SB

254

(11)

HOUSE COMMITTEE REPORT

Date Referred to Committee: April 15, 2000 FURTHER REFERRALS:

Date of Committee Action: 4/17/00

The FINANCE Committee considered: CSSB 254(HES)

CS FOR SENATE BILL NO. 254(HES) HEIRLOOM MARRIAGE CERTIFICATES

"An Act relating to heirloom certificates of marriage."

recommends it be replaced with the following committee substitute _____

[ ] the same title
[ ] a new title

[ ] additional referral to _____ Committee
[ ] attached amendment(s)

ADOPTS: _____ Letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept)

[ ] fiscal note(s) _____

[ ] zero fiscal note(s) _____

APPROVES PREVIOUS: (Dept/Date)

[X] fiscal note(s) Senate DHSS - 4-13-00

[ ] zero fiscal note(s) _____

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
Lyda Therriault	4			
Don Mackel	X			
Lon Beedle	C			
Ella Ramos	X			
Bert Sharp	X			
Terry Gerry	X			
W.K. Williams	X			
Gail Phillips			V	
	X			

CHAIR'S SIGNATURE Lyda Therriault Eldon Mulder

FISCAL NOTE

STATE OF ALASKA
2000 LEGISLATIVE SESSION

No. 2
Bill Version: CSSB 254(HES)
(S) Publish Date: 4-13-00

Revision Date/Time (Note if correction): 04/10/00
Dept. Affected: Health and Social Services
Title: Heirloom Marriage Certificates
BRU: State Health Services
Component: Bureau of Vital Statistics
Sponsor: Rules Committee by Request of the Governor
COMPONENT SERIAL NO. 961
Requestor: Senate (FIN)
See also (SNS):

Expenditures/Revenues: (Thousands of Dollars)

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

OPERATING	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
PERSONAL SERVICES	26.1	37.4	37.4	37.4	37.4	37.4
TRAVEL						
CONTRACTUAL	10.0					
SUPPLIES	10.3	10.3	10.3	10.3	10.3	10.3
EQUIPMENT	7.0					
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	55.4	47.7	47.7	47.7	47.7	47.7
CAPITAL EXPENDITURES						
CHANGES IN REVENUES (	269.9	269.9	269.9	269.9	269.9	269.9

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts	55.4	47.7	47.7	47.7	47.7	47.7
1037 GF/Mental Health						
Other (please specify)						
TOTAL	55.4	47.7	47.7	47.7	47.7	47.7

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 Bureau of Vital Statistics registers over 5,000 marriages per year and has over 200,000 marriages on file. Of the marriages on file fewer than 50% are in the bureau's automated database. To implement the heirloom marriage certificate the bureau must undertake the following activities:

1. Design and print the heirloom stock and all advertising media;
2. Develop computer program to print certificates;
3. Develop computer program to allow keying of pre-1977 marriages into automated database;
4. Key back marriages as requested; and
5. Process and mail requested certificates.

Prepared by: Elmer A. Lindstrom, Special Assistant
Phone: 465-1613
Division: Office of the Commissioner
Date/Time: 4/10/00 8:02 AM

Approved by Commissioner: Karen Perdue, Commissioner
Date: 4/10/00
Agency: Department of Health & Social Services

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#2

ANALYSIS (cont.)

Costs:

One Time Costs

Design and print certificate stock and ad media	NO COST--collaboration for donation through the Alaska Children's Trust.
Develop computer program to print certificates	$5,000
Develop pre-1977 marriage keying program	5,000
Furniture and misc. for new position	5,000
Computer for new position	2,000

On going costs for processing, keying and mailing of requests:

1 new position, Range 10 (9 months in FY 01)	$28,100
Postage and mailers (see calculations below)	10,300
Total FY 01 Costs:	$55,400

Supply and Revenue Calculations:

Expect 70% of current year marriages (5,300) and an average of 4,000 from prior year marriages to request the heirloom certificates or (.7) (5,300) ÷ 4,000 = 7,710 requests per year. (The heirloom certificate will not and cannot replace the legal certificate that is issued)

Supply costs:

Postage (@ 0.33 each)	$ 2,600
Mailers (@ 1.00 each)	7,700

Revenue calculation:

Certificate Cost (@ 10.00 each)	$ 77,100
Children's Trust Fund (@25,00 each)	192,800
Total Revenue	$269,900

Therefore, all program costs will be covered by the increased collection of program receipts

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

TONY KNOWLES, GOVERNOR

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

April 14, 2000

Honorable Gene Therriault, Co-Chair
House Finance Committee
Room 511 Capitol
Juneau, AK 99811

Dear Representative Therriault,

The Department of Health and Social Services respectfully requests a hearing in the House Finance Committee on Committee Substitute for Senate Bill 254 (HES) "*An Act relating to heirloom certificates of marriage.*"

This bill allows the department to issue special marriage certificates suitable for display with the revenue from sales, net of the costs of preparing the certificates, available to the legislature for appropriation to the Alaska Children's Trust. The department estimates net proceeds to be approximately $200,000 in fiscal year 2001.

This program mirrors the previously established heirloom birth certificate program that has generated in excess of $50,000 in revenues for the Trust.

The decision to purchase a more costly heirloom certificate is entirely the choice of the individual.

An identical companion bill, Committee Substitute for House Bill 353 (HES) is also in the House Finance Committee.

Your favorable consideration of this request will be appreciated.

Sincerely,

Elmer A. Lindstrom
Special Assistant to the Commissioner

CC: Honorable Eldon Mulder, Co-Chair
House Finance Committee

Pat Pourchot, Legislative Director
Office of the Governor

Dr. Peter Nakamura, Director
Division of Public Health

Working in partnership with communities to prevent child abuse and neglect.

CS SB 254 (HES) "An ACT relating to heirloom certificate of marriage."

- SB 254 creates an Heirloom Marriage Certificate bill with proceeds to go to the Alaska Children's Trust.
- The Heirloom Marriage Certificate bill is expected to raise close to $200,000 a year for the Alaska Children's Trust.
- The Alaska Children's Trust was created by the legislature in 1988 but was not activated until 1996. Governor Knowles appointed a seven-member board and worked with the Legislature to kick-start the fund with a $6 million dollar deposit. The trust balance is currently over $9 million thanks to donations and income reinvestment.
- Since FY 98, the Trust has awarded over $860,000 to 30 community- based programs statewide with the overall goal of reducing child abuse and neglect.
- In 1989, a bill creating an Heirloom Birth Certificate was signed into law. The proceeds from the sales of these certificates supports the Alaska Children's Trust.
- 10 years later, on June 24, 1998 the ACT in conjunction with the Division of Vital Statistics sold our first Heirloom Birth Certificate. Since that time, 1,980 heirloom birth certificates have been sold, raising $49,500 for the ACT.
- Alaskan artist Rie Munoz and graphic artist Sue Kraft donated their talents to create the birth certificate.
- The heirloom marriage certificate will be modeled after the birth certificate. An average of 5,300 couples get married in Alaska every year.
- It is anticipated that sales/revenues of these marriage certificates will be stronger than the birth certificates. It is estimated that 70 percent of newlyweds will want a keepsake marriage certificate. That, coupled with an expected 4,000 or sales from prior-year marriages, would bring in about $193,000 annually for the trust.
- All program costs will be covered by the increased collection of program receipts.

TONY KNOWLES
GOVERNOR
governor@gov.state.ak.us

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

P.O. Box 110001
Juneau, Alaska 99811-0001
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February 4, 2000

SB254

The Honorable Drue Pearce
President of the Senate
Alaska State Legislature
State Capitol
Juneau, AK 99801-1182

Dear President Pearce:

One of the efforts in which the Administration and the Legislature can take great pride is the revitalization of the Alaska Children's Trust. Alaskans have responded with overwhelming support to help build the principal of the trust to more than $9 million. Proceeds from the trust provide grants to communities and agencies statewide to prevent child abuse and neglect and create healthier lives for children.

One fundraising effort for the trust is the sale of heirloom birth certificates. The sales raised more than $50,000 for the Children's Trust last year and is the most successful fundraising program of its type nationwide.

This bill I transmit today expands the birth certificate program by establishing an heirloom marriage certificate suitable for display. Hopefully $25 from the sale proceeds for each certificate would be appropriated by the legislature to the Alaska Children's Trust. This program offers an excellent and appealing way to continue the worthwhile work of the Children's Trust.

I urge your favorable consideration of this bill.

Sincerely,

Tony Knowles
Governor

SB

254

SENATE FINANCE COMMITTEE REPORT

DATE: 2/17/00

FURTHER: REPORTED OUT OF SFC 4/12/00

DATE TURNED IN TO OFFICE: 4-13-00

Finance Committee considered SENATE BILL NO. 254

"An Act relating to heirloom certificates of marriage."

and recommends:

[ ] be replaced with _____ CS _____ (_____)

[✓] adopt previous _____ CS SB 254 (HES)

[ ] 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
	✓			↘	
					✓
	↘				
			✓		
Co-Chair:	✓	Co-Chair:			
Co-Chair:	✓	Co-Chair:			

NEW FISCAL NOTE(S):

Department	Date	Zero	Fiscal
*2 Health & Social Svc	4/10/00		55.4

PREVIOUS FISCAL NOTE(S):*

Department	Date	Zero	Fiscal

[ ] APPROPRIATION -- no fiscal note

*include fiscal notes accompanying Governor's bill

FISCAL NOTE

STATE OF ALASKA
2000 LEGISLATIVE SESSION

REPORTED OUT OF SFC 4/12/00

BILL NO. CS SB 254 (HES)

Revision Date/Time (Note if correction): 04/10/00
Dept. Affected: Health and Social Services
Title: Heirloom Marriage Certificates
BRU: State Health Services
Component: Bureau of Vital Statistics
Sponsor: Rules Committee by Request of the Governor
COMPONENT SERIAL NO. 961
Requestor: Senate (FIN)
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

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

OPERATING	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
PERSONAL SERVICES	28.1	37.4	37.4	37.4	37.4	37.4
TRAVEL						
CONTRACTUAL	10.0					
SUPPLIES	10.3	10.3	10.3	10.3	10.3	10.3
EQUIPMENT	7.0					
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
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CHANGES IN REVENUES (	269.9	269.9	269.9	269.9	269.9	269.9

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1004 GF						
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1037 GF/Mental Health						
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TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

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3. Develop computer program to allow keying of pre-1977 marriages into automated database;
4. Key back marriages as requested; and
5. Process and mail requested certificates.

Prepared by: Elmer A. Lindstrom, Special Assistant
Phone: 465-1613
Division: Office of the Commissioner
Date/Time: 4/10/00 8:02 AM

Approved by Commissioner: Karen Perdue, Commissioner
Date: 4/10/00
Agency: Department of Health & Social Services

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ANALYSIS (cont.):

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Total Revenue	$269,900

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SENATE FINANCE COMMITTEE

2000 COMMITTEE ACTION

Bill Number	SB254
Amendment	
Motion	report from Committee
Motion by	A
Objection	
Objection by	
Removed	
Second Objection by	

Committee Member	***Vote***
Senator Lyda Green	✓
Senator Randy Phillips	✓
Senator Dave Donley	—
Senator Loren Leman	✓
Senator Al Adams	✓
Senator Gary Wilken	✓
Senator Pete Kelly	✓
Co-Chair Sean Parnell	—
Co-Chair John Torgerson	✓

Tally		
Yea	5	0
Nay	2	0
Absent	2	0

MOTION	Pass

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

TONY KNOWLES, GOVERNOR

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

February 16, 2000

Honorable John Torgerson, Co-Chair
Senate Finance Committee
Room 516 Capitol
Juneau, AK 99811

Dear Senator Torgerson,

The Department of Health and Social Services respectfully requests a hearing on Senate Bill 254 "An Act relating to heirloom certificates of marriage."

This bill allows the department to issue special marriage certificates suitable for display with the revenue from sales, net of the costs of preparing the certificates, available to the legislature for appropriation to the Alaska Children's Trust. The department estimates net proceeds to be approximately $200,000 in fiscal year 2001.

This program mirrors the previously established heirloom birth certificate program which has generated in excess of $50,000 in revenues for the Trust.

The decision to purchase a more costly heirloom certificate is entirely the choice of the individual.

Your favorable consideration of this request will be appreciated.

Sincerely,

Elmer A. Lindstrom
Special Assistant to the Commissioner

CC: Pat Pourchot, Legislative Director
Office of the Governor

Dr. Peter Nakamura, Director
Division of Public Health

STATE OF ALASKA

Birth Certificate

Child: John Q Alaskan Jr

	Sex:	Male
	Date of Birth:	09-99-99
	Place of Birth:	Juneau
Mother	First Name:	Jane
	Middle Name:	M
	Maiden Name:	Doe
Father	First Name:	John
	Middle Name:	Q
	Last Name:	Alaskan

I certify that this is a true, full and correct copy of the original certificate on file in the Bureau of Vital Statistics, Department of Health & Social Services.

