ALASKA LEGISLATURE COMMITTEE FILES 1999-2000 8672

9939 HOUSE LABOR & COMMERCE

Christian Science
Committee on Publication
for the State of Alaska — *Richard L. Block*

Facsimile Cover Sheet

To:	From:
Honorable Rep. Rokeberg Alaska State Legislature Attn: Janet Seitz 907 465 2040	Christian Science Committee on Publication for the State of Alaska Richard L. Block 360 W. Benson Blvd., Suite 301 Anchorage, Alaska 99503 Tel: 907 562 5183 Ak.t. f: 877 330 5183 Fax: 907 562 5187

Date: 1/31/00 Time: 12:45 Pages: 5

Message:
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Dick Block

Christian Science
Committee on Publication
for the State of Alaska *Richard L. Block*

January 28, 2000

Honorable Norman Rokeberg, Representative
Chair, House Labor and Commerce Committee
State Capitol (MS 3100)
Juneau, Alaska 99801-1182

Attn: Janet Seitz

Re: HB 211, Patients' Bill of Rights in Medical Care Plans

Dear Representative Rokeberg,

I briefly spoke with Janet Seitz and explained that we would like to see an amendment to the bill which would permit health care insurers and managed care plan administrators to include in coverage provided by group sponsors care for those relying exclusively on prayer for healing.

Our proposed amendment is enclosed.

Background
Historically, health care insurers, those providing typical indemnity plans, were, and still are, willing to include in the benefits the cost of Christian Science practitioners and Christian Science Nursing care facilities. This is accomplished, generally, by adding to the contract, usually in the definitions section, a provision that indemnity benefits that might otherwise be paid to a physician would be paid to the practitioner and benefits that might otherwise be paid to a hospital would be paid to a Christian Science nursing facility.

The availability of this coverage stems from the fact that those relying exclusively on prayer for healing, including Christian Scientists, do not use the facilities of the physician, hospital or usual nursing care. They have, instead, relied on prayer for healing of all manner of illnesses and with complete success. The insurers, recognizing that those who rely on prayer for healing have a record of returning to full health much faster and with much less expense, have been willing to reimburse those covered persons for the much more modest costs associated with the care and treatment of the person during the healing process.

Allowing these coverages is really an element of fundamental fairness. If an employer, labor union other group sponsor is providing benefits for all the members of the group as a group participant benefit, it would be unfortunate if the member of the group who consistently relies on prayer for healing could not take advantage of the benefit because they do not use physicians or hospitals. It is even a more compelling issue of fairness if the participant is obligated to pay for the coverage as a requirement of being part of the group or because salaries are lowered in recognition of the benefits being provided.

Now, with the advent of managed care, the issue becomes more complex. As a means of grappling with the high cost of medical care, medical insurers and group sponsors are struggling to find ways of controlling expense, and one way to do that is to manage the care provided in such a way that participants cannot abuse the benefits available. This includes requiring physical exams before being permitted to receive certain types of medical care, requiring continuing

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medical review of the patient's progress to justify continuing benefits, designation of pre-approved medical care providers from which the patient must obtain their medical services, and other techniques.

For a Christian Scientist, or any other person who relies exclusively on prayer for healing, these requirements, while possibly understandable in the context of allopathic medicine, are anachronistic in a setting where the person is pursuing healing in a totally nonmedical context.

For example.

A person relying on prayer for healing may turn to a Christian Science practitioner for assistance and support. The Christian Science practitioner's approach to providing this assistance is to pray and the nature of that prayer is to follow the example of the early biblical healers, to spiritualize thought, to deny the reality of the illness and to establish the patient's perfection as a child of God. It can be seen that to require the patient, the practitioner or even a physician to provide evidence that the patient is really ill is totally contrary to what the healing process is endeavoring to establish.

Christian Science practitioners are persons experienced in praying for other people. Their knowledge is gained from inspiration gained from study of the Bible. They have no capability of diagnosing or evaluating medical conditions.

A person relying on prayer for healing may wish to be cared for in a Christian Science nursing facility or at home by Christian Science nurses. The approach of the Christian Science nurse or nursing facility is to provide nothing more than a quiet, harmonious, clean environment in which the patient, together with his or her practitioner can find the understanding required to accomplish the healing. Neither a facility nor the Christian Science nurse, administers medicines, gives tests, takes measurements, diagnoses conditiens or provides any kind of therapies whatsoever. The facility or the Christian Science nurse assists in bathing, feeding, moving and dressing the patient unable to function without assistance. Accordingly, collecting information for, maintaining or forwarding reports of medical conditions, making judgments about medical needs, etc. is beyond the scope of what either the facility or the Christian Science nurse does or is qualified to do.

Thus the requirements being established in medical care plans to qualify a participant for benefits is totally inconsistent with the kind of care and treatment provided to those relying exclusively on prayer for healing.

Adjustments in the Managed Care Setting

Despite these inconsistencies, it is widely acknowledged that it is to the benefit of the managed care programs to encourage those who rely on prayer for healing to be able to do so without imposing conditions that are inconsistent with it. Accordingly many managed care plans, including plans currently being used in Alaska, are providing benefits to Christian Scientists and not requiring the usual prerequisites that would be required of those seeking allopathic medical remedies.

Recognition of healing through prayer is now included in several of the bills currently being considered in Congress regarding managed care plans. We can provide at a later date, if you are not already in possession of this information, the bills and the language.

Similar language is needed at the state level because the federal law would govern those plans that are governed by federal law, i.e., ERISA plans. A similar law must be adopted at the state level to deal with regulation of plans that are not governed by federal law.

Proposed Amendment

The attached proposed amendment does not mandate that a managed care plan provide for religious nonmedical treatment, but it does provide statutory recognition for such treatment so

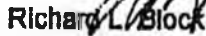
that it is clear to providers, insurers, plan administrators, that such is permitted and that they need not insist on the usual prerequisites to comply with any state law.

The language is taken directly from the language currently in most of the managed care bills currently being in Congress.

Request
We request that this amendment be included in the Committee Substitute for HB211 currently being drafted.

Your kindness and attention to our request is most appreciated.

Yours cordially,



Richard L. Block

Amendment to HB 211

This amendment will permit (not require) employers/managed care plan providers to include in a plan provision for coverage of religious non-medical providers. Religious non-medical providers are care facilities, care givers and practitioners who provide the kind of care required by those with illnesses who are relying exclusively on prayer for their healing.

1. Amend HB 211, sec. 3 as follows: (page 3 line 10)

to change the title as follows:

Sec. 21.07.020. Required and permitted contract provisions for group managed care plans.

2. Amend HB 211 sec. 3 as follows: (page 6 line 25)

to add a new subsection to AS 21.07.020 as follows;

(b) Nothing in this chapter shall be construed to:

1. restrict or limit the right of group health plans, and of health insurance issuers offering health insurance coverage in connection with group health plans, to include as providers, religious nonmedical providers; or
2. require such plans or issuers to:
   - (i) utilize medically based eligibility standards or criteria in deciding provider status of religious nonmedical providers;
   - (ii) use medical professionals or criteria to decide enrollee access to religious nonmedical providers; or
   - (iii) utilize medical professsionals or criteria in making decisions in internal or external appeals from decisions denying or limiting coverage for care by religious nonmedical providers; or
   - (iv) compel a participant or beneficiary to undergo a medical examination or test as a condition of receiving health insurance coverage for treatment by a religious nonmedical provider.
3. require such plans or issuers to exclude religious nonmedical providers because they do not provide medical or other data otherwise required, if such data is inconsistent with the religious nonmedical treatment or nursing care provided by the provider.

3. Amend HB 211, sec. 3 as follows: (page 10, line 27)

to add a new definition to AS 21.07.250 as number 14, as follows:

(14)"religious nonmedical provider" means a provider who provides no medical care but who provides only religious nonmedical treatment or religious nonmedical nursing care.

Memorandum Opinion 95-0654

LEGALITY OF PREFERRED PROVIDER ORGANIZATIONS IN ALASKA

April 21, 1995

I. INTRODUCTION

This is in response to your memorandum dated April 13, 1995, by which you requested an opinion on the following question: "Are Preferred Provider Organizations (PPOs) legal in Alaska?" Our conclusion is that they are lawful, although there is no enabling legislation for

II. BACKGROUND

PPOs are a relatively recent development in the health care delivery arena. For much of this century, traditional indemnity insurance, whether through individual or group insurance policies, provided the primary means for health care reimbursement. In the last few decades, due in large part to the trend of disproportionately large increases in health care costs, alternatives to pure indemnity insurance evolved. Many of these alternatives fall under the rubric of managed care and have a primary purpose of cost containment. For instance, in the 1970s, statutory enabling laws for health maintenance organizations (HMOs) were created.[1] Alaska enacted its version of the HMO model law (AS 21.86) in 1990. However, to date there are no licensed HMOs in Alaska.

In the 1980s, PPOs developed as a managed care device.[2] PPOs are a fee-for-service alternative to traditional health insurance. Due to their dramatic growth they soon became a central feature of health care financing and delivery reform.

The PPO, also referred to as a preferred provider arrangement (PPA),[3] involves purchasers managing the cost of health care through contracting with a group of doctors or hospitals ("preferred" or "network" providers). The salient characteristics of the preferred provider arrangement are as follows. In exchange for discounted fees for services, the providers receive a guaranteed supply of patients and a commitment to quick turnaround on claims payments. Providers also typically agree to comply with utilization review procedures intended to reduce inappropriate or unnecessary care. Through a bulk purchase of medical services, purchasers have the advantage of being able to choose providers based on competitive pricing, which is expected to result in

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cost savings. Patients are offered financial incentives such as reduced or eliminated copayments or deductibles if they use designated preferred providers. PPOs are formed by a wide variety of entities — purchasers as well as providers — including insurers, self insurers (employers), unions, physicians, hospitals, HMOs, service corporations, and third party administrators (often owned by insurers).[4]

At a recent hearing before the Senate Labor and Commerce Committee, a representative of the Division of Insurance was asked whether preferred provider organizations (PPOs) are legal in Alaska. The division's response that PPOs are not lawful has created some controversy. The largest group disability[5] insurer in the state (Aetna Life Insurance Co.) has been utilizing PPOs for years based in part on the division's approval of its insurance forms. The Division of Retirement and Benefits also has expressed concern regarding the use of PPOs in the state health plan. As a result, you have referred this question to the Department of Law for a legal opinion.

III. ANALYSIS

PPOs are lawful in Alaska. While there is no enabling legislation for PPOs, no provision of AS 21 on its face prohibits the formation of PPOs or contracting with such entities.

By way of background, and as previously indicated in this memorandum, there is a model law developed by the National Association of Insurance Commissioners (NAIC) entitled the "Preferred Provider Arrangements Act." Currently, over half of the states (29) have adopted some version of the PPO model by legislation, regulation, or bulletin.[6] Alaska has not adopted a version of the model. Whether or not it should have is beyond the scope of this opinion.

It is noteworthy that states have been criticized for passing laws that impede the implementation of PPOs. Even before the creation of the model act, legislation was introduced in Congress in 1983 to prohibit states from restricting the operations of the already emerging PPO mechanism.[7] The existence of PPOs in the absence of enabling legislation is also evidenced by a drafting note for Section 2 of the model (Purpose), which states: "The use of the term 'allowing' in this section is not intended to indicate that health care insurers are acting unlawfully in a state which has not enacted a law allowing Preferred Provider Arrangements."[8]

Although federal law recognizes the PPO mechanism, it does not

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answer the question whether PPOs are legal in Alaska. In a regulation implementing the Medicare program, the Department of Health and Human Services refers to health plans having "premium structure regulated under a State insurance statute or a State enabling statute governing health maintenance organizations or preferred provider organizations." 42 C.F.R. § 1001.952(1)(2). This regulation does not mandate the use of an enabling law for PPOs. The CHAMPUS program, which expressly authorizes federal officials to contract with PPOs, also does not require a state enabling statute. *See* 10 U.S.C. § 1095.

There are no published cases, state or federal, addressing whether PPOs are lawful in the absence of enabling legislation. One case implicitly acknowledges the validity of a state PPO enabling law. In *Stuart Circle Hospital Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993), the court held that ERISA's savings clause exempted from federal preemption a Virginia enabling law for establishing PPOs. However, there is no federal mandate for an enabling law. Each state may regulate PPOs as it sees fit, in the absence of congressional direction.[9]

Recognizing that there is no Alaska enabling law for PPOs, the Division of Insurance has previously taken the position that certain provisions of the insurance code prohibit the use of PPOs. We find this argument unpersuasive for the following reasons.

AS 21.54.020(a)

One of the provisions the division relies upon is a prohibition applicable to group disability insurers that provides in part: "The [group disability] policy may not contain a provision requiring that services be provided by a particular hospital or person, except as applicable to a health maintenance organization under AS 21.86." AS 21.54.020(a). This law does not prohibit the use of a PPO. To begin with, HMOs, which may contract with a PPO, are exempted. *See id.*; AS 21.86.060(a). In addition, the typical health plan utilizing a PPO gives covered individuals the choice of more than one provider, and often there is an option to use a nonpreferred provider, albeit at higher cost. Only if the covered person is given no choice of provider would this provision be violated.

AS 21.36.090(b)

Another statute relied upon by the division as prohibiting PPOs is AS 21.36.090(b). It provides:

> A person may not make or permit unfair discrimination between individuals of the same class and of essentially the same

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> hazard in the amount of premium, policy fees, or rates charged for a policy or contract of disability insurance or in the benefits payable, or in any of the terms or conditions of the contract, or in any other manner whatever.

This provision prohibits only disability (health) insurers from unfairly discriminating against covered individuals. It is part of the Unfair Trade Practices Act (UTPA) in Alaska's insurance code, enacted in 1966 and based upon an NAIC model. Although the legislative history for AS 21.36.090(b) is scant and has no bearing on the PPO issue, the model act is instructive. It was adopted in 1947, well before the emergence of PPOs and the managed care concept.[10] The unfair discrimination provision at AS 21.36.090(b) is substantially the same as the corresponding provision of the model act [Section 4(G)(2)]. The legislative history for Section 4(G)(2) reveals that the primary concerns about unfair discrimination were in the contexts of race, sex, marital status, residence and national origin. More recently, redlining and blackballing underwriting practices have received attention. There is no discussion of PPOs in the legislative history of the model. Indeed, it would be illogical for the NAIC to adopt a PPO model act if PPOs were per se violative of the UTPA. It is true that a PPO could violate AS 21.36.090(b) if its conduct were unfairly discriminatory for any one of a variety of reasons. However, it is additionally possible that there would be no "unfair" discrimination if a PPO treated all individuals of the same class equally as to costs, benefits payable or other contractual terms. In conclusion, AS 21.36.090(b) does not prohibit the establishment of PPOs or contracting with them.

Hospital and Medical Service Corporation (AS 21.87)

Your memorandum also addresses hospital and medical service corporations. *E.g.*, Blue Cross. These entities differ significantly from disability (health) insurers and are not even considered insurers. Unlike traditional insurance companies, which are subject to the provisions of AS 21.09, service corporations are regulated by the provisions of AS 21.87. Service corporations are nonprofit, at least in theory, and pursuant to statute. *See* AS 21.87.070(2). In essence, a service corporation delivers health care coverage through the use of two contracts. In the first one, a service agreement, the service corporation and a participant provider (typically a hospital or physician) agree to exchange health care services for a set fee. *See* AS 21.87.140 — 21.87.150. The second

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contract, called a subscriber contract, is between the service corporation and a recipient of care. *See* AS 21.87 160. It gives the subscriber access to health care services provided by the service contract.

Hospital and medical service corporations have statutory authority to contract with PPOs. *See, e.g.*, AS 21.87.070(3), 21.87.150 (service agreements with participant hospitals authorized); AS 21.87.070(4), 21.87.140 (service agreements with participant providers authorized); AS 21.87.120(a)(2), 21.87.130(a)(2), 21.87.160(b)(1), (2) (indemnity for services by nonparticipant providers and hospitals allowed). These statutes were enacted in 1966, well before the emergence of PPOs. They effectively allow a different benefit to be provided to a subscriber by a participant hospital or participant provider than benefits the subscriber may access on an indemnity basis. Although none of the statutes explicitly reference PPOs, their language is broad enough to allow contracting with PPOs.

Exclusive Provider Arrangements

Finally, your memorandum addresses "exclusive provider arrangements," also referred to as "exclusive provider organizations" or EPOs. These entities are a subspecies of PPOs. As previously indicated, for group disability (health) insurance, AS 21.54.020(a) prohibits the use of an EPO where the covered individual has no choice of provider. Depending on the circumstances, an EPO may also violate provisions of AS 21.36.

IV. CONCLUSION

Unlike most states, Alaska does not have an enabling law for establishing and using PPOs. For the reasons indicated in this memorandum, the Alaska insurance code nonetheless does not prohibit the creation of PPOs.

