NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
HEALTH, LONG-TERM CARE & HEALTH RETIREMENT ISSUES COMMITTEE
SPECIAL MEETING ON RENTAL NETWORK MODEL LEGISLATION
NEW YORK, NEW YORK
JULY 10, 2008
MINUTES

The National Conference of Insurance Legislators (NCOIL) Health, Long-Term Care & Health Retirement Issues Committee met at the Marriott Marquis in New York City on Thursday, July 10, 2008, at 5:00 p.m.

Rep. Susan Westrom of Kentucky, co-chair of the Committee, presided.

Other members of the Committee present were:

Sen. Joseph Crisco, CT	Sen. Carroll Leavell, NM
Sen. Ralph Hudgens, GA	Assem. William Barclay, NY
Sen. Vi Simpson, IN	Sen. William Larkin, Jr., NY
Rep. Tommy Thompson, KY	Del. Harvey Morgan, VA
Rep. Ronald Crimm, KY	Rep. Virginia Milkey, VT
Rep. George Keiser, ND	

Other legislators present were:
Sen. William Haine, IL
Rep. Charles Curtiss, TN

Also in attendance were:
Susan Nolan, NCOIL Executive Director
Candace Thorson, NCOIL Deputy Executive Director
Michael Humphreys, NCOIL Director of State-Federal Relations
Jordan Estey, NCOIL Director of Legislative Affairs & Education

OPENING REMARKS
Kelly Kenney of the American Medical Association (AMA) said an evolving healthcare market created problems for physicians, including reimbursement issues associated with "rental networks." She said preferred provider networks (PPNs) exist to market, lease, sell and otherwise convey their network of contracted physicians and discounts to third-party administrators, self-insured employers and other PPNs that may not have their own network.

Ms. Kenney said physicians noticed problems with these networks when they would treat an out-of-network patient at an appropriate rate and be reimbursed at much lower, in-network rates. She said a lack of transparency in this market leaves physicians in the dark about what they will be reimbursed, who is legitimately accessing a network, and what unauthorized groups were doing so. She said the AMA raised the issue before NCOIL in 2005 in hopes that states could "shine a light" on this unregulated practice.

Ms. Kenney said contracts with PPNs are a "quid-pro quo" arrangement, where physicians willingly agree to discount their usual fees in exchange for several benefits of network participation, such as increased patient volume and prompt-pay guarantees, among others.

She reiterated, however, that a lack of transparency relating to the activities of these PPNs leaves physicians and patients "in the dark" about their financial rights and responsibilities.

Ms. Kenney thanked the Committee for its continued involvement and said the previous two years of discussions among AMA, industry and trade group representatives within the NCOIL forum were informative. She said discussions enabled parties to move towards a mutual understanding of PPN business operations and related problems.

DISCUSSION OF AHIP AND AAPPO MODEL PROPOSALS

Martin Mitchell of America's Health Insurance Plans (AHIP) agreed that discussions were beneficial to all participants. He said language contained in model bills submitted by AHIP and the American Association of Preferred Provider Organizations (AAPPO) was developed from the group's efforts. He said that principles established through group discussions would "shine a light" on PPNs through transparency and disclosure requirements.

Karen Greenrose, representing the AAPPO, said most PPNs are non-risk bearing. She said the PPNs develop a network of providers and market it to other PPNs, third party administrators, employers, and payers. She said the AHIP and AAPPO models have disclosure requirements for the various market participants, including the PPN contracting with the physicians and the third parties that access this network. She said detailed responsibilities for the entities that lease a PPN are critical for transparency.

Ms. Greenrose discussed key industry proposal definitions, including contracting entity and third party. She said these definitions are important for legislators to consider because they define legitimate entities operating in the market. She said the models take a "bucket approach" and clearly define those entities that can legally participate in the market.

Ms. Greenrose said the bills define a "contracting entity" as a person or entity that enters into a provider network contract with health care providers for the delivery of health care services, in which the contract stipulates specific terms regarding network access and reimbursement for healthcare services. She said a third party, as defined by the AHIP and AAPPO models, is the person or entity that is granted access to the provider network contract.

Ms. Greenrose pointed out that both models exempt self-insured employers and third-party administrators (TPAs) operating on their behalf because the federal government has jurisdiction over these entities, as stipulated by the Employee Retirement Income Security Act of 1974 (ERISA.)

Ms. Greenrose said the AAPPO model clarifies these exemptions to stipulate that TPAs should be excluded only when they are providing services to a self-insured employer health plan. She said language contained in the AHIP bill could be easily interpreted to exempt any TPA.

Ms. Greenrose said the definition of a health care provider should not include physician organizations or physician hospital organizations when they are operating as contracting entities. She said the AAPPO found that these groups sometimes form their own networks

and lease their terms, which should subject them to the same requirements as other contracting entities.

Ms. Greenrose said a limit on downstream rentals, or the number of times that PPN can be leased, rented, sold, assigned, or otherwise conveyed to subsequent third-parties, would not prohibit unauthorized entities from accessing the PPN. She said neither the AHIP nor the AAPPO proposals limit the number of times that a network contract can be assigned.

