

- SUBJECT:** Joint negotiation by physicians with health-benefit plans
- COMMITTEE:** Insurance — committee substitute recommended
- VOTE:** 7 ayes — Smithee, Eiland, Burnam, G. Lewis, J. Moreno, Olivo, Wise
0 nays
2 absent — Seaman, Thompson
- SENATE VOTE:** On final passage, April 28 — voice vote
- WITNESSES:** (*On House companion bill, HB 3039:*)
For — Spencer Berthelson, Texas Medical Association and Kelsey Seybold Clinic; Craig Callewart; John Gill; David Hilgers, Texas Surgeons, Health Institute of Texas, South Texas Physician Association, and Premier IPA; Donald Palmisano, American Medical Association; Robert Sloane, Texas Medical Association

Against — Richard Evans, Texas Association of Business and Chambers of Commerce; Shirley Hutzler, Texas Association of Health Underwriters; Jerry Patterson, Texas Association of Health Plans
- BACKGROUND:** Federal antitrust law limits the ability of physicians to negotiate jointly with health-benefit plans. Individual physicians can negotiate on their own, and groups of physicians, such as independent provider associations or individual practice associations (IPAs), can negotiate contract terms for the physicians within the IPA. These IPAs, however, are subject to strict federal guidelines on the sharing of proprietary information and to prohibitions against price-fixing. Groups of physicians that are not organized into an IPA are not permitted to negotiate jointly with health-benefit plans and may violate antitrust laws if they discuss the terms or conditions of their contracts with health-benefit plans.

Physicians may seek advisory opinions from the Federal Trade Commission (FTC) on whether their actions would violate antitrust laws. The penalty for violating antitrust law can be up to three years in federal prison or a \$350,000

fine. An IPA or other group of physicians can be fined up to \$10 million for an antitrust violation.

Federal law allows states to carve out exceptions to antitrust laws to enable physicians to negotiate jointly.

DIGEST:

CSSB 1468 would allow groups comprising no more than 10 percent of the physicians within a health-benefit plan's service area to negotiate contract terms and conditions with the health-benefit plan, except for actual fee or discount amounts. The bill would allow the attorney general to authorize joint negotiation of actual fee and discount amounts by physicians in limited circumstances where the benefits of joint negotiation would outweigh the disadvantages from reduced competition. Physicians would be prohibited from jointly coordinating work slowdowns or strikes. Physicians could not negotiate jointly for the sole purpose of avoiding or requiring participation in all of a health-care plan's products as a condition of participation in one of the health-care plan's products.

Joint negotiation for terms other than fees or discounts. CSSB 1468 would allow competing physicians within the service area of a health-benefit plan to meet and communicate for the purpose of jointly negotiating the following terms and conditions of contracts with the health-benefit plan:

- ! practices and procedures to assess and improve the delivery of effective, cost-efficient medical care, including preventative health care, pediatric care, women's health care, disease management programs, patient education, and treatment compliance;
- ! practices and procedures to identify, correct, and prevent potential fraud;
- ! practices and procedures for the effective, cost-efficient use of outpatient surgery;
- ! clinical practice guidelines and coverage criteria;
- ! administrative procedures, including methods and timing of physician payment for services;
- ! dispute resolution procedures relating to disputes between health benefit plans and physicians;
- ! patient referral procedures;
- ! formulation and application of physician reimbursement methodology;
- ! quality assurance programs;

- ! health service utilization review procedures, which are methods used by the health-benefit plan to determine whether a treatment is medically necessary;
- ! health-benefit plans' criteria for choosing and terminating physicians; and
- ! inclusion or alteration of terms and conditions that are prohibited or required by government regulation, although physicians always would be able to petition government jointly for changes to regulation.

The bill would not prohibit individual physicians or physician associations from negotiating the terms and conditions of contracts as permitted by other state and federal law.