Registrar: Alfred A Zongri Dated: AUG 05 1998 Governor of Alaska: Tony Knowles

ISSUED BY THE ALASKA BUREAU OF VITAL STATISTICS

SENATE FINANCE COMMITTEE

S I G N - I N

SB 254-HEIRLOOM MARRIAGE CERTIFICATES

NAME: Elmer Lindstrom Subject/Bill No: SB 254

Co./Dept./Title: DHSS Spec. Assistant Phone: 465-1613

Address: _____ Zip: _____

Do you wish to testify? ___Yes ___No ✓Respond To Questions

NAME: _____ Subject/Bill No: _____

Co./Dept./Title: _____ Phone: _____

Address: _____ Zip: _____

Do you wish to testify? ___Yes ___No ___Respond To Questions

NAME: _____ Subject/Bill No: _____

Co./Dept./Title: _____ Phone: _____

Address: _____ Zip: _____

Do you wish to testify? ___Yes ___No ___Respond To Questions

NAME: _____ Subject/Bill No: _____

Co./Dept./Title: _____ Phone: _____

Address: _____ Zip: _____

Do you wish to testify? ___Yes ___No ___Respond To Questions

SENATE FINANCE COMMITTEE

S I G N - I N

SB 254-HEIRLOOM MARRIAGE CERTIFICATES

NAME: Elmer Lindstrom Subject/Bill No: SB 254

Co./Dept./Title: Special Asst /DHSS Phone: 465-1613

Address: DHSS Zip: _____

Do you wish to testify? ✓ Yes ___ No ___ Respond To Questions

NAME: SHARI PAUL Subject/Bill No: _____

Co./Dept./Title: STAFF AK CHILDREN'S TRUST Phone: 4876

Address: _____ Zip: _____

Do you wish to testify? ___ Yes ___ No X Respond To Questions

NAME: _____ Subject/Bill No: _____

Co./Dept./Title: _____ Phone: _____

Address: _____ Zip: _____

Do you wish to testify? ___ Yes ___ No ___ Respond To Questions

NAME: _____ Subject/Bill No: _____

Co./Dept./Title: _____ Phone: _____

Address: _____ Zip: _____

Do you wish to testify? ___ Yes ___ No ___ Respond To Questions

SB

256

SFIN

FILE

SENATE FINANCE COMMITTEE REPORT

DATE: 2/24/00

REPORTED OUT OF SFC 4/7/00

FURTHER:

DATE TURNED IN TO OFFICE: 7 April 00

Finance 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 (FIN)

[ ] adopt **previous** ____ CS ____ (____)

[ ] attached amendment(s) CS forthcoming

[ ] adopt Letter of Intent by ____

[ ] 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*
Kelly Ellis	✓				
Pete Kelly	✓	Gary Wilken	✓		
		Drew D. Thomas	—		
		Wes Gyldenzy	✓	✓	
		Lyda Green	✓		
Co-Chair:		*Co-Chair:* Loren Leman	✓		
Co-Chair: Jean Parnell	✓	*Co-Chair*			

NEW FISCAL NOTE(S):

Departme:		:ro	Fiscal
	forthcoming f/n's		-
____	Admin		
____	✓Law		
____	Div. Insrance		

PREVIOUS FISCAL NOTE(S):*

Department	Date	Zero	Fiscal

[ ] **APPROPRIATION -- no fiscal note**

***include fiscal notes accompanying Governor's bill**

REPORTED OUT OF SFC 4/7/00

FISCAL NOTE

STATE OF ALASKA
2000 LEGISLATIVE SESSION

BILL NO. CSSB 256 (FIN)

Revision Date/Time (Note if correction) _____ Dept. Affected Law
Title "An Act relating to allowing physicians to collectively negotiate with a health benefit plan ..." 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	190.0	190.0	190.0	190.0	190.0	
Travel	5.8	5.8	5.8	5.8	5.8	
Contractual	135.6	135.6	135.6	135.6	135.6	
Supplies	3.1	3.1	3.1	3.1	3.1	
Equipment	13.0					
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**347.5**	**334.5**	**334.5**	**334.5**	**334.5**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )		**334.5**	**334.5**	**334.5**	**334.5**	**0.0**

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	243.3					
1005 GF/Program Receipts	104.3	334.5	334.5	334.5	334.5	
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	**347.5**	**334.5**	**334.5**	**334.5**	**334.5**	**0.0**

Estimate of any current year (FY2000) cost: _____

POSITIONS

Full-time	2	2	2	2	2	
Part-time						
Temporary						

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

CSSB 256 (FIN) 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 subject matter of the negotiations must be reviewed and approved by the attorney general, who then receives various reports on the progress of the negotiations. Once a negotiated contract proposal is reached, it is to be reviewed and approved by the attorney general, using specific criteria, within thirty days. The bill provides that registration fees for authorized third parties will be established to approximately equal the regulatory costs for the attorney general's oversight of joint negotiations between physicians and health benefit plans. The bill further contains a sunset provision, repealing the new program on July 1, 2005.

Prepared by: Joan M. Kasson Joan M Kasson Phone 465-5370
Division Attorney General's Office Date/Time 4/10/00, 8:54 AM
Approved by Commissioner for Bruce M. Botelho, Attorney General Date 4/10/00
Agency Department of Law

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ANALYSIS CONTINUATION

If enacted, this legislation places substantial responsibilities on the attorney general to approve proposed negotiations, monitor reports of on-going negotiations, and to make a very fact intensive determination whether to approve or not approve a proposed negotiated contract within a very short time frame. The economic and patient care detriment or benefit criteria the Attorney General is directed to base approval or disapproval on will require significant analysis by expert health care economic assistance, as well as additional legal resources.

Under this bill, competing physicians within the service area of a health benefit plan can collectively negotiate certain defined terms and conditions of contracts with the health benefit plan. Negotiations can include fee and price related terms and conditions when the health benefit plan has a market share greater than 15 percent in the geographic service area of the negotiating physicians.

It is difficult to predict how many contracts and reports during a given year that the attorney general's office will have to review and approve. There are 2,287 licensed physicians and 47 separate medical specialties currently in the State of Alaska, and we conservatively estimate more than 7,000 health benefit plans will be potentially subject to this bill. Given these numbers, we would anticipate the volume of collective negotiations under the bill to be significant enough that we will need additional resources to complete the required reviews and approvals.

The Department of Law anticipates a minimum of one new full-time equivalent attorney position and one full-time equivalent paraprofessional 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 30 day review period. Once regulations are complete, these positions will perform the necessary investigation, review, and antitrust analyses on the collective bargaining reports submitted by the authorized third party, and represent the state when decisions of the attorney general are challenged.

Requests for approval of proposed negotiations and review of negotiated contracts by the attorney general are unlikely to be spread evenly throughout the course of a year. Instead, they may come at any time, and in any volume. Thus, we assume it will be more efficient to hire expert health care economic assistance by contract on an as needed basis. $100,000 is included for outside expert costs (500 hours at an estimated average cost of $200/hour).

In-house estimates are based on the department's FY 2001 standard full-time equivalent attorney and paraprofessional schedules, which include clerical support, communications, space, supplies, data processing, and other normal overhead expenses. (FTE attorney: $134,712, FTE paraprofessional: $89,837). Each 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.

The bill assumes fees for the registration of authorized third parties will be established to cover the cost of the program upon implementation. In the first year, it will take several months to establish the regulatory framework. During this time, no fees will be generated. General funds are necessary for the first year to implement the program, at which point, the fees will be set to cover all program costs. The Department of Law estimates, based on Texas' experience, that at least nine months will be required to get regulations in place. Accordingly, funds are split 70/30 general fund and general fund program receipts in FY 2001.

FISCAL NOTE

STATE OF ALASKA
2000 LEGISLATIVE SESSION

BILL NO. CSSB 256 (FIN)

Revision Date/Time (Note if correction) 04/11/00
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 Pete Kelly
Requester S. (FIN)
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	$23.10	23.6	24.1	24.6	25.1	25.6
Travel						
Contractual						
Supplies	1.5	1.5	1.5	1.5	1.5	1.5
Equipment	5.0	0.0	0.0	0.0	0.0	0.0
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**29.6**	**25.1**	**25.6**	**26.1**	**26.6**	**27.1**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	29.6					
1005 GF/Program Receipts		25.1	25.6	26.1	26.6	27.1
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	**29.6**	**25.1**	**25.6**	**26.1**	**26.6**	**27.1**

Estimate of any current year (FY2000) cost: 0.0

POSITIONS

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

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

A part-time administrative clerk IIII position is needed in order to gather and report the health benefit plan market share information required under Sec. 23.50.020(e)(6), page 4, line 13. This position would be responsible for developing and sending out surveys requesting data from over 18,000 employers in the state and for performing reasonableness checks on the data submitted, entering the data into a spreadsheet, and developing the required market share reports. Since the Division of Insurance does not have regulatory authority over health benefit plans (employers), it is anticipated that employers will be reluctant to respond to the survey (about 30% response rate). Therefore, a significant amount of this employee's time is anticipated to be spent following up with the employers who do not respond to the survey.

Prepared by: Robert A. Lohr
Phone 269-7900
Division Insurance
Date/Time 4-11-00 12:29 PM
Approved by Commissioner Deborah B. Sedwick
Date 4/11/00
Agency Community & Economic Development

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FISCAL NOTE

STATE OF ALASKA
2000 LEGISLATIVE SESSION

REPORTED OUT OF SFC 4/7/00

BILL NO. CS SB 256 (RLS)

Revision Date/Time	4/20/00	Dept. Affected	Administration
Title	An act relating to regulation of managed	BRU	Centralized Administrative Services
	health care and allowing physicians to collectively...	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)*

This bill would compromise the State's ability to manage health care costs. Analyses of similar legislation at the federal level estimate health care increases of 5-13% when this type of legislation is enacted. That represents a potential increase to the State's plan of $3.5 - 9.1 million.

Prepared by: Guy Bell, Director — Phone 465-4471
Division: Retirement and Benefits — Date/Time
Approved by Commissioner: Robert Poe Jr. — Date: 4/20/00
Agency: Department of Administration

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1-LS1291\I
Ford
3/27/00
adopted

CS FOR SENATE BILL NO. 256( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR PETE KELLY

A BILL

FOR AN ACT ENTITLED

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

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

* Section 1. AS 23 is amended by adding a new chapter to read:

Chapter 50. Collective Negotiation by Physicians.

Sec. 23.50.010. Legislative findings. (a) The legislature finds that permitting competing physicians to engage in collective negotiation of certain terms and conditions of contracts with a health benefit plan will benefit competition, so long as the physicians do not engage in an express or implied threat of retaliatory collective action, including boycotts or strikes.

(b) The legislature finds that permitting physicians to engage in collective negotiations over fee-related terms may, in some circumstances, yield anti-competitive effects. There are, however, instances in which a health benefit plan dominates the market to the degree that fair negotiations between physicians and the health benefit

plan are not possible in the absence of joint action on behalf of the physicians. In those circumstances, the health benefit plan can virtually dictate the terms of the contracts that it offers to physicians.

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

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

(1) clinical practice guidelines and coverage criteria;

(2) the respective liability of physicians and the health benefit plan for the treatment or lack of treatment of insured or enrolled persons;

(3) administrative procedures, including methods and timing of the payment of services to physicians;

(4) procedures for the resolution of disputes between the health benefit plan and physicians;

(5) patient referral procedures;

(6) the formulation and application of reimbursement methodology;

(7) quality assurance programs;

(8) health service utilization review procedures; and

(9) criteria to be used by health benefit plans for the selection and termination of physicians, including whether to engage in selective contracting.

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

(1) the fees or prices for services, including fees or prices arrived at by applying any reimbursement methodology procedures;

(2) the conversion factor in a resource-based relative value scale

reimbursement methodology or similar methodologies;

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

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

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

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

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

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

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

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

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

(2) physicians may communicate with an authorized third party

regarding the terms and conditions of contracts allowed under this section;

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

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

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

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

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

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

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

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

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

to the attorney general as new information becomes available that indicates that the subject matter of negotiations with the health benefit plan has changed or will change;

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

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

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

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

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

(2) the contract terms are consistent with other applicable laws and regulations.

(i) The competitive and other benefits of joint negotiations or negotiated provider contract terms may include

(1) restoration of the competitive balance in the market for health care services;

(2) protections for access to quality patient care;

(3) promotion of health care infrastructure and medical advancement; or

(4) improved communications between health care providers and health care insurers.

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

(1) provide for excessive payments; or

(2) contribute to the escalation of the cost of providing health care services.

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

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

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

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

(b) In this section, "regulatory costs" means costs of the Department of Law

that are attributable to oversight of joint negotiations between physicians and health benefit plans.

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

Sec. 23.50.099. Definitions. In this chapter,

(1) "authorized third party" means a person authorized by the physicians to negotiate on their behalf with a health benefit plan under this chapter;

(2) "covered lives" means the total number of individuals who are entitled to benefits under the health benefit plan;

(3) "geographic service area" means the geographic area of the physicians seeking to jointly negotiate;

(4) "health benefit plan" has the meaning given in AS 21.54.500.

*** Sec. 2.** AS 45.50.572 is amended by adding a new subsection to read:

(k) AS 45.50.562 - 45.50.596 do not forbid the existence or operation of organizations of physicians acting in accordance with AS 23.50, or forbid or restrain members of those organizations from lawfully carrying out the legitimate objectives of them; nor are these organizations or members illegal combinations or conspiracies in restraint of trade under the provisions of AS 45.50.562 - 45.50.596.

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

SENATE FINANCE COMMITTEE
Amendment Number: #1 1-LS1291\H.1
Bill Number: SB 256 Ford
Sponsor: Torgerson Date: 3/27/00 2/29/00
Logged In By: Mindy

A M E N D M E N T

OFFERED IN THE SENATE

TO: CSSB 256(HES)

Page 1, line 1, following "**Act**":

Insert "**relating to unfair discrimination under group health insurance;**"

Page 1, line 7:

Delete "SECTION 2"

Insert "SECTION 3"

Page 1, line 10:

Delete "sec. 2"

Insert "sec. 3"

Page 2, line 3:

Delete "sec. 2"

Insert "sec. 3"

Page 2, following line 5:

Insert a new bill section to read:

"* **Sec. 2.** AS 21.36.090(d) is amended to read:

(d) Except to the extent necessary to comply with AS 21.42.365 and AS 21.56, a person may not practice or permit unfair discrimination against a person who provides a service covered under a group health insurance policy that extends coverage on an expense incurred basis, or under a group service or indemnity type contract issued by a nonprofit corporation, if the service is within the scope of the provider's occupational license. In this subsection, "provider" means a state licensed physician, **physician assistant,** dentist, osteopath, optometrist, chiropractor, nurse

midwife, advanced nurse practitioner, naturopath, physical therapist, occupational therapist, marital and family therapist, psychologist, psychological associate, or licensed clinical social worker, or certified direct-entry midwife."

Renumber the following bill sections accordingly.

1-LS1291\H.6
Ford
3/24/00

SENATE FINANCE COMMITTEE
Amendment Number: #2
Bill Number: SB 256
Sponsor: P. Kelly Date: 3/27/00
Logged In By: C Grindle

AMENDMENT

OFFERED IN THE SENATE BY SENATOR PETE KELLY

TO: CSSB 256(HES)

Page 10, lines 8 - 10:

Delete all material.

