SB 256

FISCAL NOTE

STATE OF ALASKA
2000 LEGISLATIVE SESSION

BILL NO. CSSB 256 (HES)

Revision Date/Time (Note if correction) _____
Dept. Affected Law
Title "An Act relating to regulation of managed health care ... allowing physicians to collectively negotiate ..."
BRU Civil Division
Component Fair Business Practices
Sponsor Senator Pete Kelly
Requester Senate Finance Committee
Component No. 2206

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Personal Services	142.5	142.5	142.5	142.5	142.5	142.5
Travel	3.1	3.1	3.1	3.1	3.1	3.1
Contractual	40.5	40.5	40.5	40.5	40.5	40.5
Supplies	2.3	2.3	2.3	2.3	2.3	2.3
Equipment	6.5					
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	194.9	188.4	188.4	188.4	188.4	188.4
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	194.9	188.4	188.4	188.4	188.4	188.4
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	194.9	188.4	188.4	188.4	188.4	188.4

Estimate of any current year (FY2000) cost: _____

POSITIONS

Full-time	1	1	1	1	1	1
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

CSSB 256 (HES) establishes certain statutory provisions that must be included in contracts between anyone licensed in Alaska or the United States to provide health care services and a health insurer, hospital or medical service corporation, a health maintenance organization, an employer or employee health care organization, or managed care contractor, that operates a group managed care plan. These contracts must be reviewed and approved by the Director of the Division of Insurance. In addition, the bill provides a method for physicians to collectively negotiate certain terms and conditions of contracts with a health benefit plan. If an authorized third party negotiates with the health benefit plan, the collective negotiation is to be reviewed and approved by the Commissioner of the Department of Labor and Workforce Development, with the advice of the attorney general.

Prepared by: Joan M. Kasson Phone 465-5370
Division Attorney General's Office Date/Time 2/29/00, 4:17 PM
Approved by Commissioner Bruce M. Botelho, Attorney General Date 2/29/00
Agency Department of Law

PREPARER TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE
For further distribution information, call the Governor's Legislative Office

FISCAL NOTE

STATE OF ALASKA
2000 LEGISLATIVE SESSION

BILL NO. CSSB 256 (HES)

ANALYSIS CONTINUATION

The Division of Insurance estimates that Section 2 of the committee substitute, relating to contracts between entities operating a managed care plan and participating health care providers, will require their review of approximately 1,000 new contracts. The Department of Law provides advice and assistance during these reviews, and represents the division in administrative hearings, and in court, when the division's decisions are challenged. We estimate an additional one-quarter of a full-time equivalent attorney position would be required to handle the increased workload from this section.

Section 3 of the committee substitute would allow collective bargaining by physicians with health benefit plans. The new Chapter 50, entitled "Collective Action by Physicians," involves the Commissioner of the Department of Labor and Workforce Development in the collective bargaining process. When an authorized third party is handling negotiations, the commissioner must approve the third party to represent physicians and with the advice of the Attorney General approve the subject matter over which the physicians and health benefit plans will bargain (including physician fees).

The Department of Law anticipates a minimum of one new full-time equivalent attorney position will be needed to handle this new workload. Extensive regulation development will be necessary to implement the legislation by defining terms and setting forth the reporting requirements that authorized third parties will be required to submit in order to reduce, or preferably eliminate, investigation time during the commissioner's 30 day review period. Once regulations are complete, this position will assist in performing the necessary review and antitrust analyses on the collective bargaining reports submitted by the authorized third party, and represent the agency when decisions of the commissioner are challenged.

Costs are based on the department's FY01 standard full-time equivalent attorney schedule of $134,712, which includes clerical support, communications, space, supplies, data processing, and other normal overhead expenses. The full-time attorney position estimate also includes an additional $6,500 for one-time equipment purchases and $5,000 for direct case costs, costs that cannot be included in the rate as overhead. In addition, $15,000 is included for expert fees and costs.

COST SUMMARY:

Fund Source		100	200	300	400	500	Total
Section 2: 1/4 FTE attorney	GF	$28.5	$0.1	$4.6	$0.5	$0.0	$33.7
Section 3: 1 FTE attorney; Expert fees; Direct case costs	GF	$114.0	$3.0	$35.9	$1.8	$6.5	$161.2
Total		$142.5	$3.1	$40.5	$2.3	$6.5	$194.9

FISCAL NOTE

STATE OF ALASKA
2000 LEGISLATIVE SESSION

BILL NO. CS SB 256 (HES)

Revision Date/Time
Dept. Affected Administration
Title An act relating to regulation of managed health care and allowing physicians to collectively...
BRU Centralized Administrative Services
Component Retirement and Benefits
Sponsor Senator Pete Kelly
Requester Senate Finance
Component No. 64

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	*	*	*	*	*	*
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	*	*	*	*	*	*

Estimate of any current year (FY2000) cost: *

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

At this time the Department of Administration is uncertain whether the State's health plans would be subject to this legislation. If the State is subject to this legislation, then our ability to manage health care costs would be compromised; however, we are unable to quantify the potential cost impact.

Prepared by: Guy Ball
Phone 465-4471
Division Retirement and Benefits
Date/Time 2/29/00 10:22 AM
Approved by Commissioner Robert Poe Jr.
Date 2/29/00
Agency Department of Administration

PREPARER TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE
For further distribution information, call the Governor's Legislative Office

Senate Bill 256

Response to comments by
Gordon Evans
HIAA
2/22/00

Evans: *"Quality is not the driving force behind the physician collective bargaining movement -- it's economics*

(1)

Fact: If this bill were only about financial concerns, a doctor's contract with a health benefit plan would be about half a page long. Certainly, financial concerns are a part of any contract. However, this involves the overall care of patients. This is about giving physicians some leverage to prevent the intrusion of a giant third party into the sacred physician/patient relationship.

Evans: *"Legitimate mechanisms already exist within the boundaries of current antitrust law under which health care providers can and so collaborate and negotiate with health plans, patients, and others on clinical or quality of care issues or other concerns they may have regarding the impact of managed care on the quality of care."*

(2)

Fact: Currently, physician organization is expensive, complex, and often not logistically possible.

Organization makes the physician sacrifice his professional independence and deprives patients of choice of delivery setting.

If physicians organize there is no legitimate means to determine if the group is organized in a manner which meets FTC requirements for negotiation. Moreover, the costs of obtaining a legal opinion that can't provide any guarantees can easily run into six figures even before the group is functional.

Even if the group does meet FTC standards it doesn't prevent the plan from threatening the group with an antitrust action, resulting in six figure legal fees and the achievement of the plan's ultimate goal -- ceasing physician negotiations.

Evans: *"Consolidation among health plans has been and continues to be subject to rigorous antitrust scrutiny, at both state and federal levels."*

(3)

Fact: Under this legislation physicians would yet be subject to FTC scrutiny as well as scrutiny by the Commissioner of Labor and Work force Development and Alaska's Attorney General.

Evans: *"Antitrust waiver legislation is anti-competitive and would raise costs for health care programs..."*

(4)

Fact: In talking to several third party payers who want to do business in the State of Alaska, they talk about the efficiencies of utilizing the services of an authorized third party to help them build a network. Therefore providing an antitrust exemption to allow authorized third parties to help health benefit plans enter the market would offer consumers more choices and be pro competitive.

As an example of how uncompetitive the current oligopsonic medical health care market is when it comes to individual physician contracts, many insurance contracts offer a "take it or leave it" approach. Contracts are non-negotiable.

When physician networks do fully integrate and evolve into an entity that can wield some power in the market, the health plan refuses to negotiate with the network and begins to break it apart into individual physicians who can again be bullied into accepting one-sided contracts. A recent memo from Aetna U.S. Healthcare in California contained the following language: **"In order to participate directly in All Aetna U.S. Healthcare products you will need to withdraw your affiliation with any/all Aetna U.S. Healthcare contracted IPAs and Medicaid Groups."**

Evans: *"Legislation at either the state or federal levels will be costly. ...health care premiums in the private sector would increase by 6 to 11 percent"*

(5)

Fact: The study in which Evans based his projected increase on was done by Charles River Associates in June of 1999 (see attached study). If one reads the study carefully, particularly the first several pages, it is evident that the conclusions are based on numerous assumptions which cannot be supported by any firm data because that data does not exist.

However, for the sake of argument, if we took 8% as a mid point, that would mean that physicians component of total health care expenditures would need to increase by 50% (physicians charges currently represent approximately 16% of total health care expenditures). It is doubted that

this hypothetical 50% increase in physician charges would pass muster with the State Attorney General and Commissioner of Labor.

Page 9, paragraph two of the study, attributes most of the projected increased health care expenditures to an increase in utilization. This presumably assumes that physicians would be successful in negotiating away any utilization review. This argument is flawed by simply looking at United Health Care's scrapping of their internal utilization review procedure regarding their review of medical treatment decisions made by the physicians providing the care (see attached news article). United Health Care was spending upwards of $100 million/year on the review process. Such a review process still has merit but it must be targeted to only those situations that warrant appropriate internal utilization review.

Negotiations allowed for in this bill are voluntary. The health plan doesn't even have to come to the table. The negotiations are non-binding. Either party can stop at any time without penalty, and the health plan remains free to contract with or offer different terms and conditions to individual physicians.

Remember, the Attorney General must ensure that there is adequate competition remaining in the marketplace. So any group of physicians asking permission to negotiate with a plan cannot be so large or contain such a large component of a particular specialty so as to eliminate competition in the market.

Evans: *"The Texas legislation allowed physicians to strike or boycott."*

(6) Fact: Article 29.10 of the Texas law states: ***"Nothing contained in this chapter shall be construed to enable physicians to jointly coordinate any cessation, reduction, or limitation of health care services."***

Evans: "Physician collective bargaining legislation is opposed by the chairman of the Federal Trade Commission, Robert Pitofsky, who says that conferring a labor exemption on physicians would merely grant them broad immunity to present a unified front when negotiating price and other terms of dealing with health plans, without any efficiency benefits for consumers or any regulatory oversight to safeguard the public interest."

(7)

Fact: The FTC Chairman Pitofsky (appointed by President Clinton) has traditionally opposed permitting independently practicing physicians to collectively negotiate under the National Labor Relations Act. However, this issue is irrelevant to this legislation because it does not permit or require mandatory collective bargaining under the NLRB; nor does it and does not permit physicians to organize as a union or any other labor

organization under the NLRA. Instead, this legislation allows physicians to jointly negotiate with health plans under limited circumstances - a process that is voluntary and non-binding.

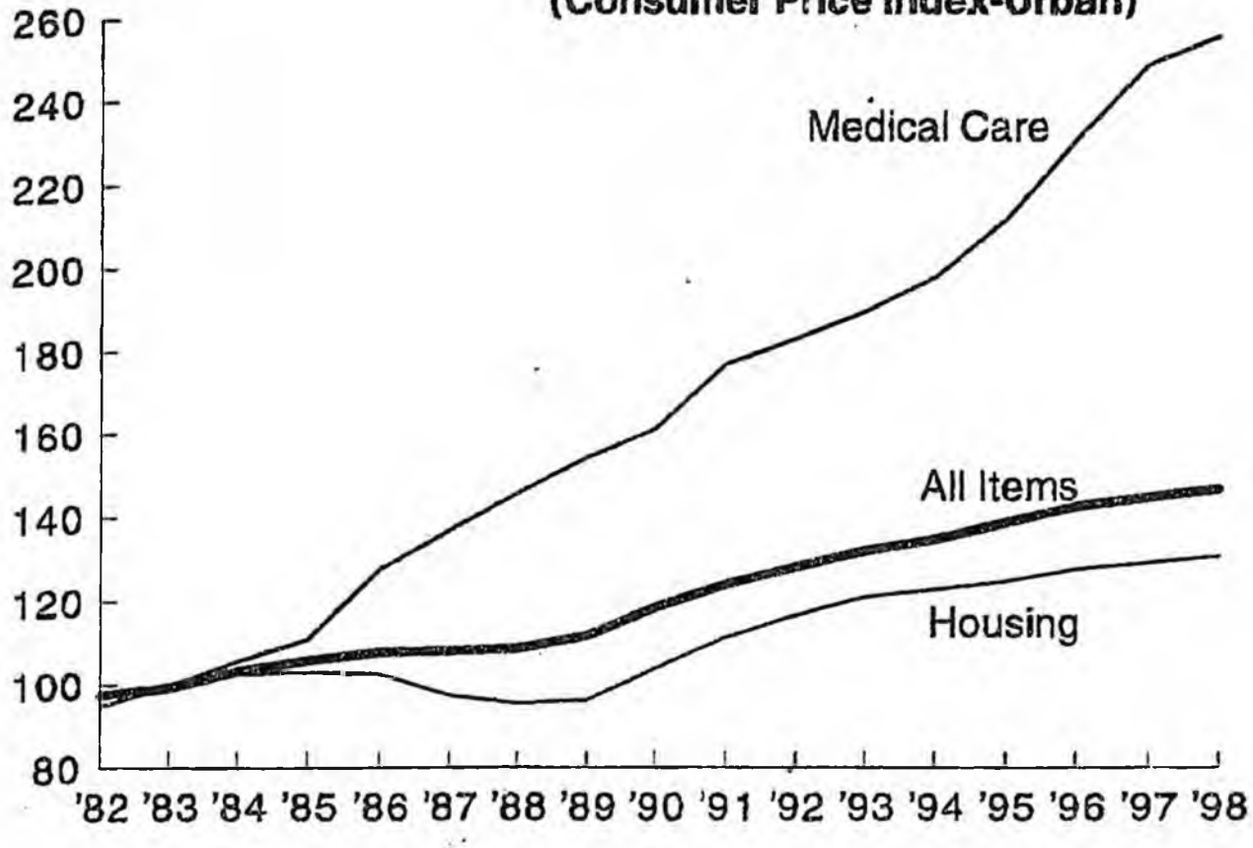
Jim Jordan + Mike Hogan

Bill Sparsons

Medical Costs Outpace Housing

In Anchorage—(CPI-U)

(Consumer Price Index-Urban)



Source: U.S. Department of Labor, Bureau of Labor Statistics

FISCAL NOTE

STATE OF ALASKA
2000 LEGISLATIVE SESSION

BILL NO. SB 256

Revision Date/Time (Note if correction) 02/22/2000
Dept. Affected Community & Economic Development
Title An Act relating to regulation of managed health care and allowing physicians to collectively negotiate with a health care...
BRU Insurance
Component Insurance
Sponsor Senator Kelly
Requester S. (HES)
Component No. 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Personal Services	$53.30	55.0	56.5	58.3	60.2	62.1
Travel						
Contractual						
Supplies	1.5	1.5	1.5	1.5	1.5	1.5
Equipment	5.0					
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**59.8**	**56.5**	**58.0**	**59.8**	**61.7**	**63.6**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	59.8					
1005 GF/Program Receipts		56.5	58.0	59.8	61.7	63.6
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	**59.8**	**56.5**	**58.0**	**59.8**	**61.7**	**63.6**

Estimate of any current year (FY2000) cost: 0.0

POSITIONS

Full-time	1	1	1	1	1	1
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The fiscal note for SB 256 is based on one new Insurance Analyst II to review the contracts between a participating health care provider and a managed care entity as required in Section 1 of SB 256, Sec 21.42.175(d) and to determine market share for a health care insurer using the number of covered lives for the most recently completed calendar year as required under Sec.23.50.020(d)(6).