Prohibition on joint fee negotiation. Most competing physicians could not meet and communicate for the purpose of jointly negotiating the following terms and conditions:

- ! fees and prices for services, including those arrived at by applying any reimbursement methodology procedures;
- ! conversion factors in a resource-based relative-value-scale reimbursement methodology, which is a fee schedule that establishes a relative value for each diagnosis code based a conversion factor relative to the amount of physician work and estimated overhead;
- ! the amount of any discount on the price of services to be rendered by physicians; and
- ! the dollar amount of capitation or fixed payment for health services rendered by physicians to health-benefit plan enrollees.

Joint fee negotiation in certain areas. Competing physicians could jointly negotiate fee and discount terms that ordinarily are prohibited if the health-benefit plan in their area had substantial market power as determined by the attorney general and those fee and discount terms already had affected or threatened to affect adversely the quality and availability of patient care. This joint negotiation would not be allowed with Medicaid managed care plans or children's health plans issued under the Health and Safety Code or designed under the federal Social Security Act.

CSSB 1468 would authorize the Texas Department of Insurance (TDI) to collect and investigate information necessary to determine, on an annual basis, the average number of covered lives per month per county by every

health-care entity in the state and the annual impact, if any, of CSSB 1468 on average physician fees in Texas.

Prohibited joint action. The bill would not enable physicians to coordinate jointly any cessation, reduction, or limitation of health-care services. Physicians could not negotiate jointly for the sole purpose of avoiding or requiring participation in all of a health-care plan's products as a condition of participation in one of the health-care plan's products.

Representatives of physicians in joint negotiation would have to advise physicians about the law and warn them of the potential for legal action if they violated state or federal antitrust laws when acting outside the authority that the bill would give.

Joint negotiation requirements. Competing physicians' joint negotiation rights would be subject to the following criteria:

- ! A physicians' representative, who could be a third party or one of the negotiating physicians, would be the sole party authorized to negotiate with health-benefit plans on behalf of the physicians as a group.
- ! Physicians could communicate with their representative over the contractual terms and conditions to be negotiated.
- ! Physicians could communicate with each other about the contractual terms and conditions to be negotiated.
- ! At the option of each physician, the physicians could agree to be bound by the terms and conditions negotiated by the physicians' representative.
- ! Health-benefit plans communicating or negotiating with the physicians' representative would remain free to contract with or offer different contract terms and conditions to individual competing physicians.
- ! The physicians' representative would have to comply with the requirements set out by the bill.

Requirements for physicians' representatives. Any person or organization proposing to act or acting as a physicians' representative in joint negotiations would have to comply with certain requirements. Before engaging in any joint negotiations, the representative would have to furnish a report, subject to the attorney general's approval, that identified:

- ! the representative's name and business address;
- ! the names and addresses of the physicians who would be represented by the identified representative;
- ! the relationship of the physicians requesting joint representation to the total population of physicians in a geographic service area;
- ! the health-benefit plans with which the representative would negotiate;
- ! the representative's plan of operation and procedures to ensure compliance with the law;
- ! the expected impact of negotiations on the quality of patient care; and
- ! the benefits of a contract between the identified health-benefit plan and physicians.

An approval of this initial filing by the attorney general would be effective for all subsequent negotiations between the parties specified in the initial filing. If the identified parties reached an agreement, the representative would have to furnish a copy of the proposed contract and plan of action to the attorney general for approval. Within 14 days of the health-benefit plan's declining negotiation, terminating negotiation, or failing to respond to a request for negotiation, the representative would have to report the end of negotiations to the attorney general. If negotiations were renewed within 60 days of the notice, the representative could renew a previously filed report without submitting a new report for approval.

Approval by the attorney general. The attorney general would have to approve a request to enter into joint negotiations or a proposed contract if the attorney general determined that the applicants had demonstrated that the likely benefits would outweigh the disadvantages from a potential reduction in competition. No more than 10 percent of the physicians in a health-benefit plan's defined geographic service area could participate in joint negotiation, except in cases where conditions supported the approval of a greater or lesser percentage according to the other considerations in the bill.

The attorney general would have to approve or disapprove an initial filing, supplemental filing, or proposed contract within 30 days of each filing. If the attorney general did not act within the specified time period, an applicant could file a petition in a Travis County district court for an order requiring the attorney general to approve or disapprove the contents of the filing or contract as soon as possible.

