



Special Legislative Commission to study the feasibility of enacting legislation to empower Primary Care Providers to jointly negotiate with health insurers

Purpose Statement (from 2007-H6502)

"The purpose of the Commission shall be to develop recommendations for strengthening the role of the state's primary care providers within the health system, including, legislative recommendations regarding the creation of a state- authorized and state-monitored mechanism allowing primary care providers to jointly negotiate health care provider and participation agreements with health insurers."

Legislative Response- Creation of HB 6502

Due to the concerns about primary care in the state, the legislature passed HB 6502 in the 2007 legislative session, establishing a special Commission. The purpose of the Commission was to develop recommendations for strengthening the role of the state's primary care providers within the health system, including, legislative recommendations regarding the creation of a state-authorized and state-monitored mechanism allowing primary care providers to jointly negotiate health care provider participation agreements with health insurers. Any legislation that may be enacted would not include Medicare, Medicaid or ERISA plans, as the state does not have jurisdiction over these plans

By statute, the Commission was comprised of Maureen Glynn, Assistant Attorney General & Health Care Advocate of the Attorney General's Office, Ana Novais, the Department of Health designee, and Patricia Huschle of the Office of the Health Insurance Commissioner, who was chair. In addition, two primary care practitioners, Stephen D'Amato, M.D., and David Ashley, M.D., who were appointed by President of the Senate and the Speaker of the House respectively.

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Current Primary Care Climate in Rhode Island

The health care system in the United States ranks as one of the most expensive per capita in the world, but health outcomes are among the lowest of industrialized countries. Studies show that a strong, well-supported primary care infrastructure improves patient satisfaction, health outcomes and lowers costs. This is the only medical specialty that can make these claims.

In Rhode Island, like elsewhere in the United States, health care reimbursement has favored procedure-based specialties over specialties like primary care that require more cognitive input. As a result, the best and brightest medical school graduates tend to migrate toward these specialties, where incomes can average 2-3 times more than primary care.

Rhode Island is fortunate to be the home of Brown University's Medical School and training programs. These programs are graduating and training high quality physicians every year. Fewer than 20 percent of internal medicine residents are choosing careers in primary care (internal medicine physicians represent about 60 percent of Rhode Island's primary care physicians) and less than 40 percent of pediatric residents are choosing primary care – not enough to replace those primary care physicians who retire or move away. Medical school graduates not going into primary care presents a potential cost and quality threat to our service delivery infrastructure, since it is our current primary care network that restrains cost and improves the health of Rhode Island's population.

Physicians are grouped with the other "learned professions" which impacts their level of sophistication when antitrust laws are applied. Physicians are not allowed to communicate with each other on any matters relating to reimbursement that might be perceived as anti-competitive. In this environment, the two major health insurers in Rhode Island have been able to determine conditions of all contracts given to physicians, are able to alter contracts at any time, and the physician has no recourse but to either accept the insurers' terms or go out of business and leave the state. Physicians reluctantly sign these health insurance contracts due to ethical commitments to care for the community, established relationships, and fear of economic risk adversity. In this take-it-or-leave-it environment physicians are looking for viable alternatives that do not put the physician/patient relationship at risk. It may be in Rhode Island's interest to level the market playing field between practices and payers, in order to strengthen our primary care infrastructure, which has a significant public purpose.

An essential component in primary care service delivery is the states' network of community health centers. The community health centers are the safety net providers and they are acutely

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vulnerable to fluctuations in reimbursement and increasing numbers of uninsureds. Current reimbursement systems need to be balanced or enhanced to protect this resource to the underserved in the community.

The Work of the Commission

The Commission met four times in November and December 2007. The Commission agreed that the first order of business was to evaluate the feasibility of recommending legislation to create a State-authorized or State-monitored mechanism that would allow physicians to collectively negotiate with health plans.