Page 10, line 11:

Delete "Sec. 23.50.050"

Insert "Sec. 23.50.040"

SENATE FINANCE
COMMITTEE
Amendment Number: #3
Bill Number: SB 256
Sponsor: P. Kelly Date: 3/27/00
AMENDMENT By: J Mindy

1-LS1291\H.7
Ford
3/25/00

OFFERED IN THE SENATE BY SENATOR PETE KELLY

TO: CSSB 256(HES)

Page 7, line 3, following "the":
Insert "geographic"

Page 7, line 11, following "power":
Insert "within the geographic service area"

Page 7, lines 16 - 17:
Delete "as reported by the director of insurance for"
Insert "at the end of"

Page 7, line 18, following "services":
Insert "at the end of the most recently completed calendar quarter divided by the total population of the geographic service area as of the most recent census"

Page 7, line 19, following "particular":
Insert "geographic"

Page 8, line 5:
Delete "service area or proposed service area"
Insert "geographic service area or proposed geographic service area"

Page 9, line 8, following "disapprove the":
Insert "contract that was the subject of the"

Page 10, following line 17:

Insert a new paragraph to read:

"(3) "covered lives" means the total number of individuals who are entitled to benefits under the health benefit plan;

(4) "geographic service area" means the geographic area of the physicians seeking to jointly negotiate;"

Renumber the following paragraph accordingly.

SENATE FINANCE
COMMITTEE
Amendment Number: #4
Bill Number: SB 256
Sponsor: P. Kelly Date: 3/27/00
Logged In By: J Mindy

1-LS1291\H.9
Ford
3/25/00

AMENDMENT

OFFERED IN THE SENATE BY SENATOR PETE KELLY

TO: CSSB 256(HES)

Page 7, line 5:
Delete "commissioner"
Insert "attorney general"

Page 7, line 7:
Delete "commissioner"
Insert "attorney general"

Page 7, line 15:
Delete "commissioner"
Insert "attorney general"

Page 8, line 15:
Delete "commissioner"
Insert "attorney general"

Page 8, line 18:
Delete "commissioner, for the commissioner's"
Insert "attorney general, for the attorney general's"

Page 8, line 22:
Delete "commissioner"
Insert "attorney general"

Page 8, line 26:

Delete "commissioner"

Insert "attorney general"

Page 9, line 1:

Delete "commissioner"

Insert "attorney general"

Page 9, line 4:

Delete "commissioner, for the commissioner's"

Insert "attorney general, for the attorney general's"

Page 9, line 7:

Delete "With the advice of the attorney general, the commissioner"

Insert "The attorney general"

Page 9, line 10:

Delete "commissioner"

Insert "attorney general"

Page 9, line 12:

Delete "commissioner's"

Insert "attorney general's"

Page 9, following line 13:

Insert new subsections to read:

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

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

(2) the contract terms are consistent with other applicable laws and regulations.

(i) The competitive and other benefits of joint negotiations or negotiated provider contract terms may include

(1) restoration of the competitive balance in the market for health care services;

(2) protections for access to quality patient care;

(3) promotion of health care infrastructure and medical advancement; or

(4) improved communications between health care providers and health care insurers.

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

(1) provide for excessive payments; or

(2) contribute to the escalation of the cost of providing health care services."

Reletter the following subsections accordingly.

Page 9, line 25:

Delete "commissioner"

Insert "attorney general"

Page 9, line 26:

Delete "commissioner"

Insert "attorney general"

Page 9, line 29:

Delete "commissioner"

Insert "attorney general"

Page 10, line 1:

Delete "commissioner"

Insert "attorney general"

Page 10, line 3:

Delete "commissioner"

Insert "attorney general"

Page 10, line 11:

Delete "commissioner"

Insert "attorney general"

Page 10, lines 16 - 17:

Delete all material.

Renumber the following paragraph accordingly.

SENATE FINANCE
COMMITTEE
Amendment Number: #5
Bill Number: SB 256
Sponsor: P Kelly Date: 3/27/00
Logged In By: Mindy

AMENDMENT

OFFERED IN THE SENATE BY SENATOR PETE KELLY
TO: CSSB 256 (HES)

Page 7, lines 10 – 12
Delete all material

SENATE FINANCE
COMMITTEE
Amendment Number: #6
Bill Number: SB 256
Sponsor: Kelly Date: 4/4/00
Logged In By: C Mindy

AMENDMENT

OFFERED IN THE SENATE BY SENATOR PETE KELLY
TO: CS SB 256 (FIN)

Page 3, line10
Delete "geographic" in front of "service"

SENATE FINANCE COMMITTEE

2000 COMMITTEE ACTION

Bill Number	SB 256
Amendment	#6
Motion	adopt
Motion by	K
Objection	
Objection by	none
Removed	
Second Objection by	

Committee Member	Y	***Vote***	N
Senator Al Adams			
Senator Gary Wilken			
Senator Pete Kelly			
Senator Lyda Green			
Senator Randy Phillips			
Senator Dave Donley			
Senator Loren Leman			
Co-Chair Sean Parnell			
Co-Chair John Torgerson			
Tally			
Yea		0	
Nay		0	
Absent		0	
MOTION		Passed	

American Medical Association
Physicians dedicated to the health of America

FOR IMMEDIATE RELEASE March 15, 2000

CAMPBELL BILL WILL GIVE POWER TO PATIENTS WITH LITTLE OR NO COST TO SOCIETY

Three-year sunset provision provides real world test of cost vs. benefits

A new cost analysis of the Campbell Bill (H.R. 1304), conducted by a Pennsylvania State University health policy economist finds the potential costs of the Campbell Bill are a tiny fraction of costs estimated by an earlier study promoted by the Health Insurance Industry of America (HIAA). In fact, the new study shows that when the benefits to society are weighed against potential costs – H.R. 1304 may cost nothing at all.

The Penn State study found that an earlier insurance-sponsored study used "questionable assumptions" and relied heavily on opinion, not empirical evidence.

"There is no definitive evidence to predict whether or not the Campbell Bill will present a cost to society, however, we do know there will be important benefits," said AMA Trustee Donald Palmisano, MD.

"We know for certain that patients are suffering under the current system that gives too much power to health plans, at the expense of individual patients. The Campbell Bill will change that. It will level the playing field so individuals have a fighting chance against enormous and powerful health plan bureaucracies."

"We propose that Congress fix the problem we know we have, and put the Campbell Bill to a real-life test. The key is this: the AMA supports a three-year sunset provision, which allows actual outcomes to replace educated guesses."

"With a three-year sunset, there's nothing to lose. If costs increase significantly, Congress is free to reevaluate." Dr. Palmisano said. "However, we predict the Campbell Bill will give power back to the patient at little or no cost to society – and that's an outcome we can all live with."

#

For more information
or a copy of the Penn State study, please call: Brenda L. Craine
202/789-7447

SUMMARY
Foreman Cost Analysis of
H. R. 1304, the "Quality Health care Coalition Act of 1999"

AMA March 9, 2000

In a new study by Stephen Foreman, J.D., Ph.D., M.P.A. from Pennsylvania State University, potential costs of H.R. 1304 are estimated to range from $71 to $814 million – only 0.005% to 0.06% of national health expenditures based on HCFA projections for 2000. The potential benefits, which are completely ignored by the opponents' estimate, could balance or outweigh the costs.

Opponents of H.R. 1304 cite a single study to support their claim that the bill would raise health care costs by $29.2 to $95 billion annually (the "Charles River estimate"). However, the Charles River estimate is replete with unwarranted assumptions and questionable methodology that leads to cost figures that are overstated and deeply flawed.

The fundamental premise of the Charles River estimate is that managed care has achieved large savings and that all health care professionals will negotiate back most or all of these savings from health plans. The estimate is based on flawed assumptions and uses the highest available savings estimates and other savings estimates that are not supported by any empirical evidence, while ignoring lower savings estimates published in a number of other studies.

A few examples include:

- Charles River uses an estimate based on a study of discounts achieved by a single plan (Aetna) in a single year (1992). However, Aetna is a large national plan with a reputation for achieving aggressive discounts and in 1992 there was substantially lower managed care penetration so health providers offered larger discounts.
- Four separate categories of savings substantially over-count savings, i.e., independent calculation of "direct price effects" and "utilization management effects" and "utilization review effects".
- The range of managed care savings (6%, 13%, 20% and 25%) is unrealistic. There is no empirical evidence that managed care has produced cost savings of 20% to 25%. In addition, Charles River uses a Barents 13% figure that was an average for only some HMOs, **not** for all managed care.
- Both Barents and Lewin estimates used by Charles River include discounts from hospital services that should not be included in an evaluation of potential costs of H.R. 1304. This is particularly misleading because many studies have found that managed care substantially reduced large levels of inefficiency in hospital costs.
- Barents uses a panel of experts to conclude that 60% to 90% of utilization savings will be lost upon the enactment of negotiating legislation. These estimates are not based on any empirical evidence - only opinion.
- The assumption that all cost discounts have been passed on in the form of reduced premiums is inaccurate. Premium dollars are also used for increasing profit structures, due in part to pressure from investors, substantial costs associated with mergers and acquisitions, and for increasing costs of technology and pharmaceuticals to name a few examples.

The Foreman estimate uses the same approach as Charles River, but with a more specific calculation of managed care savings and more realistic assumptions. To assess managed care

cost savings, Foreman uses "time series" analyses. Applying the results of his models to projections of expenditures in 2000, managed care would be expected to produce savings of 5.9 % with respect to services provided by health care professionals. The 5.9 % estimate of managed care savings is consistent with the low end of the range of savings estimates used by Charles River (6%) and is close to the low end of the Lewin estimate (7.5%).

As opposed to the Charles River assumption that health plans would "give-back" most to all of the savings from managed care as a result of negotiations under H. R. 1304, Foreman uses a more realistic, yet generous assumption. Foreman assumes that give-backs, if any, will range from 10% to 25% of managed care savings. This assumption is supported by the fact that most local markets have one or more dominant health plans that drive costs down. In fact, 82% of Standard Metropolitan Statistical Areas have at least one "dominant" HMO. 40 markets have two dominant HMOs, making them highly concentrated according to levels used by the Department of Justice to evaluate market concentration. **Almost half of the local markets have an HMO with a market share of 50% or more which is extremely concentrated.** (InterStudy1999)

In addition, only seven health plans (Aetna, Cigna, United, Foundation, Pacificare, Wellpoint and Humana) account for nearly 68 million patients and a large number of shareholders. The national Blue Cross and Blue Shield Association claims that Blues' plans have 50.5 million members nationwide. The assumption that these large powerful plans, with intense pressure to hold the line on costs, would yield back most or all managed care cost savings is certainly not a logical assumption and is not supported by experience or empirical evidence.

Foreman uses a more realistic assumption of the number of physicians that would join negotiating units under H. R. 1304 - 5% to 23%. This is due to several factors, most notably, independently practicing physicians account for 52.4% of all patient care physicians, and roughly 9.5% to 43.8% of workers who are already eligible to join negotiating units elect to do so (Bureau of Labor Statistics, 1999). To conclude, as does Charles River, that 100% of all patient care physicians would participate in negotiating units under H. R. 1304 simply ignores the facts.

Based on managed care savings of 5.9%, negotiation unit participation of 5.0% to 22.9% of all patient care physicians, and a generous give-back range of 10% to 25%, Foreman's projected cost estimate of $71 to $814 million is clearly reasonable.

Foreman believes that H.R. 1304 would also result in many benefits. For instance, improved physician contracts would lead to a greater number of physicians willing to join managed care provider networks, thereby improving the quality of the networks and reducing patient incentives to go "out of network," thereby reducing their out of pocket costs. While these types of benefits might be hard to quantify in dollars, there are other benefits related to pricing for physician services that can be estimated. The Foreman study therefore evaluates the beneficial impact of the Campbell bill strictly in terms of fees. The elimination of below market pricing of physician services will likely yield savings of $1.0 to $1.9 billion in the form of reduced "welfare losses" to society. Some examples include reduced access to services as a result of physician bankruptcies or strains on safety net services. Thus, Foreman believes the potential benefits of H.R. 1304 could likely outweighed potential costs.

PENNSTATE

1855

A Cost Analysis of Health Care Professional Negotiating Legislation

March 1, 2000

Stephen Foreman, J.D., Ph.D., M.P.A.
Assistant Professor
The Pennsylvania State University

A Cost Analysis of Health Care Professional Negotiating Legislation

March 1, 2000

Stephen Foreman, J.D., Ph.D., M.P.A.*

Introduction

On March 25, 1999, Congressman Thomas Campbell introduced legislation that would permit health care professionals to negotiate collectively with managed care plans (House of Representatives, 1999). Entitled the Quality Health-Care Coalition Act of 1999, the bill would give health care professionals immunity from antitrust laws when they negotiate as a group with HMOs and other large health plans. Proponents of the legislation are concerned about growing market power of large managed care firms and health plans. These firms purchase medical care services from health care professionals for resale to employers. Many of these entities have become so large that they can dictate contract terms to health care professionals, including price and quality. Their growing market dominance, proponents say, is a problem that requires legislation to "level the playing field." A countervailing power response is necessary to permit providers to negotiate contract terms relating to better quality and more appropriate price for medical care services.

Opponents contend that the legislation is not needed because existing legal mechanisms allow professionals to negotiate collectively (Noether, 1999). In addition, they believe, consolidation in the health insurance market is not a problem. Despite well-publicized mergers and acquisitions, they argue that the industry is "very competitive" making it "improbable if not impossible, [for large players] ... to exert significant market power in ... negotiations with health care providers" (Noether, 1999). Finally and most important, they contend that the proposed legislation will raise health care costs by a large amount (Reinhardt, 1999; Noether, 1999). The single empirical study of the potential impact of the negotiating legislation cited by opponents (the "Charles River Study") concludes that such a law would raise health care costs by $35 to $80 billion annually. This would come about because all physicians would join negotiating groups - and the negotiating groups would compel managed care firms and health insurers to give-

---

[1] Never defined by the Charles River study. Using the terms as described by the Health Care Financing Administration they include registered and practical nurses in private duty, podiatrists, optometrists, physical therapists, clinical psychologists, chiropractors, naturopaths and Christian Science practitioners. Many of these professionals are not paid by managed care firms.

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back half to all of the savings that opponents estimate managed care has produced over the past fifteen years.

Proponents of this bill cite quality concerns as the primary need for the bill. However, it is not always possible to separate quality from cost. Legislation that provides quality improvements at an excessive cost is not an effective policy intervention. Accordingly, this study addresses the concerns raised by the opponents - with particular emphasis on the potential cost of the legislation. The first part reviews the findings and conclusions of the Charles River Study. Many of the assumptions on which the Charles River Study is based are questionable. The methodology used to reach findings and conclusions could be improved.

