FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

Fiscal Note Number: 9
Bill Version: HCS CSSB 37(JUD)
(H) Publish Date: 4/25/02

Revision Date/Time (Note if correction):
Dept. Affected: DCED
Title: Physician Negotiations with Health Insurance
BRU: Insurance (116)
Component: Insurance Operations
Sponsor: Senator Kelly
Requester: House Judiciary
Component No.: 354

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
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--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2002) cost: 0.0

Check this box (X) if funding for this bill is included in the Governor's FY 2003 budget proposal: [ ]

POSITIONS

Full-time						
Part-time						
Temporary						

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

This bill requires the director of insurance to determine the number of individuals covered under health benefit plans in Alaska. A health benefit plan is now defined as a health care insurer instead of an employee welfare benefit plan. The division already collects covered lives data from health care insurers for purposes of reporting under AS 21.06.110. Therefore, any cost to modify the survey form, compile and report this data would be absorbed within existing division resources.

Prepared by: Robert A. Lohr, Director
Phone: 907-269-7900
Division: Insurance
Date/Time: 4/10/02 11:46 AM
Approved by: Deborah B. Sedwick, Commissioner
Date: 4/10/2002
Agency: Department of Community & Economic Development

(Revised 9/2001 OMB)

COMMITTEE COPY

Alaska State Legislature

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Senator Pete Kelly
District P

SB 37 Sponsor Statement

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

Senate Bill 37 attempts to level the playing field for Alaska's patients and the physicians who care for them.

Over the past eight years, the health insurance market has continued to consolidate at a rapid pace. There were once 18 national health insurance companies that physicians could choose to contract with. These companies have since merged into 6. It is even more severe for Alaskan physicians who have only 2 choices of insurers in this state. Physicians are given little if any opportunity to advocate for the best care of their patients.

Independent physicians are prevented from collective action by federal antitrust laws and are subject to aggressive antitrust enforcement actions. Large corporations, however, can adopt a "take it or leave it" position without any antitrust ramifications. This plus the market concentration of health insurers causes a damaging imbalance in bargaining power.

This inequity between health insurers and medical care providers dictates physician contracts. The resulting contracts favor the insurance companies over the health care patients receive and can result in such policies where physicians are required to use a low cost treatment when a higher cost treatment may be medically necessary.

Senate Bill 37 will enable independent, competing physicians to become effective advocates for their patients through collective negotiations with health insurers. These negotiations will fall into a narrow scope of topics with regard to the provisions of physician services contracts and will be under the scrutiny of the Attorney General's office. SB 37 will still prohibit a group of independent competing physicians from striking or otherwise engaging in activities that would result in a boycott.

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Senator Pete Kelly
District P

SB37 Talking Points

"An Act relating to collective negotiation by competing physicians with health benefit plans, to health benefit plan contracts, to the application of anti-trust laws to agreements involving providers and groups of providers affected by collective negotiations, and to the effect of the collective negotiation provisions on health care providers."

- Levels the playing field between Alaska's physicians and the outside insurance companies.
- Does **not** allow for boycotts or strikes.
- Does **not** impact nurses.
- Does **not** create doctor unions.
- Does **not** impact ERISA plans.
- It is **not** mandatory for either doctors or insurance companies to negotiate.
- Will **allow** the Attorney General to stop all negotiations and contracts at ANY time.
- Will **allow** for communication among doctors to improve the delivery of healthcare in Alaska.
- Will **allow** protected contract negotiations for non-cost provisions separate from cost provisions.

Alaska State Medical Association

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February 11, 2002

Honorable Lisa Murkowski
Alaska State House of Representatives
State Capitol, Room 408
Chair, House Labor and Commerce Committee
Juneau, AK 99801-1182

Dear Representative Murkowski:

The Alaska State Medical Association (ASMA's) lobbyist has provided me with a copy of the response (dated 1/18/ 2002) from several staff members from the Federal Trade Commission (FTC). At the risk of stating the obvious, please note that these are the comments of staff members (Messrs. Simons and Cruz) and do not represent the position of the FTC. This is the same situation when another FTC staff person (Richard Feinstein) testified on SB 256 (SB 37 during the last session) on his own behalf and not representing the views of the FTC.

The response from Mr. Simons and Mr. Cruz again reflect similarly the comments made in regard to the "state action doctrine exception" bills in both Texas and the District of Columbia. ASMA has responded to the comments with both written and oral testimony on numerous occasions, including before House Labor and Commerce Committee as well as in your work session this past December. Therefore, I am not going to comment in detail again but will instead make several comments on a broader basis. (By the way, a private attorney representing an undisclosed client in D.C. brought very similar arguments to those of Mr. Simons and Mr. Cruz in opposition to the D.C. bill establishing a state action doctrine exception. Mr. Charles James was the D.C. medical society legal council and he responded to those arguments. I will share some of Mr. James' comments with you as well.)

I will begin by framing the issue that is illustrative of why ASMA has brought forth and supported the concept embodied in SB 37. Alaska is faced with a situation where the private insurers involved in the health insurance are an oligopoly; Alaska has an inadequate number of physicians plus a great number who will be leaving practice soon due to age; and a necessary symbiotic relationship exists between physicians and the third party payors. ASMA is very interested in the physician workforce issues due to concerns over access to care issues. The symbiotic relationship, embodied by the whole concept and practice of assignment of benefits, is necessary due to legitimate public health reasons. (This relationship is required to exist by AS 21.87.140 for a medical service corporation.) Additionally, the contractual arrangements between insurers and physicians have been such that no negotiation takes place, with physicians being offered contracts on a "take it or leave it" basis. This happens because of the monopsony power that is exercised by the few insurers in the marketplace. ASMA finds this to be patently unfair.

Mr. Cruz and Mr. Simons seem to be unaware of the health care environment in Alaska and make the presumption that the health insurers can not look out after their own best interests. ASMA feels that the State is in a better position to determine what is needed to meet the health care needs of the citizens and that the large health insurers can and do vigorously look out for their own interests. (Also, and again, the entire process embodied in SB 37 is voluntary.)

Mr. James was the outside legal council for the medical association in D.C. when it was pursuing its bill embodying the "state action doctrine exception". He now is the head of the U.S. Justice Department's anti-trust enforcement division. The following is a response from Mr. James pertaining to arguments made by a lawyer (Mr. Hartwell) against D.C.'s "state action doctrine exception bill"; which represent an excellent overview:

"...It is true, the proposed legislation does not rely on elaborate pricing mechanisms to fix the outcome of the negotiations. From his letter, it appears that Mr. Hartwell would have the District insinuate itself into every facet of the negotiation process, establishing, among other things, a "framework" for the actual negotiations and a "procedural mechanism for evaluating the fairness of the negotiated terms and conditions." (Ltr. From Ray V. Hartwell, III., Esq. to Linda Crop of 4/24/00 at 6.) But the active supervision requirement does not require the District actually to sit at the bargaining table. Such a narrow interpretation indeed would turn the state action doctrine on its head. The underlying rationale of the doctrine, again, is to free the exercise of District's police powers from federal interference. Mr. Hartwell's understanding of the active supervision requirement would effectively preclude the District from adopting more progressive regulatory policies, like those embodied in the Act, that take advantage of efficiencies inherent in a bargained-for exchange. Rather than trying to impose bureaucratic notions of fairness, the Act relies on the self-interest of the physicians and the health plans to drive the bargaining process toward the most efficient result. At the same time the Mayor retains the ability to fix certain parameters before negotiations commence, (see Bill 13-333 at § 7), and to review the end-result (see id. At §§ 7-8). This structure ensures that the District has the final say on the agreement, while securing the efficiency benefits of a private bargain."

Additionally, I would like to point out that the letter from Mr. Simons and Mr. Cruz point out the need for non-fee related items to be covered in SB 37. On page 7, the last two sentences are as follows:

"...The method a health plan uses to calculate its payments to providers for particular services, however, can have a direct and significant impact on the ultimate price that providers receive for their services, and thus such are also "price" terms. Moreover, even collective bargaining over other, more clearly "non-price" issues in a health plan contract can have a substantial effect on the ultimate costs paid by consumers."

Finally, some of the points made by Mr. Simons and Mr. Cruz in last several pages of this letter pertaining to information provided the AG in the course of the process and the time in which the AG needs to make its final decision have merit. We addressed those issues with Sen. Kelly and have suggested amendments to address those issues.

Please give me a call if you wish to discuss any of the issues involving SB 37.

Sincerely,

James J. Jordan

Cc: Sen. Pete Kelly
John Troxel, MD, ASMA President

Should you have any questions about our position, please feel free to contact Marie Darlin (586-3637), Coordinator of the AARP Capitol City Task Force; Patrick Luby (907-762-3314), AARP Legislative Representative; or me (907-245-5259).

Thank you for your consideration.

Sincerely,

Marguerite Stetson

Marguerite Stetson
Executive Council Member for Advocacy

cc: Representative Bunde, Vice Chair
Representative Foster
Representative Harris
Representative Hudson
Representative Lancaster
Representative Whitaker
Representative Croft
Representative Davies
Representative Moses
Senator Kelly

SB 37
COLLECTIVE NEGOTIATION BY PHYSICIANS

Under provisions of HCS CSSB 37 (JUD):

1. There is **no demonstrated need for physicians to negotiate collectively in Alaska.** No proof has been offered that there is an imbalance in the relationship between insurers and physicians in the state

2. SB 37 poses a serious risk to currently insured working families and employers in Alaska because, whether physicians have the ability to negotiate only on "quality of care" issues or on fee-related matters, **the cost of health care will increase** as a result of this bill.

3. Federal Trade Commission (FTC) experience with physician negotiation has shown it to be **harmful to consumers.** In fact, in an Alaska case that prompted the sponsor to introduce this bill, the FTC alleged that the actions of the physicians:
   - resulted in a wide range of insurers being unable to secure physician contracts and thus unable to do business in the Fairbanks area;
   - restrained price and other competition among physicians in the Fairbanks area and thereby harmed consumers by increasing prices for physician services;
   - limited competition among health plans.

4. Increases in the cost of health insurance from this bill will result in a **larger number of uninsured Alaskans.** Alaska's uninsured rate has already been increasing and is significantly higher than the national average.

5. As currently drafted, HCS CSSB 37 (JUD) does not allow physicians to negotiate on price terms. **Legitimate collective negotiation on quality of care issues does not need an exemption** from federal antitrust laws. In fact, the FTC and U.S. DOJ have published Health Care Antitrust Guidelines for physicians wishing to conduct such negotiations.

6. Both the FTC and the Attorney General have reviewed SB 37 closely and determined that it **will not satisfy the "state action" exemption to override federal antitrust laws.** This means that physicians negotiating under the provisions of SB 37 would be at risk of FTC action for antitrust violations (the very thing this bill purports to protect them from) should they attempt to collectively negotiate with health insurers on issues not allowed under the FTC guidelines.

7. It has been stated that participation in negotiations under the provisions of SB 37 is entirely voluntary and therefore harmless. However, the bill does not require any state oversight until the physicians decide to negotiate with a health insurer and hire a representative. AS 23.50.020(h). Before this happens, substantial anticompetitive conduct has already occurred. **Once a representative is hired, the Attorney General has no authority to stop non-price negotiations.** The representative only needs to give the Attorney General notice of the negotiations. AS 23.50.020(c).

8. **Quality of care issues are already covered in Alaska law.** The Patient Bill of Rights, which became effective July 1, 2001, addresses the concerns that this bill purports to address. It requires that insurers protect the ability of the provider to communicate openly regarding treatment options and clearly prohibits insurers from imposing "gag orders" or discouraging providers from discussing all appropriate options including higher cost options.

9. The **only individuals that stand to benefit from this legislation are physicians,** already the most highly paid professionals in Alaska. Alaska ranks 49th in the number of physicians per capita. There is little competition between health care providers in Alaska, with the result being that insureds and insurance companies pay **higher costs for health care services in Alaska** and that providers **have little incentive to contract with insurers** to reduce their charges.

10. Physicians are the only group that has supported this legislation. **No consumers or consumer groups have stepped forward to support it** even though it is alleged to be primarily to benefit health care consumers.

11. **Negotiations between physicians and insurers under SB 37 exclude consumer input.** Alaskans' concerns regarding how insurers are performing insurance functions, for instance the definition of covered (or "medically necessary") benefits (such as cancer treatment options, abortion procedures, mammography, or coverage for pharmaceuticals) should be addressed in a public process and through revision of state insurance laws, not in closed negotiations between physicians and insurance companies.

If the ability to negotiate physician fees is added back into the bill:

1. **Physicians,** who are as noted the most highly paid professionals in Alaska, **will not negotiate for lower fees.** They will bargain for more, not less, just like any collective bargaining unit. This will lead to increased costs of health insurance and, thus, even more Alaskans uninsured

2. Reduced competition in physician fees will **increase the cost of health care for all Alaskans** including those with Medicaid and Medicare coverage, union-sponsored health plans, federal employees and state employees, and those currently covered under business-sponsored self-insurance plans.