David G. Stebing
ASSISTANT ATTORNEY GENERAL

NOTES

[1] *See generally* 42 U.S.C. § 300e *et seq.* (Federal Health Maintenance Organization Act of 1973); Health Maintenance Organization Model Act, Vol. II, NAIC Model Laws, Regulations and Guidelines, pp. 430-1 through 430-31 (adopted 1973).

[4] *See* Gabel, Ermann, Rice & de Lissovoy, *The Emergence and Future of PPOs*, Vol. 11, Journal of Health Politics, Policy and Law, 305 (1986); Preferred Provider Arrangements

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Act, Vol. I, NAIC Model Laws, Regulations and Guidelines, pp. 75-1 through 75-4, (adopted 1987).

[4] A PPO is the group of providers whereas a PPA is the contractual arrangement between that group of providers and purchasers of health care. Your April 13, 1995, memorandum refers to PPOs. For the purpose of this opinion, the PPO and PPA mechanisms are interchangeable.

[4] There are myriad forms of PPOs whose description is beyond the scope of this opinion. *See generally* Combe & Krugman, *Design and Pricing of the PPO and EPO Products*, Practicing Law Institute, Commercial Law and Practice Course Handbook Series, September 25, 1986.

[5] Alaska is in the clear minority of states that uses the term "disability insurance" to refer to what is commonly known as "health insurance." *See* AS 21.12.050 (disability insurance defined); AS 21.54.060 (group disability insurance defined). "Disability insurance" includes "disability income replacement insurance."

[6] *See* Vol. I, *NAIC Model Laws, Regulations and Guidelines*, pp. 75-5 through 75-8 (1993).

[7] *See* Rolph, Ginsburg & Hosek, *The Regulation of Preferred Provider Arrangements*, 6 Health Affairs, 32, 33 (Fall 1987).

[8] *See id.* p. 75-1. *See also* Statement of Commissioner Grode (Pa.), Report of Working Group on Preferred Providers, Vol. I, NAIC Proceedings, at 712 (1987) ("drafting note was added to clarify the possible ambiguity").

[9] *See generally* 15 U.S.C. §§ 1011-12 (McCarran-Ferguson Act delegation of insurance regulatory authority to states).

[10] *See* Vol. IV, *Model Laws, Regulations and Guidelines*, pp. 880-1 through 880-13 (1993). The NAIC's unfair trade practices model act was one of the initial efforts at developing uniform state legislation in response to the newly enacted McCarran-Ferguson Act. *See* NAIC Proceedings, at 142-43 (1946).

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Memorandum Opinion 96-0291

OPINION ON CHOICE AND PAYMENT OF PROVIDERS UNDER SERVICE CORPORATION BENEFITS

November 3, 1995

I. INTRODUCTION

This is in response to your memorandum dated October 9, 1995,[1] through which you requested answers to the following two questions:

1. Whether patients have the right to receive care from a provider of their choice?

Answer: Yes.

2. Whether providers are entitled to the same fees as those received by providers who enter into contracts with a medical service corporation?

Answer: No.

II. BACKGROUND

The above questions derive from inquiries made to the Alaska Division of Insurance by the Alaska Dental Society (ADS). The attachment accompanying your memorandum indicates ADS' position that the answer to both questions is "yes." Although ADS' inquiries are made in the context of dental care, my analysis and conclusions are applicable to dentists, medical doctors, and all other properly licensed health care providers[2] rendering services within the scope of their occupational licenses. In addition, my analysis for the first question addresses traditional health insurance as well as service corporations, although a primary emphasis is placed on the latter consistent with ADS' letter to you.

It is initially useful to understand the nature of a service corporation. A significant share of group health benefits in this country are provided through "service corporations." These health care financing entities are not traditional fee-for-service insurers, who typically provide for health care through indemnifying an insured after expenses are incurred. In contrast, a service corporation generally facilitates delivery of health care through periodic *pre*payments made by subscribers (recipients of

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care). *See* AS 21.87.010(a). A service corporation may, however, additionally provide subscribers with indemnity benefits. *See id.* AS 21.87.160(b)(2); AS 21.87.190(c).

There are three types of service corporations: (1) a medical service corporation principally provides medical or surgical services to subscribers; (2) a hospital service corporation principally provides hospital services to subscribers; and (3) a medical and hospital service corporation provides a combination of these services to subscribers. *See* AS 21.87.070; AS 21.87.280; and AS 21.87.330(2), (3). For the purpose of this memorandum, the term "service corporation" refers to all three of these entities. In Alaska, there are two authorized service corporations — Blue Cross of Washington & Alaska and Alaska Vision Services, Inc.

Service corporations are characterized by their use of two types of contracts. In the first one, a "service agreement," the corporation and a participant health care provider[1] (typically a hospital or physician) agree to provide health care services for a set fee. *See* AS 21.87.140; AS 21.87.150. A "nonparticipant" provider or hospital, as referenced in AS 21.87, is one that has not entered into a service agreement with the corporation. *See id.* AS 21.87.120(a)(2); AS 21.87.130(a)(2). In the second type of contract, called a "subscriber contract," a subscriber agrees to pay a set amount in exchange for certain health care benefits provided under the service agreement. *See id.* AS 21.87.160; AS 21.87.190. Another important characteristic of service corporations is that, in contrast to insurance companies, service corporations must be organized and operated in good faith as nonprofit entities. *See id.* AS 21.87.020(a); AS 21.87.070(2); AS 21.87.050(a); and AS 21.87.070(2).

Blue Cross and Blue Shield organizations are typically operated as service corporations and are the most well known types of service corporation. Historically, Blue Cross, which pioneered the hospital insurance market nearly 70 years ago, provided for hospital care, and Blue Shield provided for physicians' services (surgical and medical expenses). In 1982 the Blue Cross Association and the National Association of Blue Shield plans merged. The resulting national BlueCross BlueShield Association is currently comprised of 69 separate and locally operated companies called "plans." Blue Cross of Washington & Alaska, an affiliate of a larger holding company, is a member of the association. In the United States, more than 80 percent of hospitals and nearly 70 percent of physicians contract directly with Blue Cross and Blue Shield plans. Together, "Blues" plans in 1994 provided health care benefits for 7.6 million members, ultimately covering over 65 million people —

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roughly one in four Americans. *See BlueCross BlueShield Association 1994 Fact Book*; L. Kertesz, "A blue streak for managed care," *Modern Healthcare*, p. 63 (September 12, 1994). In Alaska, the Blue Cross plan has a large market presence, insuring about 95,000 Alaskans under group and individual policies (subscriber contracts).

There is often confusion about how to categorize a service corporation. The confusion is created in part by the fact that although a service corporation is not a traditional insurer, it is regulated by the state insurance regulatory agency. In Alaska, a traditional indemnity insurer is subject to the provisions of AS 21.09 concerning its authorization and general financial and reporting requirements. In contrast, a service corporation is primarily regulated by provisions of AS 21.87. Regulatory oversight of a service corporation remains similar in many ways to oversight of a traditional insurer by the division of insurance. *See e.g.*, AS 21.87.180 (contract language must be filed with and approved by division); AS 21.87.190 (rates must be filed with division and may not be excessive or unfairly discriminatory); AS 21.87.200 (requirements for adequate reserves); AS 21.87.210 (requirements for surplus fund); AS 21.87.220 (investment requirements); AS 21.87.230 (requirements for books and accounts); AS 21.87.240 (annual statement and fees requirements); AS 12.87.250 (periodic statutory examination); and AS 21.87.260 (taxation). In addition, AS 21.87.340 makes a service corporation subject to numerous other provisions of the insurance code, including most provisions of AS 21.09, so long as the provisions do not conflict with AS 21.87. A service corporation nonetheless is exempted from some important regulatory provisions applicable to traditional insurers. *See, e.g.*, AS 21.87.340 (exemption from Holding Company Act requirements of AS 21.22; and exemption from participation in guaranty association established by AS 21.79).

As further evidence of the confusion regarding how to categorize a service corporation, the entity is expressly prohibited from using a corporate business name including the word "insurance" or other terms descriptive of an insurer or insurer business. *See* AS 21.87.060. And, the U.S. Supreme Court has acknowledged in a case addressing what constitutes "the business of insurance" that Blue Cross as well as some members of Congress do not consider a service corporation's product to be insurance. *See Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 228-29 (1979). Nevertheless, service corporations are commonly referred to as insurers and as engaged in the business of insurance. They are also often included within the rubric "group medical

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expense insurance." *See generally* D. Gregg, *Life and Health Insurance Handbook*, 427 (2d ed. 1964) (chapter entitled: "Group Medical Expense Insurance — Blue Cross and Blue Shield"). It is therefore not uncommon to see service corporations (*e.g.*, Blues) characterized as insurance in some contexts but not as insurance in others.

III. ANALYSIS

A. A patient has the right to receive health care services from the provider of her/his choice.

Your first question focuses on the right of a patient to choose a provider. In the broad context of traditional health insurance, the answer is that a patient (insured) has an unqualified right to seek health care services from the provider of her/his choice. The Alaska insurance code uses the term "disability insurance"[4] to refer to what is commonly known as health insurance. For individual disability insurance policies, the statutory requirement for payment of indemnity to a provider is qualified by the language: "this paragraph does not require that services be provided by a particular hospital or person." *See* AS 21.51.120. Similarly, under AS 21.54.020(a) a group disability policy "may not contain a provision requiring that services be provided by a particular hospital or person," except as applicable to an HMO. The Unfair Trade Practices Act for insurance (AS 21.36) provides additional support for a patient's freedom to choose a provider. AS 21.36.090(b) prohibits a person from unfairly discriminating in a policy or contract of disability insurance. An insurer limiting a patient's ultimate right to use the provider of her/his choice — regardless of provision for payment — violates this provision.

Provisions of AS 21.87, the chapter regulating service corporations, also acknowledge the freedom to choose. As previously addressed, in the typical situation the service corporation enters a contract with "participating" providers. *See* AS 21.87.120(a)(1) (medical and surgical services); AS 21.87.130(a)(1) (hospital services). However, this does not preclude a subscriber from obtaining services of a nonparticipating provider. AS 21.87 expressly authorizes a service corporation to provide indemnification for services provided by nonparticipant providers. *See id.* AS 21.87.120(a)(2) (indemnity for medical and surgical services); AS 21.87.130(a)(2) (indemnity for hospital services).

It is necessary to distinguish that although a service corporation has the right to offer coverage extending payment to a nonparticipant provider, the corporation is not obligated to provide for indemnity of a

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nonparticipant provider. The right to provide a subscriber "indemnity in a reasonable amount" (AS 21.87.120(a)(2) and AS 21.87.130(a)(2)) is not a mandate. The following provisions support this conclusion. AS 21.87.160(b)(2) requires that a subscriber contract must include "the benefits, *if any*, to which the subscriber is entitled on an indemnity basis. . ." (emphasis added). And, it is noteworthy that the minimum service benefits which must be provided through a subscriber contract apply only to participant providers and participant hospitals. *See id.* AS 21.87.170.

As further support of a subscriber's right to choose a provider, a PPO, which allows health care recipients a choice from among a group of providers, is not prohibited by the insurance code. *See generally* 1995 Op. Att'y Gen (Apr. 21; 661-95-0654). A service corporation may contract with a PPO as a participant provider. For service corporation subscribers, this means they can choose to receive health care from among providers who have entered a service agreement, presumably at a lower (negotiated) fee. However, even if a service corporation contracts with a PPO, its subscribers still have the option to use a nonparticipant provider outside the PPO. *See* AS 21.87.120(a)(2); AS 21.87.130(a)(2).

The Unfair Trade Practices Act provides further support for the conclusion that a subscriber may seek treatment from the provider she/he chooses. AS 21.36.090(d) prohibits unfair discrimination in the group context against a provider rendering health care under a service or indemnity type contract issued by a nonprofit corporation (*e.g.*, service corporation).[5] The prohibition applies whether the provider is a participant (having entered a service agreement) or nonparticipant.

And finally, AS 21.87.160(c) provides as follows:

> A [subscriber] contract may not restrict the subscriber's right to free choice of provider or hospital, but must restrict benefits to be provided on a service basis to services rendered by participant providers and participant hospitals.

This provision, which corresponds with AS 21.87.170, reflects that a subscriber has an unqualified right to choose a provider.

B. A nonparticipant provider is not entitled to the same fees as a participant provider in the absence of a contractual provision to the contrary.

While a subscriber has the freedom to use the health care provider of

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her/his choosing, *payment* for services rendered by a nonparticipant provider is subject to terms of the subscriber contract. The insurance code provides that indemnification of a nonparticipant provider must be in a "reasonable amount." *See* AS 21.87.120(a)(2) (medical and surgical services); AS 21.87.130(a)(2) (hospital services). And, as required by statute, the language used by a service corporation in a subscriber contract must be filed with and approved by the division of insurance. *See* AS 21.87.180. This filing requirement applies to contract language providing for indemnification when a subscriber uses a nonparticipant provider.[6] In practice, when the division receives a subscriber contract, it reviews the filing for compliance with applicable provisions of the insurance code, including those of AS 21.87.120(a)(2) and AS 21.87.130(a)(2) requiring that indemnity to nonparticipant providers must be "reasonable" in amount. These provisions do not require that the amount to be indemnified must be equal to the amount paid for a covered benefit under a service agreement. In light of these provisions, AS 21.87 leaves a service corporation discretion to pay a nonparticipant provider less than a participant provider for the same covered service. Payment of different amounts, depending on whether a provider is a participant or nonparticipant, is not *unfair* discrimination. *See* AS 21.36.090(d).

Please do not hesitate to contact me if you have any questions.

David G. Stebing
ASSISTANT ATTORNEY GENERAL

NOTES

[1] I received your memo on October 25, 1995.

[2] In the context of a service corporation, "provider" is defined as "a physician, dentist, osteopath, optometrist, chiropractor, nurse midwife, or other licensed health care practitioner." AS 21.87.330(8).

[3] "Participant provider" and "participant hospital" mean a person (or hospital) that has entered into a service agreement with a service corporation. AS 21.87.330(5) and (6). These statutorily defined terms are not synonymous with the concept "preferred provider" as used in the context of a preferred provider organization (PPO).

[4] *See* AS 21.12.050. Disability insurance is not the same as disability income replacement insurance.

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[5] This provision does not apply to individual coverages.

[6] There is an exception from the filing requirement for certain contractual language (*e.g.*, endorsements, forms of unique character). *See* AS 21.87.180(a).

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§ 21.36.080 Boycott, coercion, and intimidation

A person may not enter into an agreement to commit, or by any concerted action commit, an act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

History.—§ 1, ch. 120, SLA 1966.

§ 21.36.090 Unfair discrimination

(a) A person may not make or permit unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for a contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the contract.

(b) A person may not make or permit unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for a policy or contract of health insurance or in the benefits payable, or in any of the terms or conditions of the contract, or in any other manner whatever.

(c) A person may not make or permit arbitrary or unfair discrimination between insureds or property having like insuring or risk characteristics, in the premium or rates charged for a policy or contract of property, casualty, surety, marine, wet marine or transportation insurance, or in the dividends or other benefits payable on the insurance, or in the selection of it, or in any other terms and conditions of the insurance.

Text of subsection (d) effective until January 1, 1999

(d) Except to the extent necessary to comply with AS 21.42.365 and AS 21.56, a person may not practice or permit unfair discrimination against a person who provides a service covered under a group health insurance policy that extends coverage on an expense incurred basis, or under a group service or indemnity type contract issued by a health maintenance organization or a nonprofit corporation, if the service is within the scope of the provider's occupational license. In this subsection, "provider" means a state licensed physician, dentist, osteopath, optometrist, chiropractor, nurse midwife, advanced nurse practitioner, naturopath, physical therapist, occupational therapist, psychologist, psychological associate, or licensed clinical social worker, or certified direct-entry midwife.

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the employee or member and to whom benefits are payable; if dependents are included in the coverage, only one certificate need be issued for each family unit;

(3) a provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

History.—§ 1, ch. 120, SLA 1966; § 68, ch. 56, SLA 1996, eff. 9-9-96.

§ 21.54.015 Rate discrimination prohibited

Rates charged for a group health insurance policy may not be excessive, inadequate, or unfairly discriminatory.

History.—§ 58, ch. 81, SLA 1997, eff. 7-1-97.

§ 21.54.020 Direct payment to health care provider

(a) An insurer may, and upon written request of the covered person shall, within 30 working days after receiving a proof of loss statement, pay indemnities under a group health insurance policy directly to the provider of the hospital, nursing, medical, dental, or surgical services. The policy may not contain a provision requiring that services be provided by a particular hospital or person, except as applicable to a health maintenance organization under AS 21.86. If the insurer pays indemnities to the covered person after the covered person has given the insurer written notice in the proof of loss statement of an election of direct payment of indemnities to the provider of the service, the insurer shall also pay those indemnities to the provider of the service.

(b) A covered person may revoke an election of direct payment of indemnities made under (a) of this section by giving written notice of the revocation to the insurer and to the provider of the services. The written notice of revocation given to the insurer must certify that the covered person has given written notice of revocation to the provider of the services. Revocation of an election of direct payment is not effective until the notice of revocation is received by the insurer and the provider of the services.