The second part of the study contains a more reasoned approach to estimation of the costs and benefits of the Campbell Bill. Included is a more specific calculation of costs based on a time series estimation of managed care cost savings and a more reasonable consideration of the physicians that would join negotiating units under the Campbell bill. Using these refinements, the increased costs of the proposed legislation attributable to physician fees would be $71 to $814 million. The increase in fees paid to other professionals would not be substantial.

Part three of the study considers several of the legal and economic concerns raised by the Charles River Study including adequacy of current collective negotiating laws and the competitive level of managed care markets. The proposed legislation is needed because existing laws are not adequate to "level the playing field" when providers attempt to negotiate with large managed care firms. Consolidation in the health insurance industry has produced dominant firms in many markets. These dominant firms currently dictate quality and price to health care providers. In these markets entry is neither easy nor effective to generate competition for the purchase of provider services.

Part four contains an analysis of the potential benefits of the Campbell Bill. The benefits of the legislation have been largely ignored by opponents. In addition to other benefits, the legislation has the potential to achieve efficiency gains through the reduction of inappropriate pricing of provider services. Part four discusses the potential magnitude of such gains.

Projection of the potential cost of the legislation is, like any forecast, subject to a host of unknown factors and the accuracy of a range of assumptions. Obviously, only actual experience with the effect of this type of legislation will yield accurate cost effects. For this reason, a number of advocates of the legislation have recommended use of a "sunset" provision that would permit Congress to consider the full cost impact of the legislation before reauthorizing it. A well considered sunset provision that permitted collection of information about the cost and quality impact of the legislation prior to its reconsideration could address a number of concerns that attach to the adoption of this legislation based on complex economic cost forecasts.

1. The Charles River Study

The Charles River Study estimates that the Campbell Bill will increase provider costs by $35 to $85 billion annually and that health care premiums could increase by six percent to 11%. The basis for the estimate is a so-called "price effect" and a "utilization effect."

a. Price effect-managed care savings.

The fundamental premise of the Charles River Study is that large savings have been achieved by managed care. One portion of these savings is said to be "direct" in that it is attributable to managed care plans' provider payment discounts. The amount of the "direct savings" that Charles River concludes will be lost upon enactment of the Campbell Bill is $17.8 to $27.4 billion. The Charles River Study managed care discount assumptions are based on a review by the Barents Group of prior studies of managed care cost savings (Barents Group, 1998). Barents estimated that managed care fee and price discounts ranged from six percent to 15% with an "all HMO" average of 13%. Based on this, the Charles River analysis considered a range of managed care cost savings: six percent, 13%, 20% and 25%. For a number of reasons the assumptions regarding managed care savings are deeply flawed and introduce major problems into the Charles River Study.

First, the Charles River managed care savings figure is based on an estimate (by Lewin-VHI in 1992) contained in another estimate (by Barents). The resulting joint estimation error can be expected to be quite large. Further, The Lewin-VHI estimate is based on the study of discounts achieved by a single plan (Aetna) in a single year (1992). Neither the Barents Report nor the Charles River Study attempts to explain why Aetna is a representative plan or why 1992 is a representative year for managed care cost savings. To the contrary, Aetna is a large national plan and 1992 may be a year in which managed care accomplished large discounts.[2] Other plans may well have had lower levels of savings and 1992 discount levels may have eroded over time. In short, the uncritical use by Charles River of the Barents Report for its managed care cost savings produces major questions regarding the Study's validity.

Second, there appears to be little basis for Charles River's use of the 20% and 25% ranges for managed care cost savings. The Charles River Study states that more tightly managed plans produce this level of discounts but provides no citation for the statement.[3] There is no empirical evidence that managed care has produced cost savings in this range. Indeed, Congressional Budget Office studies (reviewed by Barents but ignored by Charles River) estimated that cost savings of 15% might be available for

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[2] Indeed, most of the studies finding large managed care discounts were conducted at a time of substantially lower managed care penetration. Providers were much more likely to offer larger discounts when managed care penetration was lower than they are in mature managed care markets.

[3] The Barents Report relied on heavily by the Charles River Study found discounts of six percent for POS and PPO plans, 15% for IPAs and eight percent for group and staff model HMOs (Barents Group, 1998). The 25% figure appears to have been derived from RAND studies in the mid-1980s. The RAND study was an experiment. Not only has it been criticized, but it is now dated. More reliable cost savings figures are available.

traditional health insurance and Medicare as well as cost savings of 7.5% for Medicaid (Emmons, 1995).

Third, the 13% discount figure used by the Charles River Study is attributable to Barents' "all HMO" average discount. This figure was derived by Barents as an average for IPA and staff HMOs, **not** for all managed care as assumed by the Charles River Study. Indeed discount figures used by Barents for POS and PPO plans are available and the Charles River study could have generated a weighted average based on relative enrollments given that it did so for the utilization effect (discussed below). Barents estimated them to be six percent. Charles River could have weighted the six percent and 13% figures for managed care enrollment to develop a more realistic estimate of managed care cost savings but failed to do so.

Fourth, the Charles River Study assumes that all cost discounts have been passed on to employers and consumers in the form of premium and charge savings so that managed care cost reductions produce a one-to-one reduction in national health expenditures. This assumption is also flawed. Not all provider discounts have been passed through by health plans. The high costs of utilization review and management have increased administrative costs of many managed care firms relative to fee for service. Some firms retain the advantages of deep provider discounts by increasing their profit structures, due in part to pressure from investors in the stock market. For example, in 1998 Keystone Health Plan East reported net income (after taxes) of $62.9 million (Hospital and Health System Association of Pennsylvania, 1999). Over the past eight years Keystone East's profit structure has steadily improved. Moreover, there has been a well-reported wave of merger and acquisition activity by managed care plans. As an example, Aetna has acquired U.S. Healthcare and Aetna-U.S. has acquired Prudential. The costs associated with the mergers and acquisitions have been substantial and in many cases have offset the cost savings attributable to provider discounts.[4] A portion of the cost discounts may have been used to pay for increased technology costs. For example, a wave of expensive newer drugs has permitted physicians to deal with a range of conditions including mental health, cholesterol, allergies and arthritis. The payments associated with these drugs have increased the cost structures of managed care firms.

Fifth, the Charles River Study also assumes a static world where quantity and quality do not respond to price. However, a substantial number of health economics studies show that the quantity and quality are indeed responsive to price change (Phelps, 1997). Again, the distorted assumptions in the Charles River Study undermine its conclusions.

Sixth, the Charles River Study includes what it considers to be a small "spillover" effect.[5] However, the effect is quite substantial, $1.2 to $1.8 billion. Charles River assumes that increases in amounts paid by managed care plans will also increase fees paid by fee for service plans in the range of zero to ten percent. Actually, since the range used by Charles River is $1.2 to $1.8 billion, it could not have used a zero percent spillover percentage. The basis for calculation of the spillover effect is not explained in

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[4] Indeed, there has been a substantial amount of international merger and acquisition activity that has served to remove capital from the U.S. health system.

[5] Increases in fee for service fees associated with increases in managed care payments.

the study. However, the Barents Report totally discounted the existence of a spillover effect based on the finding that empirical "estimates are wide-ranging and many of the empirical estimates are small" and that estimates were based on past HMO penetration rates.[6] Moreover, it is possible that many providers increased fees in response to managed care discounts so that an increase in amounts paid by managed care firms might actually reduce fee levels for traditional indemnity patients. In essence, inclusion of any "spillover" effect in the Charles River calculations is questionable at best.

Finally, while the Barents Report considers a number of studies of reported managed care cost savings, most of the research reviewed related primarily to **hospital** payment discounts, not physician and other provider discounts. The study of Aetna price discounts by Lewin-VHI included hospital costs. Many studies of the impact of managed care found large levels of inefficiency in the use of hospital services prior to the growth of managed care over the past 15 years - and that managed care was able to make substantial reductions in the price and use of hospital services (Luft, 1981). There are no studies that find equivalent inefficiencies for physician and other professional services. Indeed, reduced hospital use under managed care may also be associated with increased use (and higher prices) for outpatient services (including physician visits). Thus, while there may be hospital cost discounts in the range reported by Barents, physician and provider discount levels may well be substantially lower. Use of a universal cost discount figure by Charles River may well overstate the level of discounts attributable to services provided by physicians and other providers.

In short, the managed care cost savings assumptions on which the entire Charles River Study is based are overstated and flawed.[7]

b. Utilization effect - managed care reductions

In addition to the "direct" price effect, the Charles River Study estimates large managed care savings (eight percent to 22%) attributable to "utilization" effects. This includes a weighted average savings of 6.8% attributable to utilization management and an across the board estimate of four percent for utilization review.[8] Using the Barents estimate that 60% to 90% of utilization savings would be lost if the proposed legislation were enacted, the Charles River Study estimates that the cost of the Campbell Bill attributable to reduced utilization review and management will be $14.8 to $32 billion, three percent to 9.7 % of total personal health care expenditures. The Charles River Study's utilization cost estimates are even more flawed than its estimate of direct discount savings loss.

First, the utilization effect figures contained in the Barents Report "pick and choose" among figures contained in the Lewin-VHI study of Aetna, Congressional Budget Office studies and a 1997 PPO study. The Barents Report includes both cost

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[6] At a minimum, the Charles River Study picks and chooses from the Barents Report in an unscientific manner. Where discounts contained in Barents are high the Charles River Study adopts them. Where the discounts are low the Charles River Study ignores them or uses other figures.

[7] Indeed, the Charles River Study totally ignores figures contained in a report by The Lewin Group that show total 1996 managed care savings of $23.8 to $37.4 billion, 7.5% to 11.7% of private insurance costs (Shiels, 1997).

[8] Managed care firms' ability to reduce medical care use.

savings attributable to utilization management and across the board cost savings attributable to utilization review. The Barents Report findings are not based on a systematic empirical study of savings attributable to reductions in utilization. Uncritical use of the Barents findings by Charles River produces substantial distortions in study results.

Second, the Barents findings incorporate a four percent across the board utilization review reduction based on studies that show managed fee for service (based on utilization review) reduces costs over traditional indemnity by four percent. Barents then estimates reduced managed care use of four percent (for PPOs and POSs) to 18% (for group / staff HMOs) with a weighted average (based on use) of 6.8%. However, adding the 6.8% and 4.0% may well "double count" reduced utilization attributable to managed care activities.[9] Once again Charles River incorporates these figures in its study without critical analysis.

Third, the Barents study concludes that utilization cost savings apply across the board to all types of health plans including Medicare and Medicaid plans. This may well be unrealistic since utilization reduction incentives under Medicare and Medicaid may be quite different. The Charles River Study fails to evaluate the reasonableness of this assumption.

Fourth, the Barents Report uses a panel of experts to conclude that 60% to 90% of utilization savings will be lost upon the enactment of negotiating legislation. These estimates are not based on any empirical evidence - only on opinion. Moreover, they assume that almost all providers will join negotiating groups and that such groups will be totally successful in negotiating with large managed care plans. As discussed below, the reasonableness of this assumption is open to question.

Fifth, the Charles River Study assumes that the average utilization reductions contained in the Barents Report apply to all professional services including physicians, dentists and other professionals. In actuality, as with direct savings, utilization reductions may have been much greater for hospitals than for physicians, dentists and other professionals. Use of an average utilization reduction may provide substantial distortions in cost estimations of the effect of negotiating legislation on physicians.

In short, as was the case with "price effect" cost savings, the Charles River Study's findings that lost utilization effect cost savings will be attributable to provider negotiation legislation are based on unquestioned and unwarranted assumptions. Recently United Health Care dropped its use of utilization review controls, stating that their cost did not justify any savings produced by use of this device (Fong, 1999). If, as Charles River assumes, utilization review produces a four percent cost savings it is unlikely that United would have discontinued this practice. To give its competitors a four percent cost advantage would be self-defeating. There could be no more effective rebuttal of the Charles River Study assumptions regarding managed care cost savings from utilization review and management. Use of such assumptions clearly distorts study results.

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[9] Indeed, plans with rigid utilization review may not produce as much in the way of utilization savings as plans without strict UR.

c. Double-counting

The Charles River study independently computes a managed care discount "price effect" and a managed care "utilization effect." Such methodology may well overstate the impact of both discounts and utilization review and management. Price and quantity are obviously interrelated. The Charles River Study fails to consider the interrelationship, particularly the direction and level. For example, improvements in utilization review procedures may reduce the amount of provider time spent in dealing with payment matters. This may reduce the price of professional services rather than (as assumed by Charles River) increasing them. Increased provider prices may increase the amount of services that professionals are willing to offer. This may increase access to health care by the uninsured and by the under-insured. The simplistic method of computing managed care cost savings contained in the Charles River Study suggest the existence of a range of problems that the Study fails to recognize or correct.

d. Professionals' participation in negotiating units

The Charles River Study calculates a managed care savings percentage attributable to provider discounts and a percentage attributable to utilization reductions. The study then concludes that half to all of the discounts and 60% to 90% of the utilization savings will be "given back" in provider negotiations with managed care firms. This assumes that all health care professionals will join negotiating units and that these units will break even or prevail in negotiations with large managed care firms and health care insurers. Both of these assumptions are questionable.

As an initial matter, it is very unlikely that most health care professionals will join negotiating units. The Bureau of Labor Statistics reports that 13.9% of all wage and salary workers and 9.5% of private industry workers were members of unions in 1998 (Bureau of Labor Statistics, 1999). Some 37.5% of government workers belonged to unions in 1999, far less than all employees. As discussed in part two, substantial portions of physicians engaged in patient care are employees, thus they would not join negotiating units under the Campbell bill. Physicians engaged in graduate medical education (interns and residents), those employed by the federal, state and local government (including the Department of Defense and the Veterans Administration), professionals employed by medical schools, staff members of HMOs and professionals employed in the practices of other professionals would not join negotiating units under the Campbell bill. Further, given the individualistic orientation of most physicians, even among private practitioners, substantial negotiation unit membership is unlikely.