3. Price negotiations undertaken under the ostensible cover of SB 37 will be scrutinized by both the Federal Trade Commission and the Department of Law. **This will result in both state government and the physicians expending more time, money, and other resources to monitor and defend the negotiation process.** As noted above, neither the FTC nor the Department of Law believes that the provisions in SB 37 meet the requirements of the "state action doctrine," which will ultimately expose the physicians to federal oversight.

POLITICAL CAPITAL

By Alan Murray

FTC Cracks Down On Antitrust Issue In Health-Care Area

As soaring health-care costs move center stage in Washington, the Federal Trade Commission has launched a crackdown on doctors and hospitals that fix prices to counter the bargaining power of managed-care companies.

Earlier this month, the FTC announced a settlement with a group of obstetricians and gynecologists in Napa County, Calif., of price-fixing charges. Government officials say a number of similar but larger cases will be made public in the next few weeks, as the FTC finalizes agreements with other doctor groups in a variety of medical specialties, and in metropolitan as well as rural areas, who've been found to have fixed prices.

In each case, the settlements, which prohibit the doctors from collaborating on pricing, are expected to clear the way for managed-care companies to go back to the doctors and negotiate lower fees.

Antitrust enforcement hasn't been a strong suit of the Bush administration. The Justice Department's quick and awkward move to settle the Microsoft Corp. case in November seemed to signal that the Bush team wanted to waste little effort in this area. Moreover, FTC Chairman Timothy Muris took some heat from members of Congress earlier this year when he reached a power-sharing agreement with the Justice Department that ceded to Justice control over media and telecommunications deals.

But in return, Mr. Muris got control over health-care issues. And it's now clear he believes the health-care industry is in need of antitrust attention.

The numbers tell part of the story. After rising at double-digit rates through the 1980s, health-insurance premiums slowed sharply in the first half of the 1990s, growing less than 1% at their trough in 1996. But then premium growth began to accelerate again, and by last year had returned to a double-digit gallop, with no sign of slowing. The numbers suggest the rise in managed care succeeded in capping health-care prices for a time. But now, doctors, hospitals and other health-care providers have banded together to fight back. And they seem to have gained the upper hand. The question now being addressed by the government: In banding together, did those health-care providers violate antitrust laws?

Some interesting data on that score come from Paul Gertler, an economist at the Haas School of Business at the University of California at Berkeley. In a paper co-authored with Allison Evans Cuellar of Columbia University, he set out to examine the effects of "strategic relationships" forged between hospitals and doctors in the late 1990s.

Hospitals and doctors justify the alliances by saying they increase the efficiency of care. But Mr. Gertler's examination of the data in Arizona, Florida and Wisconsin found that the alliances did little to increase efficiency, and a lot to increase prices. "In large markets, the integration of hospitals and physician groups leads to 5% to 10% increases in hospital prices," Mr. Gertler says. "In smaller markets, it leads to 15% to 30%."

His conclusion: The primary reason for these combinations is to boost the bargaining power health-care providers have when negotiating with managed-care companies. "Antitrust authorities should examine these hospital-physician relationships," he says. "They cannot be justified on efficiency grounds."

Mr. Gertler presented his paper to the staff of the FTC in March, and met with Chairman Muris as well. He's also been commissioned to do more work on the subject for the Washington-based National Institute of Health Care Management, a think tank funded in part by health-insurance companies.

Mr. Muris is also getting a prod from Tom Scully, the administrator of the Center for Medicare and Medicaid Services. Before joining the Bush administration, Mr. Scully ran the Federation of American Hospitals, which represented the for-profit hospitals that drove much of the consolidation trend. In his new job, Mr. Scully is the nation's No. 1 purchaser of health-care services, and thus the leading victim of rising prices. He's now arguing that consolidation has gone too far and is contributing to the pricing trends.

Antitrust cases against doctors and hospitals are notoriously difficult, in large part because they involve local, not national, markets. The federal government's recent record in bringing such cases against hospitals, in particular, is abysmal. Hometown judges, who often have friends on the local hospital boards, have tended to dismiss such cases by arguing that hospitals 40 or 50 miles away constitute sufficient competition.

Mr. Muris, however, appears undaunted by that poor past record. He says the FTC has found many markets where one or two hospitals clearly dominate, and cases where doctors have gotten quite bold in fixing prices. "There clearly needed to be consolidation in the health-care industry," he said. "But now, in certain areas, it has gone too far. This is something we are going to be paying a lot of attention to."

Senate Bill 37
How does it work?

Group of physicians wishing to jointly negotiate

Appoint an exclusive representative

(May not represent more than 30% of doctors in a geographic service area unless the health plan has a market share of more than 5% in that same geographic service area)

Authorized third party

1. Notifies the Attorney General and health care plan of desire to negotiate

2. Attorney General decides if negotiations may take place

3. Health care plan decides whether to negotiate

4. Agreement between physicians and health plan reached

5. Submit to Attorney General for approval

Non-Fee Related Items

Notified AG → AG says YES → Plan says YES → Agreement reached → Agreement approved → Corrections approved

- Failed to notify AG **PROCESS ENDS**
- AG says NO **PROCESS ENDS**
- Plan says NO **PROCESS ENDS**
- No agreement reached **PROCESS ENDS**
- Agreement not approved **PROCESS ENDS**
- Agreement not approved **PROCESS ENDS**

Fee Related Items

Notified AG → AG says YES → Plan says YES → Agreement reached → Agreement approved → Corrections approved

- Failed to notify AG **PROCESS ENDS**
- AG says NO* **PROCESS ENDS**
- Plan says NO **PROCESS ENDS**
- No agreement reached **PROCESS ENDS**
- Agreement not approved **PROCESS ENDS**
- Agreement not approved **PROCESS ENDS**

**Health care plan must have more than 15% of the market share for joint negotiations to take place for fee-related items*

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March 13, 2002

Alaska State Legislature
State Capitol (MS 3100)
Representative Lisa Murkowski
Chairman House Labor & Commerce Committee
Juneau, AK 99801-1182

Dear Representative Murkowski:

It has come to our attention that the Alaska Nurses Association, the Alaska Nurse Practitioners Association, and the nurse midwives still oppose SB37, the Alaska Physician Negotiation Bill in its entirety, and are attempting to generate a letter writing campaign to influence your committee's vote on the bill.

We are in possession of a form letter written at the request of Sandy Perry-Provost, which contains numerous misstatements of fact and a gross misunderstanding of what, and how, SB37 would allow physicians to negotiate with third party payors.

It is important to refute a few of the more outrageous claims made in the form letter, among which are:

- The nurses claim the bill would authorize price fixing by physicians.
    - Fact: price fixing would remain illegal even if the bill were law. Nothing in the bill authorizes price fixing.
- The nurses claim the bill would allow physicians and insurers to discriminatory exclude nurses from contracts.
    - Fact: passage of the bill would in no way protect physicians or insurers from state or federal anti-trust laws if either party conspired to shut out a different provider group from a contract. In addition, at the nurses request, the bill's sponsor Senate Pete Kelly, incorporated specific language in the bill in section; 23.50.020 (p) reiterating the point that the bill does not protect physicians from exclusionary conduct.

- The nurses claim the bill would increase costs and reduce service.

    - Fact: The bill requires final approval of a contract, including the fee schedule, by the Attorney General, who has ultimate veto power. The proposed amendments given to your office should also give the Attorney General all of the authority needed to collect any and all relevant information to make an informed decision about the merits of a final contract. One of the bill's primary purposes is to foster open communication between physicians and payors to address known inefficiencies in the healthcare delivery system, and thus potentially lower the overall cost of healthcare, and increase the level of service.

The physicians in my association feel they have gone out of their way to address the nurses concerns, and have gone so far to offer verbatim use of the language in SB37, if the nurses wish to create their own negotiation bill.

If you have any questions please contact me at 561-7705.

Sincerely,

Michael Haugen, JD, MBA
Executive Director

c: Senator Pete Kelly

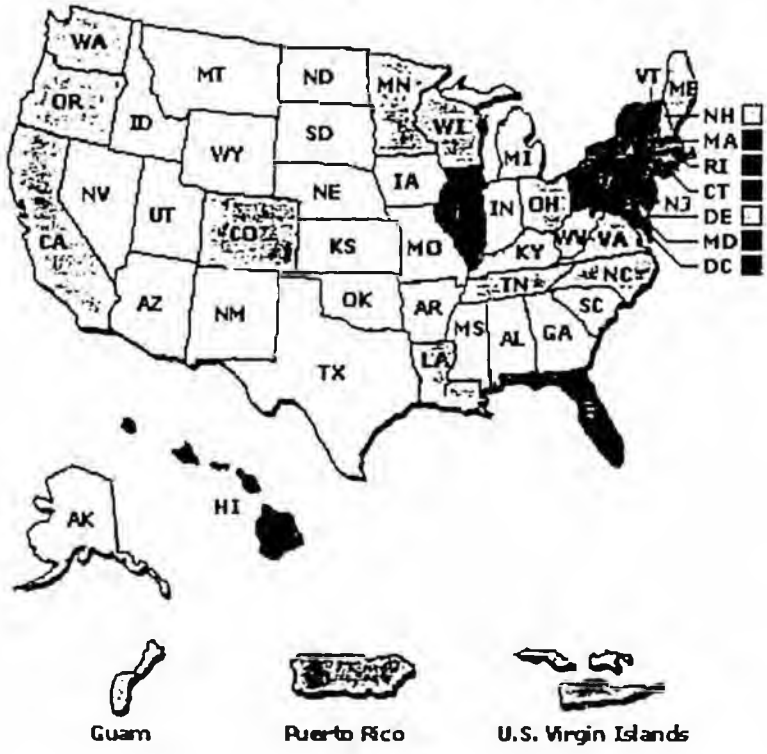
THE HENRY J. KAISER FAMILY FOUNDATION

STATE HEALTH FACTS *Online*

http://statehealthfa

Your source for state he

Rate of Nonfederal Physicians per 100,000 Civilian Population, 1999



- ☐ Less than 225
- ☐ 225 to 255
- ☐ 256 to 282
- ■ More than 282
- ☒ No data available/NSD

Rate of Nonfederal Physicians per 100,000 Civilian Population, 1999

Sort by: Rank ▼

Rate of Nonfederal Physicians per 100,000 Civilian Population, 1999		
Rank	**State**	**#**
	United States	285
1	District of Columbia	811
2	Massachusetts	454
3	New York	423

4	Maryland	413
5	Connecticut	397
6	Rhode Island	372
7	Vermont	362
8	New Jersey	327
9	Pennsylvania	321
10	Hawaii	306
11	Florida	290
12	Illinois	287
13	Minnesota	282
14	California	280
15	Colorado	274
16	New Hampshire	273
17	Washington	272
18	Louisiana	270
19	Tennessee	269
19	Virginia	269
21	Maine	268
22	Oregon	266
23	Delaware	264
24	North Carolina	262
25	Ohio	261
26	Wisconsin	256
27	Missouri	250
28	Michigan	249
29	Nebraska	247
30	North Dakota	246
31	New Mexico	243
32	Arizona	240
33	West Virginia	239
34	South Carolina	234
35	Kansas	232
35	Kentucky	232
37	Georgia	230
38	Montana	228
39	Utah	225
40	Texas	222
41	Indiana	219
42	Alabama	217
43	Arkansas	214
44	South Dakota	211
45	Iowa	200
46	Nevada	199
47	Wyoming	198
48	Oklahoma	187
49	Alaska	186
50	Mississippi	180
51	Idaho	179
NR	Guam	NA
NR	Puerto Rico	NA
NR	Virgin Islands	NA
NR	Residence Unknown	NA

Notes: Nonfederal physicians are employed in the private sector of the US physician population. They represent 98% of total physicians.
The US total excludes physicians and population in the possessions.

Sources: Physician Characteristics and Distribution in the US, 2001-2002 Edition, American Medical Association, copyright 2001, Table 5.20, p. 348.

amednews.com
THE NEWSPAPER FOR AMERICA'S PHYSICIANS

GOVERNMENT & MEDICINE

N.J. doctors get collective bargaining rights

Physicians can join together, but insurers don't have to negotiate with them. Similar provisions have hurt physician bargaining efforts in other states.

By Amy Snow Landa, *AMNews* staff. Jan. 28, 2002.
Additional information

Washington -- New Jersey has become the third state in the nation to allow independent physicians to bargain collectively with managed care plans over the terms of their contracts.

Legislation signed into law Jan. 8 exempts joint negotiating by physicians and dentists from antitrust laws as long as such activity takes place under close supervision by the state.

"We have been aching for some type of antitrust relief for years," said Angelo S. Agro, MD, president of the Medical Society of New Jersey. "Now it is up to physicians in our state to take advantage of the opportunities we have been fighting for and make them pay off."

Texas and Washington are the other states that give physicians the right to bargain collectively.

The New Jersey law allows doctors in that state to negotiate with health plans on such matters as the definition of medical necessity, utilization management procedures, quality assurance programs, clinical practice guidelines, dispute resolution and credentialing. Physicians also could negotiate payment issues as long as the attorney general found that the plan in question had substantial market power and that terms or conditions of the plan could pose a threat to quality and availability of care.

Doctors are not allowed to strike, nor can they negotiate to exclude nonphysicians from plans.