(c) The right of the covered person to request payment of indemnities under a blanket health insurance policy directly to the provider of the services or to another person may be transferred to a person who is not the covered person by a qualified domestic relations order. Rights under the qualified domestic relations order do not take effect until the

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period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof."

History.—§ 1, ch. 120, SLA 1966.

§ 21.51.120 Payment of claims

(a) A health insurance policy delivered or issued for delivery must contain the following provisions:

(1) indemnity for loss of life shall be paid according to the beneficiary designation and payment provisions contained in the policy that are effective at the time of payment; if a beneficiary has not been designated, indemnity shall be paid to the estate of the insured; accrued indemnities unpaid at the insured's death shall be paid to either the beneficiary or the estate, at the option of the insurer; all other indemnities shall be paid to the insured;

(2) the insurer may, and upon written request of the insured shall, within 30 working days after receiving a proof of loss statement, pay indemnities for hospital, nursing, medical, dental, or surgical services directly to the provider of the services; an insurer who pays indemnities to an insured, after the insured has given the insurer written notice in the proof of loss statement of an election of direct payment of indemnities to the provider of the services, shall also pay indemnities to the provider of the services; this paragraph does not require that services be provided by a particular hospital or person;

(3) a covered person may revoke an election of direct payment of indemnities made under this subsection by giving written notice of the revocation to the insurer and to the provider of the services; the written notice of revocation given to the insurer must certify that the covered person has given written notice of revocation to the provider of the services; revocation of an election of direct payment is not effective until the notice of revocation is received by the insurer and the provider of the services;

(4) the right of the insured to request payment of indemnities for hospital, nursing, medical, dental, or surgical services directly to the provider of the services or to another person may be transferred to a person who is not the insured by a qualified domestic relations order; rights under the qualified domestic relations order do not take effect until the order is received by the insurer; in this paragraph, "qualified

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AK REHAB MEDICINE, INC TEL:1-907-277-6335 Feb 22'00 12:05 No.006 P.01

ALASKA NEUROLOGICAL CONSULTANTS, L.L.C.

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Mary Downs, M.D.
Board Certified Neurology

Wayne Downs, M.D.
Marjorie J. Smith, M.D.
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3300 Providence Dr., Ste 01
Anchorage, AK 99508

FAX to 907-465-2040

2/22/00

RECEIVED FEB 22 2000

To: Rep. Rokeberg
Chairman, Labor and Commerce

From: Thomas R. Gordon, MD

Dear Rep. Rokeberg,

I am sending this in support of HB 211. It provides common-sense guidelines for the protection of our patients ~~from~~ time consuming and potentially harmful protectionism from "heath business" protectionists whose primary interest is money and not provision of timely health care or in some instances proper health care.

Sincerely,

Thomas R. Gordon MD

Stephan P. Hyams, D.O., L.L.C.

Board Certified General Surgeon

RECEIVED FEB 22 2000

22 February 2000

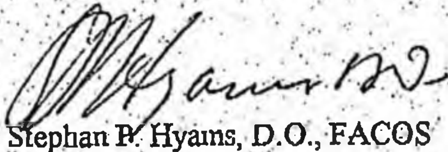
Representative Rokeberg
Chairman Labor and Commerce Committee

Mr. Rokeberg,

I would like to draw your interest to support HB2111 (Alaska's Patient Bill of Rights).

I believe that Alaskans have a unique opportunity to continue to enjoy an extremely high standard of medical care without limiting their choice of physicians, limiting their physicians in explaining state of the art therapies, or limiting access of patients to physicians services. If you have followed the lay business press and the medical journals you can appreciate that these are key issues that have been identified with the failure of the "managed care movement".

Again, we have the opportunity to prevent "mismanaged care" in Alaska with HB211. Please support it.



Stephan P. Hyams, D.O., FACOS

3300 Providence Dr., Suite 208 • Anchorage, Alaska 99508 • (907) 261-5672 • FAX (907) 261-5670

Marcelyn LePique M.D.
OBSTETRICS & GYNECOLOGY
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Anchorage, Alaska 99508
Phone: (907) 561-6661

RECEIVED
FEB 22 2000

February 22, 2000

Honorable Norm Rokeberg
State of Alaska
House of Representatives
Chairman, House Labor & Commerce Committee
State Capitol
Juneau, AK 99801-1182

Re: HB211 - Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg,

I am a private practice physician specializing in obstetrics and gynecology, and am writing to ask for your support in advocating bill HB211. The following provisions are especially important to me:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians and expect a reasonable continuation of care by the patient's physician. Also, provide a reasonable "point of service" option, so that patients may choose to see a physician of their choice outside of network.
2. Ban "gag" clauses in managed care contracts.

Sincerely,

M A LePique M.D.

Marcelyn A. LePique, MD, FACOG

Richard A. Anschuetz, MD, FACC
Leo B. Bustad, MD, FACC
John C. Finley, MD, FACC
Seth L Krauss, MD, FACC
Paul A. Peterson, MD, FACC
George S. Rhyneer, MD, FACC
David W. Sonneborn, MD, FACCD

James A. Baldauf, MD, FACC
Colleen M. Coughlin, MD, FACC
Thomas K. Kramer, MD, FACC
William P. Mayer, MD, FACC
Robert L. Pulliam, III, MD, FACC
Mark A. Selland, MD, FACC

February 21, 2000

Representative Norman Rokeberg
Chairman of Labor and Commerce Committee
716 W. 4th Avenue
Anchorage, AK 99501

RE: HB 211 (Alaska Patient Bill of Rights)

Dear Representative Rokeberg:

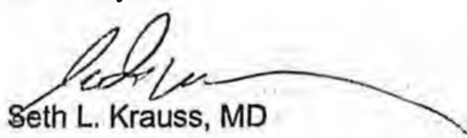
I am writing to support HB 211. This bill will ensure that Alaskans will continue to receive reasonable and appropriate health care as mandated by several important provisions:

1. The bill will protect against potential "gag" clauses that are commonly used instruments in managed care contracts.
2. It will require medically necessary decisions be reviewed by physicians and not made by an accountant or other nonqualified paramedical personnel.
3. Require a "lay person" standard be used to ensure medical services. This means that an insurance contract will provide for emergency services and not eliminate services that are necessary for acute care.
4. Ensure for timely internal as well as neutral external appeals process for denied claims. As has been the experience elsewhere, denial of claims is a frequently used gimmick by insurance companies to reduce access to necessary diagnostic and therapeutic procedures.
5. Provide a "point of service" option whereby patients will have a reasonable choice of physicians outside of the network. In Alaska, it is entirely possible that an insurance contract could exclude and limit physicians who may provide a unique service to this state. It would be wrong for an insurance contract to exclude such unique service, but entirely possible without this type of option.

While the current model of health care in Alaska requires ongoing and continuous improvement and evaluation, it would be a mistake to adopt the model of managed care that has so badly served patients in the Lower 48. It is interesting to note the experience and welcome comments of patients who have participated in the health care system in the capital Outside and in Alaska.

I certainly welcome your inquiries and urge your support.

Sincerely,



Seth L. Krauss, MD

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FEB 29 2000

/lrh

3260 Providence Dr., #537 (907) 562-7575/Fax (907) 563-9386
3340 Providence Dr., #522 & 2841 DeBarr Rd., #21 (907) 561-3211/Fax (907) 561-4652
1200 Airport Heights, #330 (907) 258-3856/Fax (907) 258-3984
Anchorage, AK 99508

RICHARD M. FARLEIGH, M.D., P.C.

FELLOW, AMERICAN COLLEGE OF GASTROENTEROLOGY
DIPLOMAT IN GASTROENTEROLOGY AND INTERNAL MEDICINE.
AMERICAN BOARD OF INTERNAL MEDICINE

4120 LAUREL STREET. SUITE 202 • ANCHORAGE. ALASKA 99508
(907) 561-4293

RECEIVED
FEB 25 2000

February 22, 2000

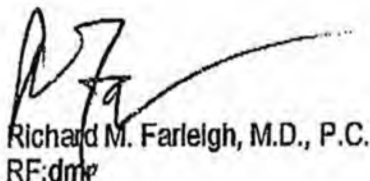
Representative Roakeberg
Chairman of House, Labor, and Commerce Committee
Fax: 907-465-2040

Dear Representative Roakeberg:

I am writing in support of House Bill #211. I am a physician in private practice in Anchorage, now in my 20th year of practice. I strongly encourage the provisions of House Bill #211 including the banning of gag clauses in managed care contracts, the requirement that medically necessary decisions be made and reviewed by physicians, and that timely internal and external reviews or appeals processes be available for denied claims. A point of service option is also important in extending a choice of physicians to patients. This also encourages physicians to compete on the basis of quality which improves medical care in general.

Thank you for your support of House Bill #211.

Sincerely,



Richard M. Farleigh, M.D., P.C.
RF:dmp

Feb.25. 2000 10:25AM DR FARLEIGH No.7255 P. 1/1

Providence | Alaska Medical Center

3200 Providence Drive
P.O. Box 196604
Anchorage, Alaska
99519-6604

Tel 907.562.2211

February 14, 2000

The Honorable Norman Rokeberg
Chairman, House Labor & Commerce Committee
Alaska State Legislature
State Capitol (MS 3100)
Juneau, AK 99801-1182

Dear Chairman Rokeberg:

We are responding to your proposed legislation as one of Alaska's largest employers, rather than as Alaska's only tertiary care hospital. Let us preface our comments by saying we certainly understand and share many of the same concerns you have for people who have or are seeking insurance coverage, as well as fairness in the over all cost of health care treatment.

We have reviewed the proposed committee substitute for HB 211 and as a major of employer of nearly 3000 people, we are very concerned about how this proposed legislation. Ultimately, if costs continue to soar, health care will become unaffordable; people will not be able to access health care easily or timely, therefore creating more obstacles to attaining health care. Due to the overall complexities of the proposed committee substitute, as written, we cannot support the bill. There are also clarifications we ask be further addressed.

Specifically, the bill will:

- Create an upward spiral effect on health care. First, health care insurance premiums would increase. Then, Providence and other providers will be faced with increasing prices in order to purchase health insurance for employees. In addition, health care premiums must increase again in response to the increased prices.

- Impact the State budget because of the cost of insuring state employees.

- Increase the number of uninsured Alaskans because insurance will become cost prohibitive, or those health care services are not reasonably available in many communities.

- Pose questions about how this legislation relates to Employees Retirement Income Security Act of 1974 (ERISA).

In conclusion, there are several other questions and more need for clarification regarding the proposed committee substitute for HB 211. We request a meeting to further address these questions.

Sincerely,

Doug Bruce, Chief Executive

cc: House Labor & Commerce Committee
Commissioner Karen Perdue

Providence | Health System

3200 Providence Drive
P.O. Box 196604
Anchorage, Alaska
99519-6604

February 22, 2000

Representative Norman Rokeberg
House of Representatives
Room 24 - District 11
State Capital
Juneau 99801-1182

RECEIVED
FEB 23 2000

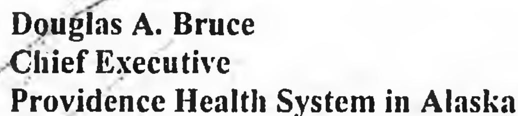
Fax: (907) 465- 2040

Dear Representative Rokeberg,

Providence Health Systems of Alaska has reviewed House Bill 211, concerning patient rights and physician/insurance company negotiations. This bill is strong in merit and its passage would aid in the improvement of the health care delivery system in Alaska. Assured access to quality health care and the protection and precedence of patient rights is paramount for every Alaskan. Safeguarding these rights is the responsibility of all of us.

Correspondingly, leveling the state of affairs for the physicians and insurance companies in Alaska is important to assure quality health care for Alaskans. This bill would help assure the integrity of medical decisions made by doctors and insure the best interest of the patients. We support the adoption of this bill into law.

Sincerely,



Douglas A. Bruce
Chief Executive
Providence Health System in Alaska

Marcelyn LePique M.D.
OBSTETRICS & GYNECOLOGY
3260 Providence Drive, Suite 520
Anchorage, Alaska 99508
Phone: (907) 561-6661

February 22, 2000

Honorable Norm Rokeberg
State of Alaska
House of Representatives
Chairman, House Labor & Commerce Committee
State Capitol
Juneau, AK 99801-1182

Re: HB211 - Regulations of Managed Care Insurance Plan

Dear Representative Rokeberg,

I am a private practice physician specializing in obstetrics and gynecology, and am writing to ask for your support in advocating bill HB211. The following provisions are especially important to me:

1. Require managed care insurance companies to allow Alaska's patients to choose their treating physicians and expect a reasonable continuation of care by the patient's physician. Also, provide a reasonable "point of service" option, so that patients may choose to see a physician of their choice outside of network.
2. Ban "gag" clauses in managed care contracts.

Sincerely,

M A LePique M.D.

Marcelyn A. LePique, MD, FACOG

RECEIVED
FEB 24 2000

Michael C. Norman, MD
P.O. Box 210749
Anchorage, AK 99521

RECEIVED
FEB 2 3 2000

Representative Norm Rokeberg
FAX (907) 465-2040

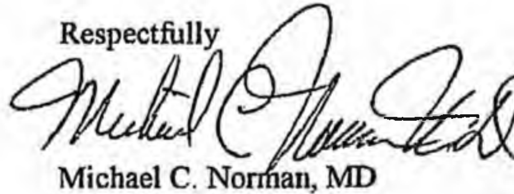
Dear Representative Rokeberg:

I urge you to support Alaska's Patient Bill of Rights, House Bill 211.

The requirement that medically necessary decisions must be made and reviewed by a physician will help to ensure patients will not be denied essential care and allow care to begin when needed. Without this provision a patient's need to use their insured medical benefits may be decided by clerical staff with little or no understanding of the medical soundness of their decisions. Delay or denial of needed care may lead to prolonged treatment and possibly death.

Please support House Bill 211.

Respectfully



Michael C. Norman, MD

Harbir S. Makin, M.D.

DIPLOMATE AMERICAN BOARD OF INTERNAL MEDICINE

3300 PROVIDENCE DR., SUITE 114
ANCHORAGE, ALASKA 99508
TELEPHONE (907) 261-3171

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FEB 2 2 2000

URGENT MEMO

02/22/00

To: **Representative Rokeberg** **FAX 907-465-2040**

Re: **HB 211**

Dear Mr. Rokeberg:

I am writing this letter asking for your attention to help move the House Bill 211 (Alaska's Patient Bill of Rights).

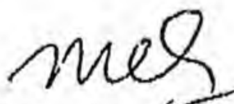
I wanted to point out that as an advocate for my patients this bill is very important to clinicians who provide care to patients in this state for the following reasons:

1. It will help ban "GAG" clauses in managed care contracts, so that doctors are free to discuss with their patients, the restrictions managed care companies put on their health care.
2. Patients will have a right to choose a physician outside of a network if he/she so desires.
3. Will allow physicians and NOT managed care Administrators to make medically necessary review decisions.

Obviously the managed care companies, Insurance companies and the hospitals, which envision profiteering in this era of managed care, will oppose the bill. These people do not care for the health of our patients. All they care about is their "BOTTOM LINE".

I sincerely appreciate you support.

Sincerely,



Harbir Makin, MD

Tanana Valley Clinic

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FEB 18 2000

February 14, 2000

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Karl B. Bauer, M.D.
Doris K. Hallman, M.D.
Richard C. Hess, M.D.
Nigel G. Wappet, M.D.
Ralph A. Wells, M.D.
Jan Swanson, CNP

SURGERY
Jon Lieberman, M.D.
David Wrigley, M.D.

INTERNAL MEDICINE
Linda L. Garcia, M.D.
Kenneth C. Starks, M.D.
Jonathan R. Starr, M.D.
Arvi Chiu, M.D.

PEDIATRICS
Marvin E. Bergeson, M.D.
J. Timothy Foote, M.D.
Michelle Nace, M.D.
Nancy J. Schultz, M.D.
Marianne B. Woodward, M.D.
Judy Kuehnert, ANP

FAMILY PRACTICE
Donald Ives, M.D.
Hunter Judkins, M.D.
Corrine Leistikow, M.D.
Charles Steiner, M.D.
Jean M.W. Tsigonis, M.D.
Dennis Rogers, PA-C
Scott Conover, PA-C
Laura Catalano, PA-C
Paul Finch, PA-C
Victor Barting, D.O.
Colleen Schramm, FNP

ORTHOPEDICS
Richard H. Cobden, M.D.
Jim Tamai, M.D.