The Charles River Study's implicit assumption that all physicians engaged in patient care will join negotiation units if the Campbell bill is enacted is particularly misplaced.

e. Savings "give-backs"

The assumption that half to all of managed care cost savings will be "given back" in negotiations with managed care plans is equally misplaced. The provider negotiating units that are at the core of the Campbell Bill will be faced with the task of negotiating with large national and local managed care firms. For example, the merged Aetna-U.S.-

Prudential entity will have more than 22 million members (Anderson, 1999).[10] As shown in Table 1, seven large for profit (generally publicly traded) managed care firms (Aetna, Cigna, United, Foundation, Pacificare, Wellpoint and Humana) have nearly 68 million members. These firms have large numbers of shareholders. The shareholders and the stock market track firm operations closely. Even small changes in firm operating results such as medical loss ratios result in large changes in stock value. For such a firm to "give-back" even a small portion of managed care cost savings would seriously depress stock values which could well produce significant changes in management.[11] Given these incentives it is unlikely that publicly traded HMOs would yield much in negotiations with providers, even if they were organized.

Table 1
1998 Membership of Large National Managed Care Firms

HMO/ Insurer	*Members (millions)*
Aetna-U.S.-Prudential	22.4
Cigna	12.7
United Health Care	7.0
Wellpoint	6.9
Humana	6.0
Foundation Health Plans	3.0
Pacificare	3.7
Horizon	1.7
Oxford	1.7
NYLife	1.2
One Health	0.8
HlthAmerica	0.5
Maxicare	0.5
Total	68.1

Source: Corporate Internet Web Sites, January 2000 and InterStudy (1999)

[10] As used in this context, members are synonymous with covered lives.
[11] For example, the 1999 change in management of Humana as a result of stock price reductions.

Table 2
1998 Membership of Blue Cross Plans

Plan	*Members*	*Plan*	*Members*
Independence	3.9		
HMO Blue (IL)	2.9	HMO Blue	1.0
CareFirst	2.3	Blue Advantage	0.7
Alliance	2.2	Blue Choice	0.7
CA Blue Shield	2.0	Anthem	0.6
NC Blue	1.6	Blue Care (MI)	0.6
Tenn Blue	1.4	Regence	0.6
Highmark	1.1	NE PA	0.6
Capital	1.0	Blue Care	0.6
HMO Blue (Tx)	1.0	Blue Choice (NY)	0.5
		Total	25.3

Members in millions. Source: Plans' Internet Web pages and InterStudy (1999)

Large regional (often nonprofit) insurers have substantial numbers of members and market power as well. The national Blue Cross and Blue Shield Association claims that Blues' plans have 50.5 million members nationwide (Blue Cross and Blue Shield Association, 2000). Twenty of the largest Blue Cross plans (excluding Wellpoint's California and Georgia operations), each with more than 500,000 members, have a total enrollment of 25.3 million. See Table 2. Most of these firms would provide strong negotiating resistance to physician negotiating units. Other large nonprofit managed care firms can be expected to offer substantial resistance as well. For example, Kaiser Permanente has more than 8 million members. See Table 3. Collectively, more than 108 million Americans are members of large health plans. These plans have strong incentives to regain and extend any managed care discounts that they have obtained from providers. The assumption that these large firms would yield back most or all of any managed care cost savings has no basis in experience, empirical evidence or inference.

Table 3
1998 Membership of Large Nonprofit Managed Care Firms

Plan	*Members*
Kaiser	8.2
Harvard	1.2
GroupHealth	0.9
Tufts	0.7
Providence	1.0
Sloans Lake	1.5
Medica	0.8
Total	14.3

Members in millions. Source: Plans' Internet Web pages and InterStudy (1999a)

The issue of HMO and insurer power is relatively widespread. According to InterStudy data, in 1998 more than three-fourths of the Metropolitan Statistical Areas in the U.S. (82%) had at least one "dominant" HMO (a dominant HMO has a market share

greater than 33%) (InterStudy, 1999). Forty MSA markets have two dominant HMOs, automatically giving them Hirschman-Herfindah Index (HHI) levels in excess of 2000.[12] Almost half of the MSAs have an HMO with a market share of 50% or more. These MSAs have an HHI of at least 2500 and are extremely concentrated. Here the dominant HMO most certainly has power to fix premiums and provider prices. It is extremely doubtful whether provider negotiating units would prevail when dealing with these payers.

Nor is it required for HMOs to operate at this level in order to achieve economies of scale. Studies indicate that HMO economies of scale are exhausted at levels less than 100,000 members (Given, 1996; Wholey, 1996). At least 166 HMOs in the U.S. operate with more members than this (InterStudy, 1999), suggesting the presence of substantial diseconomies of scale in their operations. The sole purpose for growing HMO size would, therefore, appear to be perfection of market power. To conclude, as does the Charles River Study, that provider negotiating units would be able to out-negotiate large HMOs to compel these firms to give-back most or all managed care savings is, simply put, erroneous.[13]

Finally, the assumption that health professional negotiating units will out-negotiate HMOs assumes that large national negotiating units will form with little cost and with ease. The same assumptions were made during the late 1980s and early 1990s regarding IPAs. The difficult and troubling history of IPAs negates this assumption. Unable to control use, many IPAs suffered from high medical loss ratios.[14] Between 1988 and 1994 a number of them exited the market. Formation, operation and control of IPAs tended to be difficult and costly. Many physicians viewed them with skepticism and refused to join. Of those who joined, many lost their investment. Those groups that formed to negotiate with large health plans found such negotiations to be protracted, costly and not particularly profitable.

f. Conclusions regarding Charles River Study cost estimates

The Charles River Study estimate of the cost of provider negotiation unit legislation (the Campbell Bill) is replete with unwarranted assumptions and questionable methodology. The Charles River estimates of $17.2 to $27.4 billion in annual price effect savings from managed care and $14.8 to $32.1 billion in annual utilization effect savings are based on uncritical application of prior studies that themselves contain numerous problems and improbable assumptions. In particular, the Charles River Study assumes that the level of savings will be the same for all providers: hospitals, physicians, dentists and other health care professionals. This assumption is clearly without basis.

The independent calculation of price and utilization effects in the Charles River Study may well double-count managed care savings. Indeed, footnote 11 to the Charles River Study states (based on a Mercer/ Foster Higgins national survey) that the ratio of

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[12] This level of competition would be classified by the U.S. Justice Department as highly concentrated for purposes of evaluating the impact of a potential merger on competition (U.S. Department of Justice, 1992).

[13] Indeed, a countervailing power response to monopoly would appear to be welfare-improving (Scherer, 1990).

[14] The high medical loss ratios of IPAs also negates the cost savings findings of Lewin-VHI, Barents and Charles River.

managed care costs to traditional indemnity costs is 0.939. This suggests that managed care savings are approximately six percent. If, as suggested by the Charles River Study, managed care cost savings ranges from 21% to 47%, the cost difference between managed care and indemnity coverage would be in this range.

In addition, the Charles River Study assumes that all health care professionals will join negotiating units if the Campbell bill were enacted and that these units will compel large managed care firms to give-back half to all of managed care cost savings. Neither assumption is warranted. Many health care professionals are employees and are already able to join unions. Union participation rates for private businesses are less than ten percent. Even in the most unionized sector of the economy, government workers, participation rates are only 40%. Negotiating units under the Campbell bill will be required to bargain with large national and local managed care firms. These firms have millions of members and sufficient assets to conduct protracted and costly negotiations. Their incentive to avoid giving back cost savings will be substantial.

In short, it is highly unlikely that the cost increases the Charles River Study estimates will actually be observed following passage of the Campbell bill.

2. A more reasoned approach to estimating the cost of the Campbell bill.

Given the problems evident in the Charles River Study, what cost estimation technique will provide better answers? What is the projected cost of the physician negotiating unit legislation contained in the Campbell bill? A reasonable approach is to follow the reasoning of the Charles River Study, albeit with more appropriate assumptions regarding managed care savings, physician participation in negotiation units and the level of "give-backs" of managed care savings. Under this approach the projected cost of the Campbell bill is $71 to $814 million.

a. A refined estimate of managed care savings "give-backs"

As discussed above, the Charles River Study employs distorted and inflated estimates of managed care cost savings, assumes that all health care professionals will join negotiating units and concludes that most of the managed care cost savings will be given back as a result of negotiations between professionals and managed care plans. Use of more appropriate assumptions produces a substantial change in cost projections.

(1) Managed care savings

In order to provide a more appropriate estimate of managed care cost savings we conducted a time series analysis of costs for physician services, dental services and other professionals' services. The data for the study were taken from public information sources. Cost data were taken from the Health Care Financing Administration's report of national health expenditures for 1960 to 1997 (Health Care Financing Administration, 1999). In order to assess the impact of managed care on all expenditures for each category, public and private, we included in the analysis all expenditures for physician services, dental services and other professional care.

We used enrollment data for HMOs and PPOs as provided by the American Association of Health Plans (American Association of Health Plans, 1998). Data were available through 1996. We projected enrollment for 1997 using a simple linear growth rate. For periods earlier than 1976 we assumed that HMO enrollment was stable at the 1976 figure of six million members. Since PPOs only came into being in the early 1980s, we assumed there was essentially no PPO enrollment prior to 1984.

There has been substantial inflation in medical care costs over the past thirty years. This inflation has differed from inflation rates attributable to producers and consumers generally. The Department of Labor computes and publishes a "Consumer Price Index of Medical Care Commodities" (Bureau of Labor Statistics, 1999). We used this index to deflate expenditures for physician, dental and other professional services.

The empirical method used to assess managed care cost savings attributable to managed care was ARIMA time series analysis. ARIMA models "filter" or control for three types of trends: step processes where beginning values at a particular time are taken from ending values of the preceding time period (the "I" in ARIMA), moving average processes that show the effect of changes that die out over a shorter time (the MA in ARIMA) and autoregressive processes that reflect permanent changes to a dynamic system (the AR in ARIMA).

The first step in developing an ARIMA model is to estimate the underlying dynamic processes of the variable of interest. In this case the variables of interest were

total (deflated) national expenditures for physician services, for dental services and for other professional care. We estimated ARIMA models for each of these variables. The results for physician expenditures are contained in Exhibit 2. The first part of Exhibit 2 shows the deflated trend in physician expenditures for 1960 to 1976. The second part shows the basic Box Jenkins model for physician expenditures. The model is differenced and employs an AR(1) process. Physician expenditures are a "step process." After differencing (to control for prior years' levels of expenditures for physician services), the AR(1) component of the model indicates that systematic impacts on physician expenditures are "permanent" at a one period lag. The basic Box Jenkins model is a good one. It has an R^2 of 0.99[15], a statistically significant and stable coefficient for the AR(1) process (between -1 and +1) and an autocorrelation Q statistic at lag 24 (here, 9.7) that indicates that the model residuals are "white noise" (Q<32).

To evaluate the impact of managed care[16] we combined HMO and PPO membership to create a new value called managed care membership (MC).[17] ARIMA models assess impact by incorporating a "transfer function." In our study we used managed care membership as a transfer function to assess the impact of managed care on physician expenditures. As shown in the third part of Exhibit 2, the resulting differenced AR(1) model with a five period lag for managed care membership, MC(5), meets the conditions for a good ARIMA model. The model's R^2 is high, the AR coefficient is stable and statistically significant, the coefficient for managed care is statistically significant and the autocorrelation function Q statistic at lag 24 (10.2) indicates that the residuals are white noise. Managed care showed the most significant and substantial impact at a five period lag.

Applying the results of this model to projections of deflated physician expenditures in 2000, managed care would be expected to produce a savings of 5.9% in projected physician expenditures. This estimate is consistent with the low end of the range of savings estimates used in the Charles River Study (six percent) and is close to the low end of The Lewin Group's estimate of managed care cost savings (7.5%). Reversing the medical price deflator produces estimates of total physician expenditures for 2000 of $240 billion.[18] Projected 2000 managed care savings attributable to physician expenditures would, therefore, be $14.2 billion.

We also performed a time series analysis of deflated expenditures for dental services and the services of other professionals. The coefficients for managed care in these models were small and not statistically significant. From this, we cannot conclude that managed care had any significant impact on expenditures for dental services or for

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[15] High R^2 values are expected for ARIMA models.

[16] There are causality issues related to any economic model. By virtue of their lag structures, ARIMA models have fewer causality issues than other econometric methods. However, the relationship between managed care and physician expenditures is merely a statistical association and may not be causal in nature.

[17] The impact of managed care is not a dichotomous concept. Managed care has grown over time - it was not present one year and absent the next. The best indicator of the role of managed care is the number of covered lives enrolled in managed care plans - or the proportion of total expenditures that are attributable to managed care plans. Because we were able to locate data on the former measure of managed care penetration, we used it for this study.

[18] HCFA estimates put 2000 physician expenditures at $258 billion (Health Care Financing Administration, 2000).

other professional care. This is consistent with the observation that managed care does not substantially impact the markets for dental care and for other professional services.[19]

In short, we estimate that the 2000 physician expenditure savings related to managed care is 5.9%. Because we modeled the impact of managed care on total physician expenditures our projection includes the full range of managed care's impact including price effects and utilization effects (reduced amounts paid for total physician care), public and private expenditures and amounts paid under fee for service as well as managed care plans. It is this level of savings that we use to consider the potential impact of the Campbell bill.

(2) Physician participation in negotiating units

As discussed above, the Charles River Study assumed that all patient care physicians would join negotiating units. This assumption ignores the fact a great number of physicians would not join negotiating groups under the Campbell bill. As shown in Table 4, there are a substantial number of physicians engaged in patient care (47.6%) who are employed physicians (Emmons & Kletke, 1999). These physicians are currently eligible to negotiate with their employers in collective bargaining units under the labor exception to the antitrust laws contained in the National Labor Relations Act (NLRA). Accordingly, we estimate that 52.4% of physicians who are engaged in patient care are candidates to join physician negotiating units under the Campbell bill (we define them as "eligible").

Among the physicians who are candidates to join, what is likely to be their actual participation rate? The Charles River Study assumed that all physicians would participate, ignoring negotiating unit participation rates in all other sectors of the economy. As described above, in 1998 only 9.5% of private industry workers, 33.8% of federal government workers, 27.8% of state government workers and 43.8% of local government workers who were candidates to join negotiating units elected to do so (Bureau of Labor Statistics, 1999). Using the endpoints of this range, 5.0% (52.4% * 9.5*) to 22.9% (52.4% * 43.8%) of physicians engaged in patient care are likely to join physician negotiating units under the Campbell bill.