If a filing or contract was disapproved, the attorney general would have to furnish a written explanation of any deficiencies along with a statement of how to correct those deficiencies. A representative who failed to obtain the attorney general's approval would be acting without authority.

Rulemaking authority and fees. CSSB 1468 would authorize the attorney general and the commissioner of insurance to promulgate rules necessary to implement its provisions. Physicians' representatives would have to pay a fee to TDI, while the attorney general could set reasonable fees to cover administrative costs. These fees would have to be deposited in the state treasury to the credit of the operating fund from which the expense was incurred.

Applicable and non-applicable plans. The health-benefit plans that would be covered by CSSB 1468 include plans offered by insurance companies, health-maintenance organizations, group hospital service corporations, stipulated premium insurance companies, reciprocal exchanges, and certified multiple-employer welfare arrangements.

CSSB 1468 would not apply to a health-benefit plan that offered only coverage for a specified disease or limited benefit, accidental death or dismemberment, lost wages due to sickness or injury, supplemental liability insurance, credit insurance, dental or vision care, hospital expenses, or indemnity for hospital confinement. CSSB 1468 also would not apply to small-employer health-benefit plans, Medicare supplemental policies, workers' compensation insurance coverage, medical payment insurance coverage issued as part of an automobile insurance policy, or a long-term care policy, including a nursing home indemnity policy, unless the attorney general determined that the latter policy was so comprehensive that it should be included as a covered health-benefit plan.

Expiration and effective date. CSSB 1468 would take effect September 1, 1999, and would expire on September 1, 2003.

**SUPPORTERS
SAY:**

The growth of managed care has given health-benefit plans a tremendous advantage over individual physicians in contract negotiations. These contracts typically contain terms and conditions that are terribly onerous for the individual physician, such as reducing payment if the health-plan enrollees

make too many visits to the doctor or transferring all liability for the cost of patient care to the physician. These onerous provisions hurt patient care. Individual physicians face the choice of turning down health plans that dominate the market or joining IPAs when they would rather work on their own. CSSB 1468 would prevent health-benefit plans from bullying individual physicians into accepting contracts that are good for the health-benefit plan at the expense of the patient and the physician.

Health-benefit plans now tell physicians to “take it or leave it” and justify this by arguing that the physician is free to contract with other plans or find other patients. This bill would apply the same logic to health-benefit plans, since the joint negotiations would be voluntary and not binding unless agreed to by the plan. Plans could go to other physicians or groups of physicians and even could meet individually with physicians in the negotiating group.

Every aspect of the joint negotiation would have to be approved by the attorney general. Only 10 percent of the physicians in a health-benefit plan’s service area could negotiate together. If all of the specialists in an area fell within the 10 percent limit, the attorney general could take action to prevent anticompetitive or monopolistic negotiation by the specialists. Physicians could jointly negotiate fee or discount terms only if the attorney general determined that patients would benefit. These protections ensure that CSSB 1468 would not be abused or decrease the quality of patient care.

CSSB 1468 is not a union bill. In fact, the bill likely would keep individual physicians from exercising their existing right to form unions if joint negotiation would give physicians more clout in dealing with health-benefit plans. The bill would not authorize the use of strikes or work slowdowns as negotiating tools. Physicians swear an oath to do no harm, and any collective bargaining tactic that harmed patients would violate that oath.

IPAs are not substitutes for the joint negotiation that would be provided by this bill. Forming an IPA is a complex and expensive process, and even then the IPA cannot negotiate freely without setting up strict procedures against sharing proprietary information. Even if an IPA or group of physicians goes to the expense of requesting an advisory opinion from the FTC, these advisory opinions do not prevent a health-benefit plan from bringing future antitrust actions against the physicians. The threat of bringing an antitrust action is enough to force a physician or IPA into submission, because the

expense and time involved in defending against even an unsubstantiated antitrust claim can be enormous. IPAs cannot be seen as a solution to the problem unless the Legislature is willing to give up the tradition of doctors maintaining their own individual offices.