The assumptions used are the following:

1. The standard provisions described in Sec. 21.42.175(d) are assumed to be the provisions listed in subsections (a) through (c), excluding (a)(4).
2. Based on the number of provider and group contracts that currently exist in the market, we estimate reviewing 1000 contracts.
3. We anticipate an average of 2 hours to review each contract, including time needed to obtain additional information or to correct faulty provisions in the contract.

Prepared by: Robert A. Lohr
Phone 269-7900
Division Insurance
Date/Time 2-22-00 3:40 PM
Approved by Commissioner Deborah B. Sedwick
Date 2-22-00
Agency Community & Economic Development

PREPARER TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE

For further distribution information, call the Governor's Legislative Office

Fiscal Note Analysis Continued:

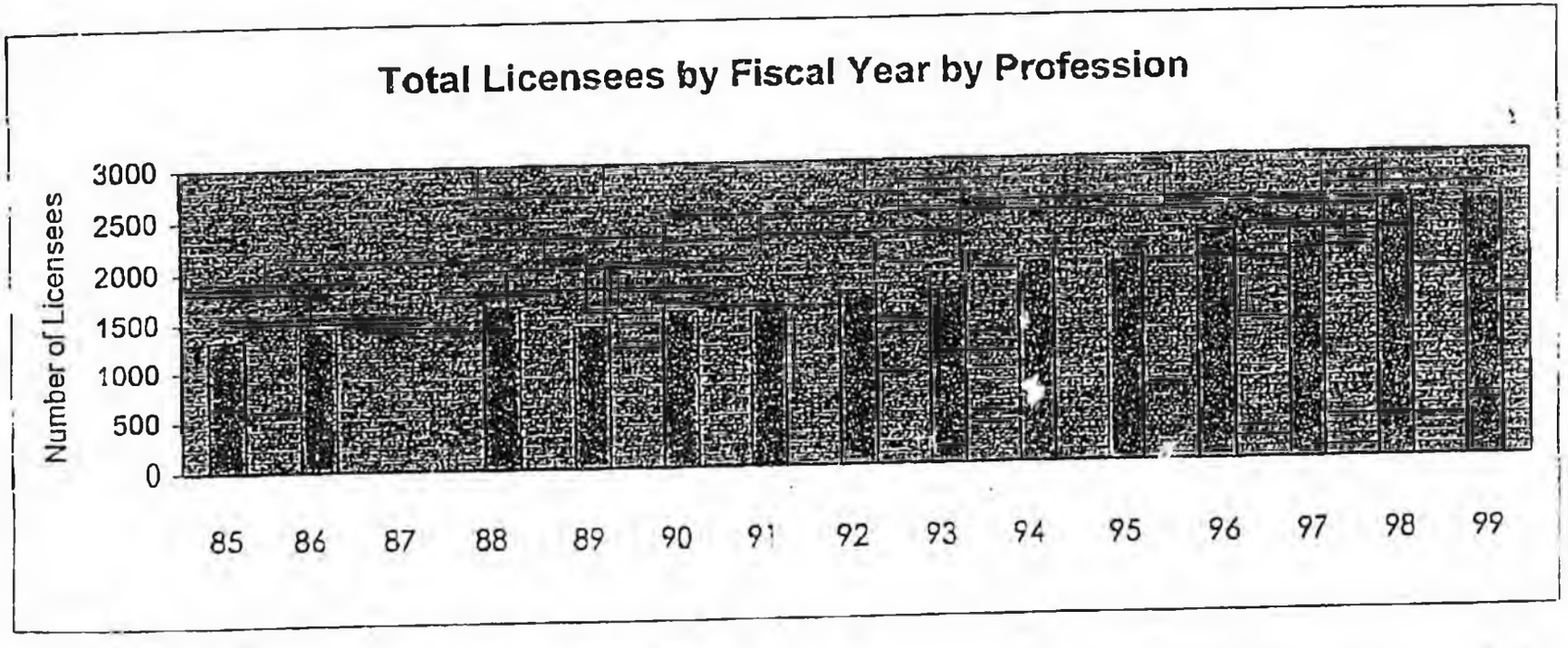
Senate Bill 256 "An Act relating to regulation of managed health care and allowing physicians to collectively negotiate with a health care insurer that has substantial market power."

Analysis:

4. We anticipate that approximately five hours of work will be needed to enter data into a spreadsheet and calculate market share each year as required under Sec. 23.50.020(d)(6).
5. The over 2,000 hours of work to accomplish the contract review and market share calculation will require one new range 16 Insurance Analyst II position.

	FY 85	FY 86	FY 87*	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99
MD/DO Active	815	934	0	1089	925	1038	1004	1152	1183	1417	1419	1593	1603	1826	1810
MD/DO Inactive	317	305	0	322	255	254	273	263	243	243	262	262	277	266	300
DPM-Act/Inact	0	11	0	0	0	0	9	11	12	15	13	14	14	15	15
PA-C	111	111	0	126	136	157	159	186	177	216	200	231	221	255	244
MICP	76	85	0	91	100	111	106	119	112	135	134	158	151	191	195
TOTAL	1321	1446	0	1628	1418	1560	1553	1731	1727	2026	2028	2258	2266	2553	2564

* Statistics not available for 1987.



MD means Medical Doctor (Allopathic)
DO means Doctor of Osteopathy
DPM means Doctor of Podiatric Medicine

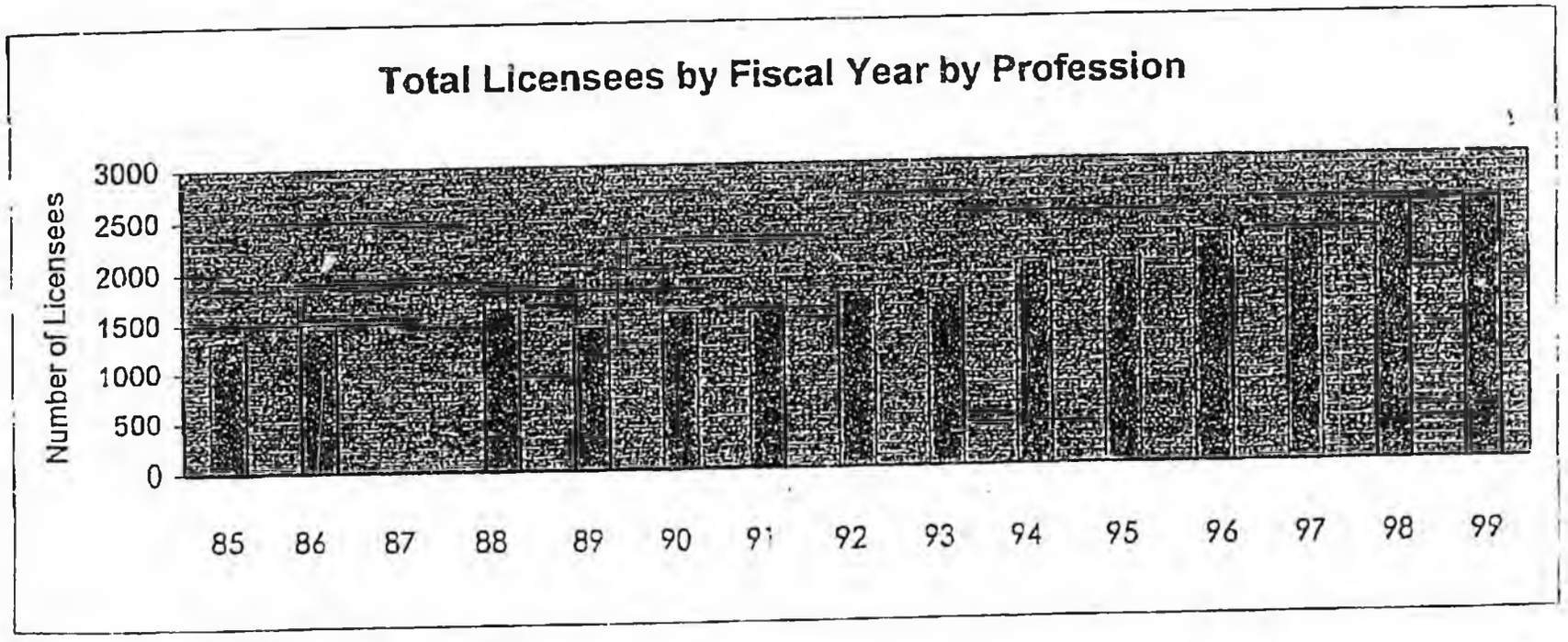
PA means Physician Assistant - Certified
MICP means Mobile Invensive Care Paramedic

CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION

	FY 85	FY 86	FY 87*	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99
MD/DO Active	815	934	0	1089	925	1038	1004	1152	1183	1417	1419	1593	1603	1826	1810
MD/DO Inactive	317	305	0	322	255	254	273	263	243	243	262	262	277	266	300
DPM-Act/Inact	0	11	0	0	0	0	9	11	12	15	13	14	14	15	15
PA-C	111	111	0	126	138	157	159	186	177	216	200	231	221	255	244
MICP	78	85	0	91	100	111	108	119	112	135	134	158	151	191	195
TOTAL	1321	1446	0	1628	1418	1560	1553	1731	1727	2026	2028	2258	2266	2553	2564

* Statistics not available for 1987.



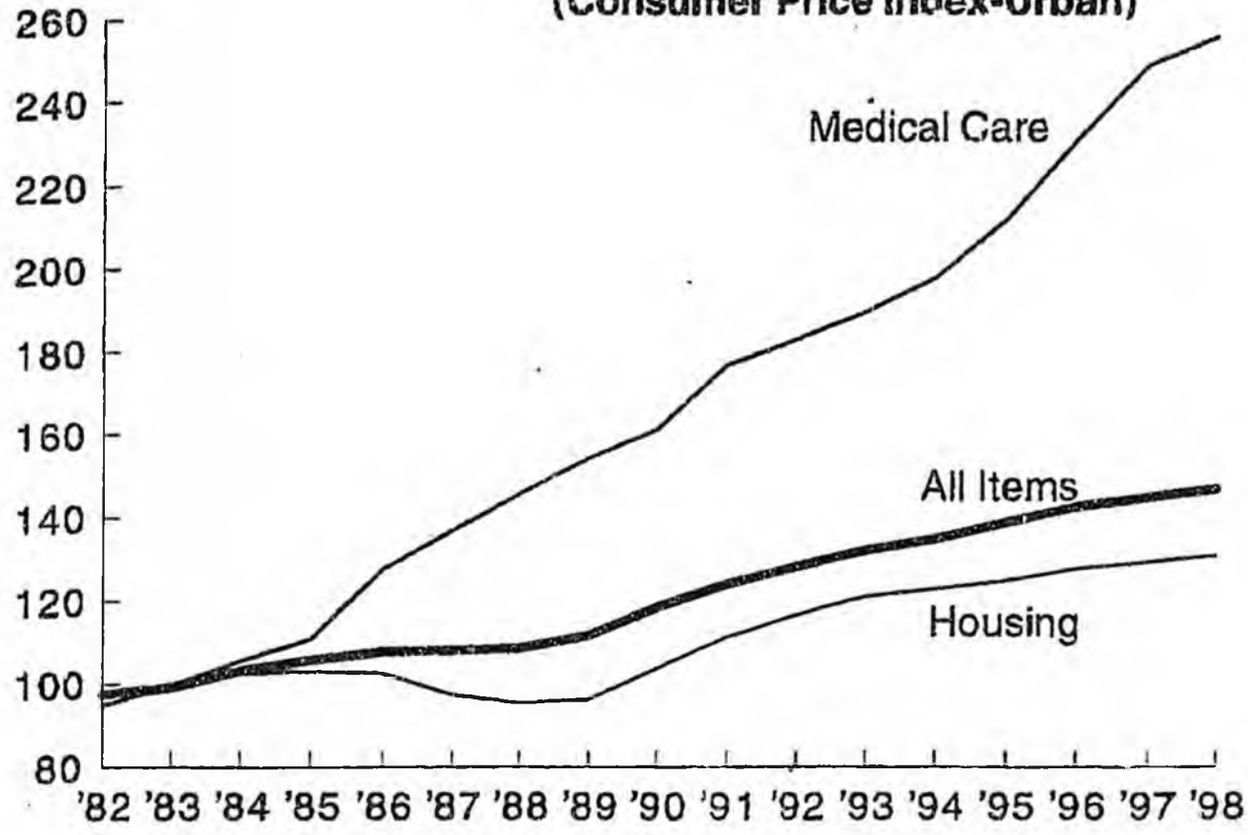
MD means Medical Doctor (Allopathic)
DO means Doctor of Osteopathy
DPM means Doctor of Podiatric Medicine

PA means Physician Assistant - Certified
MICP means Mobile Invensive Care Paramedic

Medical Costs Outpace Housing

In Anchorage—(CPI-U)

(Consumer Price Index-Urban)



Source: U.S. Department of Labor, Bureau of Labor Statistics

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

February 18, 2000

Honorable Mike Miller
State of Alaska
Senate
State Capital, Room 119
Juneau, Alaska 99801-1182

RE: SB 256–"Fairness in Health Care Contracting"

Dear Senator Miller:

The Alaska State Medical Association (ASMA) represents Alaska's patients and the physicians who care for them. Thank you for this opportunity to testify on SB 256. It was ASMA, among other organizations, that represent physicians that sought the introduction of this bill.