ADMINISTRATION
Brian Slocum, Administrator
Sandra J. Farmer, Controller
Wendalyn Tisland, Director of Human Resources
Cathy Martin, Chief Financial Officer

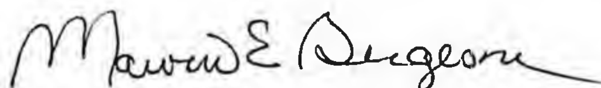
Representative Norman Rokeberg
State Capital, Room 24
Juneau, AK 99801-1182

Dear Representative Norman Rokeberg:

Currently several groups in Fairbanks are hamstrung by AS18.07.031 which was enacted in 1976. This statute regulates medically facility construction and use. This statute would benefit by regular legislative review. Since its enactment, there has been no allowance for inflation or the cost of living adjustments. Currently this statute can be used for the purposes of limiting free enterprise and I do not believe that this was the intended purpose in the original legislation. Actual construction of an out-patient surgery center in Fairbanks would lower Medicaid facility fees by competition and by the fact that a non-hospital facility would only be reimbursed at 80% of the same hospital facility fees, according to Federal mandate.

In addition, I would request your support of House Bill 211. This bill is similar to a bill passed in Texas called the State Action Doctrine. Such a bill allows independent, competing physicians to jointly negotiate terms of physician's services agreements with the very large, albeit few, insurance companies and thereby allows a more level playing field. Doctors nationwide are growing frustrated with health plan policies that seem to afford them little control over deciding what is best for their patient's. I would also like to support the Patients' Bill of Rights.

Sincerely,



Marvin E. Bergeson, M.D.
Pediatrician

MEB/dr

1001 Noble Street • Fairbanks, Alaska 99701
(907) 459-3500 • FAX (907) 456-8770

Alaska State Medical Association

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

May 4, 1999

Honorable Norm Rokeberg
State of Alaska
House of Representatives
Chairman, House Labor and Commerce Committee
State Capitol
Juneau, AK 99801-1182

RE: HB 211—Regulation of Managed Care Insurance Plans.

Dear Representative Rokeberg:

Thank-you for this opportunity to provide this written testimony on HB 211. The Alaska State Medical Association (ASMA) represents Alaska's patients and the 500 private practice physician who care for them.

ASMA requested that you introduce legislation that would provide basic protection for Alaska's patients covered now or in the future under managed care health insurance policies. Furthermore, the request was to also provide a more level playing field involving the contracting between a physician and an insurance company which issues managed care health insurance policies.

In a January 13, 1999 New York Times article, it was reported that since 1994 the top 18 health insurers in this country have consolidated to 6 at this point in time. The American Medical Association has stated that if the pending Aetna/U.S. Healthcare merger with Prudential takes place that one in every ten Americans will be covered by that corporate giant. The result of the aggregation is that fewer, much larger insurance companies remain. Their market concentration is extremely high. Historically, such market dominance by a few insurers has always been the case with seldom more than three insurers dominating the market. This situation provides for grossly unequal bargaining power between a covered Alaska resident or the treating physician and the insurance company. Both health insurance contracts and physician services in Alaska are "contracts of adhesion" and offered on a "take it or leave it basis". Such contracts need the protection and scrutiny provided by HB 211. Attached is a copy of the AMA's Model Medical Services Agreement and an analysis of an Alaskan physician services contract done by attorney Roger Holmes for ASMA. This is an example of such a contract.

Furthermore, most of the health insurance in Alaska is provided by group insurance through the workplace. As such, Alaskans with such coverage, unless they own the business, do not generally

Furthermore, most of the health insurance in Alaska is provided by group insurance through the workplace. As such, Alaskans with such coverage, unless they own the business, do not generally make the choice of coverage or insurer. As elements of managed care health insurance become more prevalent which provide financial incentives or disincentives for using certain identified physicians for treatment, employees are faced with others (the employer) making the decision as to who will provide medical treatment. HB 211 through its mandated "point of service" option provides for a reasonable choice of treating physician by a covered person. This is not only good medicine (non-interference with a long-term patient/physician relationship) but it is only fair and the right thing to do.

Section 3 of this bill provides for those basic protections for Alaska's covered residents and a "level contracting field" for Alaska's physicians. Importantly, it also leaves the determination of the medically necessary, course of treatment with the treating physician and not with some insurance company bureaucrat. Determination of "medical necessity" is made using appropriate "standard of care" criteria as opposed to some other standard based on the lowest cost treatment option without regard to the needs of a specific patient. Attached is a "Dear Colleague" letter from Rep. Greg Ganske, (R), Iowa regarding this topic that provides a compelling description of this issue.

Section 2 holds managed care entities (health insurance companies) accountable for their actions that result in injury to patients. Insurance companies through their "utilization review" and/or pre-authorization mechanisms are increasingly encroaching on medical treatment decisions. When physicians are negligent in making health care treatment decisions, they are held accountable through the legal system. Under HB 211, managed care entities would be required to exercise ordinary care when making health treatment decisions and would be held responsible for their failure to do so. ASMA believes the Alaska patients deserve no less.

You will hear that if Section 2 is enacted health care costs will significantly increase. In Texas, the first state to adopt managed care accountability legislation, the actuarial consulting firm Milliman and Robertson completed an actuarial determination of the cost to a Texas based HMO and set the cost at 34 cents per member per month. Attached is a study done by the actuarial consulting firm, William M. Mercer, Inc., for the American Medical Association titled "Estimates of the Cost Impact of Managed Care Accountability Legislation". The increased cost is stated as a percentage of the premium for managed health care plans and ranges from 0.2% to 1.8% based on varying criteria. This range does not constitute a "significant" increase.

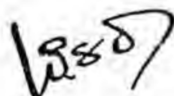
There are no HMO's in Alaska. You may hear testimony stating that because of this fact HB 211 is not needed. This is not true as "managed care" health insurance covers a continuum that ranges from full blown HMO's to insurance contracts with "preferred provider" elements. Coverage with elements defined as "managed care" under AS 21.07.250 (7) is already in place in Alaska. Even the Medicaid program is moving toward managed care with its proposed Medical Home pilot program in Anchorage.

HB 211 contains treatment of those issues, which ASMA has brought to your attention as well as others, which you have included. Obviously, ASMA supports HB 211. However, ASMA suggests several amendments as follows:

1. p. 3, lines 12 and 13
   "(4) clearly states the rate and method of compensation [RATES] for each [PROVIDER USED BY THE GROUP MANAGED CARE PLAN TO PROVIDE HEALTH CARE SERVICES] insurance policy for which the health care provider provides health care services for the covered persons;";
2. p. 6, line 23
   "(11) .... a list of specific drug formularies [FORMULAS], including specific exclusions; and"; and
3. p. 8, line 15-31; p. 9 lines 1-3.
   Amend to clarify that the "neutral health care provider" needs to be a "peer" of the treating health care provider. This may be a logical extrapolation based on the "peer" requirement inherent in the internal review procedures required in AS 21.07.050 (5). But, it would be best to make this clearly a requirement.

Again thank-you for the opportunity to provide this testimony on HB 211.

Sincerely,



BY: Jerome List, DDS, MD, President

FOR: Alaska State Medical Association

cc: Rep. Brian Porter, Speaker of the House
Rep. Andrew Halcro, Vice-Chair, House Labor and Commerce
Rep. John Harris, Member, House Labor and Commerce
Rep. Lisa Murkowski, Member, House Labor Commerce
Rep. Jerry Sanders, Member, House Labor and Commerce
Rep. Tom Brice, Member, House Labor and Commerce
Rep. Sharon Cissna, Member, House Labor and Commerce

/kms

American Medical Association

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Model Managed Care Medical Services Agreement

Division of Representation

AMERICAN MEDICAL ASSOCIATION
MODEL MANAGED CARE AGREEMENT
PART I
INTRODUCTION

Words matter. Nowhere is that truism more accurate than in the arena of business relationships and the laws that governs them. In medicine, provisions in the agreement that runs between a managed care company and a physician or physician group glossed over at the time of signing suddenly spring to life in new and often dangerous ways when a controversy arises that requires interpretation, clarification, or resolution. Physicians, as well as their attorneys, too often discover that important issues not negotiated or discussed prior to signing are the very issues that the unread or the unnegotiated contract both addresses and interprets in a manner disadvantageous to the interests of physicians and their patients.

The drafter of an agreement has two options when commencing the task. One option is to presume that every article, every paragraph, every section and subsection should be drafted to the maximum advantage of the client for whom it is written and should disadvantage to the greatest degree possible the party with whom the client is negotiating. In such a case the drafter views that party as an adversary. This often occurs when the drafter believes that his or her client has such market power that the client's adversary will have to accept terms as offered. The second option, and one far more common in the tradition of sound and lasting business relationships in the Anglo-American legal tradition, is to draft the agreement so that both parties are protected on those issues that are important to them, incorporating in the contract only those items that are fundamental to the relationship and excising extraneous, punitive elements.

It has been said that many agreements running between managed care organizations (mcos) and physicians are virtual contracts of adhesion. Contracts of adhesion are characterized by gross inequality of bargaining power between the parties and the imposition of harsh, sometimes unconscionable terms because of that inequality. While courts may not view a physician/mco as analogous to a "contract of adhesion" forced upon an unwitting average consumer, it is instructive to note that in many respects managed care contracts increasingly exhibit the elements associated with these disfavored contracts: a standardized contract drafted by the party of superior bargaining strength that relegates to the weaker party only the opportunity to adhere to the contract or reject it.

Today the deteriorating relationship between physicians and managed care organizations which is reflected in many managed care agreements that make material terms--such as the services to be provided and the compensation to be paid--wholly illusory, and add into the relationship extraneous, punitive provisions that are both unwise and unnecessary.

A more constructive approach is one that balances the rights and obligations of the parties and establishes prudent and reasonable parameters of the managed care organization. The American Medical Association (AMA) offers the following Model Medical Services Agreement as an example of that approach.

The AMA Model Medical Services Agreement sets forth certain key provisions critical to the physician or physician group wishing to conduct their affairs in a reasonable and businesslike fashion. It also incorporates the valid business and administrative concerns of managed care organizations. The annotations provided to key contract clauses and terms will assist physicians and their attorneys in understanding the important issues raised by these agreements. The contract does not include some of the more common punitive provisions that appear in many physician/mco contracts. Those are identified and described in Part III.

The AMA Model Medical Services Agreement is part of an initiative by the AMA's Division of Representation (description attached) to educate physicians about managed care contracting practices and to alert them to practices that may compromise patient care. First and foremost, physicians must read their contracts and understand the legal implications of what they are signing. Legal review is an important part of that process. If physicians identify provisions that they believe may compromise patient care or which pose liability or other concerns they should alert the Division of Representation at 312-464-5490.

American Medical Association

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AMA Division of Representation

The American Medical Association (AMA) Division of Representation focuses on aggressively representing physicians, in partnership with state, county, and specialty societies, at a time when physicians are increasingly frustrated about encroachment on their clinical decisionmaking. Division of Representation services are offered through the Advocacy Resource Center.

Division staff are available to consult with and assist state and county societies in representing individual physicians and groups before health plans. The Division of Representation operates as a true partnership model, with the local medical society, the individual physician, and the AMA each assuming specific responsibilities. The Division of Representation is designed to provide legal and practical expertise to enhance the ability of physicians and organized medicine to negotiate in favor of physicians. It cannot function as or substitute for personal legal counsel and should be considered an additional resource to physicians and medical societies. The Division can refer physicians to qualified local counsel through AMA ConsultingLink.

The Division also operates as a link to specialty societies which play an integral role in determining conflicts over clinical issues. The Division is building a databank on clinical issues to share with our partners in organized medicine and help us to identify recurring issues. With state and county medical societies taking the lead on developing the facts underlying a physician complaint, the AMA will step in to assist in developing a strong, timely response, and at the request of the medical societies, will join the local society in communications with the health plan. Response strategies also may include development of media campaigns and/or legal intervention. Individual AMA members may contact the AMA directly, but must provide substantial written documentation of their complaint and notify their state and county medical societies.

The Division of Representation has identified four priorities for 1997-1998:

- Assisting local medical societies in opening a dialogue with health plans as outlined by the Department of Justice/Federal Trade Commission antitrust guidelines.

- Providing medical societies with action plans -- including sample letters and contract provisions -- to assist physicians in common complaints before health plans and help physician and medical societies resolve these issues more effectively through various legal, media, and other strategies.

- Through local medical societies, assisting employed physicians seeking to collectively bargain with their employers, including, if requested, assisting in forming a recognized collective bargaining unit.

- Directly assisting individual physicians and group practices by providing consulting services and strategies to enhance physician/patient representation before plans on issues of critical concern such as policies and practices that interfere with the patient-physician relationship and inappropriate application of clinical guidelines.

In addition, the AMA continues to be a leader on the national level in pressuring health plans to eliminate policies that arbitrarily interfere with patient care. Question about the Division of Representation can be directed to Lynne Gavin, Division Assistant, at (312) 464-5490.

PART II
MODEL MANAGED CARE MEDICAL SERVICES AGREEMENT

THIS AGREEMENT, made this _____ day of _____ 1998 and made effective on the _____ day of ______, 1998 ("Effective Date") by and between ___________________________[a physician] [a medical group practice] [a physician joint venture, such as a Network or IPA] ("Medical Services Entity"), and ____________________________________ a [state of incorporation] Corporation ("Company") (Medical Services Entity and Company jointly the "parties").

This contract is designed for the broadest possible application. It can be entered into by an individual physician, his or her professional Corporation, or a Physician Network or IPA. As a result, the phrase "Medical Services Entity" stands for the entity (e.g. individual, corporation, limited liability company) responsible, while the phrase "Qualified Physician" is used every time the application of the contract's terms make reference to an individual physician within the entity. Where the contract is with an unincorporated individual physician, he or she is both a Medical Services Entity and a Qualified Physician.

WITNESSETH:

WHEREAS, Company offers or administers one or more health benefit products or plan (s) and wishes to arrange for the provision of medical services to enrollees of such products or plans.

The recitals describe for any third party in narrative fashion the nature of the two parties coming to terms under this contract and their intentions. These recitals can and should be changed to fit the specific facts of the contract. While recitals are generally not an enforceable part of the contract, they may be very important to a party, such as a judge or arbitrator, in its interpretation. Therefore, care should be taken that they are set forth accurately and completely.

WHEREAS, Medical Services Entity is comprised of or contracts with one or more physicians capable of meeting the credentialing criteria of Company.

WHEREAS, Company desires to engage Medical Services Entity to deliver or arrange for the delivery of medical services to the Enrollees of its plans.

WHEREAS, Medical Services Entity is willing to deliver or arrange for the delivery of such services on the terms specified herein.

NOW, THEREFORE, in consideration of the mutual promises set forth herein, and other good and valuable consideration, the parties hereby agree as follows:

I. DEFINITIONS

Definitions are a critical component of the contract. The difference, for example, between a liberal and narrow definition of "medically necessary" or "emergency services" could mean the difference between the company approving and paying for a patient's procedure or refusing to pay.

1.1 Claim. A statement of services submitted to Company by Medical Services Entity following the provision of Covered Services to an Enrollee that shall include diagnosis or diagnoses and an itemization of services and treatment provided to Enrollee.

1.2 Company Notice. A communication by Company to Medical Services Entity informing Medical Services Entity of the terms of one particular Plan, modifications to the Plan, and any other information relevant to the provision of Covered Services pursuant to this Agreement.

1.3 Company Compensation. The Total Compensation less that portion designated by the Plan as a Copayment.

1.4 Coordination of Benefits. The determination of whether Covered Services provided to an Enrollee shall be paid for, either in whole or in part, under any other private or government health benefit plan or any other legal or contractual entitlement, including, but not limited to, a private group indemnification or insurance program.

1.5 Copayment. A charge which may be collected directly by a Medical Services Entity or Medical Services Entity's designee from an Enrollee in accordance with the Plan.

1.6 Covered Services. Health care services to be delivered by or through Medical Services Entity to Enrollees pursuant to this Agreement as further defined in Article II.

1.7 Emergency Condition. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention, in the judgment of a reasonably prudent lay person prior to an initial medical screening and in the judgment of a reasonably prudent physician after benefit of such screening, could be expected to result in serious impairment to bodily function or serious dysfunction of any bodily organ or part.

This definition protects patients and physicians by acknowledging the common sense of the average patient and physician in determining whether the condition requires immediate medical attention. Note that the standard used when the patient presents initially is not whether the patient believes it is an emergency condition, but whether a reasonably prudent patient would believe the condition is an emergency. Thereafter, once a physician has had the opportunity to review the results of the screening, the standard is whether a reasonably prudent physician would consider the condition an emergency.

1.8 Enrollees. Any individual(s) entitled to health care benefits under a Plan.

1.9 Medically Necessary. Health care services that a

No payment is made for care that is not "medically necessary." Many managed care agreements define "medically

reasonably prudent physician would deem necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member of an Enrollee.

necessary" to be whatever their medical director says is medically necessary. While aggressively pursuing the right to make such judgments through their physicians agreements, some of those same companies disclaim in the courts the medical decision-making responsibility that goes along with it. This definition relies not on what the company's medical director believes, but on what would be believed by the average, reasonably prudent physician faced with such a diagnosis or condition.