Write a letter to the edit about this stor

Search

Additional information

Box: Physicians gaining clout

Plans unwilling to play

Like the laws previously enacted in Texas and Washington, the New Jersey act does not require insurers to join doctors at the negotiating table, raising questions about whether self-employed physicians will be able to exert any more leverage in contract talks with health plans than they did before. The experiences of physicians in Texas and Washington seem to provide little basis for optimism.

In June 2000, a group of 11 physicians in Henderson, Texas, applied to the state attorney general's office for permission to band together for contract negotiations with Blue Cross and Blue Shield of Texas -- the area's dominant insurer.

The Henderson group was soon granted permission by Texas Attorney General John Cornyn to bargain collectively. He determined that physicians were locked into contracts with the Blues plan and that their practices couldn't absorb the loss of income they suffered as a result.

The AMA is working on a physician collective bargaining bill it hopes to be introduced in Congress.

Cornyn also stated in his decision that the plan's "dominant position and its terms and conditions for physician compensation threaten to adversely affect the quality and availability of patient care in the Henderson area." He gave the physicians and the insurer a 60-day period to meet to negotiate.

But the Blues plan simply refused to sit down with the physicians, and that was the end of it. Since then, no other group of physicians has decided to pursue an application, said Michael Cushman, director of the Texas Medical Assn.'s health care delivery department.

Like Texas, Washington also did not require insurer cooperation when it enacted its joint negotiation law in 1993.

Physicians' interest in pursuing negotiations with plans appears to have been dampened as a result.

"We can't even get to first base," said Len Edinger, director of public policy and planning for the Washington State Medical Assn.

The WSMA supports a measure that was expected to be introduced in the state Legislature in mid-January that would

amend the 1993 law to explicitly allow negotiations about reimbursement and require insurers to negotiate in good faith with physicians.

Although the New Jersey law does not require insurers to negotiate in good faith, Dr Agro said he hopes the state's doctors will be able to exert enough pressure to bring them to the table anyway.

If one or more groups of physicians apply for and receive permission to engage in joint negotiations with an insurer, and that insurer refuses, it could become a public relations problem for the HMO, he said.

"We think it would be an untenable [position] for the HMOs to stonewall if the state attorney general sees fit to allow negotiations with various groups around the state," he said. "I'm sure it won't help sell policies if it becomes known they're unwilling to negotiate on patient care issues even when the government and physicians say they should."

The New Jersey law also has an advantage over the Texas statute, according to MSNJ. It doesn't cap the percentage of physicians in a market who can negotiate, while the Texas law sets that limit at 10%, society officials said.

The AMA applauds the MSNJ for its success, said Donald J. Palmisano, MD, the Association's secretary-treasurer and a lawyer.

"Too long have insurers used their market concentration and market share to unfairly disadvantage patients and physicians," he said. "If insurers refuse to negotiate, then this will expose the insurers as entities that do not want to listen to reason, but instead want to exercise their monopsony power."

The AMA is working on a new collective bargaining bill that it hopes will be introduced in Congress. An earlier collective bargaining measure passed in the House but died in the Senate in 2000.

Joint negotiation bills have foundered in more than a dozen state legislatures due to concern that physicians would gain too much leverage and that such measures would lead to higher health insurance costs.

That was a complaint the insurance community used in its opposition to the New Jersey law.

"The virtually certain result would be higher costs for patients

and for the health plans that pay for the health care they receive," said the New Jersey Assn. of Health Plans.

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ADDITIONAL INFORMATION:

Physicians gaining clout

The New Jersey collective bargaining law:

- Gives physicians the right to bargain collectively, through a representative they select, with insurers on many nonpayment-related subjects, including patient referral standards, drug formularies and clinical practice guidelines.
- Allows doctors to bargain with plans on payment issues as long as the state attorney general has ruled that the carrier has substantial market power and its contract terms and conditions could hurt patient care.
- Requires that physicians submit a collective bargaining petition to the attorney general and pay a filing fee. The results of any collective bargaining agreements are also subject to the attorney general's approval.
- Bars physicians from striking.
- Does not require health plans to join physicians at the bargaining table.

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Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington, DC 20580

For Release: January 31, 2002

Related Documents:

Alaska Senate Bill 37, V020003 (PDF 39KB) (January 18, 2002)

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FTC Staff Opposes Alaska Proposal to Allow Physician Collective Bargaining

Proposed Legislation Would Significantly Increase Consumer Health Care Costs

A bill pending before the Alaska legislature that seeks to authorize competing physicians to engage in collective bargaining with health plans over fees and other terms would significantly increase health care costs and harm consumers, according to the staff of the Federal Trade Commission. The Commission has opposed similar legislation at the federal level, and Commission staff have expressed concerns about similar bills before state legislatures on a number of occasions.

In response to a request for comment on Alaska Senate Bill 37 from Representative Lisa Murkowski, Chair of the Labor and Commerce Committee of the Alaska House of Representatives, staff of the Bureau of Competition and the Office of Policy Planning note that the bill would authorize horizontal price fixing by physicians, as well as collusive refusals to deal with health plans.

According to the FTC staff opinion, such anticompetitive physician conduct is likely to result in substantial consumer harm. Consumers and employers would face higher prices for health insurance coverage. Consumers would also face a reduction in access to care, as increasing costs would likely result in a reduction in health care benefit options. State Medicaid programs using managed care strategies would be forced to increase their budgets, cut optional benefits, or reduce the number of covered beneficiaries. And state and local programs providing care for the uninsured would be adversely affected as well, as an increase in health care costs would likely add additional consumers to the ranks of the uninsured.

In addition, FTC staff conclude that the proposed regulatory structure to be established by the Alaska bill does not satisfy the Supreme Court's requirements under the "state action" doctrine, which allows a state to override the national policy favoring competition only where it expressly decides to govern aspects of its economy by state regulation rather than market forces. Under that doctrine, a state may not simply authorize private parties to violate the antitrust laws; instead, it must actually substitute its own active control for the discipline that competition would otherwise provide. To that end, the state legislature must clearly articulate a policy to displace competition with regulation, and state officials must actively supervise the private anticompetitive conduct.

As the FTC staff opinion further explains, Senate Bill 37 falls far short of the "active supervision" required by Supreme Court case law. The opinion notes that the Supreme Court has made it clear that the active supervision standard is a rigorous one, designed to ensure that an anticompetitive act of a private party is shielded from antitrust liability only when "the State has

effectively made [the challenged] conduct its own." The Court has also held that active supervision requires a state to exercise "sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties." In this instance, the bill does not provide the Attorney General with the means to exercise sufficient independent judgment and control, according to the FTC staff opinion. As a result, anticompetitive conduct undertaken in conformity with the bill would not be immunized, and could subject physicians to antitrust liability.

"In sum," the letter concludes, "the proposed antitrust exemption for physician collective bargaining is likely to result in increased consumer costs and threatens to reduce access to care. Furthermore, the risk of consumer harm does not appear to be offset by any substantial procompetitive benefits or increased quality of care."

The letter represents the views of the FTC's Bureau of Competition and Office of Policy Planning. Although it does not necessarily represent the views of the Commission or any individual Commissioner, the Commission authorized submission of the letter by a vote of 5-0.

Copies of the staff opinion letter are available from the FTC's Web site at http://www.ftc.gov and also from the FTC's Consumer Response Center, Room 130, 600 Pennsylvania Avenue, N.W., Washington, D.C. 20580. The FTC's Bureau of Competition seeks to prevent business practices that restrain competition. The Bureau carries out its mission by investigating alleged law violations and, when appropriate, recommending that the Commission take formal enforcement action. To notify the Bureau concerning particular business practices, call or write the Office of Policy and Evaluation, Room 394, Bureau of Competition, Federal Trade Commission, 600 Pennsylvania Ave, N.W., Washington, D.C. 20580, Electronic Mail: antitrust@ftc.gov; Telephone (202) 326-3300. For more information on the laws that the Bureau enforces, the Commission has published "Promoting Competition, Protecting Consumers: A Plain English Guide to Antitrust Laws," which can be accessed at http://www.ftc.gov/bc/compguide/index.htm.

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(FTC Matter No.: V020003)

(http://www.ftc.gov/opa/2002/01/alaskaphysicians.htm)

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Bureau of Competition
Office of Policy Planning

By Facsimile and First Class Mail January 18, 2002

The Honorable Lisa Murkowski
Chair, House Labor and Commerce Committee
Alaska House of Representatives
Alaska State Capitol
Juneau, AK 99801-1182

Re: Alaska Senate Bill 37

Dear Representative Murkowski:

We write in response to your request for comment on Alaska Senate Bill 37, a bill that seeks to authorize competing physicians to engage in collective bargaining with health plans over fees and other terms.[1] As discussed below, the Commission has opposed legislation before the U.S. Congress that would create an antitrust exemption for physician collective bargaining, and the Commission staff has expressed similar concerns about bills before state legislatures. We continue to believe that the behavior authorized by the physician collective bargaining legislation would significantly increase health care costs and harm consumers.

You also specifically solicited our opinion on whether the bill meets the legal test of the state action doctrine. As you know, state economic regulation can immunize private parties from federal antitrust liability, but only where the displacement of competition furthers a clearly articulated policy of, and is actively supervised by, the state government. In the case of Senate Bill 37, the level of government involvement described falls far short of the level of "active supervision" required by the Supreme Court.

I. Physician Collective Bargaining

The Commission's opposition to legislation intended to create an antitrust exemption for physician

[1] These comments are views of the staff of the Bureau of Competition and of the Office of Policy Planning of the Federal Trade Commission. They do not necessarily represent the views of the Commission or of any individual Commissioner. The Commission has, however, voted to authorize the Bureau of Competition and the Office of Policy Planning to submit these comments.

collective bargaining has historically focused on two fundamental points, both of which are relevant to your consideration of Senate Bill 37:

(1) such legislation would likely harm consumers – an antitrust exemption would authorize price-fixing by physicians, which could be expected to result in increased consumer costs and decreased consumer access to care; and

(2) such legislation would not likely improve the quality of care – an antitrust exemption would not likely improve patient care, and there are other, more effective means of addressing quality of care issues that do not sacrifice the benefits of a competitive marketplace.

A. Consumer Harm

In testimony before Congress regarding a proposed federal antitrust exemption for physician collective bargaining,[2] the Commission detailed the predictable impact on consumers that such legislation would have:

> Without antitrust enforcement to block price fixing and boycotts designed to increase health plan payments to health care professionals, we can expect prices for health care services to rise substantially. Health plans would have few alternatives to accepting the collective demands of health care providers for higher fees. The effect of the bill . . . can be expected to extend to various parties, and in various ways, throughout the health care system:
>
> - Consumers and employers would face higher prices for health insurance coverage.
> - Consumers also would face higher out-of-pocket expenses as copayments and other unreimbursed expenses increased.
> - Consumers might face a reduction in benefits as costs increased.
> - Senior citizens participating in Medicare HMOs would face reduced benefits . . .
> - The federal government would pay more for health coverage for its employees through the Federal Employees Health Benefits Program and military health

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[2] Testimony of Federal Trade Commission before the House Judiciary Committee on H.R. 1304 (June 22, 1999) ("FTC Testimony on H.R. 1304") at 5-6 *available at* <http://www.ftc.gov/os/1999/9906/healthcaretestimony.htm> (Attachment A) (footnotes 3-5 in original).

programs.

- State and local governments would incur higher costs to provide health benefits to their employees.

- State Medicaid programs attempting to use managed care strategies to serve their beneficiaries could have to increase their budgets, cut optional benefits, or reduce the number of beneficiaries covered.

- State and local programs providing care for the uninsured would be further strained, because, by making health insurance coverage more costly, the bill threatens to increase the already sizable portion of the population that is uninsured.

These widespread effects are not simply theoretical possibilities. The record of antitrust law enforcement sets forth the impact of collective 'negotiations' on the public. For example, as described in the Commission's complaints, collective bargaining by anesthesiologists in Rochester, New York, and by obstetricians in Jacksonville, Florida, forced health plans to raise their reimbursement, and the result was increased premiums for the HMOs' subscribers.[3] Other cases have challenged actions by associations of pharmacists who succeeded in forcing state and local governments to raise reimbursement levels paid under their employee prescription drug plans.[4] In one such case, an administrative law judge found that the collective fee demands of pharmacists cost the State of New York an estimated $7 million.[5]

Prior Commission cases illustrate the types of physician conduct that have raised problems. Price-fixing is one type of such conduct, and last year's *Alaska Health Network, Inc.*[6] case is a prime example. In that case, the Commission alleged that competing physicians organized and conspired to fix the prices and other competitively significant terms on which they would deal with health plans in

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[3] Southbank IPA, Inc., 114 F.T.C. 783 (1991) (consent order); Rochester Anesthesiologists, 110 F.T.C. 175 (1988) (consent order).

[4] See, e.g., Baltimore Metropolitan Pharmaceutical Assoc., Inc. and Maryland Pharmacists Assoc., 117 F.T.C. 95 (1994) (consent order); Pharmaceutical Society of the State of New York, Inc., 113 F.T.C. 661 (1990) (consent order).

