community desperately wants to do that.

SENATOR DAVIS asked if the emergency room charges he was talking about were for reasons other than emergencies.

MR. RHYMEER answered that was what he was talking about.

SENATOR DAVIS asked if he was referring to incidents in Fairbanks where doctors might consider situations emergencies and insurance companies might not consider them to be, because the people were not hospitalized. Would this bill correct those situations?

MR. RHYMEER answered that he couldn't say the bill would correct them, but it would make it easier for physicians to talk to one another and come to some consensus about what the best way to practice medicine and take care of certain disease processes might be and deal with the carriers and with the people who pay the bill in taking care of that.

MR. CARROLL added that on the emergency issue, he partly misspoke when he said physicians in Fairbanks were not involved in price fixing.

If defining emergency care represents price fixing, then I would say we were probably guilty at that point, but our interests were in working with the patient so he could be part of the definition of emergency care rather than just the insurance carrier. It all depends on if you're having chest pains, you don't know if that's a heart attack or acid valve cap. Things like that were reasonable to get involved with.

The other issues were areas of inefficiency. There are several areas we started to address and would have like to addressed on a wider network basis, but now cannot address those. One of them is information systems. We were trying to put together a system so that the computers around the physicians in the hospital would talk to each other and, as a result, eliminate some of the unnecessary testing or duplication of testing that would occur, eliminate some of the paper work that may be generated in that situation. In order to do that, it gets expensive, but we had actually gotten to the point where we were staring to get compatible computer systems throughout the medical community. I think that was a really big step forward that a whole fleet of patients would have been the benefactor of. We can't get involved in that any more, I'm sorry to say.

As far as dealing with efficiencies of service, we have established committees that looked at pharmaceutical drug usage and try to address through an educational process with the physicians and ultimately with the patients the proper use of pharmaceutical agents both on the proper indications and their costs. Sometimes there are three or four drugs that have equivalent actions, but have radically different costs. We thought by educating physicians and patients along those lines and started a process of bringing up expert speakers from the University of Washington and other parts of the country, even as far away as Dallas, Texas, that we could improve on and make the cost more efficient in the use of pharmaceuticals. It's an issue that's got immense publicity on the federal level. We can't involve ourselves in that anymore, I'm sorry to say.

He added that they were trying to address the issue of quality care, but they can't address that any more, either.

MR. CLYDE SNIFFEN, Assistant Attorney General, responded that all

the concerns raised by the physicians who have testified today have been non-price related issues. One of the Department's recommendations was to eliminate those.

He explained that under the current system there is a way doctors can get to health benefit plans. "There's nothing to prohibit individual physicians from expressing concerns to health benefit plans and in limited circumstances with the integration model or the messenger model, groups of physicians can get together and give that information to the plans. I don't know if SB 37 in its current form would necessarily provide any more ability to do that."

MS. LAURA SARCONI, Alaska Nurses Association, Alaska Nurse Practitioners Association, and the Alaska Chapter of the American College of Nurse Midwives, said her concern was on page 2, lines 16 - 17 of the committee substitute, where the competing physicians meet and communicate concerning critical practice guidelines and coverage criteria. They would like language that clarifies that physicians may communicate using physicians' clinical practice guidelines, not nurse practitioners' or nurse midwife or another other practitioners' clinical practice guidelines.

SENATOR LEMAN moved to adopt the committee substitute, 3/8/01 to SB 37. There were no objections and it was so ordered.

SENATOR AUSTERMAN moved on page 2, line 17 to add amendment # 1 that would clarify that during negotiations, physicians may communicate concerning their specific clinical practice guidelines and not those of other health care providers.

MS. SARCONI indicated her approval of that language. There were no objections and to the amendment and it was adopted.

SENATOR LEMAN moved to pass CSSB 37 (L&C) from committee with individual recommendations. There were no objections and it was so ordered.

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CHAIRMAN PHILLIPS adjourned the meeting at 1:55 pm.