Alaska Stat. § 23.50.020

*** Current through all 2024 legislation.***

Alaska Statutes > Title 23. Labor and Workers' Compensation. (Chs. 05 — 90) > Chapter 50. Collective Negotiation by Physicians. (§§ 23.50.010 — 23.50.099)

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, but may not negotiate the exclusion of providers who are non-physicians from direct reimbursement by a health benefit plan, and may not negotiate the setting in which providers who are non-physicians deliver services. 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) 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.

(c) In exercising the collective rights granted by (a) 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; in this paragraph, “covered lives” means the total number of individuals who are entitled to benefits under the health benefit plan;

(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 (f) — (h) 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 (d) of this section.

(d) 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) during the negotiation process, provide the attorney general upon the attorney general’s request with a copy of all written communications that are between physicians and the health benefit plan, that are relevant to the negotiations, and that are in the possession of the authorized third party;

(4) 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.

(e) The attorney general shall either approve or disapprove the contract that was the subject of the collective negotiation within 60 days after receiving the reports required under (d) 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.

(f) 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.

(g) The competitive and other benefits of joint negotiations or negotiated provider contract terms must 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.

(h) When weighing the anticompetitive effects of contract terms, the attorney general shall consider whether the terms

(1) provide for excessive payments; or

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

(i) 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 antitrust laws by exceeding the authority granted under this section.

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

(k) 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.

(l) 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.

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

(n) Nothing in this section shall be construed to make any conduct by providers unlawful if the conduct was lawful before September 18, 2002.

(o) In this section,

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

(2) "provider" has the meaning given in AS 21.36.090(d).

History

(§ 1 ch 68 SLA 2002)