[5] See Peterson Drug Company, 115 F.T.C. 492, 540 (1992). See also Pharmaceutical Society of the State of New York, Inc., 113 F.T.C. 661 (1990) (consent order).

[6] Docket No. C-4007, 2001 WL 443471 (F.T.C. April 25, 2001) (consent order).

Fairbanks, Alaska. Another type of conduct is price-related group boycotts, such as the one addressed in the *M.D. Physicians of Southwest Louisiana, Inc.*[7] case. There, the Commission charged a group of competing physicians with conspiring not to deal with certain third-party payers, as part of an unlawful enterprise designed to prevent managed care contracts from taking hold in the Lake Charles, Louisiana region.

There is widespread agreement that horizontal agreements among competitors can raise the most significant competitive concerns. The facilitation of naked horizontal price-fixing is among the most serious of these concerns, as such conduct predictably and consistently results in substantial consumer harm. Departing from the general rules of antitrust in such a competitively sensitive area presents substantial risks that would not be offset by procompetitive gains from physician collective bargaining.

The two arguments that have typically been presented to justify a departure from the general rules of antitrust in this context are that, given health plan concentration, physician collective bargaining would (1) increase patients' quality of care, and (2) allow physicians to bargain on a more "level playing field." The former argument is based on a misunderstanding of both current law and the effects of collective bargaining, as will be discussed in the next section.

The latter argument is more straightforward, but equally problematic. As the Commission explained in its testimony before Congress:

> Arguments that consumers would not be harmed by an antitrust exemption for collective bargaining by independent health care professionals appear to rest on assertions that the [federal] bill would balance the bargaining power between health care professionals and health plans. These assertions, however, are incorrect. The bill would permit doctors to create monopolies. On the health plan side of the ledger, the evidence does not support the suggestion that most (or even many) areas have only one or two health plans.[8]

Furthermore, even if the assumption that physicians confront monopoly health plans were correct, authorizing collusive conduct by physicians would not necessarily serve the interests of consumers. The argument that physician collusion would merely counterbalance hypothetical monopsony power by health plans implicitly assumes that collective bargaining would generate physician fees no larger than the fees that would exist in a competitive market. However, there is little reason to believe that a successful physician cartel would settle for fees at the competitive level. If a health plan possessed actual market power, health care consumers could be doubly harmed by physician collective bargaining, because they could be forced to pay the health care plan's monopoly mark-up on top of the elevated fees charged by the physicians.

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[7] Docket No. C-3824, 1998 WL 566834 (F.T.C. August 31, 1998) (consent order).

[8] FTC Testimony on H.R. 1304, supra note 2, at 6-7.

B. Quality of Care

Proponents of antitrust exemptions for physicians often suggest that greater physician bargaining power against health plans would result in increased quality of care for patients. This claim fails for two reasons: (1) physician collective bargaining has historically focused on physician compensation, rather than patient care; and (2) current antitrust law already permits physicians to work collectively on legitimate quality of care issues.

Immunizing collective bargaining imposes costs while providing little assurance that consumers' interest in quality care will be served. As the Commission stated before Congress:

> Collective bargaining rights are designed to raise the incomes and improve the working conditions of union members. The law protects the United Auto Workers' right to bargain for higher wages and better working conditions, but we do not rely on the UAW to bargain for safer cars. Congress addressed those concerns in other ways.[9]

Moreover, discussions between physician groups and health plans are not illegal. Current antitrust law permits doctors to collectively negotiate with health plans in various circumstances in which consumers are likely to benefit. The Health Care Guidelines – jointly issued by the Federal Trade Commission and the Antitrust Division of the Department of Justice – emphasize physicians' ability under the antitrust laws to organize networks, and other joint arrangements, to deal collectively with health plans and other purchasers.[10] In addition, through their professional societies and other groups, health care professionals can jointly provide information and express opinions to health plans.[11]

As the Commission explained in its congressional testimony:[12]

> [T]he antitrust laws do not prohibit medical societies and other groups from engaging in collective discussions with health plans regarding issues of patient care. Among other

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[9] FTC Testimony on H.R. 1304, supra note 2, at 10.

[10] See Statements of Antitrust Enforcement Policy in Health Care, 4 Trade Reg. Rep. (CCH) ¶ 13,151 (Aug. 1996) ("Health Care Guidelines") *available at* <http://www.ftc.gov/reports/hlth3s.htm>. The Health Care Guidelines discuss "messenger model" arrangements designed to minimize the costs associated with the contracting process.

[11] See, e.g., Schachar v. American Academy of Ophthalmology, 870 F.2d 397 (7th Cir. 1989); Statements 4-5 of Health Care Guidelines, supra note 10.

[12] FTC Testimony on H.R. 1304, supra note 2, at 7-8 (footnotes 13-15 in original).

things, physicians may collectively explain to a health plan why they think a particular policy or practice is medically unsound, and may present medical or scientific data to support their views . . . .[13]

The Commission has never brought a case based on physicians' collective advocacy with a health plan on an issue involving patient care. Our cases have addressed instances in which physician groups (1) negotiated collectively on fee levels or other price-related issues, or (2) collectively refused to contract with plans, either to gain acceptance of their price-related demands or to prevent or delay market entry by managed care plans gener[illegible] all such cases, the Commission has been very careful to make sure that its orders do not interfere with the legitimate exchange of information and views between health plans and health care practitioners. Indeed, in the Commission's first litigated case involving collective negotiations by physicians - *Michigan State Medical Society* - the opinion emphasized that the antitrust laws do not prohibit health care providers' collective provision of information and views to health plans.[14] Specific language was inserted in that order, and in subsequent orders, to make it clear that bans on anticompetitive agreements among competing providers do not prohibit the provision of information and views to health plans concerning any issue, including reimbursement.[15]

Accordingly, blanket antitrust immunity for physician price-fixing is not necessary to protect patient welfare.

II. The Alaska Bill

Nonetheless, Senate Bill 37, like its federal and state counterparts, seeks to confer antitrust immunity with respect to collective physician conduct. To be sure, Senate Bill 37 also contains a number of provisions designed to protect consumers from the potential harms arising from a physician collective bargaining exemption. In some respects, these provisions resemble protections contained in physician collective bargaining bills introduced in Texas and the District of Columbia, on which the

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[13] [The Health Care Guidelines] create an antitrust safety zone for health care providers' collective provision of non-fee-related information to health plans. . . . [See Statement 4 of Health Care Guidelines, supra note 10.]

[14] 101 F.T.C. [191,] at 302-09 [(1983)].

[15] Id. at 314; see also Southbank IPA, 114 F.T.C. 783 (1991) (consent order); Rochester Anesthesiologists, 110 F.T.C. 175 (1988) (consent order).

Commission staff also has commented.[16] As with the protections in the Texas and District of Columbia bills, these provisions – addressing a health plan's market power, the size of the physician bargaining group, and potential boycott conduct – do not alleviate the risk of substantial consumer harm resulting from a collective bargaining exemption.

A. Minimum Threshold for Health Plan Market Power

Section (d)(1) of Senate Bill 37 states that physicians may "collectively negotiate with a health benefit plan the items described in (b)" – including fees or prices – provided that the health benefit plan has "substantial market power." "Substantial market power" is defined as "more than 15 percent of the market share." *Id.* at § (s)(4). Alternative formulas by which market power may be measured are set forth in Sections (f)(1) and (f)(2).

This market power screen is unlikely to guard against consumer harm.

First, the screen does not apply to all collective bargaining by physicians, or even to all price-related bargaining. Rather, it applies only to certain kinds of price-related matters. For example, the market share screen does not apply to negotiations concerning the formulation and application of reimbursement methodology. *Id.* at § (a)(6). The method a health plan uses to calculate its payments to providers for particular services, however, can have a direct and significant impact on the ultimate price that providers receive for their services, and thus such matters are also "price" terms. Moreover, even collective bargaining over other, more clearly "non-price" issues in a health plan contract can have a substantial effect on the ultimate costs paid by consumers.

Second, there are significant problems with the concept of health plan market power as defined in the bill. As the Commission staff noted in its comment on the District of Columbia bill:

> Market power is, simply put, the power to raise prices above competitive levels, or in the case of buyers, the ability to reduce prices below competitive levels. Market share can indicate market power, but only if based upon a properly defined market. Even if the bill's categories correctly identified relevant markets, a 15% market share . . . is not a level ordinarily assumed to constitute market power.[17]

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[16] Letter to the Texas Legislature on Senate Bill 1468 (May 13, 1999) *available at* <http://www.ftc.gov/be/v990009.htm> (Attachment B); Letter to the District of Columbia Office of Corporation Counsel on Bill No. 13-333 (Oct. 29, 1999) ("District of Columbia Letter") *available at* <http://www.ftc.gov/be/rigsby.htm> (Attachment C).

[17] District of Columbia Letter, supra note 16, at 3-4.

Although the Alaska bill's definition of "substantial market power" is not entirely clear, one thing is certain: it does not define antitrust markets in a legal or economic sense. For example, it uses as a proxy for a relevant geographic market the health plan's "service area," but this area does not necessarily correspond to a proper relevant antitrust geographic market, and could serve to overstate the market share of the plan.

Furthermore, by setting the market power threshold at a 15 percent market share, the bill would authorize anticompetitive behavior by physicians in many situations in which the health plan would not in fact possess market power. Indeed, 15 to 20 percent is below the level courts typically require before upholding a finding of market power.[15] Finally, the bill does not take into account that even a plan with a large share of a market might be constrained from exercising market power if new entry by competing plans is easy.

Third, in practice, the market share screen appears unlikely to provide any limitation at all. That is because the bill would create a presumption that a health plan has substantial market power (Section (f)), unless the health plan persuades the Attorney General that it does not meet the 15 percent threshold. It seems unlikely that a health plan would seek to offer such proof, however, because the kind of price-related collective bargaining to which the market share screen applies can occur only if the health plan agrees to engage in such negotiations. *See* Section (d)(3). Thus, it appears that a health plan could simply decline to negotiate with physician collective bargaining groups, without making any showing regarding market share.

In addition, it should be noted that the bill's restrictions on collective fee negotiation to situations where the health plan consents to such negotiations would offer only limited protection to consumers. Such a restriction could limit certain kinds of anticompetitive effects, by preventing groups without health plan consent from engaging in even preliminary bargaining activities (such as physicians entering into agreements on the fee levels to be sought) that could facilitate anticompetitive agreements with respect to physicians' individual dealings with health plans. Nonetheless, a variety of risks remain. First, although participation is voluntary, some health plans may feel compelled to deal with a group if it

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[15] Although the federal courts have not identified a precise market share figure that constitutes market power, the guidance they have provided strongly suggests that 15 to 20 percent is not sufficient. In Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2 (1984), for example, the Supreme Court rejected the possibility that the defendant hospital had market power in spite of the fact that it serviced roughly 30 percent of the relevant market. Subsequent opinions from lower courts have tended to adhere to this 30 percent "rule of thumb." See, e.g., United States v. Eastman Kodak Co., 63 F.3d 95 (2d Cir. 1995) (30 percent share of U.S. photocopying market too small to give rise to inference of market power); New York v. Anheuser-Busch, Inc., 811 F. Supp. 848 (E.D.N.Y. 1993) (40 percent market share insufficient to show market power in light of low barriers to entry); Manufacturer's Supply Co. v. Minnesota Mining & Manufacturing Co., 688 F. Supp. 303 (W.D. Mich. 1988) (25.8 percent market share insufficient to show market power).

includes most of the physicians in a particular specialty or many physicians with large numbers of loyal patients. Second, even absent any implicit coercion, in some circumstances a health plan may find it less troublesome to simply accede to price-setting by physicians and then pass the higher costs on to consumers. In either case, such behavior presents a risk not only to the enrollees of the particular plan in question, but also to other consumers, because a group of physicians organized to bargain with one health plan could more easily collude in its dealings with other health plans that eschew collective bargaining.

B. Limitations on Size of Physician Negotiating Group

Section (g)(6) of the Senate Bill 37 states that an authorized third party "may not represent more than 30 percent of the market of practicing physicians in the geographic service area or proposed geographic service area if the health benefit plan has less than a five percent market share." In addition, Section (g)(7) authorizes the Attorney General to limit the percentage of practicing physicians represented by an authorized third party. However, the Attorney General may not impose a limit of "less than 30 percent of the market of practicing physicians" and may not impose any limit at all if "the market of practicing physicians . . . consists of 40 or fewer individuals." *Id.*

These limitations on the size of the physician group authorized to collectively bargain are also unlikely to adequately protect consumers. First, the 30 percent limitation applies only in those cases in which the health plan has a very small share of the (potentially ill-defined) market. Furthermore, the 30 percent limit appears to contemplate a percentage of all physicians and, if so, it would not necessarily prevent aggregation of a large portion of the physicians in a given specialty. Given the high level of specialization among physicians, and the fact that different medical specialty services often are not substitutable, the relevant market for antitrust purposes may be a particular specialty or specialties rather than physicians as a whole. And just as individual specialties may constitute different product markets, relevant geographic markets may differ by specialty.