[19] Substantial amounts of care for these services are paid out of pocket. To the extent that managed care is involved in dental care, it often operates as a payment mechanism rather than as a cost control or discount device.

Table 4
Patient Care Physicians Likely to Join Negotiating Units

Types of physicians	Number	Percent
All patient care physicians	620,631	100.0%
Employed physicians		
Medical practices	47,731	
Graduate medical education	95,808	
Medical school faculty	36,797	
Hospitals	32,720	
Federal government	16,947	
HMOs	9,925	
Ambulatory care	6,500	
Other employers	35,588	
State & local government	13,614	
Total employed	295,630	47.6%
Negotiation unit eligible	325,001	52.4%

Source: Emmons & Kletke (1999)

Physicians are engaged in a private enterprise. Moreover, most self-employed physicians are, by their makeup, "independent" in their business and medical practice orientation. By virtue of this we would expect negotiation unit participation to be at or below the low end (private industry) of the range, rather than at the level of government workers' negotiating unit participation. In addition, physicians who practice in areas with less managed care market power and higher fee structures are also unlikely to participate in negotiating units. Again, we would expect negotiating unit participation to tend toward the lower rather than the higher end of the projected participation range. Finally, physicians who are patient care oriented or service oriented as opposed to business oriented may be less likely to join negotiating units. Once again, we would expect negotiation unit participation rates to be at or lower than 5.0%. To conclude, as does the Charles River Study, that physician negotiating unit participation will include 100% of physicians engaged in patient care simply ignores the reality of physician practice, the number of employed physicians and the general disinclination of Americans workers to join negotiating units.

(3) Managed care firms and insurers' willingness to "give-back" savings

The Charles River Study assumed that half to all of managed care savings would be "given back" when professional negotiating units bargain with managed care firms and health care insurers. This level of give-backs is most unlikely to occur. As discussed in part one above, more than 108 million Americans are members of (or insured by) "large" national and regional managed care firms and health insurers. These firms continue to

enjoy substantial growth.[21] Since many managed care markets are now mature, this growth is often at the expense of other smaller HMOs. These large firms can be expected to use substantial resources to avoid give-backs of managed care savings. The incentives that they have to hold the line on health care costs, both in terms of shareholder profit and the need to maintain premium levels charged to employers, suggests that the Charles River give-back range is exaggerated.

Further, InterStudy data show that there is a "dominant" managed care firm in 81% of the MSA markets in the U.S. (InterStudy, 1999). InterStudy defines a dominant HMO as one with a market share in excess of 33%. Physician negotiation units are unlikely to have much of an advantage, if any, in their negotiations with dominant managed care firms. In half of the MSA markets a managed care firm holds at least a 50% market share. Negotiations with such firms will be even more difficult.

Accordingly, for the purposes of this study we assume that savings give-backs, if any, will range from 10% to 25% of managed care savings. Because managed care firms and insurers are so large, have substantial amounts of knowledge regarding provider practice patterns and have strong financial incentives to avoid give-backs, negotiating unit legislation will probably produce give-backs substantially below this range. We have used a generous range for give-backs to strengthen the credibility of the study.

(4) Calculation of costs using more appropriate assumptions

Having developed a more-reasoned set of assumptions regarding managed care cost savings attributable to total national expenditures for physician services, portions of patient care physicians who are eligible for and likely to join negotiation units and a more considered give-back range, calculation of increased costs attributable to the negotiating unit legislation is relatively straightforward. As shown in Table 5, given total annual managed care savings attributable to payment for physician services of $14.2 billion, negotiation unit physician participation of 5.0% to 22.9% of all patient care physicians (9.5% to 43.8% of eligible physicians) and a give-back rate of 10% to 25%, the projected cost of the Campbell bill is $71 to $814 million.

Table 5
Cost of Negotiation Unit Legislation

Savings[1]	Likely to join %[2]	Give-back (GBR)	Cost[1,3]
14.2	5.0%	10%	0.0706
14.2	22.9%	25%	0.8142

[1]Billions
[2]Eligible * Likely to join
[3]Savings*Member%*GBR

HCFA projects total payment for physician services in 2000 to be $258.7 billion (Health Care Financing Administration, 2000). If physician negotiation unit legislation raises costs by $0.07 to $0.8 billion, it will increase projected physician expenditures by

[21] See, for example, the discussion of Blue Cross plans' growth at the Blue Cross and Blue Shield Association web site (Blue Cross and Blue Shield Association, 2000). See also, web sites for California Blue Shield (Blue Shield of California, 2000) and Independence Blue Cross (Independence Blue Cross, 2000).

0.03% to 0.3%. This study projects 2000 physician expenditures at $240 billion. Increased costs of $0.07 to $0.8 billion will increase projected expenditures by 0.03% to 0.34%. HCFA projects total national health expenditures of $1316 billion for 2000. The projected cost increases attributable to the Campbell bill are 0.005% to 0.06% of national health expenditures.

(5) Comparison of Charles River Study with Foreman Study

There is a substantial difference between the Charles River Study projections of the cost of the Campbell bill and the projections contained in this study. Charles River projects added costs of $30 to $85 billion. We project costs of $0.7 to $0.8 billion. What are the reasons for the difference?

As shown in Table 6, our study evaluates the impact of the Campbell bill on physician expenditures because our models for the impact of managed care on expenditures for dental services and other professionals' services found no significant effect. The Charles River Study assumed that the managed care savings rate it took from the hospital and physician literature applied to dentists and other professionals as well. This difference makes projected costs in the Charles River Study 1.5 times higher .

Table 6
Comparison of Charles River Study and Foreman Study of Campbell Bill Costs

Type	Foreman		ChasRiver			Multiple
	%	amount	%		amount	
Managed Care Savings	physicians only		all professionals			1.5
Price effect			6-25% of 80%	4.8%-20%	16.6-25.6	
Spillover-price			7-10% of 20%	1%-2%	1.2-1.8	
Utilization effect			8-22% of 80%	6.4-17.6%	14.8-32.1	
Utilization spillover			11% of 80%	8.80%	20.5	
Total MC Savings	5.90%	14.2		21%-48.4%	35-80	3 to 8
Physician Eligibility	52.4%		100%			20
Physicians joining	9.5%-43.8%		100%			2 to 10
Give-back rate	10-25%		50-100%			2 to 10
Total		0.07-0.8			35-80	200-1000

Collectively, the Charles River Study assumes managed care cost savings rates of 21% to 48.4%. See Table 6. This is substantially higher than the 5.9% managed care savings rate generated by the ARIMA models used in this study. The Charles River figures are based on the highest available savings estimates and ignore lower savings

estimates published in a number of other studies. Moreover, the four categories of savings estimated by Charles River provide for substantial double counting. Some savings estimates are unsupported by any empirical evidence. To use these figures Charles River ignored a Lewin report that found managed care reduced premiums for private insurance by 7.5% to 11%.

Also as shown in Table 6, the Charles River Study assumes that provider negotiating units will compel half to all of managed care savings to be "given back." This assumes that all provider negotiating units will break even or totally prevail in their negotiations with large national and regional managed care firms that hold substantial market power and have strong financial incentives to resist the negotiating pressures of the negotiating units. The Charles River give-back assumptions inflate cost findings by two to ten times those generated in our study.

Collectively, the cost findings of the Charles River Study that the Campbell bill will raise year 2000 physician expenditures by $35 to $80 billion are approximately 58 times greater than the $71 to $814 million in costs estimated by our study. The break downs in Table 6 show how this difference is generated. By and large the difference is attributable to a series of assumptions by Charles River that overestimate the impact of managed care and provider expenditures and overestimate physicians' probable response to the proposed legislation. The impact of the failure of these assumptions is joint, not several and generates a substantial overestimation of the impact of the Campbell bill.

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[22] Given HMO growth from 1997 to 1998, some of the new members were not members for all of 1998.

3. Current antitrust law does not permit effective physician negotiating units.

The Charles River Study claims that current antitrust law permits formation and operation of effective provider negotiating units. The main basis for this contention is the 1996 Federal Trade Commission and Department of Justice *Statements of Antitrust Enforcement Policy in Health Care* (Federal Trade Commission and U.S. Department of Justice, 1996). These Statements permit physicians to negotiate collectively if they form a network and substantially integrate their practices and/or share substantial financial risk. These networks are limited to 20% of the physicians in a market if they are exclusive and 30% if they are non-exclusive. There are significant barriers to forming networks. Formation of networks capable of assuming substantial financial risk and integrating multiple independent practices are major undertakings that require significant expertise and financial capital not readily available to many independent practitioners.

The Charles River Study also argues that Justice and the FTC rarely prosecute physician network joint ventures, that it is easy to obtain advisory opinions regarding joint ventures, (citing no data or studies at all) that competition among health plans is intense and that in most markets concentration is low, that formation of cartels by managed care plans would be unsuccessful, that antitrust laws are applied to health plans, that physicians are continuing to join larger groups and that bilateral monopoly would lead to better outcomes. None of these arguments is based on facts or on published studies. Most of it is merely the unsupported opinion of the Study's author.

First, the contention that competition among health plans is intense and that in most markets concentration is low simply ignores the facts underlying the current managed care environment. Leading health economists are concerned about growing concentration in managed care markets (Gaynor, 1999; Haas-Wilson, 1998; Pauly, 1998). InterStudy data show that growing concentration in managed care markets is clearly a problem. 280 of the 316 MSA markets in the U.S. are *highly concentrated* using the InterStudy analogue of the HHI, the InterStudy Index of Competition (InterStudy, 1999). 259 of 316 MSAs have at least one dominant HMO (one with a market share greater than 33%) (InterStudy, 1999). 151 of the 316 MSAs have an HMO with at least a 50% market share. These MSAs have an HHI of at least 2500 and an Index of Competition at 0.75 or lower, making them highly concentrated as well. 40 markets have two dominant HMOs (InterStudy, 1999) automatically giving them HHI levels in excess of 2000, making them *highly* concentrated without reference to any other activity. Not only are these markets concentrated, concentration has been growing over time. There is evidence of exit from concentrated markets. Competition among health plans is not, as a general rule, intense and it has waned. Moreover, the safe-harbor provisions of the FTC and DOJ Statements are insufficient to deal with the current level of managed care firm concentration. Non-exclusive physician negotiating unit joint ventures that could form to balance the market power of dominant HMOs (a 33% market share) in 259 of the 316 MSAs would be outside of the safe harbor provisions in the Statements. Physician negotiating units that form at a level to deal with the firms that hold 50% of the market (as is the case in 151 of 316 MSAs) would be so far outside the safe harbor provisions that they would most likely be prosecuted by the FTC and the DOJ and would be subject to private antitrust

suits. In short, current antitrust safe harbor provisions do *not* give physicians enough latitude to deal with the managed care market concentration problem.

Second, the position that any level of collective physician action is appropriate since the FTC and DOJ rarely prosecute physician joint ventures also fails the reality test. Collective physician negotiating activity absent substantial integration or sharing of substantial financial risk clearly violates the Sherman Act barring contracts, combinations and conspiracies in restraint of trade. (15 U.S.C. section 1). The FTC and DOJ do in fact investigate and prosecute physician joint ventures. In 1998 the formation of physician unions in Delaware and the Philadelphia areas became the subject of a well-publicized DOJ investigation. The mere fact of an investigation can be chilling to physicians. The time, expense and notoriety involved in a prosecution can be a substantial detriment to the formation of physician negotiating units. The mere threat of prosecution can be a substantial impediment. Moreover, the Statements only apply to FTC and DOJ enforcement policy. Private parties (managed care firms) can successfully bring a civil antitrust action (including a claim for treble damages) if physicians attempt to negotiate collectively. In short, to suggest that providers (as the Charles River Study would urge) should rely upon prosecutorial discretion to avoid responsibility for violating the antitrust law rather than amending the law itself, is an inappropriate basis to formulate public policy.

Third, the statement that the problem of managed care firm concentration will go away because many physicians are joining large groups anyway ignores current reality and fails to consider the economic effect of this trend. Even the largest of physician groups does not have nearly the size, the resources or the market share to successfully negotiate with large national and regional managed care firms with millions of members and billions of dollars in income and assets. Were such groups to form through acquisitions and mergers, the consolidations would be subject to the antitrust laws. Moreover, this position fails to address the question of whether the provision of medical care through large physician groups is economically efficient. This question has not been studied in detail. Were we to encourage the formation of massive physician practices merely to negotiate with massive managed care firms, an unintended consequence of such a public policy might be a substantial diminution in medical practice efficiency.

Fourth, the Charles River contention that antitrust enforcement regarding managed care firms is vigorous and that managed care cartels will not work is inaccurate. Antitrust enforcement at the federal level has been anything but vigorous. Although it has been presented with a substantial number of Hart Scott Rodino reviews of managed care firm mergers and acquisitions, the Department of Justice has elected to challenge only one merger. The problem that Campbell attempts to address is the growing market power of existing firms and its misuse. To date, neither the FTC nor the DOJ has brought an action to challenge misuse of any managed care firm's market power. Moreover, to claim that cartels will not work is a non sequitor. The problem lies not with collective action by managed care firms, but with the size and power of a number of existing managed care firms that are having an adverse impact on providers, on employers and on the public.

The Charles River Study's position, that there is no need for changes in the antitrust law to deal with growing concentration in managed care markets, ignores facts

regarding concentration and mistakes the current state and application of the antitrust laws.

4. Campbell bill benefits

The Charles River Study contains a discussion of the costs of the Campbell bill, with no recognition of any potential benefits. The failure to consider any benefit from the legislation is yet another indication of bias in that study. The main point of the legislation is that there is a need to "level the playing field," to remedy the situation where much smaller professional groups are required to negotiate with large managed care organizations and providers.

Indeed, many if not most of the dominant managed care plans unilaterally dictate physician contracts terms so that one might be hard-pressed to conclude that managed care firms negotiate at all (Freudenheim, 1998). For example, many of the contracts between managed care firms and physicians give the managed care firm the power to fix a fee schedule and to change it at any time (Independence Blue Cross, 1999). Given the growing market power of managed care firms, some health economists question whether this growing concentration is healthy (Gaynor & Haas-Wilson, 1999; Pauly, 1998). If large managed care firms have market power, legislation that permits a countervailing power response by allowing physicians to negotiate with such firms as a group, could have a welfare-improving effect (Scherer & Ross, 1990).