Attached you will find a copy of a sectional analysis of SB 256. In this analysis you will see that ASMA strongly supports the enactment of this measure. However, several amendments are suggested. The major amendment would be to have this act apply to all types of health plans and not just those insured by health care insurers in Alaska. This suggestion would mean that physicians would also be allowed to jointly negotiate with large self-insured plans as well. (ASMA has already had discussion about this matter with Senator Kelly's staff prior to the introduction of SB 256).

SB 256 would create a more fair and equitable negotiating process between doctors and the large and powerful insurance companies. This is not a measure that would allow doctors to strike or engage in any boycott of services.

ASMA urges you to support SB 256 with the amendments suggested.

Sincerely,

Peter Lawrason

BY: Peter Lawrason, MD, President

FOR: Alaska State Medical Association

cc: Sen. Pete Kelly

JJJ/kms

Senate Bill 256
"Fairness in Health Care Contracting"
Sectional Analysis

Section 1

This section adds those provisions of any physician services contract that are either required or currently prohibited. The purpose, theoretically, for this section is to provide consistency with the provisions of HB 211 (Regulation of Managed Care) pertaining to physician services agreements. By including this section, the same requirements are in place for physician services contracts arrived at through joint negotiations.

AS21.42.175 is not stated correctly in that it would require the disclosure in each contract all of the rates of compensation for all providers with whom the health care insurer contracts. The intent is to have the contract clearly state the rate of compensation for the physician who is the party to that contract only. It should read as follows:

> "(4) clearly states the rate and method of compensation for each group managed care health plan for which the health care provider is to provide health care services for the covered persons;"

It is expected and desired to have SB 256 amended so that it covers negotiations with self-insured groups as well. When this happens, it is suggested that Section 1 not be in the form it currently is in. Those provisions in Section 1 should be included in a section under AS23.50. Perhaps, they could be included in AS23.50.025 a new section titled "Contract Provisions". The change in this "lead in" language could be changed to reflect the all inclusiveness (insured and self-insured plans) desired by using the term "health benefit plan" instead of the term "managed care entity". The term "health benefit plan" is defined in AS21.54.500 (15) and appears to include both insured and self-insured plans. (Other editorial changes would need to be made to reflect this change as well.)

Section 2

AS23.50.010

AS23.50.010 articulates the reasons for the Legislature to set policy to allow joint negations between a group of competing physicians and a health insurance company.

AS23.50.020

AS23.50.020 (a) enumerates those items which may be the subject of joint negotiations. Those items include clinical practice guidelines and coverage criteria; respective liability of physicians and health care insurers; administrative procedures that include methods and timing of payments to physicians; resolution despute procedures; patient referral procedures; application of the reimbursement methodologies to be used; quality assurance programs; utilization review procedures; and criteria for the selection and termination of participating physicians. Note that this subsection does not allow for negotiation of fees or payments. AS21.050.020 (b) prohibits joint negotiation for those fee or payment related items unless the conditions of AS21.050.020 (c) are met.

AS21.050.020 (b) prohibits joint negotiations involving fees or prices for services; the conversion factor in a RBRVS type payment methodology; amounts of discount on the physician's services; and dollar amounts for a "capitation" basis of payment. However, it still allows physicians to jointly and collectively petitions the government for a change in law that provides for payment to doctors under a governmental program (e.g., Medicaid).

The exception is made to allow for joint negotiation for those fee items listed in AS21.050.020 (b) when a health insurer has "substantial market power". AS21.050.020 (c) defines substantial market power when an insurer has more than 15% of the market place as measured by the number of people covered. Included in the numbers of people covered are those covered under Medicare and Medicaid if an insurer provides any claim payment services for the government for those programs. The concept is based in that all "bodies" covered and threats of not contracting with a certain physician are based on the deleterious effect on a physician's practice by removing those patents from his/her practice. Enumerating the persons covered may be difficult for the Division of Insurance. In fact, it is impossible for the Division of Insurance to compel self-insureds to provide it with those data. In one state currently addressing the State Action Doctrine exception issue (California), it is being considered to just require all health plans to negotiate with physicians without having to prove the "substantial market power" percentage. (Obviously this would allow physicians to still jointly negotiate and under active state oversight). The reason for this is that it is clear in California that less than 10 health plans dominate its market place. It is perceived that less than 6 health plans dominate Alaska's marketplace. One suggestion would be to make the negotiations a requirement but with a "rebuttable presumption" that a particular health insurer could make that it does not have "substantial market power" as defined as a market share that exceeds 15%.

AS21.050 (d) sets out the criteria for how those collective rights are to be carried out by the physicians jointly negotiating. The core provision is that negotiations are to be conducted through an "authorized third party" who will negotiate on behalf of the physicians who have joined together for that purpose. Conceivably,

that person acting as the authorized third party representative could be an IPA, a lawyer, a physician, a specialty medical society, a local medical association, a state medical association, etc. It is presumed a contractual relationship will exist between the represented physicians and the authorized third party that memorializes the obligations and requirements of the parties. This subsection states that the physicians who have joined for the purpose of negotiation may communicate with their authorized third party about terms and conditions, which are to be negotiated. The authorized third party is the sole person who is to negotiate on behalf of the doctors. Subsection (5) of this section may provide some confusion in that it would appear to defeat the purpose of the joint negotiations. The intent of subsection (5) is to provide, for example, for different rates of reimbursement to be included for different specialties. (For example, anesthesiologists are typically reimbursed in a different manner than a surgeon and both may be in the same group of physicians engaged in joint negotiations.) Generally, an authorized third party may not represent more than 30% of the physicians in a particular geographic area. However, if an insurer or health plan has 5% or more market penetration in a geographic area, then an authorized third party may represent more than 30% of the physicians. Obviously, the concern would be that physicians represented in great numbers would dictate the terms of a contract to an insurer or health plan. By the same token, for example, it would be unfair for a specialist, who is the only one in a particular area, not be able to join with other physicians to jointly negotiate. This is an area that active state oversight would be necessary so that a fair result for the general public would be the outcome.

AS21.050.020 (e) sets out what a person desiring to act as an authorized third party needs to do in order to act in that capacity. In short, the authorized third party needs to register with the Commissioner of Labor and Workforce Development. That registration requires an identification of the authorized third party and how that person intends to operate. It is presumed that this would include a detailed plan of operation along with the contract that it has entered into with the group of physicians to be represented. This must be done for each physician service contract that the authorized third party wishes to jointly negotiate on behalf of the physicians represented. The efficiencies or benefits that are expected to be achieved must be identified. The authorized third party is required to report to the Commissioner of Labor if a health care insurer or health plan declines to negotiate or terminates a negotiation within 14 days of receiving that decision. Also, if an insurer or health plan fails to respond within 14 days of a request for negotiation, that fast also needs to be reported to the Commissioner.

AS21.050.020 (f) requires the Commissioner, with the advice of the Attorney General, to either approve or disapprove a negotiated contract within 30 days of when it is presented. If it is disapproved, the Commissioner must give a written explanation of the deficiencies and how they could be corrected.

AS21.050.020 (g) prohibits the physicians represented from acting together in response to a report from their authorized third party regarding its discussion or negotiation with a health care insurer or health plan. The authorized third party has a duty to warn the physicians represented of the potential of legal action under state and federal anti-trust laws for exceeding the authority granted by this measure.

AS21.050.020 (h) limits the terms of any contract negotiated to 5 years. It is expected that terms of actual contracts will be for less than 5 years.

AS21.050.020 (i) keeps all documents relating to joint negotiations, that would come from both the physicians and insurers or health plans, confidential and not subject to public inspection.

AS23.50.030

AS23.50.030 creates a fee mechanism to cover the State's cost of providing its active oversight of the joint negotiation authorized by this bill. The fee is to be reflective of the actual costs that the State incurs. The Commissioner sets the fees by regulation and must report on the fees each year to the Office of Management and Budget. At least one other state in dealing with a "State Action Doctrine" exception (California) charges the regulatory costs to the health care insurers and health plans on a pro-rata share based on their market share. Theoretically, the cost should be the same without regard to who pays it. If the physicians pay it via their authorized third party, then they will negotiate sufficient payment levels to cover that cost. Conversely, if the insurers and health plans pay it, then they will negotiate a sufficiently lower payment level to cover that cost. The issue is what is the most efficient and fair method to cover the cost. Obviously, the physician community will not be supportive of a fee mechanism that requires a payment upfront only to have an insurer decline to negotiate and not receive any refund.

AS23.50.040

AS23.50.040 allows the Commissioner of Labor and Workforce Development to adopt regulations to implement this law.

AS23.50.099

AS23.50.099 is the definition section and contains the definition of the terms "authorized third party", "commissioner", and "health care insurer". These definitions are straightforward and unambiguous. This section will be expanded if the SB 256 is amended to also include self-insured health plans. For example, the term "health benefit plan" would need to be defined as it is in AS 21.54.500 (15).

Section 3

This section is needed to provide for joint negotiation by physicians under the "State Action Doctrine" exemption under Alaska's laws pertaining to competitive practices and regulation of competition.

JJJ/kms

TESTIMONY ON SENATE BILL 256
ALASKA SENATE HESS COMMITTEE

February 21, 2000

My name is Gordon Evans and I represent the Health Insurance Association of America ("HIAA"), which is a trade association of the nation's leading commercial health insurance companies which provide health insurance for approximately 55 million Americans.

Thank you, Mr. Chairman, for providing an opportunity to present HIAA's position on Senate Bill 256. HIAA opposes SB 256 for two simple reasons -- first, giving physicians an antitrust waiver would deny consumers choice, quality, and affordability; and second, health care costs would increase significantly for both the public and private sectors.

In the past year, there has been significant debate at both the federal and state level about physician collective bargaining or physician antitrust waivers. Despite differences among the various proposals, there are four incontrovertible facts:

* Quality is not the driving force behind the physician collective bargaining movement -- it's economics. Legitimate mechanisms already exist within the boundaries of current antitrust law under which health care providers can and do collaborate and negotiate with health plans, patients, and others on clinical or quality of care issues or other concerns they may have regarding the impact of managed care on the quality of care.

* Second -- Consolidation among health plans has been and continues to be subject to rigorous antitrust scrutiny, at both the state and federal levels.

* Third -- Antitrust waiver legislation is anti-competitive and would raise costs for health care programs financed by both the public and private sectors -- through Medicare, Medicaid, and other government programs, as well as employer- and union-sponsored plans.

* Fourth -- Legislation at either the state or federal levels will be costly. For example, if legislation such as that proposed at the federal level (H.R. 1304 by Congressman Campbell) were to become law, health care premiums in the private sector would increase by 6 to 11 percent. Total annual personal health care spending would rise up to $80 billion annually. These added costs would be paid for by consumers, employers, and taxpayers, without any improvement in the quality of patient care. Or, at least 1.2 to 2.4 million more Americans would be uninsured.

Physicians, who are already among the nation's highest paid professionals, are among the least likely Americans to need the benefits of unionization. Over the last decade, as managed care has grown, physician incomes have increased more than 77 percent, with a median net income in 1997 of $199,600. Antitrust waivers or some other form of the special treatment that they are seeking through Senate Bill 256, would effectively allow physicians to further increase their salaries.

Moreover, the reality is that physicians are not seeking to form real unions. Rather, they seek to form unrestricted collective bargaining units without the regulatory oversight that all unions are subject to.

Physicians are asking state and federal governments for unique legal rights to engage in conduct that would otherwise be *per se* illegal under the antitrust laws. Granting physicians, whether as physician employees or as independent contractors, special waivers to collectively bargain and set prices, without regulatory oversight fundamental to the very concept of unionization, is unwarranted, not to mention detrimental to consumers.

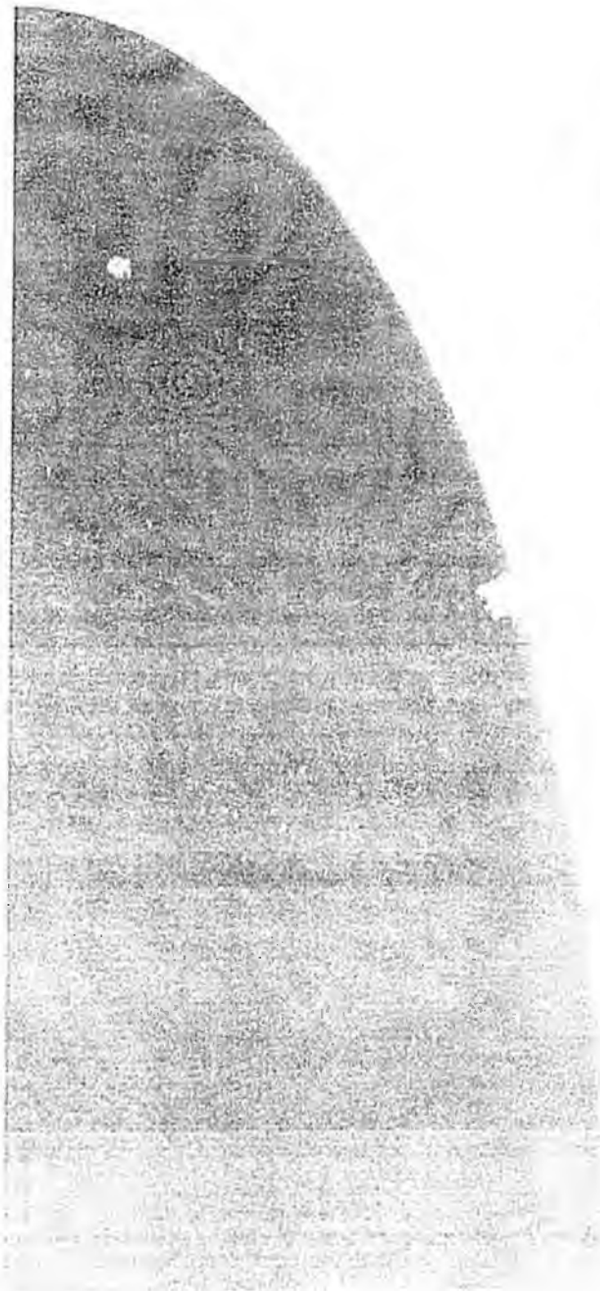
Physician collective bargaining legislation is opposed by the chairman of the Federal Trade Commission, Robert Pitofsky, who says that conferring a labor exemption on physicians "would merely grant them broad immunity to present a 'unified front' when negotiating price and other terms of dealing with health plans, without any efficiency benefits for consumers or any regulatory oversight to safeguard the public interest."