C. Exclusion of Physician Boycott Conduct

Section (m) of the bill states that the antitrust exemption for physician collective bargaining does not extend to boycott conduct. Specifically, Section (m) states that no provision of the bill should be construed as authorizing "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." It further notes that authorized third parties "shall" inform physicians of Section (m) and "warn them of the potential for legal action against those who violate state or federal antitrust laws." *Id.*

Although this provision is likely to prevent Senate Bill 37 from being used as legal cover for explicit boycott threats, it does not protect consumers from all boycott-related concerns arising from physician collective bargaining. As the Commission has previously observed, collective negotiations

can by their very nature convey an implicit threat that, if the health plan does not agree to terms acceptable to the physician group as a whole, it will be prevented from successfully negotiating agreements with the members of the group separately.[19] Furthermore, by immunizing agreements among competing physicians on the fees and other terms they will accept from health plans, the bill facilitates coordinated conduct – such as collusive refusals to deal – that, even though not immune, would be difficult to detect and prosecute.

III. State Action Immunity

Under the judicially-created "state action" doctrine, a state may override the national policy favoring competition only where it expressly decides to govern aspects of its economy by state regulation rather than market forces. A state may not simply authorize private parties to violate the antitrust laws.[20] Instead, it must actually substitute its own active control for the discipline that competition would otherwise provide. To that end, the state legislature must clearly articulate a policy to displace competition with regulation, and state officials must actively supervise the private anticompetitive conduct.[21]

Senate Bill 37 faces severe difficulties under the "active supervision" prong of that test. In order for state supervision to be adequate for state action purposes, state officials must "have and exercise ultimate authority over the challenged anticompetitive conduct."[22] Senate Bill 37 falls far short of providing the "pointed reexamination"[23] of private anticompetitive conduct necessary to confer antitrust immunity.

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[19] See Alaska Healthcare Network, Inc., Docket No. C-4007, 2001 WL 443471 (F.T.C. Apr. 25, 2001) ("Payors believed that they could not go around [Alaska Healthcare Network] to contract individually with physicians in Fairbanks, and thus that they had no alternative but to reach agreement with AHN or to give up their planned entry into Fairbanks."). See also Michigan State Medical Society, 101 F.T.C. 191, 296 n.32 (1983) ("the bargaining process itself carries the implication of adverse consequences if a satisfactory agreement cannot be obtained"); Preferred Physicians Inc., 110 F.T.C. 157, 160 (1988) (consent order) (threat of adverse consequences inherent in collective negotiations).

[20] See Parker v. Brown, 317 U.S. 341, 351 (1943) ("a state does not give immunity to those who violate the Sherman Act by authorizing them to violate it, or declaring that their action is lawful").

[21] See California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc., 445 U.S. 92 (1980).

[22] Patrick v. Burget, 486 U.S. 94, 100 (1988).

[23] Midcal, 445 U.S. at 105-06.

The Supreme Court has made it clear that the active supervision standard is a rigorous one, designed to ensure that an anticompetitive act of a private party is shielded from antitrust liability only when "the State has effectively made [the challenged] conduct its own."[24] Active supervision requires that the state exercise "sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties."[25] In this instance, the bill does not appear to provide the Attorney General with the means to exercise sufficient independent judgment and control.

Lack of Active Supervision

The regulatory scheme established by Senate Bill 37 endeavors to provide state supervision of physician collective bargaining by authorizing the Attorney General to approve or disapprove: (1) the composition of a physician collective bargaining group, (2) a brief report on any proposed collective negotiations, and (3) a contract that was the subject of collective bargaining. The Attorney General's role is limited in significant respects, however, making it unlikely that the regulatory scheme would be found to provide the level of active supervision required to confer antitrust immunity.

1. Review of Composition of Physician Groups

The power to approve or disapprove the composition of a physician collective bargaining group is provided by Section (g)(7). This provision states that the Attorney General may limit the percentage of physicians represented by an authorized third party, but that the limitation "may not be less than 30 percent of the market." Furthermore, the Attorney Ger. 'shall" consider the potential competitive benefits and anticompetitive effects described in Sections (k) and (l). The Attorney General has no power to impose such limitations when the market of practicing physicians consists of "40 or fewer individuals."

The Supreme Court has emphasized that active supervision requires that state officials "*have and exercise* power to review *particular anticompetitive acts* of private parties and disapprove those that fail to accord with state policy."[26] The Attorney General's limited review of bargaining groups at the formation stage, under Section (g)(7), would not amount to active supervision of "particular anticompetitive acts." Indeed, in a market of "40 or fewer individuals," the Attorney General has no authority whatsoever to review the composition of physician groups. This loophole may be particularly significant in a state like Alaska which, due to its population and its large geographic area, may have a large number of physician specialty markets consisting of 40 or fewer providers.

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[24] Patrick, 486 U.S. at 106.

[25] Federal Trade Commission v. Ticor Title Insurance Co., 504 U.S. 621, 634-35 (1992).

[26] Id. at 634 (emphases added).

2. Review of "Brief Report" on Proposed Negotiations

The power to approve or disapprove a "brief report" on any proposed collective negotiations is provided by Section (h)(1)(B). This provision appears to provide the Attorney General with authority to disapprove proposed negotiations if the physician group is found to be "not appropriate to represent the interests involved in the proposed negotiations."[27] It is unclear, however, what authority this actually would confer, or how the Attorney General could make such an assessment on the basis of the limited information that the third party representative is required to submit. The report would describe the proposed subject matter of the negotiations and a statement of the expected efficiencies or benefits, but it would not supply a wide variety of information that would enable the Attorney General to assess the likely competitive effects of the negotiations. Further, there is no provision for the Attorney General to require submission of additional information, nor any mechanism by which to receive input from other physicians, affected health plans, or patients.

3. Review of Collectively Negotiated Contracts

The power to approve or disapprove a contract that was the subject of collective bargaining is provided by Sections (i) and (j). Section (i) states that the Attorney General "shall" either approve or disapprove a contract "within 30 days after receiving the reports required under (n)." During that brief period of time, the Attorney General is to attempt to ascertain whether "the competitive and other benefits of the contract terms outweigh any anticompetitive effects." Lists of competitive benefits and anticompetitive effects that the Attorney General "may" consider are provided in Sections (k) and (l), respectively.

These provisions have two principal defects that are likely to vitiate the active supervision required by the state action doctrine: (1) the Attorney General is presented with insufficient information, and (2) the Attorney General is given insufficient time. Additionally, a provision requiring a written decision for both contract approvals and disapprovals would help to ensure that adequate information is both sought and reviewed.

(a) Insufficient Information

In order for state action immunity to apply, Supreme Court precedent requires the State to

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[27] The Attorney General may not approve the report if: (1) the group of physicians "is not appropriate to represent the interests involved in the negotiations" (a provision seemingly redundant with Section (g)(7), discussed above), or (2) the proposed negotiations "exceed the authority granted in this chapter." If either of these conditions is satisfied, the Attorney General "shall" enter an order "prohibiting the collective negotiations from proceeding."

"undertake[] the necessary steps to determine the specifics of the ratesetting scheme."[28] Senate Bill 37 falls far short of providing the information necessary for state officials to make such a determination. Moreover, what little information is provided is all at the initiative of third parties. The bill does not authorize the Attorney General to request or gather specific additional information of any kind.[29]

The "brief report" would contain the "proposed subject matter" of the negotiations and one party's "explanation of the [expected] efficiencies or benefits." Notably absent from the "brief report" is a wide variety of information that would assist the Attorney General in assessing the likely competitive effects of the negotiations. An Attorney General armed with greater information – including, for example, information concerning product and geographic market definition, current price levels, availability of substitutes, or ease of entry for new competing physicians – would, of course, be better able to make appropriate determinations. An equally troubling omission from the process is any mechanism by which to receive input from other physicians, affected health benefit plans, or patients. Indeed, the process provides no notice to any of these groups, and so no means for them even to be aware of the potential value of their input.

To attempt to ascertain credibly whether "the competitive and other benefits of the contract terms outweigh any anticompetitive effects" – the core stated criterion of the Attorney General's review – without sufficient data, or adequate input from other parties, would be extremely difficult. Making judgments about competitive effects is the Commission's core function. To carry out this function, the Commission employs a large staff of lawyers and economists, who rely on information gathered from the careful review of a complete documentary record and interviews of numerous key witnesses. "Active supervision" need not necessarily entail the same exhaustive examination but, at the very least, it should constitute a pointed and meaningful review.

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[28] Ticor, 504 U.S. at 638.

[29] Courts have tended to reject claims of state action immunity where state officials lacked sufficient information to conduct a meaningful review of the private conduct. See, e.g., Ticor Title Insurance Co. v. Federal Trade Commission, 998 F.2d 1129, 1140 (3d Cir. 1993) (finding lack of state supervision where Connecticut never obtained necessary information that would have enabled it to assess the appropriateness of filed rates). In contrast, courts have tended to accept such claims where the review included hearings and an opportunity for potentially affected parties to be heard. See, e.g., TEC Cogeneration Inc. v. Florida Power & Light Co., 76 F.3d 1560 (11th Cir.), amended in part, 86 F.3d 1028 (11th Cir. 1996) (rates determined by Public Service Commission rulemaking and subject to extensive agency proceedings); DFW Metro Line Services v. Southwestern Bell Telephone, 988 F.2d 601, 606-07 (5th Cir. 1993) (Public Utility Commission conducted both broad-based ratemaking proceedings and adjudications of specific complaints about the reasonableness of rates); Lease Lights, Inc. v. Public Serv. Co., 849 F.2d 1330, 1334-35 (10th Cir. 1988) (state held public hearings to assess reasonableness of rates).

In addition, Section (h)(3) requires an authorized third party to provide the Attorney General with all communications "to be made to physicians" related to negotiations. This requirement, however, omits at least four additional categories of potentially critical competitive information: (1) communications from physicians to authorized third parties, (2) communications from authorized third parties to health plans, (3) communications between physicians, and (4) communications between authorized third parties.

It is worth noting that the core conduct at issue here, naked price-fixing among horizontal competitors, is deemed to be *per se* illegal precisely because the law presumes that in almost no circumstances imaginable will the benefits "outweigh any anticompetitive effects."[30] To be able to attempt such a judgment, the Attorney General needs to be able to review the relevant information.

(b) Insufficient Time

The law of active supervision requires that the Attorney General have and exercise "independent judgment and control" sufficient to render the challenged conduct effectively that of the State and not that of private parties. Yet Section (i) allows only 30 days for the Attorney General to review the facts and render a decision about the anticompetitive effects of a given contract. The time period is mandatory ("shall either approve or disapprove . . . within 30 days") and there is no provision for extension.[31] It is by no means clear that the Attorney General could complete the "pointed reexamination" required to immunize the underlying physician conduct in such a short time.

IV. Transparency

Section (i) of Senate Bill 37 provides that "[i]f 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." Notably, the bill contains no complementary provision requiring a written decision to *approve* a proposed contract. A written decision, expressly considering the potentially anticompetitive implications of a proposed contract and attempting to quantify the consumer impact and expected effect on consumer prices, would serve a number of salutary purposes. First, it would inform affected parties of the levels at which prices were being fixed, and so provide an opportunity for comment or challenge as to the appropriateness of those levels. Second, it would help inform the public of the likely impact of the proposed contract on their health

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[30] See Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982) (holding naked horizontal price-fixing among physicians to be per se illegal).

[31] In addition, the current legislative draft is ambiguous as to when the 30-day clock commences. Section (i) allows 30 days from receipt of "the reports required under section (h)," without specifying which report – the "brief report," the "copy of all communications," or the contract itself.

care costs.

Under the current draft, an explanation is required only when the Attorney General disapproves a contract. From a consumer perspective, however, disapproval of a contract is the less troubling result. Disapproval indicates that market forces will continue to govern, whereas approval indicates that they will be temporarily suspended, with a potentially adverse impact on price and access. It is the latter situation that more clearly warrants an explanation and is more properly subject to consumer scrutiny.

* * *

In sum, the proposed antitrust exemption for physician collective bargaining is likely to result in increased consumer costs and threatens to reduce access to care. Furthermore, the risk of consumer harm does not appear to be offset by any substantial procompetitive benefits or increased quality of care.

Parties claiming immunity under the state action doctrine bear the burden of establishing their entitlement to such immunity. If the Alaska Legislature were to enact a bill that fails to provide for the level of active supervision required by Supreme Court precedent, physicians relying on the bill's provisions to confer antitrust immunity would risk exposure to potentially significant financial liability for their actions.

Thank you for your inquiry. We hope you find these comments helpful. Should you have any additional questions, please feel free to contact Jeff Brennan at (202) 326-3688.

Sincerely,

Joseph J. Simons, Director
Jeffrey W. Brennan, Assistant Director
Bureau of Competition

R. Ted Cruz, Director
John T. Delacourt, Attorney
Office of Policy Planning

VIA FACSIMILE & REGULAR MAIL

April 10, 2002

The Honorable Norm Rokeberg
Chair, House Judiciary Committee
Alaska House of Representatives
Alaska State Capitol
Juneau, AK 99801-1182

RE Opposition to Collective Negotiation by Physicians, S.B. 37

Dear Representative Rokeberg:

I am writing on behalf of the Principal Financial Group to urge you and your committee members to oppose S.B. 37, a bill that permits collective negotiation by competing physicians with health benefits plans. The Principal is a leader in offering businesses, individuals and institutional clients products and services, including life and health insurance, retirement and investment services, and mortgage banking through its diverse family of financial service companies. We provide medical, dental, or vision insurance to over 10,000 Alaskans through Principal Life Insurance Company.