1.10 <u>Non-Covered Services</u>. Health care services that are not Covered Services as defined herein.

1.11 <u>Payor</u>. The entity or organization directly responsible for the payment of Company Compensation to the Medical Services Entity under a Plan. With respect to a self-funded Plan covering the employees of one or more employers, the Payor shall be the employer(s) and/or any funding mechanism used by the employer(s) to pay Plan benefits. With respect to an insured Plan or Plan providing benefits through a health maintenance organization, the Payor shall be the insurance company or health maintenance organization, as the case may be.

1.12 <u>Plan</u>. An individual set of health service delivery and compensation procedures offered as a "managed care" product by Company or administered by Company on behalf of a Payor for the benefit of Enrollees, as it may be modified from time to time, and all the terms, conditions, limitations, exclusions, benefits, rights and obligations thereof to which Company and Enrollees are subject.

This contract contemplates that the managed care company and physician or physician group may, for the convenience of both parties, enter into a single set of legal terms to govern their relationship no matter what product is offered by the company or health benefits plan administered by the company on behalf of an employer. Even though the managed care company and physician group will agree to a single set of legal terms guiding their relationship, separate business terms for each and every product and plan will be recognized, permitting termination of one plan or product without termination of others. This contract provides for separate arrangements to be described and attached as Exhibits A and B.

1.13 <u>Qualified Physician</u>. A doctor of medicine or osteopathy licensed to practice medicine who has agreed in writing, either through this Agreement or through another written instrument, to provide Covered Services to Enrollees and who has been credentialed pursuant to the rules and procedures of the Plan by the Company or a duly appointed and authorized agent to which such responsibility has been delegated.

1.14 <u>Quality Management</u>. The process designed to monitor and evaluate the quality and appropriateness of care, pursue opportunities to improve care, and resolve identified problems in the quality and delivery of care.

1.15 <u>Total Compensation</u>. The total amount payable by Payor and Enrollee for Covered Services furnished pursuant to this Agreement.

1.16 Utilization Review. The process by which Company, or a duly appointed and authorized entity, including Medical Services Entity, to which such responsibility has been delegated, determines on a prospective, concurrent, and/or retrospective basis the medical appropriateness of Covered Services furnished to Enrollees.

II. DELIVERY OF SERVICES

2.1 Covered Services. Medical Services Entity shall provide or, through its Qualified Physicians, arrange for the provision to Enrollees of, those Covered Services that are identified in Exhibit A, attached hereto and made a part of this Agreement by this reference. Exhibit A shall be comprised of separate schedules designated as Exhibit A1, A2, etc., which shall identify separately the Covered Services relating to each Company Plan. Where such schedule contemplates a global or capitated arrangement requiring Covered Services not normally provided by the Qualified Physicians of Medical Services Entity, such Covered Services shall be designated in bold type and a note shall be prominently displayed stating that payment for these Covered Services shall be the Medical Service Entity's responsibility. In the event Exhibit A is not attached or contains descriptions of Covered Services that are so materially lacking in specificity that the purpose of this Agreement is defeated, Company shall pay Medical Services Entity the Qualified Physician's billed charge for each service performed by a Qualified Physician for the benefit of Enrollee. All Covered Services shall be provided in accordance with generally accepted clinical and legal standards, consistent with medical ethics governing the Qualified Physician.

The chief failing of many managed care contracts, in the view of many reasonable and prudent physicians, is that the services covered by the company are either poorly defined or not defined at all. Sometimes, companies go so far as to simply confuse Covered Services with medical necessity, ultimately identifying only those services deemed necessary by their medical director to be "covered" under the contract. On other occasions, capitation agreements that require physicians to perform a certain set of services for a fixed fee are not completely and clearly articulated or may be absent altogether, allowing the company to demand that the physician provide virtually open-ended services for the fixed fee. These situations sometimes occur because a company requires a physician or physician group to execute an agreement prior to attaching a schedule of covered services, and fails to later attach or provide the list required by the contract.

This provision defines the "Covered Services" for each plan or product to be those specifically set forth on one or more schedules attached as Exhibit A. It places the responsibility for completing this process on the managed care administrative agent: the company. If it fails to fulfill this responsibility, or if its terms are so unclear that it is difficult to interpret the contract, the company is penalized by requiring a payment more similar to a standard private pay or indemnity arrangement.

2.2 Verification of Enrollees. Except in the case of emergency, Medical Services Entity shall utilize the mechanism, including identification card, on-line service or telephone, chosen by Company or its agent designated for

Physicians are sometimes denied payment because of the administrative mistakes of managed care companies in either

such purpose, to confirm an Enrollee's eligibility prior to rendering any Covered Service, in order to guarantee payment. Company or Payor shall be bound by its confirmation of eligibility and/or coverage and shall not retroactively deny payment for Covered Services rendered to individuals the Plan has confirmed as eligible through such mechanism. Should Medical Services Entity after following Company procedure to the extent reasonably possible, be unable to ascertain the eligibility of a patient who holds him or herself out to be an Enrollee, Medical Services Entity shall render necessary care through its Qualified Physician. At the first available opportunity, Medical Services Entity shall attempt to verify eligibility. In the event patient is not an Enrollee, Medical Services Entity shall attempt to collect from patient the amount due, up to the usual and customary fee of the Qualified Physician providing service. If, after two billing cycles, Medical Services Entity or Qualified Physician has not received full payment, Company will pay Medical Services Entity the Qualified Physician's usual and customary fee, minus that which the Qualified Physician or Medical Services Entity has already collected from the patient, not to exceed the amount provided for as Total Compensation herein.

identifying Enrollees properly or failing to provide for enough telephone access or other convenient means of communication to obtain such verification in a timely fashion. Under many managed care agreements, the physician or physician group must suffer the consequences of such administrative short-comings. This section reverses that presumption and sets forth a reasonable procedure for ensuring that a physician, without penalty, can verify Enrollees in a timely fashion.

III. COMPENSATION AND RELATED TERMS

3.1 <u>Compensation</u>. Medical Services Entity, or its designee, shall accept, as full payment for the provision of Covered Services, the Total Compensation identified in Exhibit B, attached hereto and made a part hereof by this reference. Exhibit B shall be comprised of separate schedules designated as B1, B2, etc., which shall identify separately the total compensation and related terms for each Company Plan. The Total Compensation set forth on the Exhibit B schedule(s) shall specify for each Payor and Plan, the manner of payment for professional services (such as fee for service, capitation, risk withholds, global payment, or bonus arrangement) rendered pursuant to the provision of Covered Services as set forth in the counterpart schedule of Exhibit A, and shall identify the portion of the Total Compensation that shall be the Company Compensation. It shall also identify with specificity the additional business terms negotiated by the parties related to such Total Compensation. By way of example, and without limiting the requirements of this section,

This article is a critical component of the contract and provides a unique and sensible approach to the negotiation of separate business terms between the physician or physician group and company with respect to each of company's plans. First, it simply requires that such terms be attached. (Incredibly, in an increasing number of managed care relationships, managed care companies lead physicians to believe that a particular compensation schedule has been set when the contract actually provides for compensation terms to be set from time to time in the sole discretion of the company.) Next, the Agreement requires that any compensation exhibit beyond a standard fee for service schedule specify in some detail the precise terms by which the moneys will be paid. Subsections A through C provide a checklist of issues to be identified and resolved in negotiating three of the alternatives to a simple fee schedule. Such a checklist should be

Exhibit B shall specify the following:

(A) In the case of a **capitation arrangement,**

i. the amount to be paid per Enrollee, per month;

ii. the manner by which Company will determine who is an Enrollee of Medical Services Entity for these purposes at the beginning of any particular month;

iii. the precise terms of the stop-loss arrangement offered to Medical Services Entity by Company, or a recital indicating that Medical Services Entity shall obtain any stop-loss protection through other arrangements;

iv. the boundaries of the service area in which treatment of Enrollees shall be arranged for by Medical Services Entity and outside of which treatment provided to Enrollees shall become the obligation of Company;

v. the fee-for-service schedule to which this compensation arrangement will revert in the event the number of Enrollees assigned to Medical Services Entity falls below a designated actuarial minimum, defeating the predictability of risk that both parties rely on in the arrangement;

vi. number of covered lives and the fee-for-service schedule upon which Medical Services Entity will be paid for those Covered Services provided to Enrollees not specifically made a part of the capitation arrangement on

helpful to consultants negotiating such agreements or attorneys with little health care business experience negotiating on behalf of the physician groups.

Note that separate Exhibit A schedules are required for each plan or company product, so that they can be negotiated, renewed or terminated individually. Finally, just as with the covered services on Exhibit A, to which the compensation terms of Exhibit B are related, it establishes a penalty where the company fails to discuss and articulate these matters fully, honestly and in sufficient detail.

Exhibit A. In the case of a capitation arrangement, Medical Services Entity shall have the right to audit, at Medical Services Entity's expense, the books and records of the Company or a Payor solely for purposes of determining the accuracy of any capitation payment.

(B) In the case of hospital/Medical Services Entity or Payor/Medical Services Entity **risk sharing on Non-Covered Services,**

i. the amount allocated by a Payor for Non-Covered Services including the figure used for measuring hospital inpatient days per one thousand (1,000) Enrollees assigned to Medical Services Entity and applicable hospital per diems or capitation payment;

ii. those services that will be charged against the hospital budget, such as hospital inpatient and outpatient care, ambulance service, home health services, durable medical equipment; the capitation payment withhold, if any, of the Medical Services Entity's contribution to the hospital budget;

iii. the monthly date upon which Medical Services Entity may rely on receiving a report from the Company regarding current charges made against the hospital budget;

iv. the amount of the hospital budget surplus to which Medical Services Entity would be entitled in the event utilization of institutional services is favorable: and the degree and scope of risk to Medical Services Entity, if any, in the event utilization of institutional

services is excessive.

(C) In the case of a **withhold or bonus,**

i. the method by which the amount to be released or paid will be calculated; the date on which such calculations will be complete;

ii. the records or other information on which Company will rely to calculate the release of the withhold or the payment of the bonus;

iii. the date upon which Medical Services Entity will have access to such records or information relied on by Company in making such calculation for the purpose of verifying the accuracy thereof;

iv. and the date upon which such payment release or, if any is finally due, shall be made.

In the event Exhibit B is not attached or contains descriptions of compensation and related terms that are so materially lacking in specificity that the purpose of this Agreement is defeated, then, Exhibit B shall be considered null and void and Company shall pay Medical Services Entity the Qualified Physician's billed charge for each service performed by a Qualified Physician hereunder. The Parties agree that the precise terms, as opposed to the general description of the manner of payment, to Exhibit B shall remain confidential between the parties.

3.2 Billing for Covered Services. Medical Services Entity shall submit a Claim to Company and, in the event such payment is contemplated under the terms of Exhibit B, Company shall pay Medical Services Entity for Covered Services rendered to Enrollees in accordance with the terms of this Agreement. Medical Services Entity shall arrange for all Claims for Covered Services to be submitted to

Company within six (6) months after the date services were rendered. Medical Services Entity shall submit such claims on a billing form HCFA-1600 or on another form that Company directs Medical Services Entity, in writing, to utilize.

3.3 Copayments to be Collected from Enrollees. When the Plan requires Enrollees to make Copayments, such Copayments shall be collected from the Enrollee at the time of service by Medical Services Entity or one of its Qualified Physicians. Company shall require Enrollees to make Copayments at the time of service. Company shall educate Enrollees that making Copayment at the time of service is mandatory. If Copayment is not remitted to Medical Services Entity within ten (10) days of the date of service, Company will assist Medical Services Entity in obtaining Copayment from Enrollee on behalf of Medical Services Entity.

3.4 Coordination of Benefits. When Enrollees are covered, either fully or partially, for service provided by a Qualified Physician under any other contractual or legal entitlement, including, but not limited to, a private group or indemnification program, Medical Services Entity shall be entitled to keep any sums it recovers from such other entities consistent with applicable federal and state law. Payor will pay Medical Services Entity the usual and customary fee of the Qualified Physician providing service for Medical Services Entity, less that which is obtained from any primary source; provided, however that if Exhibit B contemplates a fee-for-service compensation arrangement, the sum of such payments shall not exceed the Total Compensation set forth in Exhibit B.

3.5 Promptness of Payment. Each Payor shall remit to Medical Services Entity the Company Compensation within forty-five (45) days of its receipt of the submission of a Claim by Medical Services Entity sufficient in detail that Payor is able to reasonably determine the amount to be paid. If additional information is needed by Payor to evaluate or validate any Claim for payment by Medical Services Entity, Payor shall request any additional information in writing within forty-five (45) days of receipt of the Claim. Payor shall affirm and pay any valid Claims within thirty (30) days of receipt of such additional information. In the case of Total

This provision requires payments to be made within forty-five (45) days of a claim clean enough that a payor can reasonably determine the service performed and amount to be paid. Whether the payor is "reasonable" in making such a determination is a proper subject for mediation and arbitration, should a dispute arise. Claims not clean enough for payment must be directed back to a physician or physician group within forty-five (45) days of receipt, and paid within thirty (30) days of the company's

Compensation described on Exhibit B that requires prepayment or lump sum payment for services, such as capitation, such Company Compensation shall be made by the fifteenth day of the month covered by such payments. In the event that a Payor fails to make such payment in a timely fashion as specified herein, Payor shall be obligated for payment of such amounts plus interest accruing at the annualized rate of the Wall Street Journal prime rate of interest on the first day of the month on which such amounts were due plus three (3) percent. All payments to Medical Services Entity will be considered final unless adjustments are requested in writing by Medical Services Entity within ninety (90) days after receipt of payment explanation from Payor.

return receipt of the additional information requested. This provision should prevent the practice engaged in by some companies of silently "sitting" on unprocessed claims or delaying payment on those the company has determined are not "clean" and waiting for the physician to notice and inquire regarding the status. In the event these unnecessary delays occur, the payor will be obligated to pay interest at three percent above prime on the claims that it should have promptly paid.

3.6 Sole Source of Payment. Where Enrollee is enrolled in a Plan subject to legal requirements that prohibit a physician from billing patients for Covered Services in the event the Payor fails to make such payment, Medical Services Entity agrees to look solely to that Payor for payment of all Covered Services. In such circumstances, Medical Services Entity shall make no charges or claims against Enrollees for Covered Services except for Copayments as authorized in the Plan agreement covering Enrollee. In such circumstances Medical Services Entity expressly agrees that it shall not charge, assess, or claim any fees for Covered Services rendered to Enrollees from such Enrollees under any circumstances, including, but not limited to, the event of Payor's insolvency or failure to pay the Qualified Physician providing services, and shall direct any such claim for payment only to the Payor, acknowledging that whenever Payor receives notice of any such charges, it shall take appropriate action. Notwithstanding the foregoing, Company shall cooperate in the processing of such claims to provide Medical Services Entity with its greatest chance to receive compensation for services provided, and this provision shall not prohibit Medical Services Entity from collecting payment for: (A) Covered Services delivered to an individual who is not an Enrollee at the time services were provided; (B) services provided to an Enrollee that are not Covered Services, provided that Medical Services Entity advises the Enrollee in advance that the services may not be Covered Services; or (C) services provided to any Enrollee after this Agreement is terminated.

This provision, or some variation on it, is required in most states. It essentially says that patients will be held harmless from payment for medical services where an HMO, for example, is in bankruptcy. Model language is included here, rather than relying on the parties to address it in Article X, because this state law requirement has traditionally been the subject of abuse. Some managed care companies, using the explanation that state law requires it, expand the concept of this provision to effectively require physicians to continue to treat patients indefinitely for no pay and prevent them from making any claims as a creditor of the company or payor. This model provision is limited to satisfying the intent of most state statutes protecting consumers, and allowing the physician or physician group to pursue any other remedies they may have under law.

IV. MEDICAL SERVICES ENTITY'S OBLIGATION

These provisions set forth the obligations of physicians or physician groups that are reasonable and necessary in the managed care arrangement. They have been drafted to recognize the administrative realities that managed care companies face in balancing the needs of the various payors they work with.

4.1 Licensed/Good Standing. Medical Services Entity represents that it, or each of its Qualified Physicians is and shall remain licensed and/or registered to Practice Medicine and, if such Medical Services Entity is an entity, such entity is registered and in good standing with the state in which it is chartered and each state in which it is doing business.

4.2 Nondiscrimination. Medical Services Entity agrees that it, and each of its Qualified Physicians, shall not differentiate or discriminate in its provision of Covered Services to Enrollees because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, income, health status or age. Further, Medical Services Entity agrees that its Qualified Physicians shall render Covered Services to Enrollees in the same manner, in accordance with the same standards, and within the same time availability as such services are offered to patients not associated with Company or any of the Plans consistent with medical ethics and applicable legal requirements for providing continuity of care.

4.3 Standards. Covered Services provided by or arranged for by Medical Services Entity shall be delivered by professional personnel qualified by licensure, training or experience to discharge their responsibilities and operate their facilities in a manner that complies with generally accepted standards in the industry.