Much has been made of the growth and consolidation of managed care organizations. In fact, physicians cite this as one of the reasons why they need antitrust waivers. Under current law, consolidation among health plans and insurers is subject to rigorous antitrust scrutiny at both the state and federal levels.

The health insurance industry continues to remain very competitive, making it improbable -- if not impossible -- for any one plan to be able to exercise significant market power in its negotiations with health care providers.

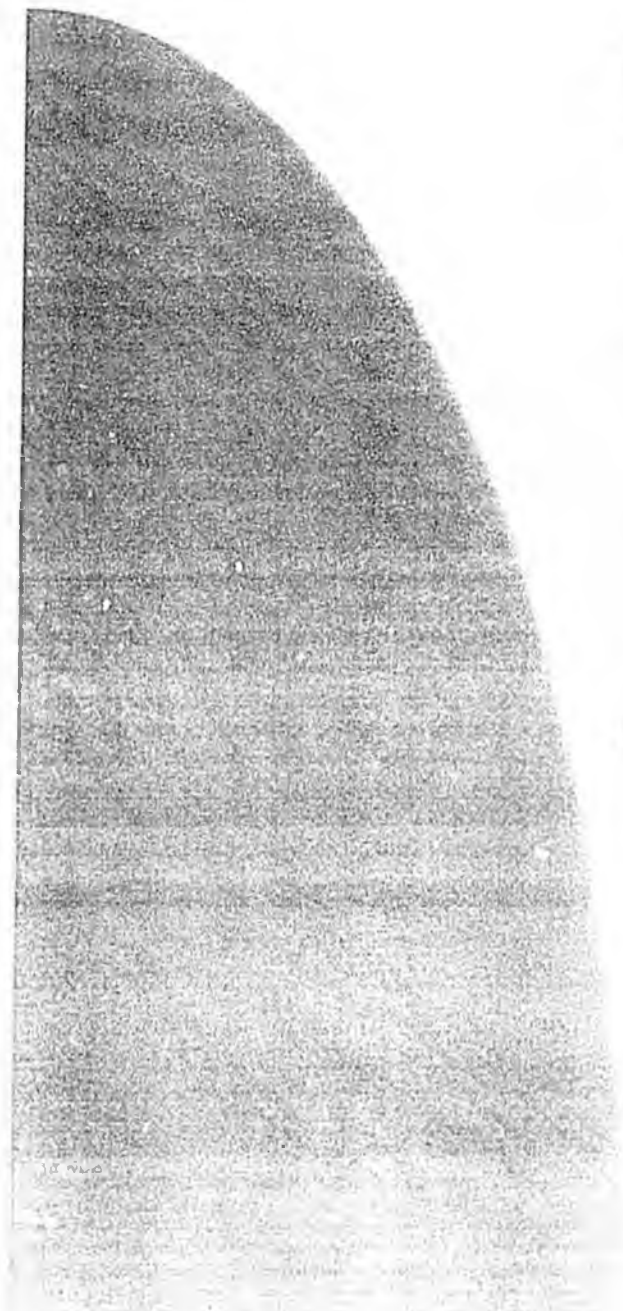
In conclusion, Mr. Chairman, collective bargaining for physicians truly would serve to benefit the few at the expense of consumers and taxpayers. It would level a devastating blow to the health care system and the success that market competition has achieved in limiting health-care inflation.

##



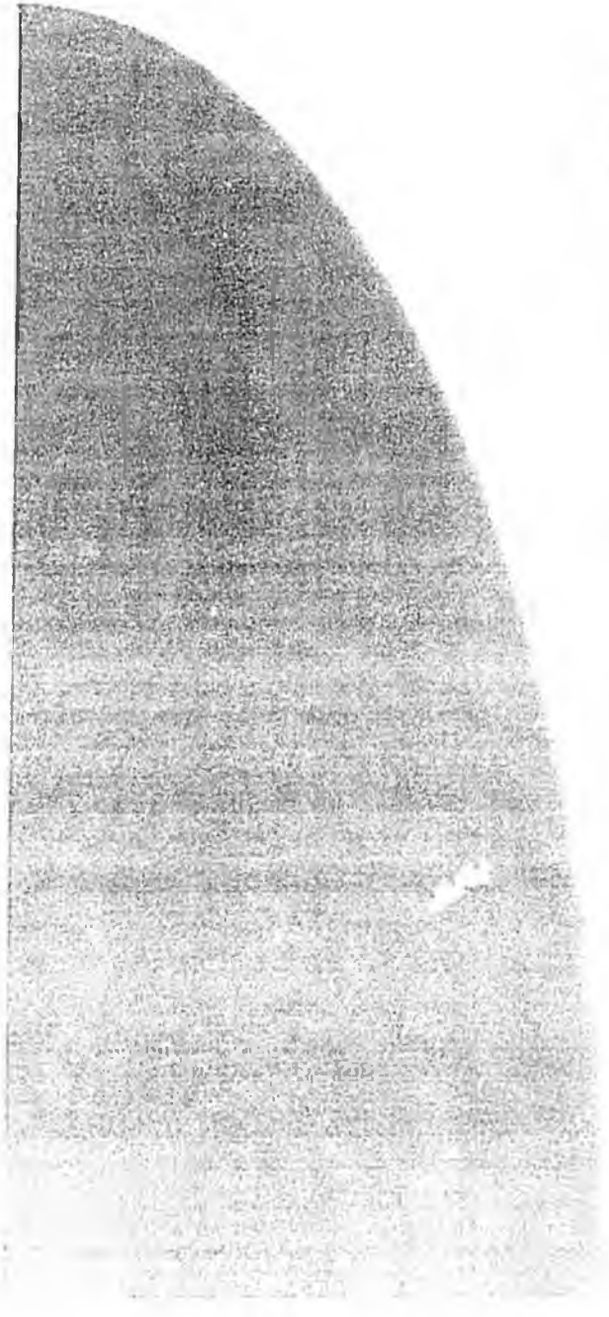
Issue

- SB256 is intended to address perceived inequities in bargaining power between physicians and insurers in Alaska. From our perspective this inequity does not exist.



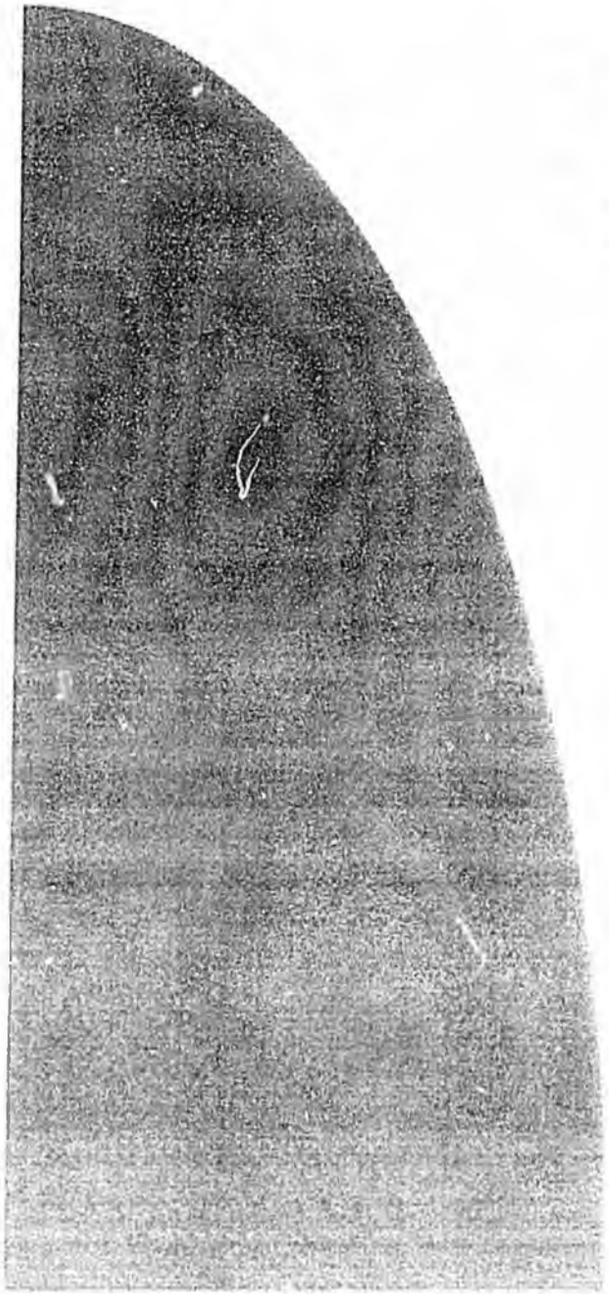
What evidence supports our perspective?

- The Results of 11 years of negotiations in AK
- The Terms of the contracts being offered in AK
- The contracting Process in AK



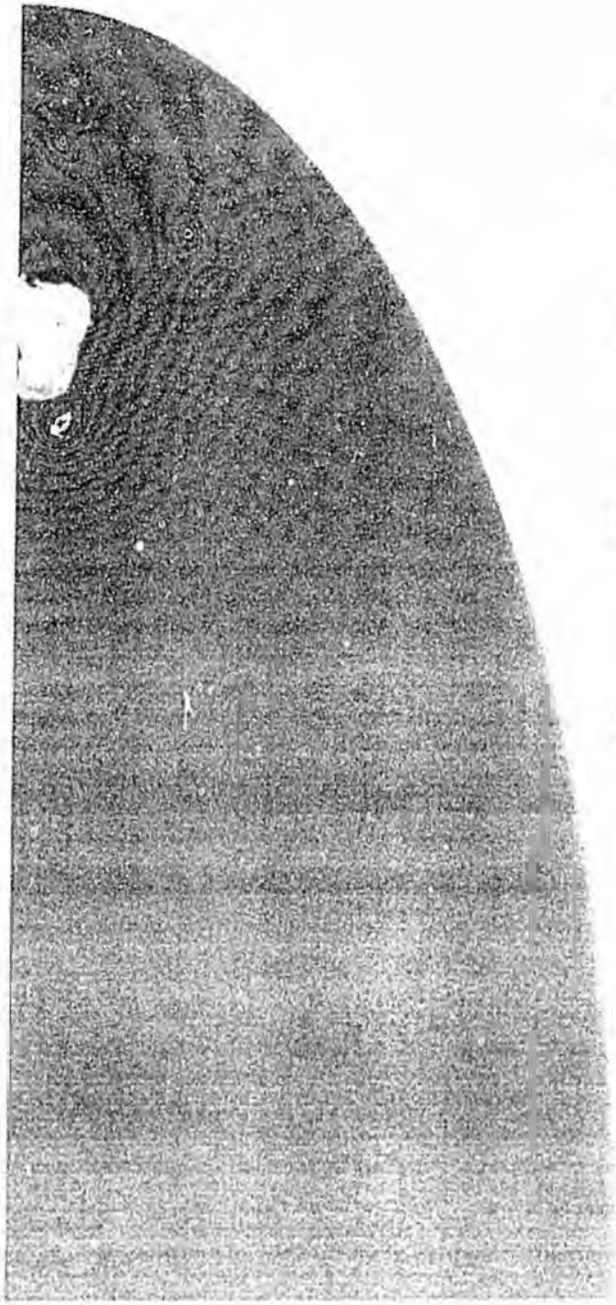
Results after 11 years:

- Approximately 1700 physicians in AK
- Blue Cross Blue Shield of Alaska has approximately 700 agreements
- Aetna, after repeated attempts, approximately 100 agreements
- Other Insurers, virtually no physician contracts



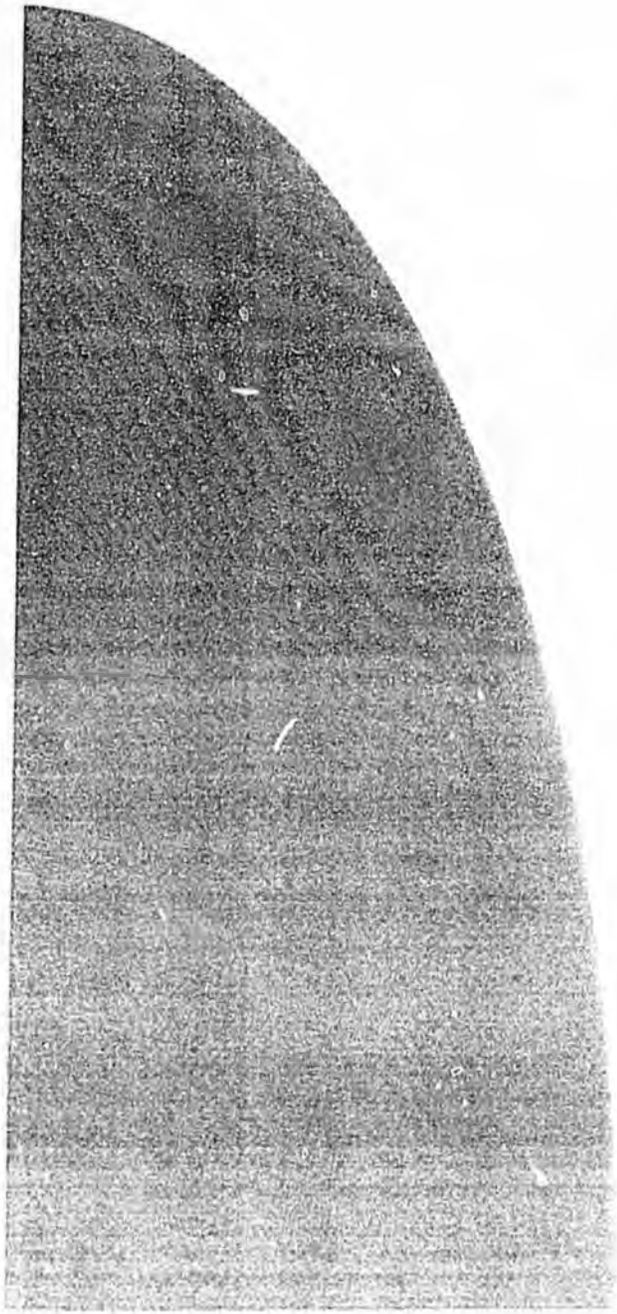
Results: Examples of specialty "holes"