The Principal opposes this legislation because it will be very detrimental for consumers in your state. Competition is essential in order to provide quality health services on a cost-effective basis. Existing antitrust laws provide adequate flexibility for physicians, hospitals and health professionals to work together to organize networks and other provider delivery systems and distinguish themselves in ways that will benefit customers. However, S.B. 37 will ultimately cause health care costs to increase, while doing very little, if any, to improve the quality of health care for Alaskans.

Vigorous enforcement of federal and state antitrust laws is also essential if health plans are to enter new communities and continue to expand their presence by developing innovative, cost effective health care programs. Health care plans must be able to contract with quality providers without facing boycotts, price-fixing, artificial ethical restraints on the ability of doctors to enter into contracts, or local provider monopolies.

We strongly believe that enactment of S.B. 37 will diminish competition. In addition, any weakening of current antitrust laws will hamper efforts to control health care costs as health plans seek to contract with high-quality providers and reward care that is delivered both effectively and efficiently.

I hope you will consider our views and oppose this legislation. If you have any questions please call me or Martha Crist at 1-800-325-2532. Thank you.

Sincerely,

James M. Crawford
Director, Government Relations
515-247-5480
crawford.jim@principal.com

JMC:klp

cc Judiciary Committee
Merle Pederson
Jeff Tindall
Martha Crist

HIAA

Health Insurance Association of America

May 6, 2002

The Honorable Eldon Mulder and Bill Williams
Co-Chairmen, House Finance Committee
Alaska House of Representatives
Alaska State Capitol
Juneau, AK 99801-1182

Re: Senate Bill 37

Dear Co-Chairmen Mulder and Williams:

This letter pertains to CSSB 37, concerning antitrust waivers for physicians, on behalf of the Health Insurance Association of America (HIAA). HIAA is the nation's most prominent trade association representing the private health care system. Its 294 members provide health, long-term care, dental, disability, and supplemental coverage to more than 123 million Americans. We represent many of the health insurance companies which would be subject to this legislation.

HIAA respectfully recommends the committee defeat this legislation since it is unnecessary and does not improve competition or, more importantly, benefit the citizens of Alaska. Health benefit plans are not prohibited from negotiating with independent physician groups under existing law and currently negotiate with large physician groups through an independent practice association, among others. In fact, without a physician antitrust waiver, physicians have *increasingly* joined these large groups to reduce administrative costs in negotiating contracts with managed care companies, risk sharing and the need to purchase expensive equipment. As recently as February 22, 2002, the Federal Trade Commission (FTC) permitted a multi-specialty physician practice association in Denver, Colorado to proceed to improve quality.[1] Approximately 60 percent of physicians nationally belong to groups with three or more physicians and the figures are expected to dramatically increase in the next few years.[2] Competition among health insurers in Alaska is impacted primarily by the small population base in the state, and the high costs of medical care, not due to the cost of negotiating contracts with physicians and other medical service providers.

Since the contract negotiation process does not influence competition, HIAA would respectfully request the legislature amend the legislative finding in Section 23.50.010(a) which alleges competition would be increased through a physician antitrust waiver. As the trade association that represents most of the carriers affected by this legislation and the carriers

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[1] Federal Trade Commission letter authored by Jeffrey Brennan, Assistant Director, to John Miles of Ober, Kaler, Grimes & Shriver, dated February 19, 2002

[2] "Wall Street Comes to Washington: Analysts' Perspectives on Health System Change," Issue Brief, Center for Studying Health System Change, No. 17, December 1998

considering conducting business in Alaska, HIAA contends that competition would be diminished, and not improved, with the enactment of CSSB 37

The impact of the proposed CSSB 37 on small businesses could be devastating. When similar legislation was introduced at the federal level, Charles River Associates calculated that total annual personal health care spending would increase between 2.5 and 8.3 percent and that private health insurance premiums would annually increase by 4.7 to 13.2 percent as a result of this granting an antitrust waiver to physicians[3]. A premium increase at the conservative level of 4.7 percent, discounting any other factors which may increase premiums, could significantly decrease the ability of small employers to offer coverage to their employees because of the increased cost.

HIAA has significant specific concerns with CSSB 37. We support the comments in the FTC letter dated January 18, 2002 outlining the strong antitrust implications of the bill regardless of whether the issues negotiated on are fee or non-fee related, as well as their testimony before the House Labor and Commerce Committee (3/22/02). In addition, HIAA concurs with concerns raised by the Office of Attorney General (the entity charged with oversight of the proceedings under CSSB 37) as they have testified before the Senate Judiciary Committee (1/23/01) and the Senate Commerce and Labor Committee (3/8/01) that the legislation contains insufficient state supervision and would ultimately violate state and federal antitrust law[4]. Even if the legislature amended the bill to address the concerns of the Attorney General's Office and the FTC, we would respectfully recommend a thorough study of the issue before proceeding in order to examine the effects on Alaskans.

In addition, under Section 23.50.020(c), providers are permitted to negotiate with health plans over terms of fees and price if the plan exhibits substantial market power, presumably measured as 15 percent of the market under Section 23.50.020(f). This threshold appears extremely low to gauge substantial market power. HIAA would respectfully recommend, at a minimum, adhering to 30 percent of the market as recommended by FTC guidelines[5]. Increasing the substantial market threshold to 30 percent would also compare to the provisions in Section 23.50.020 (e)(6) and 23.50.020 (e)(7) which prohibits the Attorney General from limiting the representation of providers to less than 30 percent of the practicing physicians in the geographic service area. Further, why include a rebuttable presumption that a carrier has substantial market power and force the carrier to prove they do not meet the 15 percent threshold? The burden should be to prove the carrier possesses greater than the 15 percent of the market. Since few health insurers will possess the necessary market power to permit negotiations on fee-related issues, HIAA would respectfully suggest the legislature attempt to minimize the unnecessary administrative burden to all parties and amend this section.

In Section 23.50.020 (e)(f)(2), health insurers must prove they possess lower than the 15 percent substantial market power as measured by covered lives, including Medicaid and

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[3] The National Costs of Physician Antitrust Waivers, Charles River Associates Inc., March 2000, p. 21

[4] see also March 8, 2001 letter to Senate Commerce and Labor Chairman Randy Phillips, and February 5, 2001 letter to Senate Judiciary Chairman Robin Taylor, both from Attorney General Bruce Botelho

[5] Statements of Antitrust Enforcement Policy in Health Care, Issued by the U.S. Department of Justice and the Federal Trade Commission, page 65, August 1996

Medicare beneficiaries within a defined geographic area. HIAA respectfully requests both of these groups be removed from the definition of a covered life. The inclusion of the Medicare and Medicaid beneficiaries in this section may be interpreted as applying the entire legislation to these programs, which obviously is illegal in the case of Medicare, and may falsely illustrate a market power that is inapplicable to the negotiation process. CSSB 37 is aimed at the private market and inclusion of Medicaid and Medicare confuses the process.

In Section 23.50.020 (e)(f), an authorized third party may not represent more than 30 percent of the physicians unless the carrier possesses more than 5 percent of the market. HIAA would respectfully suggest amending this section to provide consistency with Section 23.50.020 (e)(f) where a carrier is deemed to have substantial market power if they enjoy 15 percent of the market. This section permits a third party representative to provide representation to all of the physicians in a designated market if a carrier has 5.01 percent of the market yet is not deemed to possess substantial market power. A carrier with 5.01 percent of the market has minimal effect on the market and should not provide all physicians with the ability to collectively negotiate as a single group. Neither of these thresholds meets the standards provided by the FTC. However, HIAA would respectfully request some equity and consistency in these provisions.

These issues raised are a few of the concerns of the insurance industry and amongst the challenges confronting the legislature with CSSB 37. HIAA respectfully believes this bill neglects to address the concerns raised by the FTC or the Attorney General's Office and cautions the committee members in their deliberations over this legislation. Thank you very much for considering our concerns. If you have any questions concerning our viewpoint, please contact me at 202.824.1708 or at jtindall@hiaa.org.

Sincerely,

Jeffrey E. Tindall
Legislative Director

cc: Reed Stoops

Alaska State Medical Association

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

May 2, 2002

Honorable Eldon Mulder, Co-Chair, House Finance Committee
Honorable Bill Williams, Co-Chair, House Finance Committee
State of Alaska
House of Representatives
House Finance Committee
Room 519
State Capitol
Juneau, AK 99801-1182

RE: SB 37 - Physician Joint Negotiations

Dear Representatives Mulder and Williams:

The Alaska State Medical Association (ASMA) represents Alaska's patients and the physicians who care for them.

ASMA supports the concepts included in SB 37 and urges you to support those concepts as well Please support and vote for SB 37.

Let me know should you have any questions. I can be reached at 907-562-6886 or you can contact ASMA's Executive Director, Jim Jordan at 907-562-0304.

Sincerely,

By: John M. Troxel, MD, President
For: Alaska State Medical Association

cc: House Finance Committee Members
ASMA Board of Trustees
Senator Pete Kelly

Alaska Physicians & Surgeons, Inc
4120 Laurel Street, Suite 206
Anchorage, Alaska 99508
Ph: 907-561-7705 Fax: 907-561-7704
E-Mail: akphys@alaska.net
Website: www.apsdoctors.org

March 13, 2002

Alaska State Legislature
State Capitol (MS 3100)
Representative Lisa Murkowski
Chairman House Labor & Commerce Committee
Juneau, AK 99801-1182

Dear Representative Murkowski:

It has come to our attention that the Alaska Nurses Association, the Alaska Nurse Practitioners Association, and the nurse midwives still oppose SB37, the Alaska Physician Negotiation Bill in its entirety, and are attempting to generate a letter writing campaign to influence your committee's vote on the bill.

We are in possession of a form letter written at the request of Sandy Perry-Provost, which contains numerous misstatements of fact and a gross misunderstanding of what, and how, SB37 would allow physicians to negotiate with third party payors.

It is important to refute a few of the more outrageous claims made in the form letter, among which are:

- The nurses claim the bill would authorize price fixing by physicians.
    - Fact: price fixing would remain illegal even if the bill were law. Nothing in the bill authorizes price fixing.
- The nurses claim the bill would allow physicians and insurers to discriminatory exclude nurses from contracts.
    - Fact: passage of the bill would in no way protect physicians or insurers from state or federal anti-trust laws if either party conspired to shut out a different provider group from a contract. In addition, at the nurses request, the bill's sponsor Senate Pete Kelly, incorporated specific language in the bill in section; 23.50.020 (p) reiterating the point that the bill does not protect physicians from exclusionary conduct.

- The nurses claim the bill would increase costs and reduce service.
    - Fact: The bill requires final approval of a contract, including the fee schedule, by the Attorney General, who has ultimate veto power. The proposed amendments given to your office should also give the Attorney General all of the authority needed to collect any and all relevant information to make an informed decision about the merits of a final contract. One of the bill's primary purposes is to foster open communication between physicians and payors to address known inefficiencies in the healthcare delivery system, and thus potentially lower the overall cost of healthcare, and increase the level of service.

The physicians in my association feel they have gone out of their way to address the nurses concerns, and have gone so far to offer verbatim use of the language in SB37, if the nurses wish to create their own negotiation bill.

If you have any questions please contact me at 561-7705.

Sincerely,

Michael Haugen, JD, MBA
Executive Director

c: Senator Pete Kelly

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

February 5, 2002

Alaska State Legislature
State Capitol (MS 3100)
Representative Lisa Murkowski
Chairman House Labor & Commerce Committee
Juneau, AK 99801-1182

Dear Representative Murkowski:

Our lobbyist has made available to us a copy of the Federal Trade Commission's comments on SB37 the Alaska Physician Negotiation Bill, and I have several comments to make.

First, the tenor and tone of the letter does not surprise me given the FTC's long-standing opposition to exemptions to federal anti-trust law. What does surprise me is that Mr. Simons and Mr. Cruz seem to be out of sink with their boss (President Bush) and his opinion on the merits of this type of legislation, given that while President Bush was Governor of Texas, he signed similar legislation.

The FTC also seems at odds with a Mr. Charles James, the current head of the US Justice Department's anti-trust enforcement division, who while counsel to Washington, DC's medical association, wrote eloquently on the merits of allowing groups of independent physicians to negotiate with third party payors, provided there is active oversight.

The first 5-½ pages of the FTC response, in my mind is nothing more than a recitation of their opposition to a federal bill (The Campbell Bill). The FTC keeps hammering the point that "costs" will rise out of control. What is critical to understand is that our bill contains substantial state oversight and safe guards, which were not included in the Campbell Bill. The discussion of the Campbell Bill was therefore gratuitous and misleading.

The FTC's criticisms on pages 6 through 9, center around issues of: substantial market power, screens for market share, and limitations on physician negotiation group size. Each of these issues and our reasoning behind the specific bill language have repeatedly been expressed in written and oral testimony by both my group, Alaska Physicians & Surgeons, and the Alaska State Medical Association. In each case the language was chosen to account for the unique nature of Alaska's geographic and demographic challenges.