4.4 Cooperation in Credentialing. Medical Services Entity shall cooperate with Company in the process of credentialing Qualified Physicians consistent with section 5.4 of this Agreement.

4.5 Authority. Medical Services Entity shall, and hereby does, represent and warrant that it has full legal power and authority to bind its Qualified Physicians to the provisions hereof.

4.6 Administrative Procedures. Medical Services Entity and each of its Qualified Physicians will comply with the policies and procedures established by Company or any of its Plans to the extent Medical Services Entity has received notice of same consistent with the terms of this Agreement. At the effective date hereof, the policies, rules and procedures applicable to Medical Services Entity are contained in those manuals and other writings attached hereto as Exhibit C and incorporated by this reference. Medical Services Entity shall be privileged to rely on these policies and procedures as the sole material policies and procedures of the Company or its various Payors until such time as Medical Services Entity receives a Company Notice or is notified otherwise consistent with this Agreement. Neither Company nor a Payor may modify these policies and procedures in a manner that would have a material adverse effect on Medical Services Entity without Medical Services Entity's prior written consent.

This provision recognizes that each company will have certain policies and procedures on minor administrative matters that should be followed by each physician or physician group. This is most often subject to abuse when managed care companies fail to communicate those policies and reserve the right in their agreement to change such policies at any time, unilaterally, without any written notice or time to prepare for such changes. This provision prevents that occurrence by requiring that all such policies be attached to the contract and not be changed until such time as the company sends a "company notice," which by the terms of section 5.2 requires a written statement thirty (30) days in advance of the policy's implementation. Importantly, this provision prohibits the company or payor from modifying the policies and procedures in a way that would have a material effect on the contract, without the physician or physician group first giving written consent.

4.7 Assistance in Grievance Procedure. Medical Services Entity agrees to have each of its Qualified Physicians keep available for Enrollees explanations of the grievance procedures and grievance encounter forms relating to Company Plan, if any, which shall be supplied by Company. Medical Services Entity further agrees that it and its Qualified Physicians will abide by Company's and or Company Plan's process for resolving Enrollee grievances, which procedures are a part of Exhibits C, consistent with this Agreement. Medical Services Entity also agrees to require each of its Qualified Physicians to participate in helping resolve the grievances described in 5.6 hereof.

4.8 Use of Names for Marketing. Medical Services Entity and each of its Qualified Physicians shall permit Company to utilize the name, address, and telephone number of it or its Qualified Physicians, in its list of Medical Services Entities distributed to Enrollees; provided, however, that such rights shall not extend to the listing of such Qualified Physicians or Medical Services Entity in any newspaper, radio, or television advertising without receiving the prior written consent of Medical Services Entity before hand.

4.9 Provision of Covered Services. In the event Exhibit B contemplates the provision of full medical services, including emergency services on a capitated basis to a defined population of patients, Medical Services Entity agrees to provide or arrange for the provision of Covered Services on a 24 hour per day, 7 day per week, 365 day per year basis.

4.10 Noninterference with Medical Care. Nothing in this Agreement is intended to create (nor shall be construed or deemed to create) any right of Company or any Payor to intervene in any manner in the methods or means by which Medical Services Entity renders health care services or provides health care supplies to Enrollees. Nothing herein shall be construed to require Medical Services Entity to take any action inconsistent with professional judgment concerning the medical care and treatment to be rendered to Enrollees.

This provision sets forth a clear statement that not withstanding the active assistance physicians and physician groups provide in helping the managed care company carry out its administrative responsibilities, nothing in the contract should be construed to force any physician to take any action that is inconsistent with his or her professional judgment in providing care to a patient.

V. COMPANY'S OBLIGATIONS

This article sets forth a number of obligations that normally are, or should be, part of the obligations of the managed care company. In some agreements these provisions are absent altogether. In others they are set forth in a way that either makes the obligations meaningless or subject to the company's sole interpretation.

5.1 List of Payors. Company shall include as part of Exhibit C a list of each Payor and shall promptly update Exhibit C upon the addition or deletion of Payors.

5.2 Deemed Notification. Company shall notify Medical Services Entity in writing of all policies, procedures, rules, regulations, schedules, in addition to those attached as Exhibit C that Company considers material to the performance of this Agreement, as well as any amendments thereto. Medical Services Entity shall be deemed notified of such policies, procedures, rules or regulations, or any amendment thereto, or any Company Notice thirty (30) days after receipt of written notice of same is delivered consistent with the notice provisions of this Agreement. Neither Company nor a Payor may modify these policies and procedures in a manner that would have a material adverse effect on Medical Services Entity without Medical Services Entity's prior written consent.

This provision sets forth a rational approach to the changes a company may make from time to time to its policies by requiring that physicians or physician groups be notified thirty (30) days in advance in writing. It prohibits changes to policies or procedures that would have a material effect on the physician or physician group, without their prior consent.

5.3 Adverse UR/QM Decisions. Not withstanding anything to the contrary contained in the policies, procedures, rules, or regulations of Company,

This provision requires that adverse decisions on medical utilization review or

Company shall grant Medical Services Entity or Qualified Physician a right and a mechanism to appeal any Utilization Review or Quality Management decision made by Company on behalf of a Payor. Such appeal shall be coordinated with any related appeal by the Enrollee. Unless existing Company policies provide for a more liberal rule, and except for utilization review decisions related to emergency care, which shall be heard more quickly, written notice of such appeal shall be given by either the Medical Services Entity or Qualified Physician to Company on behalf of Plan no more than ten (10) calendar days following the contested decision. Company shall have five (5) calendar days after receipt of such notice to appoint a licensed physician not employed by Company to hear the appeal, which shall be heard and a decision communicated to the parties within ten (10) days of hearing. In any such appeal, a prior authorization for treatment granted by Company shall be conclusive in determining whether payment for services should be made.

medical quality matters be subject to a due process review, that is ultimately decided not by the company in its sole discretion but by independent peers. In this way the utilization review and quality oversight procedure more closely resembles the peer review process traditionally found at the hospital medical staff level.

5.4 Administration. With respect to each Plan it offers or administers, Company shall perform all necessary administrative, accounting, enrollment, and other functions including, but not limited to, eligibility determination, claims review, data collection and evaluation, and, if applicable maintenance of medical, ancillary, and hospital group risk pools. With respect to each Plan, Company shall issue a Company Notice to Medical Services Entity identifying the manner in which rules, regulations, or policies relating to a particular Plan are at variance with the general rules, regulations, or policies of the Company upon which the Medical Services Entity generally relies. In the credentialing of Qualified Physicians, Company agrees that neither it nor its agents to whom such duties have been delegated shall request that Qualified Physicians sign an information release broader than necessary to obtain the specific credentialing information sought, limiting such request to that which is reasonable and necessary to achieving valid credentialing purposes.

5.5 Payment by Parties other than Company. In the event Company contemplates that payment for services provided hereunder is to be made by a Payor other than Company, and in the event that such payment is not received by Medical Services Entity, Company, within five (5) days of the receipt of written notice from Medical Services Entity, shall make a written demand on behalf of such Medical Services Entity for payment. In the event that a Payor refuses to make payment within sixty (60) days after receipt of such notice, Company shall either (a) make such payment on behalf of the Payor, (b) initiate legal action to recover such payment on behalf of Medical Services Entity, or (c) assign the right to initiate such action to Medical Services Entity. In the event of subsection (b) or (c), Company shall tender to Medical Services Entity a copy of the Agreement that governs the relationship between Company and the Payor and upon which Medical Services Entity may rely in prosecuting such action and shall release Medical Services Entity, at Medical Services Entity's option, from any further obligation to provide services to Enrollees of the Payor. Company shall notify Payor of the provisions hereof and obligate Payor with respect to such provisions.

Many physicians do not realize that most managed care arrangements do not require the company with whom they contract to make payment, but require the party who is obligated to make payment (such as the employer under an employer based plan) to make such payment. While this is virtually unavoidable in the managed care arrangement, it presents a significant problem for physicians in that, since there is not direct relationship between the physician and the party who was supposed to pay him or her, the physician does not have an immediate remedy in the event payment is not received. This provision is a businesslike approach to granting physicians the right they generally believe they have: the right to pursue the appropriate party, if necessary, in court.

5.6 Physician Grievances. Company shall establish and maintain systems to process and resolve a grievance by a Qualified Physician toward the Company or a Payor. Such process shall be set forth in the procedures which are a part of Exhibit C and any Company Notice amending such process. In connection with such grievances, to the extent that confidential patient information is discussed or made part of the record, or confidential patient records are submitted to the Company, the Company shall either abstract such information or shall remove the name of the patient such that none of the information or records would allow a third party to identify the patient involved. Notwithstanding anything in Company's policies, procedures or rules to the contrary, the internal procedure for resolving such grievance will be conclusively presumed concluded in the event such grievance is not resolved to the parties' satisfaction within forty-five (45) days of the submission of such grievance and will allow either party resort to the dispute remedies of Article IX.

Each company should maintain a system to process and resolve grievances brought by physicians and patients. This provision protects patients by limiting to the extent possible, the use of patient record information, and protects physicians by providing a clear point in time when the company's internal procedures have been exhausted and the matter may be resolved by arbitration. Under many managed care grievance procedures, it is possible for the managed care company to delay resolving grievances, preventing physicians from taking up the matter in other forums.

5.7 Benefit Information. Company shall advise and counsel its Enrollees and Medical Services Entity on the type, scope, and duration of benefits and services to which Enrollees are entitled pursuant to the applicable agreement between the Company or a Payor and Enrollees.

Often, it is the physician and his or her office staff, at their time and expense, that is left to explain the details of health plan policies to patients. This provision makes such explanations an affirmative duty on part of the company.

5.8 Cooperation on Care Review and Management. In the event that Medical Services Entity is responsible for utilization review and quality management procedures, Company shall assist and cooperate with Medical Services Entity in the development and initial implementation of such procedures that are necessary to carry out the terms of the Agreement. In the event that utilization review and quality management procedures are the sole responsibility of Company, Company shall fully advise Medical Services Entity of the methods used and underlying information relied on to develop, implement and manage or monitor utilization and quality on an ongoing basis, and shall develop a mechanism to allow Qualified Physicians to participate in the development of utilization review and quality management ongoing assessment and evaluation.

This provision requires a company to actively assist or fully advise, as the case may be, on the "management" portion of managed care. Often, companies fail to fully inform physicians or physician groups of the methods and information that underlie their monitoring of utilization and quality issues. Most importantly, this provision requires the managed care company to develop a mechanism that will allow physicians to participate in this process.

5.9 Context of Company/Payor Obligations. To the extent Company is also a Payor under this Agreement, it shall perform and satisfy all duties and obligations of the Payor under this Agreement. To the extent Company is not a Payor under this Agreement, this Agreement shall be construed to require Company to use its best efforts to cause the Payor to perform and satisfy the Payor's duties and obligations under this Agreement. During the term of this Agreement, Company and each Payor shall maintain features in each Plan, such as copayment, deductible and coinsurance percentage differentials, that encourage Enrollees to utilize the services of Medical Services Entity.

5.10 Provision of Financial Information. Company shall provide to Medical Services Entity, no less frequently than quarterly, a balance sheet and income statement (collectively, "financial statements") accurately depicting the financial condition of Company. Such financial statements shall be prepared in accordance with generally accepted accounting principles and shall be provided on an

Occasionally it is suspected that managed care companies slow payment of claims or reject an excessive number of claims as not being "clean" in order to improve their financial reporting. This provision grants physicians and physician groups the right to review the company's quarterly balance sheet and income statement to eliminate such practices where they exist.

audited basis to the extent available. Medical Services Entity acknowledges the confidentiality of such financial statements and shall not: (a) use such financial statements for any purpose other than evaluating the financial condition of Company; or (b) disclose the financial statements, or any non-public information contained therein, to any third party, other than Medical Services Entity's attorneys or accountants, without the prior written consent of Company. The obligations of Medical Services Entity under the immediately preceding sentence shall survive termination of this Agreement.

VI. RECORDS AND CONFIDENTIALITY

6.1 Records. All data and information obtained, created or collected by Medical Services Entity relating to services provided to Enrollees that is not a part of the medical record shall be freely shared by Medical Services Entity with Company. Such information may be obtained by the Company upon written request to Medical Services Entity without a requirement for obtaining the written release by Enrollee.

6.2 Access to Records. During normal business hours, each party shall have access to and the right to examine records of the other which relate to any Covered Services or payments provided under this Agreement. Upon written request of Company or Medical Services Entity, such access shall be extended beyond normal business hours with respect to any records which are identified in such written request as the actual or potential subject of an investigation or litigation.

6.3 **Confidential Medical Records.** All medical records of Enrollees shall be maintained as confidential in accordance with applicable state and federal laws. All medical records shall belong to Medical Services Entity's Qualified Physicians consistent with the dictates of medical ethics. The release, removal or transfer of such records shall be governed by the Medical Services Entity's established policies and procedures. Prior to the release of copies of any medical records to Company or other third parties, Company shall obtain from the subject Enrollee (or Enrollee's legal representative) and present to Medical Services Entity an effective written consent or release that satisfies ethical constraints and applicable laws and is narrowly tailored to

Many managed care agreements make little distinction between nonconfidential information and those records that must remain confidential within the physician patient relationship: they simply request access to all such records. To the extent that they recognize patient confidentiality at all, they generally make obtaining patient waivers the responsibility of the physician or physician group. This provision strengthens the right of confidentiality expected by patients. When such records are relevant, it requires the company, not the physician, to obtain a consent that is narrowly tailored to accomplish the company's purposes. It also requires the company to agree to counsel its employees on keeping

accomplish the sole purpose of such release, which the parties agree is determining whether care was properly and efficiently rendered. The cost associated with copying these or any such records referred to in this Article VI shall be paid by Company. In handling such medical records, Company agrees to comply with all applicable state and federal laws and with any requirements or limitations described in the written consent or release. Company agrees it shall not release such information to other parties without written consent of the patient, and shall share such information internally only with the narrowest circle of Company's agents necessary to effectuate Company's stated objectives, counseling such agents on their obligations to ensure such information remains confidential.

such information confidential to further protect patient interests.

6.4 Other Confidential Information. Generally, the parties agree that the sole items of information subject to confidentiality under this Agreement are: medical information relating to individual Enrollees, so as to protect the patient's medical record as required by medical ethics and law; and the precise schedule of compensation to be paid to Medical Services Entity pursuant to Exhibit B, so as not to facilitate price collusion among Medical Services Entity's competitors in derogation of the antitrust laws. Otherwise, all other information, including the general manner by which Medical Services Entity is paid under this Agreement and the general terms and conditions of this Agreement, may be shared with non-parties in the reasonable and prudent judgment of the parties to this Agreement or Qualified Physicians.

This provision clarifies that except for a limited number of matters that are proprietary to both the managed care company and physician or physician group, there are no other inhibitions on free communication between the physician and his or her patient or indeed any other parties. It protects the confidentiality of patient treatment matters; specific prices paid, as opposed to the method of paying them; and proprietary value of financial or utilization information provided by the physician group, except to the extent that such information is needed for managed care company report card purposes.

Any financial or utilization information provided by Medical Services Entity to Company or a Payor (including the Compensation schedule(s) set forth in Exhibit B) shall be maintained in strict confidence by Company and each Payor and may not be disclosed by Company or the Payor to any third party or used by the payor for any purpose, other than: (a) to satisfy mandatory governmental or regulatory reporting requirements; (b) to compare cost, quality and service among providers with whom Company has contracted; (c) for premium setting purposes; (d) for HEDIS reporting; or (e) to perform any of Company's obligations under this Agreement.

Notwithstanding the foregoing, Company shall be

permitted to prepare and disclose to a third party a report of "Medical Services Entity Quality Data." For purposes of this section, Medical Services Entity Quality Data shall be limited to: (a) utilization data of all contracted Medical Services Entities in the aggregate; (b) HEDIS data production and performance evaluation; (c) Enrollee satisfaction data; (d) overall compliance with NCQA or other comparable quality standards; and (e) Payor disenrollment data; provided, however, that Medical Services Entity Quality Data shall not include any information that identifies an individual Enrollee or an individual Qualified Physician or that is privileged or confidential under applicable peer review or patient confidentiality laws. At least thirty (30) days prior to providing Medical Services Entity Quality Data to a third party, the third party shall provide such Medical Services Entity Quality Data to Medical Services Entity so that Medical Services Entity may confirm the accuracy, completeness or validity of the data and/or prepare a written response to such data to the extent Medical Services Entity deems appropriate. To the extent Medical Services Entity believes that all or any portion of the Medical Services Entity Quality Data is inaccurate or incomplete, Medical Services Entity and Company shall negotiate in good faith to correct such inaccuracies or to make such data complete prior to its submission to the third party. If such inaccuracies or deficiencies are not corrected to the satisfaction of Medical Services Entity, Company shall submit, at the time the Medical Services Entity Quality Data is provided to the third party, any written response to such Medical Services Entity Quality Data prepared by Medical Services Entity.