- Anchorage: Gastroenterology, Otolaryngology, Cardiovascular Surgery, Colon and Rectal Surgery, Plastic Surgery
- Fairbanks: Medical Oncology, Plastic Surgery, Urology
- Juneau: Otolaryngology, Pediatrics, Neurosurgery, Plastic Surgery



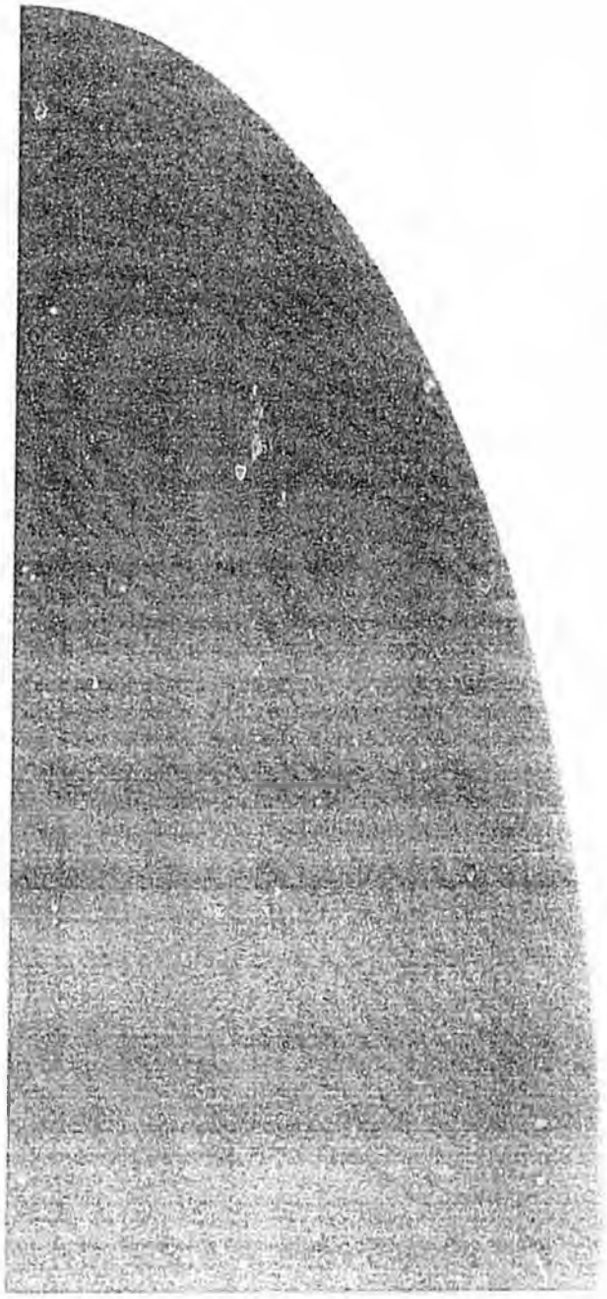
The Terms:

- Physician bill BCBSAK directly: not the member
- BCBSAK pays the physician directly: not the member
- Physician submits to credentially process: additional member protection
- Physician cooperates with Care Management program



The Terms continued:

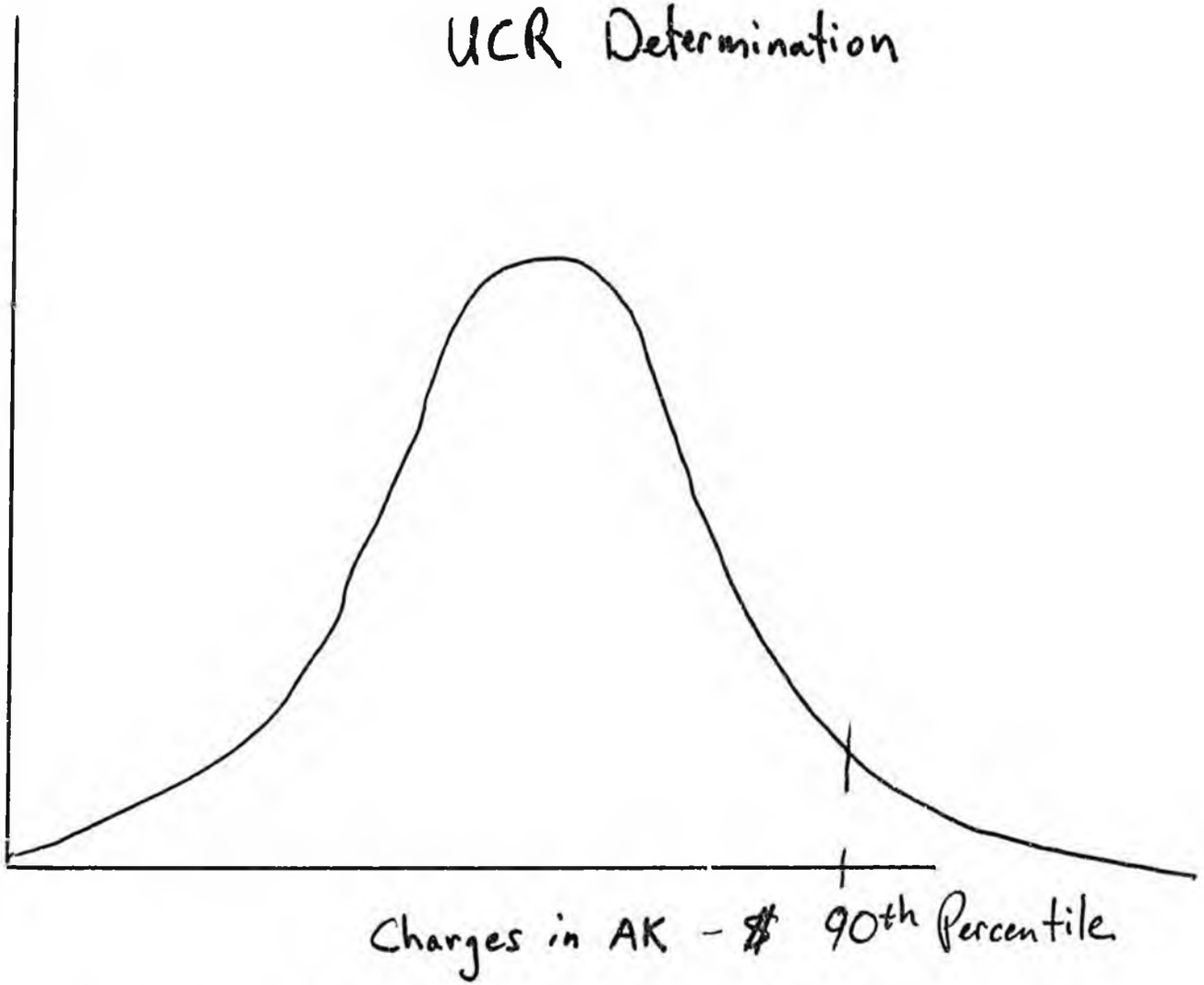
- Physician agrees to refer to network providers: "The Provider will admit or arrange for admission of Preferred Enrollees only to Preferred Hospitals provided that one is locally available and, **in the professional judgement of the Provider**, admission to or treatment at the Preferred hospital **will adequately provide the enrollee's medical care needs**."



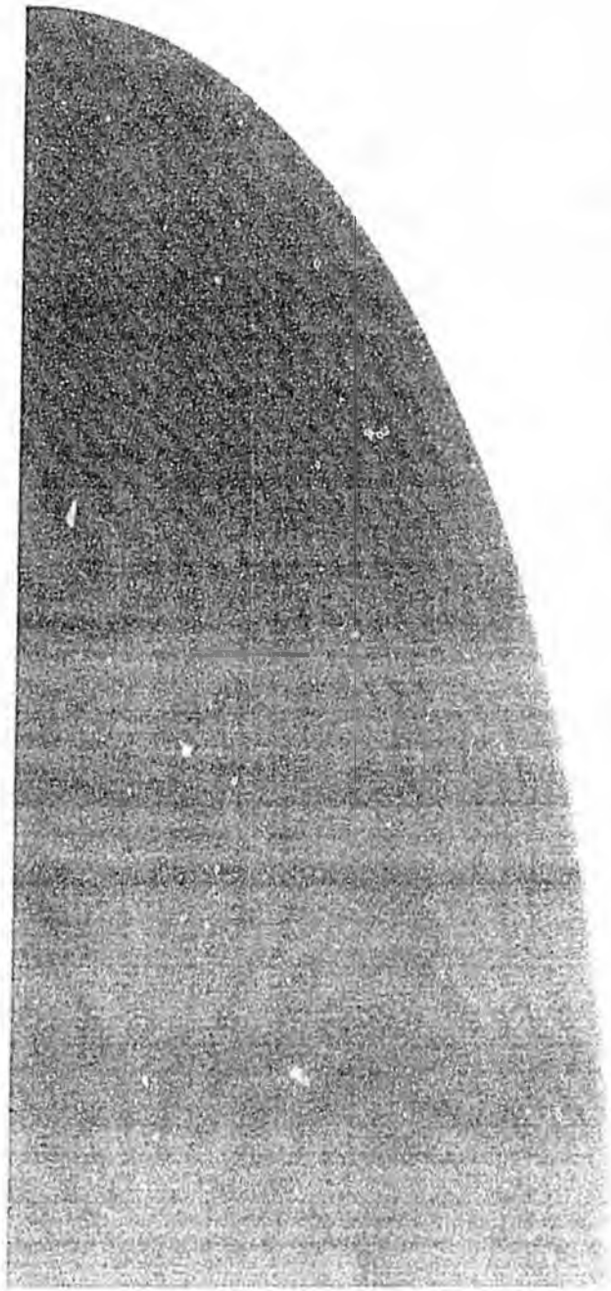
The Terms continued:

- Physician agrees not to bill member for amounts, if any, which exceed Usual, Reasonable and Customary charges.
- Termination by either party without cause with 30 days notice
- Above are standard terms. Many physicians have **negotiated** special terms.

UCR Determination



+ According to AK statute
+ 12 months of data, updated every 6 months
+ Subject to review by Division of Insurance



How does reimbursement work?

- If charge below the 90th percentile, full charge allowed.
- If charge at or above the 90th percentile, 90th percentile allowed.
- Physician agrees not to bill member for amounts over 90th percentile.

Example A: Charge less than UCR

UCR = $120
Charge = $100
"Allowed = $100
Coinsurance = 80%
Plan Payment = $80
Member pays = $100 - 80 = $20

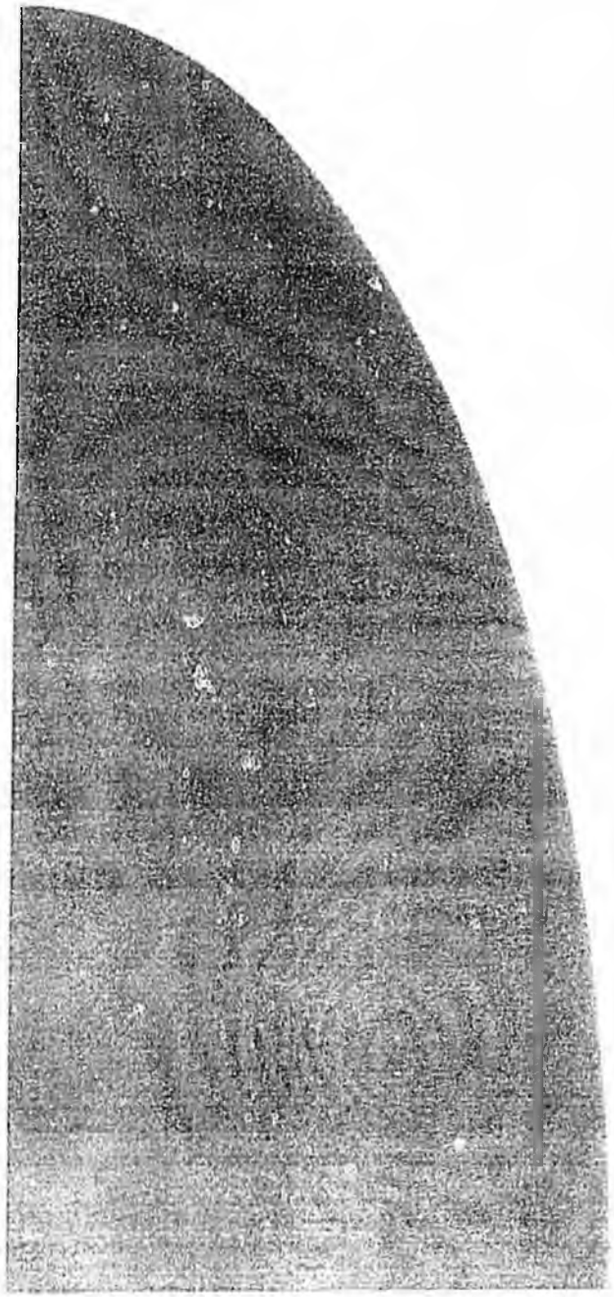
Example B: Charge more than UCR

UCR = $200
Charge = $220
Allowed = $200
Coinsurance = 80%
Plan Payment = $160

If contracted physician:
Member pays = $200 - $160 = $40

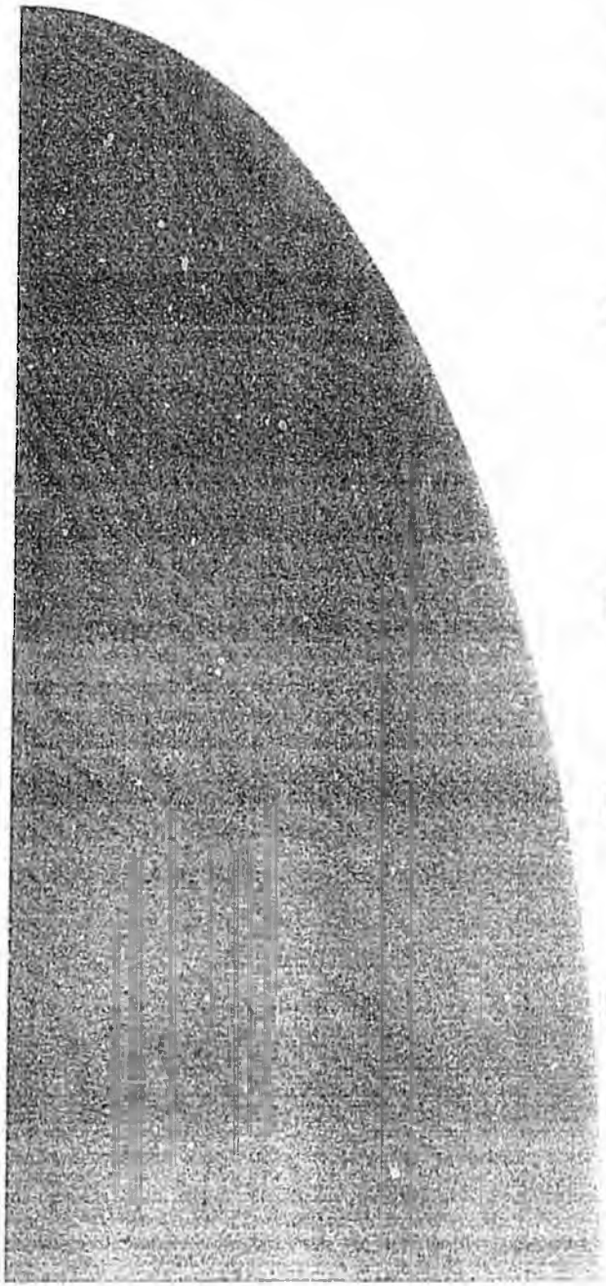
If physician not contracted:
Member pays = $220 - 160 = $60