Finally, the FTC's comments on pages 10 through 14 all revolve around in Mr. Simons' and Mr. Cruz's opinion that the bill, as written does not provide the State Attorney General with enough on-going information, or time, to fulfill the requirements of the active state oversight component of the State Action Doctrine. We think both of these points have merit and have addressed each issue in proposed amendments, which we have given to Senator Kelly.

It has always been the physician's intention that the oversight agency, in this case the Attorney General's office has the authority under the bill, to comply with the requirements of the active state oversight function of the State Action Doctrine. After all, it is the physicians and only the physicians who would be in legal jeopardy, if the federal requirements are not met.

If you would like to discuss any of these issues in more detail, please call me at 561-7705.

Sincerely,

Michael Haugen, JD, MBA
Executive Director

AARP Alaska

Honorable Eldon Mulder, Co-Chair
House Finance Committee
Alaska Capitol, Room 507
Juneau, AK 99801-1182

Honorable Bill Williams, Co-Chair
House Finance Committee
Alaska Capitol, Room 511
May 3, 2002

RE: SB 37 (Kelly) – Oppose

Dear Co-Chairs Mulder and Williams:

On behalf of the members of AARP in Alaska, we urge you and your colleagues on the House Finance Committee to oppose SB 37, authored by Senator Pete Kelly.

Although some of the worst aspects of SB 37 have been amended out, this is still a bill that will not help any Alaskans, except for those who happen to be physicians. The Department of Law and the Department of Insurance have both recommended against this bill. Likewise, the Federal Trade Commission has also indicated that the bill is inappropriate. AARP agrees with that opposition.

AARP considers itself a consumer organization. As consumers, we are well aware of the cost of medical services. We believe that SB 37 would increase the cost of health care to everyone who pays for it, employers (including the State of Alaska), employees with health benefits, retirees, the self-employed, and the growing number of uninsured in our State.

AARP members live throughout our State. We believe SB 37 might be particularly harmful to our rural members who often rely on nurse practitioners for their primary care.

Alaska has a Patient's Bill of Rights. If we need to address quality of care issues, we should determine what is already included in the Patient's Bill of Rights and, if additional measures need to be added, that is the appropriate venue. At this time AARP does not see any additional issues in SB 37 that are not already in law.

AARP members, possibly more than other segment of the population, are consumers of health care. Our members have told us that fewer physicians are willing to accept Medicare, fewer physicians are willing to see Medicare patients, and more and more physicians are telling 64 year olds that they will not see them once they turn 65 and are eligible for Medicare. We understand that this is a health care business but AARP would prefer to see legislation that addresses improved "care" rather than improved "profits". SB 37 does not offer any opportunity for consumer input into this issue.

We already have some of the highest health care costs in the United States. We believe SB 37 would only increase those costs without any increase in the quality of care.

AARP urges a "Nay" vote on SB 37.

3601 C Street, Suite 1420 |Anchorage, AK 99503 |907-341-2277 |907-341-2270 fax |1-877-434-7598 TTY
Esther "Toss" Canja, President |William D. Novelli, Executive Director and CEO | www.aarp.org

SB

37

REPORTED OUT
MAR 2 8 2001
SENATE FINANCE COMMITEE

SENATE FINANCE COMMITTEE REPORT

DATE: 3/14/01

FURTHER:

DATE TURNED IN TO OFFICE: 29 Mar01

Finance Committee considered SENATE BILL NO. 37

PHYSICIAN NEGOTIATIONS WITH HEALTH INSURE

"An Act relating to collective negotiation by physicians with health benefit plans; and to health benefit plan contracts with individual competing physicians."

and recommends:

[✓] be **replaced** with ____ **CS** SB 37 (FIN)

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

[ ] attached amendment(s)

[ ] adopt Letter of Intent by _____ Committee

[ ] further referral to _____ Committee

Senate Bill:
[✓] same title
[ ] new title

House Bill:
[ ] same title
[ ] technical title
[ ] new: SCR #____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Zero	FN#
amended fiscal note administration zero				

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Zero	FN#
H&SS	1/17/01		✓	#4
DCED	1/19/01	30.1		#2
LAW	1/22/01	357.0		#1

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	DO PASS	DO NOT PASS	NO REC	AMEND
			✓	
		✓		
			✓	
	✓			
			✓	
	✓			
COCHAIR:			✓	
COCHAIR:	✓			

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CSSB 37 (FIN)
(S) Publish Date:

Revision Date/Time (Note if correction): 3/28/2001
Dept. Affected: Administration
Title: "An Act relating to collective negotiation by physicians with health benefit...
BRU: Centralized Admin Svcs.
Component: Retirement & Benefits
Sponsor: Senate Finance
Requester: Senate Finance Committee
Component Number: 64

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
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	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2001) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

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

This version of the bill will have no fiscal impact on the State's ability to manage health care costs.

Prepared by: SENATE FINANCE COMMITTEE
Phone: 465-1881

Senator: SENATOR PETE KELLY,CO-CHAIR
SENATOR DAVE DONLEY,CO-CHAIR
Date: 3/28/2001

REPORTED OUT

MAR 2 8 2001

SENATE FINANCE COMMITEE

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: SB 37
(S) Publish Date: 2/22/01

Revision Date/Time (Note if correction):
Dept. Affected: Law
Title "An Act relating to collective negotiation by physicians with health benefit plans; ..."
BRU Civil Division
Component Fair Business Practices
Sponsor Senator Pete Kelly
Requester Senate Judiciary Committee
Component No. 2206

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services	199.8	199.8	199.8	199.8	199.8	
Travel	5.6	5.6	5.6	5.6	5.6	
Contractual	135.9	135.9	135.9	135.9	135.9	
Supplies	2.7	2.7	2.7	2.7	2.7	
Equipment	13.0					
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**357.0**	**344.0**	**344.0**	**344.0**	**344.0**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )		344.0	344.0	344.0	344.0	0.0

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts						
1003 GF Match						
1004 GF	249.9					
1005 GF/Program Receipts	107.1	344.0	344.0	344.0	344.0	
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	**357.0**	**344.0**	**344.0**	**344.0**	**344.0**	**0.0**

Estimate of any current year (FY2001) cost: 0.0

POSITIONS

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

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

SB 37 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, 2006.

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

Prepared by: Joan M. Kasson
Phone 465-5370
Division Attorney General's Office
Date/Time 1/22/01 8:59 AM
Approved by: Kathryn Daughhetee for Bruce M. Botelho, Attorney General
Date 1/22/2001
Agency Department of Law

For distribution information, call the Governor's Legislative Office

(Rev 11/2000 OMB)

COMMITTEE COPY

ANALYSIS CONTINUATION

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 2,050 licensed physicians 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 2002 standard full-time equivalent attorney and paraprofessional schedules, which include clerical support, communications, space, supplies, data processing, and other normal overhead expenses. (FTE attorney: $141,776, FTE paraprofessional: $92,230). 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 2002.

REPORTED OUT

MAR 2 8 2001

SENATE FINANCE COMMITEE

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number: 2
Bill Version: SB 37
(S) Publish Date: 2/22/01

Revision Date/Time (Note if correction): 1/19/2001 5:25pm
Dept. Affected: DCED
Title: An act relating to collective negotiation by physicians with health benefit plans
BRU: Insurance
Component: Insurance
Sponsor: Senator Pete Kelly
Requester: Senate Judiciary
Component Number: 354

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services	23.6	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					
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**30.1**	**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	30.1					
1005 GF/Program Receipts		25.1	25.6	26.1	26.6	27.1
1037 GF/Mental Health						
1156 RSS						
TOTAL	**30.1**	**25.1**	**25.6**	**26.1**	**26.6**	**27.1**

Estimate of any current year (FY2001) cost: 0.0

POSITIONS

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

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

A part-time administrative clerk III position is needed in order to gather and report the health benefit plan market share information required under Sec. 23.50.020 (e)(C), page 4, lines 12&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 employers who do not respond to the survey.

Prepared by: Robert A. Lohr
Phone 907-269-7900
Division: Insurance
Date/Time 1/19/2001 5:25:00pm
Approved by: Commissioner, Deborah B. Sedwick
Date 1/19/2001
Agency: Dept. of Community & Economic Development

For distribution information, call the Governor's Legislative Office

(Rev 11/2000 OMB)

COMMITTEE CC:

REPORTED OUT

MAR 2 8 2001

SENATE FINANCE COMMITEE

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number: 4
Bill Version: SB 37
(S) Publish Date: 2/22/01

Revision Date/Time (Note if correction):
Dept. Affected: Health and Social Services
Title: Collective bargaining by physicians
BRU: Medical Assistance
Component: Medicaid Services
Sponsor: Kelly
Requester: Judiciary
Component Number: 2077

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 G.						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2001) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

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

The Division of Medical Assistance assumes this bill will not impact the Medicaid and CAMA programs as the definition of health benefit plan in AS 21.54.500 does not include these public programs. Federal rules require Medicaid compensation to be sufficient to enlist enough providers so that services under the plan are available to the same extent as to the general public, however reimbursement rates for all services are also driven by appropriations. The Department of Health and Social Services supports exclusion of public programs from the physician negotiations provisions of this legislation.

Prepared by: Nancy Weller
Phone 465-3355
Division Medical Assistance
Date/Time 1/17/01 12:00 AM
Approved by: Elmer A. Lindstrom, Special Assistant to the Commissioner
Date 1/23/01 3:44 PM
Agency Department of Health & Social Services

For distribution information, call the Gove .or's Legislative Office

(Rev 11/2000 OMB)

COMMITTEE CC:

amended (+ adopted)

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CSSB(37)(L&C)
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Administration
Title: An Act relating to collective negotiation by physicians with health benefit...
BRU: Centralized Administrative Services
Component: Retirement and Benefits
Sponsor: Senator Pete Kelly
Requester: Senate Finance
Component Number: 64

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0	*	*	*	*	*
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 (FY2001) cost: *

POSITIONS

Full-time						
Part-time						
Temporary						

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

~~The 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.~~

~~The State's contribution as an employer is capped by collective bargaining agreements and is in statute for non covered employees. Any increase in cost will be borne by employees. Based upon FY 01 premiums, this could raise each employee's cost $34 to $88 per month.~~

Delete language

Prepared by: Guy Bell, Director
Phone 465-4471
Division Retirement and Benefits
Date/Time March 14, 2001

Approved by: Jim Duncan, Commissioner
Date March 15, 2001
Agency Department of Administration

For distribution information, call the Governor's Legislative Office

(Rev 11/2000 OMB)

SENATE FINANCE
COMMITTEE
Amendment Number: #1 adopted
Bill Number: SB 57
Sponsor: Kelly Date: 3/28/01
Logged In By: Cindy

22-LS0323\B.1
Bannister
3/28/01

AMENDMENT

OFFERED IN THE SENATE Senator Kelly

TO: CSSB 37( ), Draft Version "B"

Page 7, lines 15 – 19:

Delete all material and insert:

"(p) Nothing in this section shall be construed as exempting from the application of the antitrust laws the conduct of providers or negotiations or agreements between providers and a health benefit plan if the purpose or effect of the conduct, negotiations, or agreements would be, directly or indirectly, to exclude, limit the participation or reimbursement of, or otherwise limit the scope of services to be provided by separate or competing classes of providers who practice or seek to practice within the scope of the occupational licenses held by the providers."

Amend #2. (adopted)

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) "health benefit plan" has the meaning given in AS 21.54.500, but does not include a health benefit plan that is a self-insured health benefit plan.

* **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, 2006.~~ delete

Alaska State Senate

Senate Finance Committee

Official Business

Mail Stop 3100
State Capitol
Juneau, Alaska 99801-1182

FAX COVER SHEET

DATE: 28 March 2001 TIME: 6:45 pm

TO: Legal Services

NUMBER OF PAGES, INCLUDING COVER SHEET: 3

FROM: MINDY ROWLAND
SENATE FINANCE COMMITTEE SECRETARY
PHONE: 465-4935
FAX: 465-2187

NOTES: Request for final
SB 34 22-LS0323\B 3/27/01
with 2 amendments attached

Thanks.
Mindy

faxed

CS FOR SENATE BILL NO. 37(FIN)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SECOND LEGISLATURE - FIRST SESSION

BY THE SENATE FINANCE COMMITTEE

Offered:
Referred:

Sponsor(s): SENATOR KELLY

A BILL

FOR AN ACT ENTITLED

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

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 competing physicians. (a) Competing physicians may meet and communicate in order to collectively negotiate with a 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) physician 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 (d) 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) An authorized third party that intends to negotiate with a health benefit plan the items identified under (a) of this section shall provide the attorney general with written notice of the intended negotiations before the negotiations begin. Negotiation of items identified in (a) of this section shall be conducted separately from, and shall be concluded before, negotiations are begun of the items identified in (b) of this section.

(d) Competing physicians within the service area of a health benefit plan may collectively negotiate with a health benefit plan the items described in (b) of this section if

(1) the health benefit plan has substantial market power;

(2) negotiation of items identified under (a) of this section has concluded;

(3) the physicians and the health benefit plan jointly request the attorney general to authorize them to negotiate the items identified under (b) of this section; and

(4) the attorney general issues a written authorization for the physicians and the health benefit plan to negotiate the items.