VII. INSURANCE

7.1 Medical Services Entity Insurance. Medical Services Entity shall require each Qualified Physician to maintain, at all times, in limits and amounts standard in the community, a professional liability insurance policy and other insurance as shall be necessary to insure such Qualified Physician against any claim for damages arising directly or indirectly in connection with the performance or non-performance of any services furnished to Enrollees by such Qualified Physician. In the event that Medical Services Entity discovers that such insurance coverage is not maintained,

Medical Services Entity shall immediately upon making such discovery ensure that such Qualified Physician discontinues the delivery of Covered Services to Enrollees until such insurance is obtained. Evidence of such coverage shall be tendered to Company by Medical Services Entity upon Company's request.

VIII. TERM AND TERMINATION

8.1 Term. Agreement shall commence on the Effective Date and extend until terminated pursuant to this Article VIII.

8.2 Negotiation of Renewal of Exhibits A and B. Not later than ninety (90) days prior to each anniversary of the effective date hereof, either party wishing to revise Exhibits A or B or any of the schedules affixed thereto shall serve notice in writing of such intention and the new terms offered. Within sixty (60) days thereafter, the parties shall agree to a new Exhibit A and Exhibit B. In the event the parties are unable to come to such agreement, either party may notify the other within ten (10) days following the deadline for such agreement that it intends to terminate the Agreement or the Agreement with respect to a specific Plan reflected on a schedule. In such event, this Agreement or the Agreement with respect to that particular Plan, shall be terminated sixty (60) days after such notice.

8.3 Termination for Cause. In the event either party shall fail to keep, observe or perform any covenant, term or provision of this Agreement applicable to such party, the other party shall give the defaulting party notice that specifies the nature of such default. If the defaulting party shall have failed to cure such default within thirty (30) days after the giving of such notice, the non-defaulting party may terminate this Agreement upon five (5) days notice; provided, however, that it shall be grounds for immediate termination if Company should lose its license to underwrite or administer Company Plans; or if any Qualified Physician suffers a loss or suspension of medical license, a final unappealable loss of hospital medical staff privileges for reasons that would require reporting to the National Practitioners Data Bank pursuant to

Many managed care agreements provide the illusion of running for a full year prior to renewal, when in fact they are ninety (90) day agreements that can be terminated by the company within that period. This contract rejects that approach. Instead, it makes the non-business terms binding throughout the relationship of the parties. The business terms for each plan or product, as set forth in Exhibits A and B, are to be renegotiated annually and renewed or rejected individually.

Certain clearly objectionable occurrences by either party could cause the contract to be terminated in thirty (30) days or less. Otherwise, either party must give a four month notice of termination. Most importantly, however, whenever the contract is terminated by either party, a reason for such termination must be stated in writing. This should provide assistance to physicians who are unfairly discriminated against by managed care company "B" when it learns that managed care company "A" has terminated its relationship with the physician, even though the termination may have been strictly for business or administrative reasons. It also will provide some protections where a physician fears he or she is being terminated for violating an informal "gag" policy of the company. It also will allow the physician or company to insure that no mistake of fact was relied on when the other party came to its conclusion to terminate. The dispute resolution procedures described below would be available to either party in the event of a termination.

the requirements of the Health Care Quality Improvement Act of 1986, a conviction of a felony, or a loss of credentials for stated quality reasons under Company's Plan, and upon notice to Medical Services Entity, Medical Services Entity fails to immediately terminate such Qualified Physician from the provision of services to Enrollees.

8.4 **Voluntary Termination.** Either party may terminate this Agreement or Medical Services Entity participation in any Company Plan with or without cause upon one hundred twenty (120) days written notice to the other party specifying whether the termination relates to a specific Plan or to the Agreement generally. In the event of such termination, the terminating party shall state the reason for such termination. In the event of a voluntary termination hereunder, neither party shall be foreclosed from participation in the procedures described in article IX.

8.5 **Termination for Failure to Satisfy Financial Obligations.** If either party or a Payor is (1) more than sixty (60) days behind its financial obligations to its creditors or (2) files in any court of competent jurisdiction (a) a petition in bankruptcy (b) a petition for protection against creditors or (c) files an assignment in favor of creditors or has such a petition filed against it that is not discharged within ninety (90) days, this Agreement may be terminated by the other party in its entirety or with respect to a Payor upon five (5) days written notice.

8.6 **Effect of Termination.** This Agreement shall remain in full force and effect during the period between the date that notice of termination is given and the effective date of such termination. As of the date of termination of this Agreement, this Agreement shall be of no further force and effect, and each of the parties hereto shall be discharged from all rights, duties, and obligations under this Agreement, except that Company shall remain liable for Covered Services then being rendered by Qualified Physicians to Enrollees who retain eligibility under the applicable Plan or by operation of law until the episode of illness then being treated is completed and the obligation of Company to pay for Covered Services rendered pursuant to this Agreement is discharged. Payment for such services shall be made pursuant to the fee schedule

contained on Exhibit B or, if Exhibit B does not contain a fee schedule, at the usual and customary charge of the Qualified Physician performing the service.

IX. DISPUTE RESOLUTION

9.1 **Initial Mediation of Dispute.** In the event of a dispute between the parties to this Agreement, the following procedure shall be used to resolve the dispute prior to either party pursuing other remedies:

(A) A meeting shall be held within seven (7) days at which all parties are present or represented by individuals with full decision-making authority regarding the matters in dispute (the "Initial Meeting").

(B) if, within thirty (30) days following the Initial Meeting, the parties have not resolved the dispute, the dispute shall be submitted to mediation directed by a mediator mutually agreeable to the parties and not regularly contracted or employed by either of the parties ("Mediation"). Each party shall bear its proportionate share of the costs of Mediation, including the mediator's fee.

(C) The parties agree to negotiate in good faith in the Initial Meeting and in Mediation.

(D) If, after a period of sixty (60) days following commencement of Mediation the parties are unable to resolve the dispute, either party may submit the dispute to binding arbitration in accordance with Paragraph 9.2 upon ten (10) days prior written notice to the other party.

9.2 **Binding Arbitration.** Either party may submit any dispute arising out of this Agreement that is not resolved through Mediation to final and binding arbitration. Any such arbitration shall be held in the state where the services at issues in the dispute were or are to be performed and shall be conducted pursuant to the rules of the National

Perhaps the most critical component of this contract is its reliance on mediation and arbitration to settle disputes within the physician-managed care context. Many managed care companies seem to rely on the twin strategies of disenfranchising physicians from legal rights in the text of the agreement, and if the matter is taken to a court of law, banking on the likelihood that the physician or physician group will have far fewer resources to pursue an appropriate resolution of the matter.

Initial mediation often helps two parties with a misunderstanding to settle their differences. When they can't, arbitration allows the two parties to move quickly through a trial-like proceeding and obtain a final, legal, and binding resolution of the matter in much less time and at much less expense than otherwise would be associated with a legal controversy. The adoption of these dispute resolution procedures may greatly enhance both sides' attention to the nature of their relationship and need to settle differences fairly, impartially, and quickly.

Health Lawyers Association of America Alternative Dispute Resolution Project. Each party shall be responsible for its own costs and expenses related to the arbitration, including attorneys' fees, and shall bear its proportionate share of the arbitrator's fees. The arbitrator shall be selected on the mutual agreement of both parties and shall be an attorney and member of the National Academy of Arbitrators or the National Health Lawyers Association.

X. ADDITIONAL PROVISIONS AS REQUIRED BY STATE LAW

Each state may have specific language that must be included in a Medical Services or "Provider" Agreement of this type.

[RESERVED]

XI. MISCELLANEOUS

10.1 <u>Nature of Medical Services Entity</u>. In the performance of the work, duties and obligations of Medical Services Entity under this Agreement, is mutually understood and agreed that Medical Services Entity and each of its Qualified Physicians are at all times acting and performing as independent contractors, practicing medicine or providing for the delivery of medical services.

10.2 <u>**Additional Assurances**</u>. The provisions of this Agreement shall be self-operative and shall require no further agreement by the parties except as may be specifically provided in this Agreement. However, at the request of either party, the other party shall execute such additional instruments and take such additional acts as may be reasonably requested in order to effectuate this Agreement.

10.3 <u>**Governing Law**</u>. This Agreement shall be governed by and construed in accordance with the applicable federal laws and regulations and the laws of the State in which the subject services are primarily performed by or through Medical Services Entity.

10.4 <u>**Assignment**</u>. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives, successors, and assigns. Company may not assign this Agreement without Medical Services Entity's prior written consent, except that Company may assign this Agreement to an entity related to Company by ownership or control or to any successor organization without Medical Services Entity's prior written consent. Medical Services Entity may not assign this Agreement without Company's prior written consent, except that Medical Services Entity may assign this Agreement to an entity related to Medical Services Entity by ownership or control or to any successor organization without Company's prior written consent.

This assignment provision, unlike that contained in many managed care agreements, is mutual. It allows the assignment of the contract to closely connected entities, but no others, without the consent of the other party.

10.5 <u>**Waiver**</u>. No waiver by either party of any breach or violation of any provision of this Agreement shall operate as, or be construed to be, a waiver of any subsequent breach of the same or any other provisions

10.6 <u>**Force Majeure**</u>. Neither party shall be liable for nor deemed to be in default for any delay or failure to perform under this Agreement deemed to result, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, failure of transportation, strikes or other work interruptions by either party's employees or any other cause beyond the reasonable control of either party.

10.7 Time is of the Essence. Time is of the essence in this Agreement. The parties shall perform their obligations within the time specified,

10.8 Notices. Any notice, demand or communication required, permitted or desired to be given hereunder shall be deemed effectively given when personally delivered or sent by fax with a copy sent by overnight courier, addressed as follows:

If to Company: ____________________

Attention: ____________________
____
____
____

If to Medical Services Entity:

____

Attention: ____________________
____
____
____

or to such other address, and to the attention of such other person or officer as either party may designate in writing.

10.9 Severability. In the event any portion of this Agreement is found to be void, illegal or unenforceable, the validity or enforceability of any other portion shall not be affected.

10.10 Third-Party Rights. This Agreement is entered into by and between the parties hereto and for their benefit. There is no intent by either party to create or establish a third-party beneficiary status or rights in a third party to this Agreement, except for Enrollees or as such rights are expressly created and as set forth in this Agreement. Except for such parties, no such third party shall have any

Unlike virtually every managed care agreement, this contract recognizes that the patient many have a legally recognizable right to benefit from this relationship.

right to enforce or any right to enjoy any benefit created or established under this Agreement.

10.11 Entire Agreement. This Agreement supersedes any prior agreements, promises, negotiation or representations, either oral or written, relating to the subject matter of this Agreement and, except as provided for herein, may not be modified without the express written approval of both parties.

Unlike most managed care agreements, this ensures that neither side can amend the agreement without authorization.

10.12 Notification of Legal Matters. If any action is instituted against either party relating to this Agreement or any services provided hereunder, or in the event such party becomes aware of facts or circumstances which indicate a reasonable possibility of litigation with any Employer utilizing Medical Services Entity, any Enrollee, or any other third person or entity, relevant to the rights, obligations or responsibilities or duties of the other party under this Agreement, such party shall provide timely notice to the other, and the other party shall cooperate with the first party in connection with the defense of any such action by furnishing such material or information as is in the possession and control of the other party relevant to such action.

10.13 Survival. Notwithstanding any provisions contained herein to the contrary, the obligations of the parties under Articles III, VI and IX shall survive termination of this Agreement.

Even after the contract is terminated, this provision ensures that the compensation, confidentiality and dispute resolution provisions survive.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed in their names by the undersigned officers, the same being duly authorized to do so.

MEDICAL SERVICES ENTITY

By: ______________________________

Title: ______________________________

COMPANY

By: ______________________________

Title: ______________________________

PART III

ADDENDUM TO MODEL MANAGED CARE MEDICAL SERVICES AGREEMENT

Common Managed Care Agreement Clauses Not Contained in the Model Agreement

Many managed care agreements contain clauses that are a variation on the themes found in this addendum. They are not included in the Model Managed Care Medical Services Agreement because reasonably prudent and businesslike physicians often find them patently unfair and unnecessary given the relationship between the managed care company and the physician or physician group. Physicians who identify clauses such as these in managed care agreements might do well to ask themselves whether the subject matter contained in these clauses is really necessary to address in the managed care relationship. If not, they need not be addressed in the agreement.

1.0 **General Offsets and Adjustments.** Provider agrees to authorize Company to deduct moneys that may otherwise be due and payable to Provider from any outstanding moneys that Provider may, for any reason, owe to Company. Provider agrees that Company may make retroactive adjustments to the payment outline in Exhibit B.

This provision gives the managed care company a free hand to do whatever accounting it desires and deduct moneys from a physician or physician group in its sole discretion without a requirement to account to the physician or physician group and explain such deductions.

2.0 **Litigation.** In the event of any litigation between the parties arising out of or related to this Agreement, the prevailing party shall be entitled to recover the other party its reasonable attorney's fees and cost of litigation, including, without limitation, any expert witness fees.

This clause seems designed to appeal to the unsophisticated physician who abhors litigation and has not stopped to consider that he or she is already greatly disadvantaged in any potential controversy with the company, since the managed care company has far more to spend in legal fees. This clause would simply up the ante by potentially doubling (at least) a physician's cost and further chill any prospect for the physician to obtain relief in a court of law.

3.0 **Noninterference with Members.** During the term of this Agreement, Provider and its Qualified Physician shall not advise or counsel an Enrollee to dis-enroll from Company's Plan and will not directly or indirectly solicit any Enrollee to enroll in any other HMP, PPO or similar Health care service plan or insurance program.

No matter how it is dressed up, provisions that prohibit physicians from speaking freely with their patients chill the physician-patient relationship and are considered by many reasonable physicians to be a form of "gag clause". While a managed care company may believe that such terms are commercially reasonably because they have spent time and money marketing to obtain the business of the employer who is

covering health care costs for the patient, they fail to realize that because of the increasingly complex medical delivery system created by managed care, the physician is often the first and most valued person a patient turns to for discussion of health care coverage options. This communication is becoming one of the most common in the physician-patient relationship, given today's evolving health care climate. Any such discussion could be deemed as advice or counseling that could cause the patient to disenroll from the plan or prompt the patient to enroll in any other plan.

4.0 **Indemnification and Hold Harmless.** Provider and Company shall indemnify the other and hold the other harmless against any and all loss, damage, liability and expense, including court cost, with respect to this agreement directly resulting from or arising out of the dishonest, fraudulent, negligent, or criminal acts or omissions of the respective party's employee, or contractors excluding each other, agents, shareholders, officers, and directors acting alone or in inclusion with others.

Most physicians do not realize that when they agree to this provision they are agreeing to pay for any such lawsuits, including both the lawyer's fees and any settlements or judgments, out of their own personal pocket, since liability insurance policies virtually never cover this type of voluntary obligation. Further, the likelihood that managed care companies will, in fact, be named in such suits is increasingly common. With this agreement, the managed care company has the leverage to force a physician into settling a case that may be frivolous, and suffer the associated report to the National Practitioners Data Bank, because of the potentially bankrupting implications of the indemnity clause.

5.0 **Termination Without Cause.** This Agreement may be terminated without cause by either party by written notice given to the other party at least one hundred twenty (120) days in advance of such of termination. In such cases termination will occur on the last day of the month in which the one hundred and twentieth (120) day following such notice occurs. Upon said termination by Provider, the rights of each party hereunder will terminate with respect to subscriber groups enrolled by the Company after the Company receives Providers notice of termination. However, this Agreement will continue in effect with respect to Enrollees existing prior to the Company's receipt of such notice until the anniversary date of the Company's contract with the subscriber group or for one (1) year, whichever is earlier, unless otherwise agreed to by the Company. If termination is by the Company, the rights of each party will terminate on the effective date of termination.

Although virtually every managed care agreement contains a termination without clause provision, many, such as this one, effectively allow the managed care company to terminate on 120 days notice but, upon close inspection, requires the physician group to continue providing services for one year or more after the group has given its notice. Businesslike physicians and physician groups generally insist that any termination without cause provision be mutual.

6.0 Liability. Notwithstanding anything herein to the contrary, Company's liability, if any, for damages to Provider for any cause whatsoever arising out of or related to this Agreement, regardless of the form of the action, shall be limited to Provider's actual damages, which shall not exceed the amount actually paid to Provider by Company under this Agreement during the twelve (12) months immediately prior to the date the cause of action arose. The Company shall not be liable for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind whatsoever sustained as a result of a breach of agreement or any action, inaction, alleged tortious conduct, or delay by Company.

This provision simply strips the physician or physician group of any legitimate legal rights it may have in a litigation with the managed care company by taking away all remedies that may be available except actual damages that are equal to or less than the total amount of compensation a physician or physician group has received from the company in the previous year. There can be no rational basis in the managed care relationship for a provision such as this. No attempt is made to make such limitation on remedies mutual, and, therefore, many reasonably prudent and businesslike physicians would conclude that it should have no place in the managed care agreement.