Contract protects Member from amounts over UCR/Allowable



The Process:

- We identify physicians for discussion
  - Member requests
  - "holes" in network
- Often physicians contact us
- Make contact; information for consideration
  - Not interested - 33
  - Wish more information - 91
  - Agreement reached - 15



Federal Employee Program:

- Rules determined by Federal Office of Personnel Management in Baltimore
- BCBSAK required to administer according to Federal rules
- If contracted, reimbursed 95% or AK UCR
- If not contracted, reimbursed 75% of Medicare rates

Alaska State Legislature
Senator Pete Kelly

Session
Capitol Building, Room 510
Juneau, Alaska 99801
Phone: (907) 465-2327
Fax: (907) 465-5241

Interim
119 N. Cushman St. Suite 201
Fairbanks, AK 99701
Phone: (907) 456-8161
Fax: (907) 451-9293

Senate Bill 256

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

Senate Bill 256 attempts to level the playing field for Alaska's patients and the physicians who care for them.

In a perfect world, equal bargaining power would exist between the medical care providers and the health insurers. Big hospitals have more equal bargaining power with the health insurers than the typical Alaskan physician in a solo or small group practice. Obviously, a gross inequity in bargaining power exists and there is no conceivable way any health insurer will bargain with an individual doctor regarding individual contract provisions other than on a take it or leave it basis. The resultant effect is physician service contracts heavily weighted in favor of the insurance company. The bottom line is that, in many respects, this adversely affects the care that patients receive. For example, requiring a physician to use a lower cost treatment when a higher cost treatment may be medically necessary or preventing a physician from discussing alternative treatments.

Independent, competing physicians are prevented from any collective action by the federal anti-trust laws to which, ironically, the insurers are not subject. This fact plus the market concentration of health insurers causes the imbalance in bargaining power. With insurers having such a high degree of leverage, a balance of interest no longer exists in the market for health care delivery and finance.

Senate Bill 256 can permit independent, competing physicians to collectively negotiate with health insurers in regard to the provisions of physician services contracts to provide quality health care to Alaskans. When the provisions set forth in SB 256 are met, behavior that would otherwise violate the anti-trust laws will be exempt from antitrust scrutiny. The test for qualifying exemption varies depending on the identity of the party performing the action in question. But SB 256 will still prohibit a group of independent competing physicians from striking or otherwise engaging in activities that would result in a boycott.

Senate Bill 256
"Fairness in Health Care Contracting"
Sectional Analysis

Section 1

This section adds those provisions of any physician services contract that are either required or currently prohibited. The purpose, theoretically, for this section is to provide consistency with the provisions of HB 211 (Regulation of Managed Care) pertaining to physician services agreements. By including this section, the same requirements are in place for physician services contracts arrived at through joint negotiations.

AS21.42.175 is not stated correctly in that it would require the disclosure in each contract all of the rates of compensation for all providers with whom the health care insurer contracts. The intent is to have the contract clearly state the rate of compensation for the physician who is the party to that contract only. It should read as follows:

> "(4) clearly states the rate and method of compensation for each group managed care health plan for which the health care provider is to provide health care services for the covered persons;"

It is expected and desired to have SB 256 amended so that it covers negotiations with self-insured groups as well. When this happens, it is suggested that Section 1 not be in the form it currently is in. Those provisions in Section 1 should be included in a section under AS23.50. Perhaps, they could be included in AS23.50.025 a new section titled "Contract Provisions". The change in this "lead in" language could be changed to reflect the all inclusiveness (insured and self-insured plans) desired by using the term "health benefit plan" instead of the term "managed care entity". The term "health benefit plan" is defined in AS21.54.500 (15) and appears to include both insured and self-insured plans. (Other editorial changes would need to be made to reflect this change as well.)

Section 2

AS23.50.010

AS23.50.010 articulates the reasons for the Legislature to set policy to allow joint negations between a group of competing physicians and a health insurance company.

AS23.50.020

AS23.50.020 (a) enumerates those items which may be the subject of joint negotiations. Those items include clinical practice guidelines and coverage criteria; respective liability of physicians and health care insurers; administrative procedures that include methods and timing of payments to physicians; resolution despute procedures; patient referral procedures; application of the reimbursement methodologies to be used; quality assurance programs; utilization review procedures; and criteria for the selection and termination of participating physicians. Note that this subsection does not allow for negotiation of fees or payments. AS21.050.020 (b) prohibits joint negotiation for those fee or payment related items unless the conditions of AS21.050.020 (c) are met.

AS21.050.020 (b) prohibits joint negotiations involving fees or prices for services; the conversion factor in a RBRVS type payment methodology; amounts of discount on the physician's services; and dollar amounts for a "capitation" basis of payment. However, it still allows physicians to jointly and collectively petitions the government for a change in law that provides for payment to doctors under a governmental program (e.g., Medicaid).

The exception is made to allow for joint negotiation for those fee items listed in AS21.050.020 (b) when a health insurer has "substantial market power". AS21.050.020 (c) defines substantial market power when an insurer has more than 15% of the market place as measured by the number of people covered. Included in the numbers of people covered are those covered under Medicare and Medicaid if an insurer provides any claim payment services for the government for those programs. The concept is based in that all "bodies" covered and threats of not contracting with a certain physician are based on the deleterious effect on a physician's practice by removing those patents from his/her practice. Enumerating the persons covered may be difficult for the Division of Insurance. In fact, it is impossible for the Division of Insurance to compel self-insureds to provide it with those data. In one state currently addressing the State Action Doctrine exception issue (California), it is being considered to just require all health plans to negotiate with physicians without having to prove the "substantial market power" percentage. (Obviously this would allow physicians to still jointly negotiate and under active state oversight). The reason for this is that it is clear in California that less than 10 health plans dominate its market place. It is perceived that less than 6 health plans dominate Alaska's marketplace. One suggestion would be to make the negotiations a requirement but with a "rebuttable presumption" that a particular health insurer could make that it does not have "substantial market power" as defined as a market share that exceeds 15%.

AS21.050 (d) sets out the criteria for how those collective rights are to be carried out by the physicians jointly negotiating. The core provision is that negotiations are to be conducted through an "authorized third party" who will negotiate on behalf of the physicians who have joined together for that purpose. Conceivably,

that person acting as the authorized third party representative could be an IPA, a lawyer, a physician, a specialty medical society, a local medical association, a state medical association, etc. It is presumed a contractual relationship will exist between the represented physicians and the authorized third party that memorializes the obligations and requirements of the parties. This subsection states that the physicians who have joined for the purpose of negotiation may communicate with their authorized third party about terms and conditions, which are to be negotiated. The authorized third party is the sole person who is to negotiate on behalf of the doctors. Subsection (5) of this section may provide some confusion in that it would appear to defeat the purpose of the joint negotiations. The intent of subsection (5) is to provide, for example, for different rates of reimbursement to be included for different specialties. (For example, anesthesiologists are typically reimbursed in a different manner than a surgeon and both may be in the same group of physicians engaged in joint negotiations.) Generally, an authorized third party may not represent more than 30% of the physicians in a particular geographic area. However, if an insurer or health plan has 5% or more market penetration in a geographic area, then an authorized third party may represent more than 30% of the physicians. Obviously, the concern would be that physicians represented in great numbers would dictate the terms of a contract to an insurer or health plan. By the same token, for example, it would be unfair for a specialist, who is the only one in a particular area, not be able to join with other physicians to jointly negotiate. This is an area that active state oversight would be necessary so that a fair result for the general public would be the outcome.

AS21.050.020 (e) sets out what a person desiring to act as an authorized third party needs to do in order to act in that capacity. In short, the authorized third party needs to register with the Commissioner of Labor and Workforce Development. That registration requires an identification of the authorized third party and how that person intends to operate. It is presumed that this would include a detailed plan of operation along with the contract that it has entered into with the group of physicians to be represented. This must be done for each physician service contract that the authorized third party wishes to jointly negotiate on behalf of the physicians represented. The efficiencies or benefits that are expected to be achieved must be identified. The authorized third party is required to report to the Commissioner of Labor if a health care insurer or health plan declines to negotiate or terminates a negotiation within 14 days of receiving that decision. Also, if an insurer or health plan fails to respond within 14 days of a request for negotiation, that fact also needs to be reported to the Commissioner.

AS21.050.020 (f) requires the Commissioner, with the advice of the Attorney General, to either approve or disapprove a negotiated contract within 30 days of when it is presented. If it is disapproved, the Commissioner must give a written explanation of the deficiencies and how they could be corrected.

AS21.050.020 (g) prohibits the physicians represented from acting together in response to a report from their authorized third party regarding its discussion or negotiation with a health care insurer or health plan. The authorized third party has a duty to warn the physicians represented of the potential of legal action under state and federal anti-trust laws for exceeding the authority granted by this measure.

AS21.050.020 (h) limits the terms of any contract negotiated to 5 years. It is expected that terms of actual contracts will be for less than 5 years.

AS21.050.020 (i) keeps all documents relating to joint negotiations, that would come from both the physicians and insurers or health plans, confidential and not subject to public inspection.

AS23.50.030

AS23.50.030 creates a fee mechanism to cover the State's cost of providing its active oversight of the joint negotiation authorized by this bill. The fee is to be reflective of the actual costs that the State incurs. The Commissioner sets the fees by regulation and must report on the fees each year to the Office of Management and Budget. At least one other state in dealing with a "State Action Doctrine" exception (California) charges the regulatory costs to the health care insurers and health plans on a pro-rata share based on their market share. Theoretically, the cost should be the same without regard to who pays it. If the physicians pay it via their authorized third party, then they will negotiate sufficient payment levels to cover that cost. Conversely, if the insurers and health plans pay it, then they will negotiate a sufficiently lower payment level to cover that cost. The issue is what is the most efficient and fair method to cover the cost. Obviously, the physician community will not be supportive of a fee mechanism that requires a payment upfront only to have an insurer decline to negotiate and not receive any refund.

AS23.50.040

AS23.50.040 allows the Commissioner of Labor and Workforce Development to adopt regulations to implement this law.

AS23.50.099

AS23.50.099 is the definition section and contains the definition of the terms "authorized third party", "commissioner", and "health care insurer". These definitions are straightforward and unambiguous. This section will be expanded if the SB 256 is amended to also include self-insured health plans. For example, the term "health benefit plan" would need to be defined as it is in AS 21.54.500 (15).

Section 3

This section is needed to provide for joint negotiation by physicians under the "State Action Doctrine" exemption under Alaska's laws pertaining to competitive practices and regulation of competition.

JJJ/kms

Antitrust Relief

Egregious Contract Clauses

The Campbell bill would allow physicians to jointly negotiate against such clauses

The "Cheapest" Care

This clause allows the plan to restrict care to the cheapest treatments, not the best or most appropriate for the patient.

> "*Medical necessity* means the SHORTEST, LEAST EXPENSIVE, OR LEAST INTENSE LEVEL of treatment, care or service rendered, or supply provided, as determined by us [health plan], to the extent required to diagnose or treat an injury or sickness. [Emphasis added] (American Medical Security, Inc., plan supervisor and administrator for self-funded employee benefit plan)

The "Fall Guy"

Health plans shift liability to physicians for patient harm caused by the plan's own actions. Taken together these three clauses effectively require physicians to comply with the plan's decisions and policies - that directly affect the quality of patient care - while the plan avoids legal liability for them.

> "Provider agrees to participate in, cooperate with and comply with all decisions rendered in connection with [health plan's] Utilization Management Program..."
>
> "Provider agrees to render Covered Services to Beneficiaries...in accordance with... the clinical quality of care and performance standards that are professionally recognized andor accepted by [health plan]." - not necessarily the physician
>
> "PROVIDER SHALL BE SOLELY RESPONSIBLE for the quality of Covered Services rendered to beneficiaries." [Emphasis added]
>
> (Independence Blue Cross p. 2, Clause 1.13, p.4, Clause 2.2(a), and p.5, Clause 2.7 and 2.10)

Pass The Buck

Health plans shift responsibility to physicians for their own breaches of confidentiality.