An unbiased evaluation of the impact of the Campbell bill would consider the benefits of the bill as well as its costs. Some of these benefits are not quantifiable. For example, if physician contracts were improved, more physicians might be willing to join managed care provider networks. The quality of the networks might increase. With a wider range of choice, fewer patients might go "out of network," reducing out of pocket costs to consumers. Physicians could negotiate for improvements in a range of ancillary services. For example, if physicians were able to successfully negotiate for improved drug formularies or better physician choice in drug prescribing, patient care could improve and, once again, consumers' out of pocket expenditures (related to consumer payment for non formulary drugs) might decrease. Physicians could negotiate for improved laboratory services. Again, quality could increase and out of pocket expenditures might be less. While these benefits might be hard to quantify, there are other benefits related to pricing for physician services that can be evaluated.

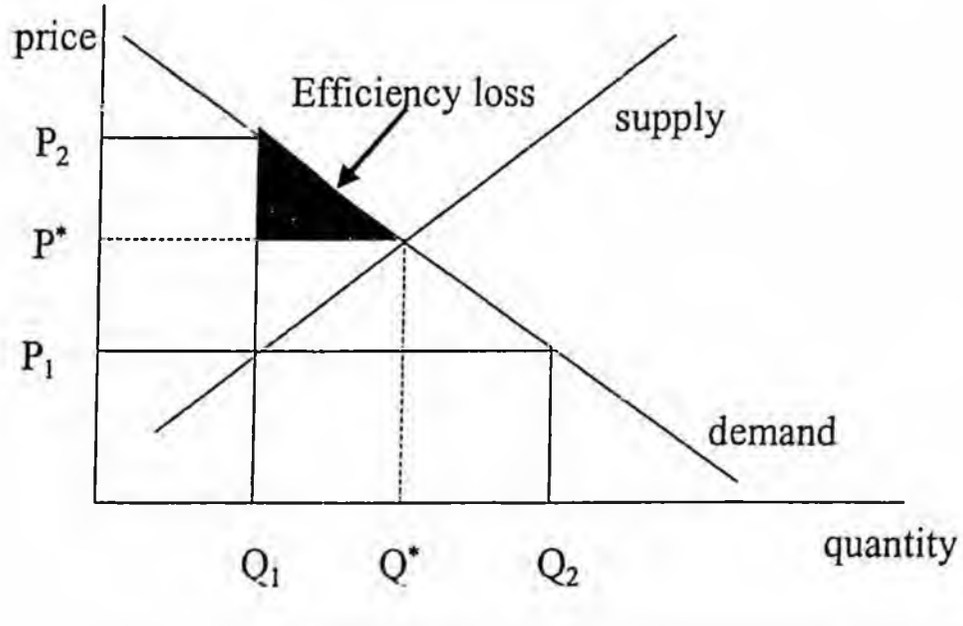
In this part of the study, we evaluate the beneficial impact of the Campbell bill strictly in terms of the negotiation of fees. Since large managed care firms and health insurers have market power over input price (medical care provider services) they can dictate fees for physician services below competitive (optimal) levels (the physicians' marginal cost of providing service including the opportunity cost of their own time). If managed care firms and health insurers fix fees below physicians' marginal cost there will be inefficiency losses often called welfare losses or deadweight loss. In this part of the study we simulate the level of welfare loss that may be attributable to managed care firm market power and consider the potential welfare gain that might be produced by the Campbell bill.

Graphically, as shown in Figure 1, there is in theory an optimal price (P^*) where marginal revenue equals marginal cost, supply and demand equate and markets clear. There is no surplus or dearth of provider services. If the managed care firm forces

physician price below P^* quantity (or quality) of services provided will drop, and there will be surplus demand (the difference between Q_2 and Q_1). Actual price (P_1) will be less than the price should be at this level of service (P_2). The efficiency loss or lost consumer surplus is represented by the shaded triangle.

Unfortunately, figures for physician practice costs and prices (by payer) are not available. As was the case in parts one and two above, in order to estimate the potential welfare loss from managed care firm pricing strategies we perform a simple simulation. Again we use InterStudy data for physician payment per member per month by HMOs in regional (MSA) markets (InterStudy, 1999). We assume that physicians in the bottom quartile receive payment below their marginal cost of providing service and that the marginal cost of providing physician services is equal to the lowest payment per member per month of the physicians in the third quartile, $39. See Exhibit 2. The average fourth quartile physician receives $31.81 per member per month, $7.19 or 18.4% below marginal cost.

Figure 1
Below Market Pricing Welfare Loss



Using estimates of welfare loss from transportation industry studies (Gomez-Ibanez, 1999) and applying them in the context of buyer market power, one measure of welfare loss is:

$$\Delta W = 0.5 * \Delta P * \Delta Q$$

where W is a welfare measure, ΔP is the difference between actual price and marginal cost price and ΔQ is the difference between. In our simulation, ΔP is $7.19 per member per month or $86.28 per member per year. If half of the number of uninsured Americans is an approximation for ΔQ on the assumption that half of the uninsured level is due to insurance premiums and half is attributable to health care insurer pricing policies, ΔQ would be 22.1 million (U.S. Department of Commerce, 1999). ΔW or the total inefficiency loss would be $1.9 billion. If the Campbell bill permitted fourth quartile physicians to eliminate below-market pricing, welfare could be improved by as much as $1.9 billion. If half of fourth quartile physicians participated in negotiation units and successfully negotiated away the below market pricing differential, nearly $1.0 billion in inefficiency losses would be eliminated.

Thus, if the Campbell bill cost is $71 to $814 million as shown above for the first estimation technique, the simulated benefits of the Campbell bill that would be produced by eliminating market distortions would balance or outweigh its costs. Moreover, the true harm addressed by the Campbell bill is not the current level of provider payments, but the imbalance that could be generated by a continuation of the current trend toward greater concentration in health care financing services markets. If current trends were to continue to the extent that ΔP and ΔQ increased, the inefficiency losses would magnify.[23] If, for example, ΔP were to double from the level included in the simulation and ΔQ increased by half, inefficiency losses would increase to $6 billion. If the Campbell bill permitted physicians to negotiate more effectively with managed care firms and health care insurers to the extent that any portion of such a loss could be avoided its benefits would far outweigh its costs.

In addition, where a monopsonist buyer also holds monopoly power in output markets (dominant managed care firms with regard to HMO, POS and PPO products may have market power), there is a second distortion. As shown in Figure 2, the monopolist will fix marginal cost equal to marginal revenue. Because the monopolist faces a downward sloping demand curve the resulting equilibrium occurs at a higher price and at a lower output quantity than would be the case in a competitive setting (the firm fixes price where supply equals demand). Thus, both the input (factor) market and the output market operate with price and quantity distortions (Layard and Walters 1979).[24] If large managed care firms hold and exercise monopoly and monopsony power, the potential benefit from enactment of the Campbell bill could be substantially greater than the input factor deadweight loss estimated above.

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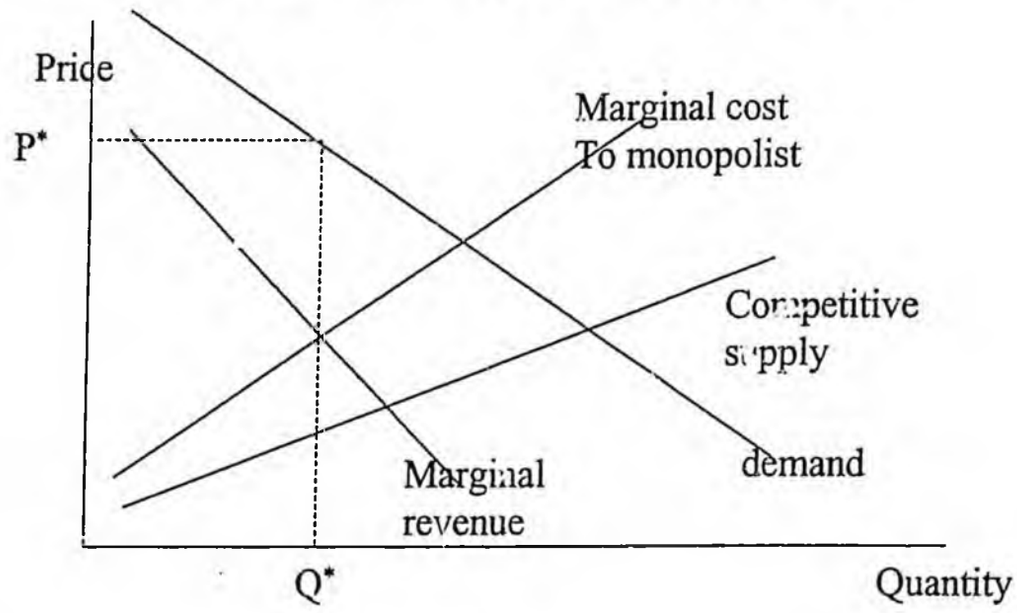
[23] This is not an unreasonable concern. For example, in the summer of 1998 Independence Blue Cross announced unilateral reductions of physician fee payment schedules - to 80% of amounts paid by Medicare. These payment levels may have been 20% to 30% below market. Given IBC's input price advantage, in order to compete other providers would have to follow suit. In this sense bad can be said to drive out good.

[24] If demand also relates to quality, quality demanded by the monopsonist and supplied by the monopolist will also be lower than in a competitive equilibrium.

Figure 2
The Monopolist in the Output Market



5. Conclusion.

The Campbell bill has been introduced to deal with concerns about the growing market power of large managed care firms and health insurers. The bill's proponents are attempting to permit physicians and other health care professionals to use countervailing power to negotiate better contracts with managed care payers. Many of these entities are so large that they dictate contract terms. The bill would help to prevent inefficient pricing by managed care payers who can now unilaterally fix provider fees. Using inflated cost projections provided by a Charles River Study, opponents of the legislation argue that the bill will cost too much, in the range of $35 to $80 billion. However, these estimates assume that price discounts and utilization reductions for all health care professionals are the same, use inordinately high estimates for managed care cost savings, assume that all providers will join negotiating units, and that such units will compel large regional and national managed care firms to give-back all of the savings that they have obtained over time. The Charles River Study ignores any benefit whatsoever that may be produced by the legislation.

A more considered estimate of the cost of the Campbell bill is $71 to $814 million. Moreover, a simulation of benefits of the Campbell bill produces current benefits of $1.0 to $1.9 billion by eliminating distortions related to under market pricing. Therefore, the legislation has the potential to produce greater future benefits than its costs if the trend toward consolidation of managed care firms and unilateral reductions in physician fees continues unabated. If leveling the playing field is a genuine policy concern, the benefits of the Campbell bill may well outweigh its costs.