(e) The attorney general shall provide the authorization described under (d) of this section if the requirements of (d)(1), (2), and (3) have been met.

(f) A health benefit plan is rebuttably presumed to have substantial market

power. A health benefit plan may rebut the presumption of substantial market power 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.

(g) In exercising the collective rights granted by (a) and (d) 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 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;

(7) the attorney general may limit the percentage of practicing physicians represented by an authorized third party; however, the limitation may not

be less than 30 percent of the market of practicing physicians in the geographic service area or proposed geographic service area: when determining whether to impose a limitation described under this paragraph, the attorney general shall consider the provisions described under (j), (k), and (l) of this section: this paragraph does not apply if the market of practicing physicians in the geographic service area or proposed geographic service area consists of 40 or fewer individuals; and

(8) the authorized third party shall comply with the provisions of (h) of this section.

(h) 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 physicians represented by the 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 shall review whether the group of physicians represented by the authorized third party is appropriate to represent the interests involved in the negotiations; the attorney general may not approve the report if the group of physicians is not appropriate to represent the interests involved in the negotiations or if the proposed negotiations exceed the authority granted in this chapter and, if the group is not appropriate or the negotiations exceed the granted authority, 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 terminate negotiations, or within 14 days after requesting negotiations with a health benefit plan that 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.

(i) 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 (h) 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.

(j) The attorney general shall approve a collective negotiation contract 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.

(k) 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.

(l) 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.

(m) 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.

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

(o) 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.

(p) Nothing in this section shall be construed as exempting from the application of the antitrust laws the conduct of providers or negotiations or agreements between providers and a health benefit plan if the purpose or effect of the conduct, negotiations, or agreements would be, directly or indirectly, to exclude, limit the participation or reimbursement of, or otherwise limit the scope of services to be provided by separate or competing classes of providers who practice or seek to practice within the scope of the occupational licenses held by the providers. #1

(q) A contract entered into under this section must be consistent with AS 21.36.090(d).

(r) Nothing in this section shall be construed to make any conduct by providers unlawful if the conduct was lawful before the effective date of this Act.

(s) In this section,

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

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

(3) "provider" has the meaning given in AS 21.36.090(d);

(4) "substantial market power" means more than 15 percent of the market share.

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) "health benefit plan" has the meaning given in AS 21.54.500, but does not include a health benefit plan that is a self-insured health benefit plan.

* **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.

#2

adopted

22-LS0323\B
Bannister
3/27/01

CS FOR SENATE BILL NO. 37( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SECOND LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR KELLY

A BILL

FOR AN ACT ENTITLED

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

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 competing physicians. (a) Competing physicians may meet and communicate in order to collectively negotiate with a 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) physician 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 (d) 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) An authorized third party that intends to negotiate with a health benefit plan the items identified under (a) of this section shall provide the attorney general with written notice of the intended negotiations before the negotiations begin. Negotiation of items identified in (a) of this section shall be conducted separately from, and shall be concluded before, negotiations are begun of the items identified in (b) of this section.

(d) Competing physicians within the service area of a health benefit plan may collectively negotiate with a health benefit plan the items described in (b) of this section if

(1) the health benefit plan has substantial market power;

(2) negotiation of items identified under (a) of this section has concluded;

(3) the physicians and the health benefit plan jointly request the attorney general to authorize them to negotiate the items identified under (b) of this section; and

(4) the attorney general issues a written authorization for the physicians and the health benefit plan to negotiate the items.

(e) The attorney general shall provide the authorization described under (d) of this section if the requirements of (d)(1), (2), and (3) have been met.

(f) A health benefit plan is rebuttably presumed to have substantial market

power. A health benefit plan may rebut the presumption of substantial market power 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.

(g) In exercising the collective rights granted by (a) and (d) 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 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;

(7) the attorney general may limit the percentage of practicing physicians represented by an authorized third party; however, the limitation may not

be less than 30 percent of the market of practicing physicians in the geographic service area or proposed geographic service area; when determining whether to impose a limitation described under this paragraph, the attorney general shall consider the provisions described under (j), (k), and (l) of this section; this paragraph does not apply if the market of practicing physicians in the geographic service area or proposed geographic service area consists of 40 or fewer individuals; and

(8) the authorized third party shall comply with the provisions of (h) of this section.

(h) 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 physicians represented by the 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 shall review whether the group of physicians represented by the authorized third party is appropriate to represent the interests involved in the negotiations; the attorney general may not approve the report if the group of physicians is not appropriate to represent the interests involved in the negotiations or if the proposed negotiations exceed the authority granted in this chapter and, if the group is not appropriate or the negotiations exceed the granted authority, 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 terminate negotiations, or within 14 days after requesting negotiations with a health benefit plan that 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.

(i) 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 (h) 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.

(j) The attorney general shall approve a collective negotiation contract 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.

(k) 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.

(l) 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.

(m) 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.

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

(o) 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.

(p) Nothing in this section exempts from the application of the antitrust laws an agreement or activity that is not allowed under this chapter and that excludes, limits the participation in, limits the reimbursement of, or limits the scope of services to be provided by providers or groups of providers with respect to the performance of services that are within the scope of the providers' occupational licenses.

(q) A contract entered into under this section must be consistent with AS 21.36.090(d).

(r) Nothing in this section shall be construed to make any conduct by providers unlawful if the conduct was lawful before the effective date of this Act.

(s) In this section,

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

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

(3) "provider" has the meaning given in AS 21.36.090(d);

(4) "substantial market power" means more than 15 percent of the market share.

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) "health benefit plan" has the meaning given in AS 21.54.500, but does not include a health benefit plan that is a self-insured health benefit plan.

* **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, 2006.

CS for Senate Bill 37
Version: 22-LS0323\B
Sectional Analysis

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

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

Chapter 50. Collective Negotiation by Physicians.

AS 23.50.010

AS 23.50.010 articulates the reasons for the Legislature to set policy to allow joint negotiations between a group of competing physicians and a health insurance company.

AS 23.50.020

AS 23.50.020 (a) enumerates those items which may be the subject of joint negotiations. Those items include clinical practice guidelines and coverage criteria; respective liability of physicians and health care insurers; administrative procedures that include methods and timing of payments to physicians; resolution dispute procedures; patient referral procedures; application of the reimbursement methodologies to be used; quality assurance programs; utilization review procedures; and criteria for the selection and termination of participating physicians. Note that this subsection does not allow for negotiation for that fee or payment related items unless the conditions of AS 21.50.020 (c) are met.

AS 21.050.020 (b) prohibits joint negotiations involving fees or prices for services; the conversion factor in a RBRVS type payment methodology; amounts of discount on the physician services; and dollar amounts for a "captivation" basis of payment. However, it still allows physicians to jointly and collectively petition government for a change in law that provides for payment to doctors under a governmental program (e.g., Medicaid).

AS 21.050.020(c) requires an authorized third party that intends to negotiate with a health benefit plan provide written notification to the Attorney General of when the process is to commence. This section also notes if fees are to be negotiated, medical services must be negotiated first and concluded in (b) of this section.

AS 21.050.020 (d) states that physicians within a service area of a health benefit plan may collectively negotiate if "substantial market power" is present. The Attorney General shall then notify parties of the intent of the negotiations.

The exception is made to allow for joint negotiation for those fee items listed in AS 21.050.020 (d) when a health insurer has "substantial market power." AS 21.050.020 (s)(4) defines a substantial market power when an insurer has more than 15% of the market place as measured by the number of people covered are those covered under Medicaid and Medicare if an insurer provides any claim payment services for the government for those programs. The concept is based in that all "bodies" covered and threats of not contracting with a certain physician are based on the deleterious effect on a physician's practice by removing those patients from his/her practice. Enumerating the persons covered may be difficult for the Division of Insurance. In fact, it is impossible for the Division of Insurance to compel self-insureds to provide it with those data. In one state currently addressing the State Action Doctrine exemption issue (California), it is being considered to just require all health plans to negotiate with physicians without having to prove the "substantial market power" percentage. (Obviously this would allow physicians to still jointly negotiate under active state oversight). The reason for this is that it is clear in California that less than 6 health plans dominate Alaska's marketplace. In (1) of this section, substantial market power is calculated by the numbe· of covered lives per calendar year or number of consumers of prepaid health services divided by the total population of a geographic service area from the most recent census.

AS 21.050 (g) sets out the criteria for those collective rights to be carried out by the physicians jointly negotiating. The core provision is that negotiations are to be conducted through an "authorized third party" that will negotiate on behalf of the physicians who ha· e joined together for that purpose. Conceivably, that person acting as the authorized third party representative could be an IPA, a lawyer, a physician, a specialty medical society, a local medical association, a state medical association, etc. It is presumed a contractual relationship will exist between the represented physicians and the authorized third party that memorializes the obligations and requirements of the parties. This subsection states that the physician who have joined for the purpose of negotiation may communicate with their authorized third party about terms and conditions, which are to be negotiated. The authorized third party is the sole person who is to negotiate on behalf of the doctors. Subsection (5) of this section may provide some confusion in that it would appear to defeat the purpose of the joint negotiations. The intent of subsection (5) is to provide, for example, for different rates of reimbursement to be included for different specialties. (For example, anesthesiologists are typically reimbursed in a different manner than a surgeon and both may be in the same group of physicians engaged in joint negotiations.) Generally, an authorized third party may not represent more than 30% of the physicians. Obviously, the concern would be that physicians represented in great numbers would dictate the terms of a contract to an insurer or health plan. By the same token, for example, it would be unfair for a specialist, who is the only one in a particular area, not be able to join with other physicians to jointly negotiate. This is an area that active state oversight would be necessary so that a fair result for the general public would be the outcome.

AS 21.050.020 (h) sets out what a person desiring to act as an authorized third party needs to do in order to act in that capacity. In short, the authorized third party needs to

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

AS 21.050.020 (i) requires the Commissioner, with the advice of the Attorney General, to either approve or disapprove a negotiated contract within 30 days of when it was presented. If it is disapproved, the Commissioner must give a written explanation of the deficiencies and how they could be corrected.

AS 21.050.020 (j) explains the Attorney General shall approve a collective negotiation if a competitive aspects outweigh any anti-competitive effects. Also, that the contract terms must be consistent with other applicable laws and regulations.

AS 21.050.020 (k) states the terms of the contracts may include a competitive balance in the market; protections for access to quality patient care; promotion of health care infrastructure and medical advancement; and improved communications between the providers and insurers.

AS 21.050.020 (l) explains the Attorney General may examine possible anti-competitive effects in the terms. Under that consideration the AG examines the possibility of excessive payment; or contributes to the escalation of cost in providing health care services.

AS 21.050.020 (m) prohibits the physicians represented from acting together in response to a report from their authorized third party regarding its discussion or negotiation with a health care insurer or health plan. The authorized third party has a duty to warn the physicians represented of the potential legal action under state and federal anti-trust laws for exceeding the authority granted by this measure.

AS 21.050.020 (n) limits the terms of any contract negotiated to 5 years. It is expected that terms of actual contracts will be for less than 5 years.

AS 21.050.020 (o) keeps all documents relating to joint negotiations, that would come from both physicians and insurers or health plans, confidential and not subject to public inspection.

AS 21.050.020 (p) does not exempt from to exclude the services provided by a provider or group of providers or that limits the participation or scope of services provided within

the scope of certain occupational licenses. This portion of the legislation was amended to meet concerns of the nurse practitioners and midwives. They were concerned their services could be negotiated out of the agreements. This reaffirms AS 21.36.090(d) which prohibits an insurer, HMO, hospital, or medical service-corporation from unfairly discriminating in its benefits between different types of medical care providers.

AS 21.050.020 (s) defines the terms "covered lives", "geographic service area", and "provider", and "substantial market power".

***AS 23.50.030**

AS 23.50.030 creates a fee mechanism to Cover State's cost of providing its active oversight of the joint negotiation authorized by this bill. The fee is to be reflective of the actual costs that the State incurs. The Commissioner sets the fees by regulation and must report on the fees each year to the Office of Management and Budget. At least one other state in dealing with a "State Action Doctrine" exception (California) charges the regulatory costs to health care insurers and health plans on a pro-rata share based on their market share. Theoretically, the cost should be the same without regard to who pays it. If the physicians pay it via their authorized third party, then they will negotiate sufficient payment levels to cover that cost. Conversely, if the insurers and health plans pay it, then they will negotiate sufficient payment levels to cover that cost. The issue is what is the most efficient and fair method of payment to cover the cost. Obviously, the physician community will not be supportive of a fee mechanism that requires a payment up-front only to have an insurer decline to negotiate and not receive any refund.

***AS 23.50.040**

AS 23.50.040 allows the Commissioner of Labor and Workforce Development to adopt regulations to implement this law.

***AS 23.50.099**

AS 23.50.099 is the definition section and contains the definition of the terms "authorized third party", "health benefit plan". The definition of "health benefit plan" in this section excludes those self-insured health benefit plans. These definitions are straightforward and unambiguous.

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

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