> "Provider agrees to defend, hold harmless and indemnify Company and its officers, shareholders, employees, agents and subagents from any and all claims, causes of action, lawsuits, liabilities, damages and expenses ...arising from or relating to any release or disclosure MADE BY COMPANY..." [emphasis added] (Wellmark Blue Cross/Blue Shield of Iowa p. 10, clause 10.4)

The Great "Unknown"

Physicians are forced to agree to terms without knowing what they will be. In this example, the health plan would force a physician to participate in a plan without knowing the type of plan, the rules and procedures, the number of patients, the payment, etc.

> "Company reserves the right to introduce new Plans during the course of this agreement. Provider agrees that Provider will provide covered services to Members of such Plans under applicable compensation arrangements determined by company." (Aetna Specialist Physician Agreement, clause 8.2)

Our Way or the Highway!
Health Plans can unilaterally change the contract terms at any time without physician consent:

> "BLUE CROSS has established a Utilization Review (UR) program which shall seek to assure that Hospital Services or Medical Services provided to Members are Medically Necessary. The Utilization Review shall follow the procedures described on Exhibit C, attached to and made part of this Agreement. BLUE CROSS may change UR procedures by delivering amendments to, or a replacement for, Exhibit C at least thirty (30) days prior to implementation." (Blue Cross of California Prudent Buyer Plan, clause 7.1)

Surprise!
Changes can be made at any time *without notice:*

> "Provider agrees: a) To participate, as requested, and to abide by Company's utilization review, patient management, quality improvement programs, and all other related programs (AS MODIFIED FROM TIME TO TIME) and decisions with respect to all members." (Aetna Specialist Physician Agreement, clause 4.2)

No competition
Health Plans prevent physicians from accepting any new patients from competing health plans.

> "To prevent discrimination against Company or its members, for such time as provider declines to accept new members as patients, provider shall not accept as patients additional members from any other health maintenance organization." (Aetna proposed Primary Care Physician Agreement, paragraph 1.2)

"Lemon Laws"
Health Plans insist upon contracts that do not disclose essential terms- one way is to refuse to disclose reimbursement rates and better yet, retain the right to change them at any time:

> "Company shall ... pay Provider for [services] rendered to Members in accordance with: (a) the THEN-CURRENT Company Reasonable, Equitable Fee Schedule (REF); or (b) the compensation arrangement THEN IN EFFECT as applicable to such Member's Plans; either of which may be modified from time to time by company." [Emphasis added] (Aetna Specialist Physician Agreement, clause 3.1)

Patients - Don't Bother Asking!
Gag practices prevent physicians from discussing treatment options with their patients if there is a chance that the health plan won't pay:

> "Provider shall not provide or threaten to provide inferior care or imply to members that their care or access to care will be inferior due to the source of payment." (Aetna Specialist Physician Agreement p. 2, clause 1.2)

Return to regular version

Published Feb 3 2000

American Medical Association

Physicians dedicated to the health of America

Memo to: Executive Directors
State Government Affairs Contacts
State Medical Societies
National Medical Specialty Societies

From: Ross N. Rubin, Vice President
Legislative Affairs

Rebecca A. Cerny, Director
Division of State Legislation

Date: February 17, 1999

Subject: AMA Model State Legislation on State Action Doctrine

As you know, one of the main focuses of the Association has been to identify strategies to help physicians achieve greater bargaining leverage against health plans. This is particularly important in the current health care market, where health plans have amassed enough market leverage to virtually dictate the terms of the contracts they offer physicians. To many physicians, the "strength in numbers" derived from coming together to negotiate fees and other contractual terms is the most obvious way to achieve favorable contracts with health plans. The antitrust laws, however, present a major roadblock to physicians, in that they prohibit physicians from coming together to bargain collectively with health plans and other payers.

At the June 1998 meeting, the House of Delegates adopted Resolution 258. Resolution 258 called upon the Association to develop a negotiating unit, within organized medicine and with no affiliation with national trade unions, free of antitrust constraints for all of its members in order to help level the playing field with health care payors. At the December, 1998 meeting, the House adopted Board of Trustees Report 14, which in part calls upon the Association continue to identify ways in which collaboration by physicians can benefit the public and to inform antitrust enforcement agencies of these findings. In addition, Board of Trustees Report 14 asked the Association to examine the feasibility of drafting model state legislation and, if appropriate, draft such legislation for dissemination. *The AMA Council on Legislation considered and approved model state legislation on the state action doctrine at its January 1999 meeting. The AMA Board of Trustees adopted the model state legislation during its February 1999 meeting.*

Enclosed you will find 1) a summary of the state action doctrine as it pertains to collective negotiation among physicians, including a discussion of the Washington state law on this issue, and 2) model state legislation relating to state action doctrine recently approved by the AMA's Board of Trustees. Please feel free to contact Ross Rubin at (312) 464 – 4040 or Rebecca Cerny at (312) 464 – 4503 with any questions you may have.

STATE ACTION DOCTRINE

The American Medical Association has been working to develop a collective bargaining unit, recognized under the National Labor Relations Act (NLRA), to provide a professionally grounded entity for physicians eligible to organize under that Act. The Association is also continuing to support federal legislation to amend the antitrust laws to allow physicians not eligible under the NLRA. It is expected that Representative Campbell will reintroduce his bill soon.

There is, however, an interim step that in some cases can permit independent physicians to negotiate with plans. This step is based on a line of cases that creates a "state-action doctrine" under the antitrust laws. (Parker v. Brown).

Summary of the State Action Doctrine

The state action doctrine was first set forth in a 1943 Supreme Court decision in *Parker v. Brown*. In general, it states that the **antitrust laws do not apply to action by a state operating in its sovereign capacity, or to private conduct compelled or approved by the state. In other words, where the requirements of the state action doctrine are met, behavior that would otherwise violate the antitrust laws will be exempt from antitrust scrutiny.**

The test for qualifying for the exemption varies, depending on the identity of the party performing the action in question:

1. Where the party is a state legislature or a state court, the exemption is complete, and no further inquiry is required;

2. Where the party is a state agency or local government official, further inquiry is required with respect to whether the action in question followed "clearly articulated and affirmatively expressed state policy;" and

3. Where the party is a private party, the test for qualifying for the state action exemption is the strictest. In addition to having to comport with the "clearly articulated and affirmatively expressed state policy" spelled out above; the action must be subject to "active state supervision." In other words, the state must, *in practice*, exercise some degree of independent judgment or control over the activity. Passive or theoretical power of a state to review private action will be insufficient to meet this standard.

Collective Negotiation Among Physicians Under the State Action Doctrine

Independent physicians fall into the category of private party. Therefore, actions taken by physicians that would ordinarily be illegal under the antitrust laws – in this instance, collective negotiation with health plans – will be exempt from antitrust scrutiny ***only to the***

extent that the activity comports with the requirements laid out above in item 3. Specifically, the antitrust laws will not prohibit independent physicians in a particular state from negotiating collectively with health plans where:

- **The relevant state has a "clearly articulated and affirmatively expressed state policy" that permits independent physicians to negotiate collectively with health plans.**

  The most obvious way for a state to lay out this policy is through legislation. If a state has on its books legislation specifically stating that physicians may negotiate collectively with health plans, then the first requirement for the state action exemption will be satisfied. *[It should be noted that the introduction of a bill that permits independent physicians to negotiate collectively with health plans is bound to generate a certain degree of controversy. This is because such legislation will be perceived as opening the door to activity that will have anti-competitive effects that will ultimately harm the consumer. For example, critics of such legislation might argue that allowing independent physicians to negotiate collectively with health plans will benefit physicians by helping them to keep their fees up, but will harm consumers in that higher fees will translate into higher premiums. Critics might also point to the risk of physicians engaging in boycott activity, where the health plans do not respond favorably to the terms and conditions the physicians demand in the course of the collective negotiations. This, too, could have a negative impact on consumers, who might not be able to secure medical services when needed. Consequently, to increase its chance of passage, such legislation must be carefully drafted, pointing out the possible pro-competitive reasons for allowing physicians to negotiate collectively with health plans. It should also contain provisions that provide reassurance to legislators that boycott activity, or other activity that causes direct harm to the consumer, will not qualify for antitrust exemption."*

- **The collective negotiations between physicians and health plans must be subject to "active" state supervision.**

  Although legislation should include a provision that gives a state body the authority to oversee physicians' collective negotiation activity, the mere inclusion of such language in a state statute will not be enough to constitute "active" state supervision. The state body must, in practice, review the negotiations, which might include following certain procedures that give the state body input into the negotiations themselves. A sound way to ensure that a state body has active oversight over the negotiations is to incorporate within the legislation certain duties of the state body in the course of physician negotiations. This way, negotiations can not go forward and be in compliance with the law unless the state body performs certain functions and, hence, is actively involved.

The Washington Example

Before moving directly into possible model legislation, it is helpful first to look at legislation that was passed in Washington state in 1995. This legislation was designed to provide independent physicians with increased negotiating power with health plans. The legislation serves as a good starting point with respect to drafting language that, when implemented, yields a paradigm in which physicians can collectively negotiate with health plans on certain issues without being subject to the antitrust laws. **However, the Washington law has one major shortcoming for our purposes, and that is that it specifically excludes collective negotiation over fees from state action exemption.** Consequently, while model legislation will borrow many of the provisions of the Washington statute, it will reach further to encompass collective negotiations over fees in identified circumstances.

In summary, the provisions of the statute are organized to address the following issues, in order:

1. The policy reasons for permitting collective negotiations in certain circumstances, and for disallowing collective negotiations in others.

2. The terms and conditions over which physicians may collectively negotiate with health plans

3. The terms and conditions over which physicians may not collectively negotiate with health plans

The first three provisions of the statute set forth Washington's "clearly articulated and affirmatively expressed state policy" in favor of collective negotiations between physicians and health plans on specified issues. Therefore, where physicians engage in the practices enumerated by the statutory provisions, they will be exempted from antitrust prosecution, provided the state actively supervises these activities. The remaining statutory provisions institute a formal process involving the state, thereby ensuring that the state is, in practice, actively involved in reviewing collective negotiations conducted by physicians. The provisions address the following issues:

1. The process competing physicians must follow when negotiating with health plans (e.g., physicians must negotiate through a third party they so authorize);

2. The information third parties must supply to the state prior to engaging in collective negotiations on behalf of physicians;

3. The requirement of state approval of the proposed activity as described within the information supplied by the third part representative; and

4. Loss of antitrust exemption as a result of physicians' acting outside of the parameters laid out by the statutory provisions.

Provided Washington physicians act in accordance with the statutory provisions, they will avoid scrutiny under the antitrust laws. However, the statute is actually quite limited with respect to what it allows physicians to do. Most notably, it forbids collective negotiations over fees or price information, and even backs up this prohibition with a policy statement that points to the anti-competitive effects of such practices.

WSMA's Negotiation Service

Following the passage of legislation allowing independent physicians to negotiate collectively with health plans, the Washington State Medical Association (WSMA) developed a negotiation service to assist Washington physicians in conducting such negotiations. The service was set up so that WSMA staff, in conjunction with outside legal counsel, would actually conduct the physicians' negotiations with health plans.

According to John Arveson at WSMA, thus far, the negotiation service has not been used to conduct any negotiations with health plans. When WSMA first announced the availability of the service to Washington physicians, the response was fairly good, with approximately 2400 physicians signing up. However, in light of increasing consolidation among health plans in Washington, the number of physicians signing up to take part in the service did not amount to a critical mass, for the purposes of "making a difference" against area health plans. By way of example, last summer, when one of Washington's largest HMOs offered a contract containing egregious terms and the negotiation service requested to negotiate with the HMO, the HMO declined to negotiate with the physicians.

The events that transpired following the HMO's refusal to negotiate with the physicians suggest that there might be increased demand for the negotiation service in the future. Considering the HMO's contract to be sufficiently egregious, the WSMA presented the contract to the state's insurance commissioner and put together a media campaign against the HMO's contractual practices. The insurance commissioner, who has a reputation for being very pro-consumer, found the contract to be in need of modification. As a result, the HMO is now in negotiations with the insurance commissioner over the terms of the contract. Because the commissioner is "not known to be particularly friendly" to insurance companies, Arveson notes that the next time the HMO is approached by the physicians to negotiate, it will be more open to private negotiations with physicians. Moreover, the media campaign has generated increased physician interest in participating in the negotiation service. Since this summer, WSMA has received an additional 200 to 300 physician applications.

When asked what impact allowing physicians to negotiate on fee-related issues in certain circumstances would likely have on interest in the negotiation service, Arveson said many more physicians would be interested. Therefore, the possibility of including a provision within proposed legislation that permits collective negotiation over fee-related issues in limited circumstances should not be overlooked.

Conclusion

While not a complete solution for independent physicians not eligible to negotiate under the NLRA, pursuit of state legislation to authorize negotiations provides an approach that can be utilized. Such a strategy is not without risk. By operating under the state action doctrine, a certain amount of autonomy will be lost, in that the state will now be involved in the negotiating process. State medical societies will have to weigh the benefits of the antitrust exemption under the state action doctrine against the risks of active state involvement.

MYTHS ABOUT PHYSICIAN NEGOTIATION
(SB1468/HB3039)

MYTH: *Doctors can form groups to negotiate now.*

FACTS:

1) Currently, physician organization is expensive, complex, and often not logistically possible.
2) Organization makes the physician sacrifice his professional option and **deprives patients of choice** of delivery setting.
3) If physicians organize there is no legitimate means to determine if the group is organized in a manner which meets FTC requirements for negotiation. Moreover, the costs of obtaining a legal opinion that can't provide any guarantees can easily run into six figures even before the group is functional.
4) Even if the group does meet FTC standards it doesn't prevent the plan from threatening the group with an antitrust action, resulting in six figure legal fees and the achievement of the plan's ultimate goal—ceasing physician negotiations.

MYTH: *The Federal Trade Commission and the Department of Justice are "easing up" on enforcement and investigation of physician networking and other initiatives.*

FACT:

At their recent joint report to the American Health Lawyers Association, the FTC and DOJ made it clear that physician mergers and other activities continue to be high on their enforcement agenda this year. For example, to show how nearly impossible it is to understand and/or comply with the law, their staff noted that if a physician merger includes the best physicians in the community (the "must haves"), it might be anti-competitive for this fact alone, even if physician organization doesn't have what the enforcement agencies traditionally consider "market power."