The Commission sought out legal advice in order to make an informed recommendation to the general assembly. The Commission invited Jeffery Chase-Lubitz a lawyer who represents the Rhode Island Medical Society and Don Wineberg, a lawyer who represents Neighborhood Health Plan and other medical providers to educate the Commission on antitrust, the history of State action exemption legislation in Rhode Island and detail on how similar legislation has worked in other states. In addition, the Commission invited the local health plans to provide information concerning provider contracts and the impact of joint negotiations. Steven Snow of Partridge, Snow and Hahn presented Blue Cross and Blue Shield of Rhode Island's position.

Antitrust Considerations

Antitrust laws strictly prohibit unrelated physicians from discussing fees, price fixing or boycotting (competing physicians cannot jointly agree to terminate plan participation). In 1996 the Department of Justice and the Federal Trade Commission issued Health Care Antitrust Guidelines to clarify how providers may join together for negotiations with health plans. These guidelines remain in effect today and allow for joint negotiation in certain circumstances. Physicians may form an integrated group practice (e.g. Coastal Medical) that is a single legal entity. Providers may also create a joint venture for purposes of entering into a risk based (capitated) fee arrangement, but not for fee-for-service arrangements. Providers that are clinically integrated may also jointly negotiate, but clinical integration is very complicated to prove and health plans are not inclined to negotiate with these types of groups unless Federal authorities have recognized them as clinically integrated, due to antitrust concerns.

Overview of State Action Exemption Legislation in Rhode Island and Elsewhere

The issue of smaller groups of medical providers or solo practitioners struggling to negotiate effectively with health plans is not a new issue. In 2000, the American Medical Society encouraged states to enact legislation that would permit providers to jointly negotiate with health plans without violating antitrust laws through a state monitored system. The antitrust

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limitations have led some states to enact State action exemption legislation, which permits behavior that would otherwise be illegal. Between 1999 and 2003 many States considered legislation to allow physicians to collectively negotiate fee-for-service arrangements with health plans with state supervision. New Jersey, Texas and Alaska passed State action exemption laws that allow fee-based negotiations. The Texas law has since expired.

Each State law included varying processes for the state to certify the bargainers and approve the results of the negotiation. None of these statutes either encourages or compels payers to bargain. Indeed, the Texas and Alaska laws prohibit boycotts if negotiations fail. National experience has shown that payers have not been interested in negotiating under these systems and none of the enacted statutes has resulted in any contracts that Mr. Wineberg could determine.

Legislation drafted in Rhode Island in 2000 created a structure where groups of unrelated physicians could jointly negotiate with health insurers for both global issues and fees after filing an application with the Attorney General's office. An economic analysis would also need to be completed to determine whether or not the joint provider negotiations would adversely impact the market. The Superior Court would supervise the fee negotiations. Binding arbitration would be initiated if the providers and insurers could not reach agreement. The legislation did not pass.

In 2001, the legislation again allowed for the Attorney General to have an active role in approving the negotiation and monitoring the process. The final negotiation would then be sent to the Rhode Island Superior Court who would approve the final negotiated agreement. This process was considered both costly and time consuming and did not pass. The legislation proposed in 2002 and 2003 was similar and also failed.

In 2004, the proposed legislation was modified to include oversight of the newly established Office of the Health Insurance Commissioner and required binding arbitration in the event that the parties could not reach agreement. The legislation proposed that providers submit to the Attorney General an application to jointly negotiate and the Attorney General would conduct an economic analysis on the market impact of such joint negotiations. This legislation passed the Rhode Island House of Representatives but failed to pass the Rhode Island Senate. None of the Rhode Island legislative proposals presumed to meet State action exemption requirements under antitrust law.

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Commission Response to the Feasibility of State Action Exemption Legislation

It was concluded that if the Commission were to recommend legislation that only allows the negotiations to occur, it is unlikely that much will change since the health plans are not interested in negotiating in this manner. The Commission could recommend legislation that requires the plans to negotiate by inclusion of binding arbitration, court review of an impasse or allowing providers to boycott if mutually agreeable terms are not reached. These alternatives may have antitrust implications. It is clear that the health plans will oppose such legislation.