Health-benefit plans often argue that legislation intended to protect patients and physicians would raise the cost of premiums. The major factors that contribute to higher medical costs are an aging population, new medications, and advances in medical technology. There is no proof that limited joint negotiation by physicians would increase costs. Any savings that now come to health-benefit plans from abusive conditions in their contracts are kept by the plans and not passed on to patients.

The problem of unfair bargaining power cannot be left to the free market because there is no free market for health-benefit plans. The plans are losing money in the current market by undercutting each other until finally the few surviving plans will dominate and reap huge profits. In some areas, individual plans control up to 60 percent of the market. Physician joint negotiation is no more anticompetitive than the tactics being used by the plans. The Legislature should take action before mergers and consolidations in the health-care market make the balance of power even more unequal.

**OPPONENTS
SAY:**

The FTC has stated that CSSB 1468 would have anticompetitive effects that would harm consumers. An increase of only 1 to 5 percent in the cost of medical care due to physician joint negotiation would add from \$10 million to \$40 million to the cost of state and local government health plans. Regardless of its well-meaning protections, the end result of CSHB 1468 would be higher medical costs.

According to FTC advisory opinions, physicians already can share information on patient care and managed care development for the purpose of providing better patient care. Since physicians already may work together for the benefit of patients, the ultimate goal of increased joint negotiation power must be to increase the physicians' fees and profits at the expense of patients and health plans. Once the door is opened to physician joint negotiation, it would be hard to enforce the protections against obstructionist tactics and to prevent the general dissemination of a plan's proprietary information.

Though CSSB 1468 would limit joint negotiation to groups of physicians that

represent less than 10 percent of the plan's geographic service area, all of the physicians in an individual medical specialty make up only 3 to 5 percent of the total physicians in most areas. Only family practice and general internal medicine specialties make up more than 10 percent of the physicians in most areas. A group of all the heart surgeons or neurologists in an area could have monopoly power and an unfair advantage in negotiations with health-benefit plans.

Texas would be the first state to allow joint negotiation — really collective bargaining — outside of the employment relationship for independent contractors. Only Washington state has attempted this type of measure, and that state excluded fee and discount terms from physician joint negotiation.

CSHB 1468 has not benefitted from any interim study on physician joint negotiation. This lack of research, coupled with last-minute overhauls to the bill, are foreboding in view of the huge impact that the bill would have on health care in Texas.

OTHER
OPPONENTS
SAY:

The definition of “substantial market power” that would allow joint negotiation of fee and discount terms should not be left to the attorney general's interpretation. The bill should define this term so that the definition would not change with every election cycle.

The provision of the bill that is intended to protect against “cherry-picking” by physicians would apply only if the physicians jointly negotiated “solely” for the purpose of excluding participation in some of a health plan's products. Simply by adding one more issue to their agenda, physicians could cherry-pick at will. This loophole should be closed.

NOTES:

The House committee substitute made several substantive changes to the Senate-passed version of the bill:

- ! setting an expiration date for the bill;
- ! adding the prohibition against “cherry-picking”;
- ! allowing one of the negotiating physicians to be the physician's representative;
- ! allowing joint negotiation of terms and conditions related to practices and procedures to assess and improve the delivery of effective, cost-efficient medical care, including preventative health care, pediatric care, women's

health care, disease management programs, patient education, treatment compliance, fraud prevention, and the use of outpatient surgery;

- ! requiring contract terms and conditions to have already affected or threaten to affect the quality and availability of health care before joint negotiation of fee and discount terms could be authorized;
- ! adding an exemption for Medicaid managed care plans and government-supported child health plans;
- ! removing an exemption for group model health-maintenance organizations;
- ! changing the 10 percent limitation to 10 percent of physicians in a plan's defined geographic service area rather than in a defined geographic area;
- ! removing the right of physicians and plans to appeal the 10 percent designation and instead giving the attorney general discretion to modify the 10 percent limit when necessary;
- ! making the terms and conditions negotiated by the physicians' representative subject to each physician's approval and not immediately binding; and
- ! requiring TDI to study the annual impact of joint negotiation on physician fees.