Ms. Greenrose said the AAPPO model is, however, specific about who can assign the terms of a provider network contract. She said AAPPO believes that only a preferred provider organization (PPO), a PPN, and a physician hospital organization (PHO) should be allowed to engage in this activity.

Mr. Mitchell said the industry proposals seek to assign responsibility, establish transparency and require disclosure through a set of rules that can be applied to all entities. According to the proposals, he said, discounts can only be rented, leased, sold, assigned, and otherwise conveyed when the original contract clearly allows for it. He said that it is important for physicians to understand the nature of these networks before they sign a contract.

Mr. Mitchell said the industry proposals require third-parties taking a network discount to abide by all terms of the original contract between a provider and contracting entity. He said the models also obligate third-parties to supply information about their transactions. He said third-parties that lease information to subsequent third parties must also ensure that information is relayed back to the contracting entity so that a physician is aware of his/her contractual obligations the minute a patient walks in the door to receive treatment.

Mr. Mitchell said the industry models also attempt to provide transparency through post-service notification requirements. He said the models require language on a remittance advice (RA) or explanation of payment (EOP) form to identify the source of a discount taken and the entity responsible for paying claims.

Ms. Greenrose said disclosure requirements for contract terminations need to be reformed. She said the two models require a contracting entity to inform third parties of a contract's termination. She said third parties should also be noticed that their right to a discount ceases with a contract's termination. She said requirements should be applicable to state continuity of care laws, which allow patients to continue to receive care medical care for a reasonable amount of time.

Mr. Mitchell said the models yield enforcement to a state's Unfair Trade Practices Act, which establishes fines and penalties, and allows the insurance department to enforce penalties for bad behavior. He said the state acts are appropriate because they were already in place—making enforcement and compliance easier for all parties.

Ms. Greenrose said the AAPPO believes PPNs should be registered with an appropriate state agency, and model legislation should clearly require this. She said the AAPPO bill requires PPNs not already registered with a state's insurance department to do so. She said this will help physicians to identify the legitimate entities operating in a given state. She noted that in some states, an entity must be registered to be subject to the terms of an Unfair Trade Practices Act.

AMA PROPOSAL

Ms. Kenney said that the AHIP, AAPPO and AMA model bills attempt to establish transparency and disclosure in this market, but take different approaches. She said the AMA agreed, in principle, with the industry model provisions regarding pre and post service disclosure requirements, contracting rights and responsibilities, and clear disclosure of contract termination, but used different language to address these issues.

Ms. Kenney said the goal of the AMA proposal is to reduce administrative costs for physicians by establishing transparency. She said that if physicians have access to information up front, then they don't need to allocate resources tracking down claims. She said model legislation should set up a system to create administrative efficiencies for physicians.

Elizabeth Schumacher of the AMA said the AMA believes that only a contracting entity may rent, lease or otherwise provide access to its physician discount to a PPN. She said the AMA remains unconvinced that downstream rentals can be tracked, processed and enforced. She said the AMA model prohibits any entity that is not a contracting entity from assigning access to the preferred provider network.

Ms. Schumacher said the AMA model contains specific language regarding pre-service transparency, including several provisions in the original contract.

Ms. Schumacher said the AMA model also includes anti-retaliation language. She said it is important to prevent physicians from being in situation where they are forced to accept a contract. She said that fee schedule integrity is also important because the AMA is not convinced that computerized mechanisms that transmit fee information are not fail-safe and that underlying contract language is followed downstream.

OTHER DISCUSSION

Ms. Kenney said the AMA objects to the exclusions in the AAPPO and AHIP proposals. She said the two proposals exclude the entire self-insured market, several "affiliates" and other programs, which constitute more than half of the market. She said this issue would be critical for the Committee to address in any subsequent legislation.

Mr. Mitchell rebutted Ms. Kenney's concerns and noted that "affiliates" were not exempted, but were included as part of the definition to preclude them from having to reproduce costly disclosure requirements. He said renting between an entity and a subsidiary should not require duplication because the parent company has already complied with the contract requirements.

Ms. Greenrose said most PPNs are small regional and state networks that don't have the leverage to access the types of discounts that doctors allow big payers. She said that if you change the way these markets operate, it will force many of these smaller PPNs out of business. She said larger payers would then be able to monopolize a market.

Rep. Keiser asked how state legislators could incorporate self-insured ERISA plans into this legislation. He said states had no authority over these plans.

Ms. Kenney said the real issue was the contractual obligations between a provider and contracting entities, not a set of mandates on health benefit plans. She said the AMA model is carefully drafted to avoid any regulation of health benefit plans and the AMA does not believe that ERISA would preempt the legislation because it deals with a contracting issue.

Assem. Barclay asked if physicians could negotiate anti-assignment clauses as part of these agreements. Ms. Greenrose said she had seen such practices in rural areas, but not in cities because patient volume is decided.

ADJOURNMENT
There being no further business, the meeting adjourned at 6:45 p.m.