MYTH: *This is the first step in a plan by the AMA to unionize physicians.*

FACTS:

1) The AMA has plans to represent those physicians who are eligible to unionize today without the passage of SB 1468 under the National Labor Relations Act (NLRA). These physicians must be employed physicians, and the negotiations must be with their employer. **Texas has a prohibition of the corporate practice of medicine.** Therefore, Texas would not serve as a model for the AMA's ability to represent physicians in NLRA recognized negotiations with employers.
2) This has to do with the ability of physicians to engage in meaningful contract negotiations with very powerful, monopsonistic forces. This is about a **balance of power in the marketplace** and has nothing to do with unionizing.
3) This bill amends the insurance code and deals only with negotiations between physicians and managed care plans. Furthermore, the bill **specifically prohibits strikes and boycotts or any other tactic that would result in denial of patient care.** The AMA and TMA both believe that it is unethical to strike or otherwise use patients as a bargaining chip.

MYTH: *This bill is anti-competitive and such negotiations should be left to the two equally matched, sophisticated parties.*

FACTS:

1) These plans offer a "take it or leave it" approach. **Contracts are non-negotiable.** Furthermore, some plans control as much as 60% of the market. With this kind of market power, physicians have no ability to negotiate.

2) When physician networks do fully integrate and evolve into an entity that can wield some power in the market, the health plan refuses to negotiate with the network and begins to break it apart into individual physicians who can again be bullied into accepting one-sided contracts. A recent memo from Aetna U.S. Healthcare in California contained the following language: ***"In order to participate directly in <u>All</u> Aetna U.S. Healthcare products you will need to withdraw your affiliation with any/all Aetna U.S. Healthcare contracted IPAs and Medicaid Groups."***

MYTH: *These matters should be left to the "free market."*

FACT:
Sure, managed care companies say "free market" when they virtually own the market and have vast anti-trust protections which no other industry enjoys.

MYTH: *This bill will allow physicians to "price fix" and will increase health care costs.*

FACT:
This bill **does not allow physicians to discuss fees unless given specific permission by the Attorney General** to do so. In order for fees to be part of negotiations, the plan must have substantial market power. The AG must also consider the number of physicians involved in fee negotiations relative to the total number of physicians available in the geographic area. **There is no evidence that this bill will increase costs.** The thrust of this bill – and its clear language – is obviously directed to non-fee related, patient care issues.

MYTH: *This bill will increase the number of uninsured at a time when Texas has the dubious distinction of having the largest percentage of uninsured in the country.*

FACTS:

1) Health plans have used this argument over and over again to try to defeat every significant reform measure at the state and federal level. This is transparently self-serving and especially ironic because as managed care has grown, so has the number of uninsured.

2) Once again, the argument is smokescreen. As noted, the issue is irrelevant because any discussion on fees is limited to circumstances where the plan has substantial market power (as determined by the state).

3) Health plans have never been able to demonstrate cost increases specifically related to any managed care reforms.

4) In addition, health plans have not been able to substantiate their claims that small increases in cost result in loss of insurance coverage.

Managed Care Freedom of Choice Act
HB 3039/SB 1468

Question: Why should the Legislature pass this bill?
Answer: Managed care plans are merging at an alarming rate. These mergers are creating huge, powerful health plans that refuse to negotiate with physicians regarding onerous contract provisions. These "take it or leave it" contracts have requirements that can have direct impact on patient care. When physicians attempt to form networks that are large enough to oppose unreasonable contract provisions, the health plans threaten them with bringing an antitrust action. This is becoming a common ploy, not only in Texas, but in other states as well. This bill will give physicians limited protection from such threats when they attempt to negotiate for the removal of contract provisions that can interfere with patients' access to care.

Question: How can a state bill offer any protection from federal anti-trust laws?
Answer: Under a 1943 Supreme Court ruling, *Parker v. Brown*, states can supercede federal antitrust law if there is "a clearly articulated state policy," and "active state supervision." In general, the ruling states that the antitrust laws do not apply to action by the state operating in its sovereign capacity, or to private conduct compelled or approved by the state. In other words, where the requirements of the state action doctrine are met, behavior that would otherwise violate the antitrust laws will be exempt from antirust scrutiny.

Question: Will this bill allow physicians to strike or boycott?
Answer: No! In fact, such activities are specifically prohibited.

Question: Will the passage of this bill drive up health care costs by giving physicians the ability to set fees and other reimbursement rates?
Answer: No! This bill does not allow physicians to "price fix." Physicians may meet and discuss contract provisions only in most situations. These provisions include items like referral requirements, drugs to be included in formularies, access to certain kinds of specialty care for the plan's enrollees, utilization review criteria, etc. Fees can be discussed only in situations where the health plan has substantial market power in a specified geographic area. Substantial market power will be determined by the Attorney General.

Question: Will the physicians be able to act together and agree to accept or reject a health plans offer?
Answer: Yes. However, the plan is free to make offers to physicians individually as well. Physicians may not act in concert with the intent to fix prices, boycott, or otherwise have an unfair advantage over the health plan. Such actions would not be protected from antitrust actions.

Question: If physicians can't negotiate price in most cases, what advantage does this bill give them over what they are currently able to do?
Answer: In today's market, physicians are not allowed to even meet and discuss contracts without threat of an anti-trust action. This means that multi-billion dollar corporations with full time legal staffs present 80 page contracts to solo and small group practitioners. These doctors must retain legal advice just to understand what is included in the contracts. This advice often does not include the impact on patient care that some provisions can have. The doctors have no idea what should be eliminated or amended, and even if they did, the health plan will not make changes at the request of one or two physicians. When a health plan controls 30% or more of a market, it doesn't have to deal with individual doctors. This bill will allow physicians to join together to be represented by a knowledgeable individual who can facilitate discussions about the impact of various contract provisions. It will allow doctors to talk to one another, to educate one another, and to express concerns to the health plan as a group. When acting in accordance with the provisions of this act, the physicians cannot be threatened with an antitrust action.

Question: How does the state "supervise" these activities in order to meet the requirements under *Parker v. Brown*?
Answer: The physicians' representative will file a plan of operation with the Attorney General. The plan will include information on the representative, the physicians to be represented, the health plan with which negotiations will occur and the items for discussion. When the plan makes an offer to the physicians' representative, it will be filed with the Attorney General. The offer must be approved by the Attorney General before it is presented to the physicians.

Question: How will this bill improve patient care?
Answer: Contract provisions that impede the ability of physicians to advocate for their patients must be challenged. Unless there is a balance of power between huge, powerful managed care plans and physicians who care for patients, abusive managed care organizations will continue to place profits above patients. Physicians who refuse to cooperate will be driven from the market and patients will lose access to physicians. Diminished access delays care and decreases choice for every patient.

Legislative Proposal
"State Action Doctrine"

Alaska has never had a great number of health insurance companies competing in the market place. The prospect of even fewer players exists not only here but nationwide. On January 13, 1999, the New York Times reported that since 1994 the leading 18 health insurance companies have combined into 6. As further evidence of this phenomena, if the proposed merger of Aetna/U.S. Health Care and Prudential takes place, the entity created would cover one in every 10 Americans and potentially even a larger number of Alaskans.

Health insurance plans have increasingly incorporated practices and procedures to manage health care in order to keep costs down. One mechanism used is for a health insurer to contract with different types of providers of health care to provide care for its insureds. Theoretically, the health insurer negotiates discounted fees for health care for the promise of a more guaranteed stream of patients.

In a perfect world, equal bargaining power would exist between the medical care providers and the health insurers. Large group medical practices (none of which exist in Alaska) and big hospitals have more equal bargaining power with the health insurers than the typical Alaskan physician in a solo or small group practice. Obviously, a gross in-equity in bargaining power exists and there is no conceivable way any health insurer will bargain with an individual doctor regarding individual contract provisions other than on a take it or leave it basis. The resultant effect is physician service contracts heavily weighted in the favor of the insurance company. The bottom line is that, in many respects, this adversely affects the care that patients receive. For example, requiring a physician to use a lower cost treatment when a higher cost treatment may be medically necessary or preventing a physician from discussing alternative treatments.

Independent, competing physicians are prevented from any collective action by the federal anti-trust laws to which, ironically, the insurers are not subject. This fact plus the market concentration of health insurers causes the imbalance in bargaining power. With insurers having such a high degree of leverage, a balance of interest no longer exists in the market for health care delivery and finance.

A mechanism, however, is available that can permit independent, competing physicians to collectively negotiate with health insurers in regard to the provisions of physician services contracts. That mechanism is an act of the legislature which would create a "state action doctrine" which was first set forth in a 1943 U.S. Supreme Court decision in Parker v. Brown. In general, the state action doctrine states that the anti-trust actions do not apply to actions by a state operating in its sovereign capacity, or to private conduct compelled or approved by the state In other words, where the requirements of the state action doctrine are met, behavior that would otherwise violate the anti-trust laws will be exempt from antitrust scrutiny. The test for qualifying for exemption varies depending on the identity of the party performing the action in question.

If the party is a state legislature or a state court, the exemption is complete and no further inquiry is required. Where the party is a state agency or local government official, further inquiry is required

with respect to whether the action in question followed a "clearly articulated and affirmatively expressed state policy." However, when the party is a private party, the test for qualifying for the state action exemption is the strictest. In addition to having to comport with the "clearly articulated and affirmatively expressed state policy," the action must also be subject to active state supervision. In other words, the state must, in practice, exercise some degree of independent judgement or control over the activity in question. Passive or theoretical power of a state to review a private action in question is insufficient to meet this standard.

Physicians fall into the category of private party. Therefore, collective actions taken by physicians would ordinarily be illegal under anti-trust laws. In the instance of independent, competitive physicians engaging in collective negotiations with a health insurer, such actions would only be exempt from anti-trust scrutiny if the requirements above for a private party are met.

The most obvious way for a state to lay out those requirements is through legislation. Attached is a draft of a bill that lays out the "clearly articulated and affirmatively expressed state policy" and provides for active state supervision through oversight by the Commissioner of the Department of Labor and the Attorney General. Important to note is that this bill will still prohibit a group of independent competing physicians from striking or otherwise engaging in activities that would result in a boycott.

On behalf of Alaska's patients, we ask that you please introduce a bill that comports with the draft bill provided. Please help level the playing field for Alaska's patients and the physicians who care for them.

Alaska Physicians & Surgeons, Inc.
4120 Laurel Street, Ste. 206
Anchorage, Alaska 99508
Phone: 907-561-7705 Fax: 907-561-7704
E-mail: akphys@alaska.net

February 15, 2000

Dear Senator Pete Kelly:

Thank you for the opportunity to provide you and your colleagues with this written statement on why Alaska Physicians & Surgeons (APS) is strongly supporting the passage of SB256. Before I highlight the merits of SB256, I would like to give you some background on APS.

APS is an Anchorage based Independent Practice Association (IPA) formed in 1997. APS now includes over 165 physicians (primary care & specialists). APS' primary goal is to find a solution to what is generally perceived to be the steady encroachment into the practice of medicine by hospitals, 3rd party payors and others. Another important APS goal is to be a more effective advocate for patients. Physicians are without doubt in the best position to understand the medical needs of patients. However, in the recent past there has been a growing disconnect between physicians and patients caused by the current national medical economic delivery models.

In 1998, APS and its board of directors sought legal counsel to ascertain what APS could legally do as a group, and still not run afoul of Federal and State anti-trust prohibitions on communications between independent, competing physicians. The board quickly discovered there was very little they could do when it came to the issue of direct negotiations with 3rd party payors. In fact APS is barred from direct negotiations and is forced to use something called the "messenger model" in contract discussions. APS' messenger can do little more than pass individual physician's opinions on to the carriers and messenger the carrier's response back to the physicians. APS can offer no opinions and the carriers are free to ignore the IPA if they choose, and simply go around us directly to the doctors. This suits the established carriers interests, particularly the largest players in any given market. It is the old rule of divide and conqueror.

The current state of affairs assures a stagnant market, because new carriers find it prohibitively expensive and time consuming to try and penetrate the Alaskan market without assurances they can sign up a significant number of doctors from the start. The most efficient mechanism for these new carriers, is to deal with the doctors through an IPA like APS. If the doctors were allowed to collectively negotiate, new carriers would be much more likely to enter the Alaskan market thereby increasing the competition for patient's health care dollars.

The ultimate question that SB256 addresses is one of simple fairness for patients and physicians. SB256 would provide a mechanism to bring physicians and the larger carriers together to talk about patient and physician protection issues, without the fear on the physicians' part of being sued by the FTC or a private party for violating Federal or State anti-trust law.

The current state of affairs has reached such a low point, that similar legislation is pending at the national level and in numerous states across the country. Currently, doctors in Alaska and nationally feel metaphorically, as though they are forced to sit gagged in small cubicles, isolated from each other and unable to advocate with carriers on behalf of patients.

Let me sum it up by stating that the process outlined in SB256 is voluntary on the part of the carriers, and the state of Alaska would have the obligation and the duty to oversee the process, to ensure both sides comply with the rules.

If you or your staff have any additional questions, please feel free to give me a call at (907) 561-7705.

Sincerely,

Michael Haugen, JD, MBA
Executive Director

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 2/8/00 FURTHER: Finance

Date of 5-Day Notice: 2/7/00
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2/24/00

Health, Education and Social Services Committee considered SENATE BILL NO. 256

"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."

and recommends:

[✓] be replaced with ______ CS SB 256 (S) HES
[ ] adopt previous ______ CS CS (HES) forthcoming ____(______)
[ ] attached amendment(s)
[ ] adopt Letter of Intent by ________________ Committee
[ ] further referral to the ________________ Committee

Senate Bill:
[✓] same title
[ ] new title
House Bill:
[ ] same title
[ ] technical title
[ ] new: SCR#______

SIGNING DO PASS	*DP*	*OTHER RECOMMENDATIONS*	*NR*	*DNP*	*AM*
Pete Kelly	✓	Gary Wilken	✓		
		[illegible signature]	✓		
CHAIR:		*CHAIR:* Pete Kelly	✓		

NEW FISCAL NOTE(S):

Department	Date	Zero	Fiscal
CED	2/22/00		✓

PREVIOUS FISCAL NOTE(S):*

Department	Date	Zero	Fiscal