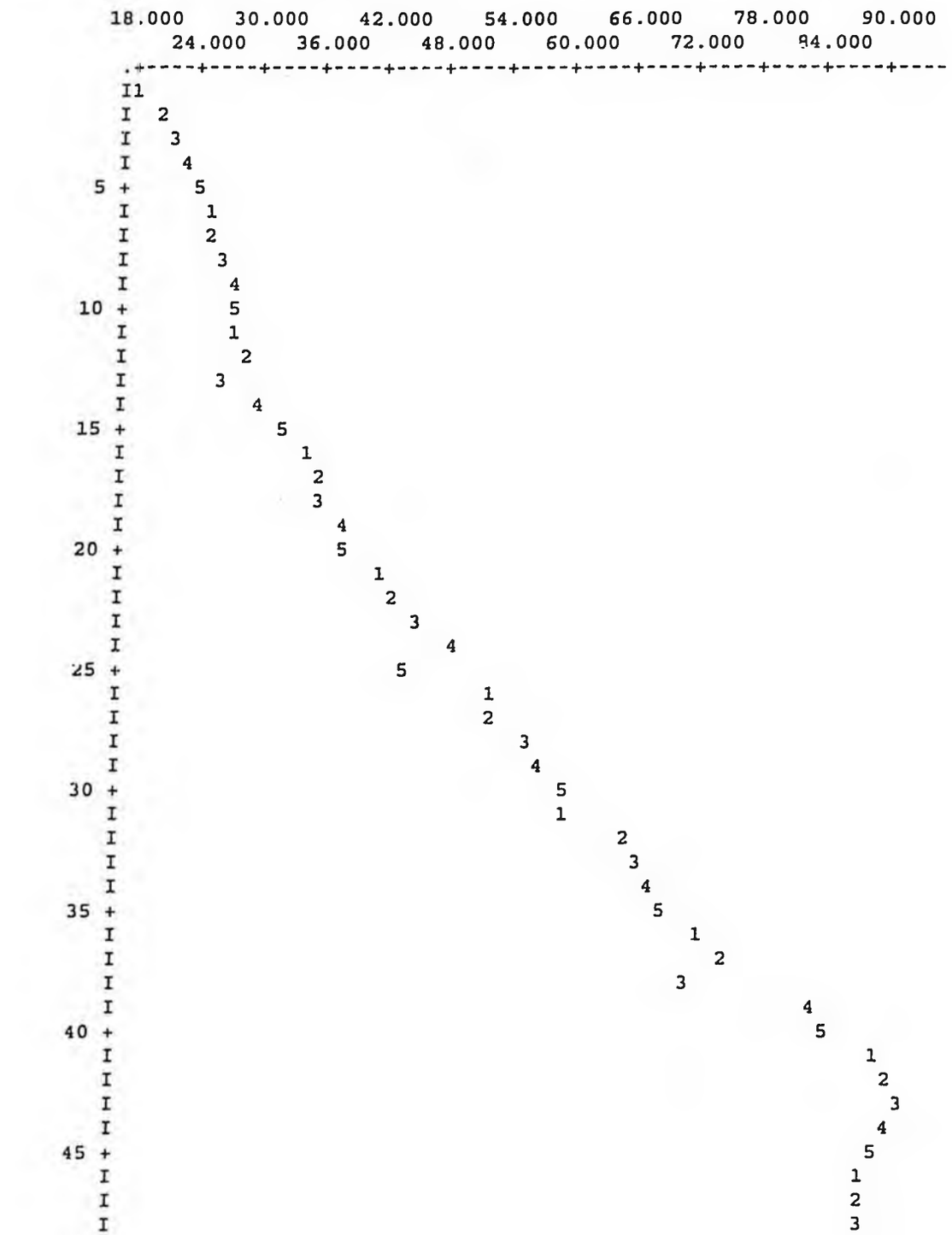
Exhibit 1
Study Data

Year	Physician Expends	Deflated Physician	Dental Expends	Other Prof Expends	HMO Members	PPO Members	MC Members	Mprice Index
1960	5283	28.16	1963	604	6.0	0.0	6.0	22.3
1961	5517	28.96	2079	632	6.0	0.0	6.0	22.9
1962	5909	26.72	2198	666	6.0	0.0	6.0	23.5
1963	6658	29.47	2344	705	6.0	0.0	6.0	24.1
1964	7706	32.09	2589	769	6.0	0.0	6.0	24.7
1965	8191	34.72	2793	865	6.0	0.0	6.0	25.2
1966	8807	35.70	2961	955	6.0	0.0	6.0	26.3
1967	9867	36.03	3409	1060	6.0	0.0	6.0	28.2
1968	10754	38.66	3664	1140	6.0	0.0	6.0	29.9
1969	12059	38.81	4174	1252	6.0	0.0	6.0	31.9
1970	13579	42.06	4669	1406	6.0	0.0	6.0	34.0
1971	15033	43.77	5181	1601	6.0	0.0	6.0	36.1
1972	16656	45.84	5516	1847	6.0	0.0	6.0	37.3
1973	18417	48.97	6323	2103	6.0	0.0	6.0	38.8
1974	20974	44.81	7076	2380	6.0	0.0	6.0	42.4
1975	23909	52.42	7956	2730	6.0	0.0	6.0	47.5
1976	27101	53.08	8972	3216	6.0	0.0	6.0	52.0
1977	31387	55.96	10055	3793	6.3	0.0	6.3	57.0
1978	33810	57.93	10957	4518	7.5	0.0	7.5	61.8
1979	38814	60.15	11893	5464	8.2	0.0	8.2	67.5
1980	45232	60.35	13323	6352	9.1	0.0	9.1	74.9
1981	52164	66.10	15698	8180	10.2	0.0	10.2	82.9
1982	57692	66.81	16953	9423	10.8	0.0	10.8	92.5
1983	64626	67.99	18271	10709	12.5	4.8	17.3	100.6
1984	72586	69.66	19833	13623	15.1	9.6	24.7	106.8
1985	83618	73.66	21650	16639	18.9	14.3	33.2	113.5
1986	93068	75.08	23108	19285	25.7	19.1	44.8	122.0
1987	104138	71.48	25343	22606	29.3	23.9	53.2	130.1
1988	118692	84.34	27460	26787	32.7	28.7	61.4	138.6
1989	131301	85.26	29496	29785	34.7	33.4	68.1	149.3
1990	146346	89.86	31566	34675	36.5	38.2	74.7	162.8
1991	162167	91.64	33348	38267	38.6	43.8	82.4	177.0
1992	175912	92.53	37013	42089	41.4	50.5	91.9	190.1
1993	185929	91.01	39526	46145	45.2	60.6	105.8	201.4
1994	192998	90.24	42394	49612	51.1	72.5	133.6	211.0
1995	201863	89.07	45000	53627	59.1	91.8	150.9	220.5
1996	208509	88.56	47541	57472	67.5	97.8	165.3	228.2
1997	217628	88.58	50648	61916	75.9	103.8	179.7	234.6

Expenditures in millions

Exhibit 2
ARIMA Analysis of Managed Care Cost Savings

1. Time series plot for deflated physician expenditures (1960-97)



2. Basic Box Jenkins Model. Differenced - AR(1)

PARAMETER LABEL	VARIABLE NAME	NUM./ DENOM.	FACTOR	ORDER	CONS-TRAINT	VALUE	STD ERROR	T VALUE
1 C		CNST	1	0	NONE	646.8229	413.8828	1.56
2	PHYS	AR	1	1	NONE	.9291	.0560	16.59

TOTAL SUM OF SQUARES	.181837E+12
TOTAL NUMBER OF OBSERVATIONS	38
RESIDUAL SUM OF SQUARES.	.923980E+08
R-SQUARE	.999
EFFECTIVE NUMBER OF OBSERVATIONS . .	36
RESIDUAL VARIANCE ESTIMATE	.256661E+07
RESIDUAL STANDARD ERROR.	.160206E+04

TIME PERIOD ANALYZED	3 TO 38
NAME OF THE SERIES	MOD1R
EFFECTIVE NUMBER OF OBSERVATIONS . . .	36
STANDARD DEVIATION OF THE SERIES . . .	1602.0650
MEAN OF THE (DIFFERENCED) SERIES . . .	-.0001
STANDARD DEVIATION OF THE MEAN	267.0108
T-VALUE OF MEAN (AGAINST ZERO)	.0000

AUTOCORRELATIONS

1- 12	-.09	.08	.06	-.02	-.02	-.17	.13	-.09	-.13	.03	.06	.00
ST.E.	.17	.17	.17	.17	.17	.17	.17	.18	.18	.18	.18	.18
Q	.3	.5	.7	.7	.7	2.0	2.9	3.2	4.1	4.1	4.3	4.3
13- 24	-.13	-.03	-.08	.05	-.13	.09	-.14	-.04	.03	-.04	-.02	.01
ST.E.	.18	.18	.18	.19	.19	.19	.19	.19	.19	.19	.19	.19
Q	5.3	5.3	5.8	6.0	7.2	7.8	9.3	9.4	9.5	9.7	9.7	9.7
25- 35	-.02	-.01	.02	.06	.02	.01	.04	-.01	-.01	.00	-.01	
ST.E.	.19	.19	.19	.19	.19	.19	.19	.19	.19	.19	.19	
Q	9.8	9.8	9.9	10.4	10.5	10.5	10.9	10.9	11.0	11.0	11.2	

3. Managed care Box Taio transfer function model. Differenced AR(1). Managed care impact at lag five.

PARAMETER LABEL		VARIABLE NAME	NUM./ DENOM.	FACTOR	ORDER	CONS-TRAINT	VALUE	STD ERROR	T VALUE
1	C		CNST	1	0	NONE	2.6410	.5492	4.81
2		MC	NUM.	1	5	NONE	-.0329	.0165	-1.99
3		PHYS	AR	1	1	NONE	-.3583	.1415	-2.53

TOTAL SUM OF SQUARES	.285387E+05
TOTAL NUMBER OF OBSERVATIONS	48
RESIDUAL SUM OF SQUARES.	.269971E+03
R-SQUARE	.989
EFFECTIVE NUMBER OF OBSERVATIONS . .	43
RESIDUAL VARIANCE ESTIMATE	.627840E+01
RESIDUAL STANDARD ERROR.	.250567E+01

TIME PERIOD ANALYZED	6 TO 48
NAME OF THE SERIES	MOD1R
EFFECTIVE NUMBER OF OBSERVATIONS . . .	43
STANDARD DEVIATION OF THE SERIES . . .	2.5057
MEAN OF THE (DIFFERENCED) SERIES . . .	.0000
STANDARD DEVIATION OF THE MEAN	.3821
T-VALUE OF MEAN (AGAINST ZERO)	.0000

AUTOCORRELATIONS

1- 12	.01	.09	.11	.01	-.07	-.03	.12	-.04	.03	.03	.00	.02
ST.E.	.15	.15	.15	.16	.16	.16	.16	.16	.16	.16	.16	.16
Q	.0	.4	1.0	1.0	1.2	1.2	2.0	2.1	2.1	2.2	2.2	2.2
13- 24	.23	-.19	-.01	-.04	-.03	.02	-.10	.01	-.04	-.08	-.08	.02
ST.E.	.16	.17	.17	.17	.17	.17	.17	.17	.17	.17	.17	.17
Q	5.6	7.9	7.9	8.0	8.1	8.1	8.9	8.9	9.1	9.6	10.2	10.2
25- 36	.07	-.12	-.06	-.11	-.12	-.11	-.06	-.04	-.04	-.00	.01	.02
ST.E.	.17	.18	.18	.18	.18	.18	.18	.18	.18	.18	.18	.18
Q	10.7	12.3	12.8	14.5	16.6	18.5	19.1	19.4	19.7	19.7	19.7	19.8

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March 31, 2000

Senator John Torgerson
Co-chair Senate Finance Committee
State Capitol Building
Juneau, Alaska 99801-1182

Re: Senate Bill 256

Dear Senator Torgerson:

Pursuant to your request, the State of Alaska, Department of Law submits the following written comments regarding Senate Bill 256, "An Act relating to regulation of managed health care and allowing physicians to collectively negotiate with a health benefit plan that has substantial market power." These comments assume that proposed amendments number 1 through 4, offered by the bill's sponsor, Senator Kelly, on March 27, 2000, will be incorporated into a committee substitute, as you had requested. In general, the department has serious legal and policy concerns regarding the collective bargaining aspects of this bill. We believe that the bill if passed in its present form may result in substantial harm to consumers in the form of increased health care costs and reduced health care options. Further, the level of state involvement provided in the legislation may not be sufficient "active state supervision" under the state action doctrine to immunize physicians from federal anti-trust enforcement. While the majority of our comments in this letter relate to Section 3 of the bill, we also ac concerns related to Section 2 of the bill in the final numbered paragraph of this letter.

I. Purpose of Senate Bill 256, Section 3.

Under current law, collective negotiations of price and price related terms by physicians is considered "per se" illegal price fixing in violation of state and federal antitrust laws. See Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982). Section 3 of SB 256, displaces free market competition and state antitrust laws and allows competing physicians to collectively negotiate with health plans on non-price and price terms of a contract under certain circumstances. Section 3 also attempts to provide the physicians immunity from prosecution under federal antitrust laws, through the state action doctrine, by establishing a review process of the negotiations and contracts through the Office of the Attorney General.

II. Issues relating to SB 256, Section 3.

A. Harm to Consumers.

The Department of Law agrees with the concerns relating to collective negotiations by physicians raised by Federal Trade Commission (FTC) representative, Richard Feinstein, in the oral testimony given before the Finance Committee on February 25, 2000, and in the letters submitted to the Committee dated May 13, 1999, and October 29, 1999, relating to collective negotiation legislation in Texas and Washington, D.C. Specifically, according to the FTC, allowing physicians to collectively negotiate on price terms will not ensure better care for patients, and may result in substantial harm to consumers. For instance, likely increased rates negotiated by physicians under negotiated contracts threatens to raise health care costs for individuals, employers, and state and federal governments, and may reduce access to care and increase the number of uninsured. The FTC's conclusions are based on prior investigations and enforcement actions where similar results occurred when physicians collectively negotiated price terms. *See* October 29, 1999 letter from FTC to Robert R. Rigsby, Office of Corporate Counsel, Washington, D.C., pg. 2.

Further, as discussed by Robert Lohr, Director, Division of Insurance, in his March 30, 2000, letter submitted to the Senate Finance Committee, a recent study conducted by Charles Rivers Associates, Inc., estimates that private health insurance premiums would rise by approximately 5 to 13 percent under the pending federal legislation (H.R. 1304) permitting health care professionals to negotiate collectively with health care plans. Based on this study, and Mr. Lohr's discussions, it can be assumed that Alaska will experience similar increased health care costs as a result of collective negotiations by physicians, absent adequate limits on the collective bargaining.

B. Limits on collective bargaining are not sufficient to protect consumers from substantial harm.

1. Market share limits.

SB 256 provides that health plans must have substantial market power, defined as 15% of the market share, in order to allow price negotiations by physicians. Further, where a health plan has less than 5% market share, the physician group may not exceed 30% of the market in the physician's geographic service area.

Although the bill appears to make the concept of market power an important limitation on physician's ability to collectively negotiate price terms, these provisions are not based on accepted concepts of market power in a legal or economic sense. See FTC letter dated October 29, 1999. Specifically, a 15% market share is not ordinarily presumed to constitute market power. Therefore, although a health plan may meet the presumption of market power under the bill, it may not in fact have the market power which gives them the ability to reduce prices below competitive levels, justifying collective negotiations by physicians.

Further, the bill's limits on physician group size do not reflect the potential market power (ability to raise prices) of physician groups. SB 256 lacks a cap on the market share of a physician group when negotiating with a health plan with greater than 5% market share. This may result in a disproportionately large physician group (up to 100% of the market share in a geographic market) negotiating with a small health plan (small as 5% market share), resulting in substantial market power by the physicians. Further, the limit on the market share of physicians groups (30 %) negotiating with small (less than 5%) health plans does not necessarily reflect market power, and may underestimate the economic clout of a physician group which is dealing with the small health plan.

2. Prohibition on boycotts/concerted action.

Another limitation in SB 256 relates to the prohibitions on boycotts and concerted action by physicians. Two sections in the bill dealing with these provisions raise significant questions of interpretation and may not offer adequate protections to consumers.

Section 23.50.020 (a) of the bill prohibits competing physicians from engaging in boycotts relating to the non-price terms and conditions listed in that subsection. However, a similar prohibition is absent from the price and price related terms and conditions listed in subsection (c). It is not clear whether this omission was purposeful, or a drafting error. The effect is significant, however, in that the prohibition on boycotts is absent for price and price related terms.

Subsection (h) of the bill, relating to concerted action by physicians, does not fully correct the problem. Subsection (h) provides that new section 23.50.020 does not authorize competing physicians to act in concert in response to a report issued by an authorized third party related to the third party's discussions or negotiations with a health benefit plan. First, this section does not clearly prohibit concerted action, such as boycotts. It only states that it is not authorized by the section. Subsection (h) needs to be amended to provided that concerted action is clearly prohibited, as it is in subsection (a). Second, the only conduct that is affected under subsection (h) is concerted action in response to third party discussions/negotiations with health plans. Concerted conduct by physicians prior to, or during negotiations, is not affected by this section. Therefore, for instance, a boycott or strike by physicians in response to a health plan's refusal to collectively negotiate with a physician group on price terms would not be prohibited by this subsection.

Another issue, which must be clarified, relates to the definition of boycott. As the FTC points out in its letter to the Washington D.C. Corporate Counsel, dated October 29, 1999, it is unclear whether the boycott prohibition is intended to bar agreements not to deal with health plans except on collectively-determined terms, or whether it would only prohibit agreements to withhold services from third parties, in order to pressure health plans to accede to the contract terms demanded by the physician group. *Id* at pg. 4. The bill needs to be clarified to indicate which type of boycott is prohibited by this section, the former being the much more coercive type of boycott which should not be allowed.