The health plans indicated at the meetings that they would prefer to work with the community physicians outside the legislative process and are concerned that any legislation that ultimately increases provider fees may increase the premium costs to employers. Public comment also indicated concern of the impact of such legislation on the cost of insurance and increasing the number of uninsureds, although there is no evidence that improved primary care reimbursement either increases the cost of insurance or contributes to the number of uninsured. Indeed, there is considerable evidence that improving the primary care infrastructure has the opposite effect.

After careful consideration of the facts that were presented to the group, the Commission unanimously agreed not to recommend State Action exemption legislation as a mechanism to strengthen primary care in the state. The Commission articulated this position based on the following reasons:

- Lack of success in leveling the playing field for providers in States where similar laws have been passed
- Prohibitively expensive with many financial hurdles including Attorney General/OHIC/ judiciary costs staffing, cost to physicians for economic studies and legal representation
- Time consuming and lengthy process
- Such negotiations would not apply to all insurance lines of business, only to commercial plans fully insured and regulated by the State of Rhode Island
- Risk of antitrust violations even "getting to the table"
- Potential conflicts of interest for both the OHIC and the Department of the Attorney General
- Potential cost to the health care system through increase in premiums and potential increase in the number of uninsureds
- A legislative proposal for binding arbitration is expensive and may not be sufficient to protect insurance companies or physicians from violating antitrust laws

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- Ineffective due to lack of interest by payers to be willing to negotiate in this manner

Other Recommendations to Support Primary Care

The Commission then “brainstormed” on other ideas to strengthen primary care. All ideas were documented and are wide ranging in scope. It is understood that any potential mechanism would require a full evaluation to include its potential success on addressing the issues of primary care physicians, the impact on primary care access, the cost of health care, the potential effect on uninsured and the availability of state funding necessary to support such mechanisms.

The list includes:

- “Voluntary” Commission made up of physicians, health plans and a neutral third party where issues (fee and non-fee) can be presented. Potentially OHIC to set the ground rules with the goal being a voluntary dispute resolution between an individual practice and a single health plan.
- Consider expansion of OHIC or DOH jurisdiction to include review of material health plan/ provider contract changes with a formal mechanism for provider input and public review.
- OHIC/DOH to establish regulations with which to measure the impact of proposed contract modifications prior to implementation; to include patient safety, administrative burden to the practice and impact of change on health care system as a whole.
- Consider legislation that would require health plans to provide their fee schedules to OHIC/DOH for transparency and competitiveness review and consider regulations to establish minimum provider rates.
- Encourage health insurance carriers to offer catastrophic plans (hospital only) where physicians can charge patients fee for service.
- Require that benefit plans pay for tests at participating testing facilities when such tests are ordered by non-participating physicians for all lines of business.
- Encourage health plans to promote funding mechanisms other than fee-for-service to primary care physicians for pay for performance or for establishing a Medical Home infrastructure.
- Encourage legislation that promotes tax incentives and/or loan forgiveness for primary care physicians to practice in Rhode Island.
- Consider the impact of requiring elimination of ‘all- product” clauses in providers’ managed care contracts.

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Summary

The Commission recognizes the plight of primary care physicians in the state and is sensitive to the important balance of the health care delivery system. Primary care physicians, and primary care practices, operate in a constrained business environment with unequal market power. This inequality is one of the factors that has prevented the development of a robust primary care service delivery system for Rhode Island.

Although action exemption legislation does not appear to hold promise in creating such a balanced delivery system, there are a number of other ways in which the Legislature could act to create a more balanced delivery system, and incentivize the primary care infrastructure so that it becomes more secure, and more effective at containing cost and improving quality. The Commission is supportive of the evaluation of the above alternatives to strengthen primary care.