7.0 Limitation on Action. Notwithstanding anything herein to the contrary, no action, regardless of form, arising out of or relating to this agreement may be bought by Provider more than twelve (12) months after such cause of action has arisen.

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The statute of limitations for actions on contracts such as this vary from state to state but generally extend for five (5) years. There is no rational reason why a managed care company should seek special treatment not available to others in limiting such actions to a twelve (12) month period.

Alaska State Medical Association
September 4, 1998

Participating Physician Agreements in Alaska

A Topic-by-Topic Comparison of the AMA model agreement with those from Blue Cross of Washington and Alaska

Prepared for the Alaska State Medical Association by the law firm of Biss & Holmes

Copies of the AMA model physician agreement are available to ASMA members upon request.

Please note: This comparison is not intended as legal advice and is not a substitute for direct consultation with an attorney. Physicians are encouraged to consult with their own legal counsel and other advisors regarding the specific terms of participating agreements.

Definitions

AMA Model Form

Contains an extensive definition section to aid in understanding and interpreting the agreement. Medically necessary standard is based on reasonably prudent physician standard vs common approach of determination by plan medical director.

BCWA

This agreement does not have a separate definition section. Among the significant terms used in the Agreement which are not defined but have been defined by the AMA are: Claim. Copayment. Covered Services. Emergency condition. Enrollees. Medically Necessary. Utilization Review.

Specifically, no payment is to be made to the physician unless the services are medically necessary, but that term is never defined by the Agreement.

Delivery of Services

AMA Model Form

Contemplates a separate schedule for each plan covered by the Agreement listing covered services. Plan provides that if description of covered services is materially lacking, plan must pay physician for each service performed for benefit of Enrollee. List of covered services must be attached before physician signs agreement. Requires plan to be bound by its verification of eligibility and/or coverage. Makes plan responsible for care rendered to those claiming to be Enrollees if the physician is unable to verify eligibility after following plan procedure. Provides that revisions or amendments will not be enforceable unless they have been provided to the physician.

Blue Cross

Allows for physicians to bill the plan for medically necessary covered services. Covered services are not defined in or attached to the agreement, the same apparently being whatever BCWA decides they are at any given time. There is no provision that covered service be defined in advance or that physicians receive advance written notice of any changes in covered services (nor a provision telling physicians how to determine what is a covered service).

In addition, the physician is obligated to provide services to those covered by other Blue Cross and Blue Shield Plans a well as their subsidiaries and affiliates, none of which is described. Even if it were possible for the physician to obtain a copy of BCWA's list of covered services, it may be almost impossible for the physician to obtain information on what is a covered service under the other affiliated plans. Company is not bound by its verification of eligibility. Allows plan to recapture payments to physicians if it misapplied its benefits.

Compensation

AMA Model Form

Requires that the compensation schedule be attached and made a part of the Agreement. A separate schedule must be attached for each affiliated plan which is covered under the agreement. It must specify the manner of payment. It addresses the manner in which copayments are to be collected and addresses coordination of benefits. The agreement requires payment within forty-five (45) days of receipt of the submission of a claim or notification to the physician of the need for more information within that time period and payment within thirty (30) days of receipt of the missing information. Requires payment of interest for delay beyond terms of agreement.

Blue Cross

No compensation schedule attached to the Agreement. Allows the compensation schedule to be set from time to time in the sole discretion of the company. Company can set new fees and rates unilaterally, at any time, at its discretion. There is no necessity that the fee schedule be set in advance or that physicians receive advance written notice of any changes in allowed amounts. (See AS 21.87.140(c)(1) requiring the physician to be compensated for services in accordance with the terms to be contained in the agreement or attached to and made a part of the agreement.) Requires submission of claims within 365 days of service. States that disputes regarding payment and medical necessity will be mutually resolved or submitted to arbitration before the American Arbitration Association. The term "medically necessary" is not defined. Presumably this is whatever the company's medical director says is medically necessary. (The AMA defines it as what a reasonably prudent physician would deem necessary for the diagnosis or treatment of illness or injury.) Disagreements over medical necessity, apparently even those requiring emergency treatment, are to be mutually discussed, then must go through an expensive and time consuming arbitration process.

Requires physician to refund monies to company if company determines that payment was based upon erroneous or incomplete information or if it misapplied benefits.

The physician must bill in a manner acceptable to BCWA, which is undefined in the contract. Requires company to pay claims in a timely fashion without defining what is timely or requiring interest to be paid on those claims not paid in a timely fashion. There is no discussion of how copayments or coinsurance are to be handled. The physician agrees to accept the BCWA payment as payment in full and not to otherwise bill the Enrollee except for deductibles, copayments, coinsurance, non covered services or covered services not deemed medically necessary if the patient agreed in writing before the treatment.

Physician Duties

AMA Model Form

Requires the physician to be licensed, in good standing and not to discriminate. It requires the physician to comply with the policies and procedures established by the plan to the extent the physician has received notice of the same. Requires policies and procedures to be attached to the contract, not to be changed without thirty days written notice to the physician and prohibits company from modifying policies and procedures in a way which would have a material effect on the contract without written consent of the physician. The physician agrees to advise Enrollees of the company grievance procedures. Contains a provision that nothing in the Agreement should be construed to force any physician to take any action inconsistent with his/her professional judgment in providing care to a patient.

Blue Cross

Requires physicians to provide services to Enrollees on same basis as services are provided to patients who are not Enrollees. This could be construed as an attempt to require the physician to charge no more that (s)he does to any other non-governmental payor for similar services. Requires physician to cooperate with BCWA utilization management programs, which are undefined. Does not provide for any appeal process concerning utilization management decisions. The physician must abide by BCWA's policies and procedures which are undefined and may be modified by the company at its sole discretion. Does not contain a provision stating physician need not take any action inconsistent with professional judgment in providing care to the patient.

Company Obligations

AMA Model Form

The company should list each payor and plan and update them promptly to reflect additions or deletions. Company shall notify physician of all policies, procedures, rules, regulations that it considers material to performance of Agreement as well as amendments. Thirty day notice of any changes. No modifications allowed in a manner that would have a material adverse effect on contract without physician approval. Provides a right and a mechanism to appeal any Utilization Review or Quality Management decision by the company that is ultimately decided not by the company in its sole discretion but by independent peers. Decisions are rendered within thirty (30) days except for those utilization review decisions related to emergency care, which shall be heard more quickly. Requires the company to establish and maintain systems to process and resolve grievances by physicians towards the company. Requires the company and not physicians to explain details of health plan policies to patients. Requires the company to provide the physician with quarterly financial statements accurately depicting the financial condition of the company.

Blue Cross

There is no list of payors or plans, only a reference that other Blue Cross and Blue Shield plans with reciprocal agreements are included. See above description under Physician duties. The physician must abide by BCWA's policies and procedures which are undefined and may be modified by the company at its sole discretion even if they should have a materially adverse effect on the contract. There is no definition of utilization review, no mechanism for expedited decision concerning emergency medical care and no mechanism of determination by independent peers. The questions appear to be subject to arbitration pursuant to the rules of the American Arbitration Association. No grievance procedure is spelled out. No discussion of who is required to explain plan details to patients.

Records/Confidentiality

AMA Model Form

Gives each party right to access to and right to examine records of the other which relate to any Covered Services or payments provided under this Agreement. Requires company to obtain from the Enrollee a consent for the release of medical information narrowly tailored

to accomplish the purpose necessary. Company agrees not to release such information to other parties without written consent of the patient. Costs associated with this are paid by the company. Insures that only medical records and precise schedules of compensation are confidential. Within strict limits it allows the company to prepare and disclose to a third party a report of the physician's quality data relating to utilization and Enrollee satisfaction surveys, but does not allow for disclosure of identity of individual physicians. The report must be provided to the physician for review at least 30 days before it is given to a third party.

Blue Cross

Allows BCWA to review and duplicate any data or records maintained by the physician with respect to an Enrollee for a period of eighteen (18) months after termination of the Agreement. Does not require company to pay for copies. Appears to make physician responsible for obtaining release from patient and paying for copies of records. Does not give physician right of access to company records pertaining to covered services or claims. Contains a vague provision requiring company and physician to take all reasonable precautions to prevent unauthorized disclosure of any information obtained pursuant to Agreement. Does not give physicians right to review quality assurance data, utilization surveys, etc.

Insurance

AMA Model Form

Requires the physician to maintain E&O insurance.

Blue Cross

Requires the physician to maintain E&O insurance. Fails to disclose what is an appropriate amount of E&O insurance.

Term and Termination

AMA Model Form

Agreement runs until terminated except that covered services and compensation schedules are to be renegotiated annually and renewed or rejected individually. Ninety (90) days written notice of any proposed change is required. In the event parties cannot agree on

new schedules either may terminate the contract. Contract can be terminated for cause, otherwise either party may cancel by giving four month (120 days) notice. When the contract is terminated by either party a reason for such termination must be stated in writing. This provides assistance to physicians who fear they are being unfairly discriminated against or punished for violation of some "gag" rule. It also insures that there is no mistake of fact which was relied upon when the other party decided to terminate.

Dispute resolution procedures are available to either party in event of a termination. If company is in financial difficulty the agreement may be terminated. Agreement may be terminated by either party for "cause", but only after giving the other party written notice of the deficiency and thirty days to cure the deficiency. Company remains liable to pay for covered services then being rendered until the episode of illness is complete.

Blue Cross

Can be terminated by either party on thirty (30) days written notice. Can be terminated immediately by either party upon written notice for failure to comply with any of the provisions of the Agreement. Payments then accrued to the physician will be made. Physician agrees that regardless of termination (s)he will continue to treat any Enrollee until the termination of that Enrollee's agreement or the next anniversary of the subscriber, whichever is earlier. This really means that the physician can be forced to continue providing services for one year or more after (s)he has given notice of termination. (This last provision appears mandated, as to Blue Cross, by AS 21.87.140(c)(3).) Physician is required to notify enrollees seeking services that agreement has been terminated. There is no opportunity to cure any alleged breach of the agreement. No reasons for termination are necessary. Company does not remain liable to pay for services related to an ongoing episode of illness.

Dispute Resolutions

AMA Model Form

Provides for an initial meeting within seven (7) days by parties with decision making authority followed by Mediation within thirty days (30) with each party to bear its proportionate share of costs. If unsuccessful this is followed by binding arbitration held in the state where services were performed and conducted according to procedures of the Health Lawyers Association of America Alternative Dispute Resolution Project. Also provides for appeal of quality assurance and utilization review decisions. See Company's Obligations discussed above.

Blue Cross

Only disputes regarding payment and medical necessity are part of the process. First step is for physician and company to communicate directly in attempt to mutually resolve dispute. Second step is for arbitration before American Arbitration Association. No time limits are set for the procedures, nor is there a provision for who bears the costs or where the procedures should take place. Does not provided a right or mechanism to appeal any Utilization Review or Quality Management decision by the company to independent peers and there is no provision to review decisions related to emergency medical care, which should be heard more quickly. There is no grievance procedure.

Amendments/Miscellaneous

AMA Model Form

The Agreement cannot be assigned to an unrelated entity, by either party, without prior written consent of other party. No one except for enrollees has any third party rights under the agreement. The agreement may not be modified without express written approval of both parties. Requires notice to other party of legal matters instituted against either party relating to the Agreement or services provided under the agreement.

Blue Cross

It is possible that this agreement has been filed with and approved by the Director of the Division of Insurance (See AS 21.87.140(d).) The agreement allows the company to set the fee schedules, policies and procedures and covered services at its discretion. The company may amend the Agreement at any time with thirty (30) days written notice to the physician. The amendment becomes binding upon the physician unless BCWA is otherwise notified by the physician within this period. Neither party can assign this Agreement without the written consent of the other except that it allows BCWA to merge or consolidate with another entity. States that Agreement is interpreted according to Alaska law but does not say that any arbitration, mediation, litigation, etc. must take place in Alaska.

GREG GANSKE
4TH DISTRICT, IOWA

COMMERCE COMMITTEE
SUBCOMMITTEES
HEALTH AND ENVIRONMENT
FINANCE AND HAZARDOUS MATERIALS
OVERSIGHT AND INVESTIGATIONS

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES

Dear Colleague:

On May 30, 1996, a small, nervous woman testified before the House Commerce Committee. Her testimony was buried in the fourth panel at the end of a long day about the abuses of managed health care. The reporters were gone, the television cameras had packed up, most of the original crowd had dispersed.

She should have been the first witness that day, not one of the last. She told about the "choices" that managed care companies and self-insured plans are making everyday when they determine "medical necessity." Linda Peeno had been a claims reviewer for several HMOs. Here's her story:

"...I wish to begin by making a public confession. ***In the spring of 1987, as a physician, I caused the death of a man.***

"Although this was known to many people, I have not been taken before any court of law or called to account for this in any professional or public forum. In fact, just the opposite occurred: I was 'rewarded' for this. It brought me an improved reputation in my job, and contributed to my advancement afterwards. Not only did I demonstrate I could do what was expected of me, I exemplified the "good" company doctor: I saved a half million dollars!"

As she spoke, a hush came over the room. The representatives of the trade associations who were still there averted their eyes. The audience shifted uncomfortably in their seats, both gripped and alarmed by her story. Her voice became husky and I could see tears in her eyes. Her anguish over harming patients as a managed care reviewer had caused this woman to come forth and bare her soul.

She continued, *" . . . Since that day I have lived with this act, and many others, eating into my heart and soul. For me, a physician is a professional charged with the care, or healing, of his or her fellow human beings. The primary ethical norm is: do no harm. I did worse: I caused death. Instead of using a clumsy, bloody weapon, I used the simplest, cleanest of tools—my words. This man died because I denied him a necessary operation to save his heart. I felt little pain or remorse at the time. The man's faceless distance soothed my conscience. Like a skilled soldier, I was trained for this moment.* ***When any moral qualms arose, I was to remember: I am not denying care; I am only denying payment."***

By this time, trade association representatives were staring at the floor. The Congressmen who had spoken on behalf of the HMO's were distinctly uncomfortable,

and the staff, several of whom subsequently became representatives of HMO trade associations, were thanking God that this witness came at the end of the day.

Dr. Peeno's testimony continued, *"...at the time, this helped me avoid any sense of responsibility for my decision. Now I am no longer willing to accept the escapist reasoning that allowed me to rationalize this action. I accept my responsibility now for this man's death, as well as for the immeasurable pain and suffering many other decisions of mine caused."*

She then listed the many ways managed health plans deny care to patients. But she emphasized one particular issue--the right to decide what care is medically necessary. *"There is one last activity that I think deserves a special place on this list, and this is what I call the* ***smart bomb of cost containment, and that is medical necessities denials*** *. . . Even when medical criteria is used, it is rarely developed in any kind of standard, traditional, clinical process. It is rarely standardized across the field. The criteria is rarely available for prior review by the physicians or members of the plan. . . ."*

"We have enough experience from history to demonstrate the consequences of secretive, unregulated systems that go awry . . . " After exposing her own transgressions, she closed by urging everyone in the room to examine their own conscience. " . . . *One can only wonder: how much pain, suffering, and death will we have before we have the courage to change our course? Personally, I have decided even one death is too much for me."*

The room was stone-cold quiet. The Chairman mumbled: "Thank you, Doctor."

Linda Peeno could have rationalized her decisions as so many do: "I was just working within guidelines" or "I was just following orders" or "we have to save resources" or "this isn't about treatment, it's really just about benefits." Dr. Peeno refused to continue this denial and will do penance for her sins the rest of her life by exposing the dirty little secret of HMO's determining "medical necessity."

My friend, if there is only one thing you read before voting on patient protection legislation, I beg you to read the following. Before voting on any patient protection legislation, please keep in mind the fact that **no amount of procedural protection or schemes of external review can help patients if insurers are legislatively given broad powers to determine what standards will be used to make decisions about coverage.**

As Dr. Peeno so poignantly observed, insurers now routinely make treatment decisions by determining what goods and services they will pay for. The difference between clinical decisions about medically necessary care and decisions about insurance coverage are especially blurred. Because all but the wealthy rely on insurance, the power of insurers to determine coverage gives them the power to dictate professional standards of care.

Make no mistake, along with the question of health plan liability, **the determination of who should decide when health care is medically necessary is the key issue in patient protection legislation.**

Contrary to the claims of HMOs that this is some new concept, for over two hundred years most private insurers and third-party payers have viewed as medically necessary those products or services provided in accordance with the "prevailing standards of medical practice." This is the definition used in many managed care reform bills, including my own--the Managed Care Reform Act of 1999. The courts have been sensitive to the fact that insurers have a conflict of interest because they stand to gain financially from denying care and have used "clinically derived professional standards of care" to reverse insurers' attempts to deviate from these standards.

This is why it is so important that managed care reform legislation include an independent appeals panel with no financial interest in the outcome. A fair review process utilizing **clinical standards of care** guarantees that the decision of the review board is made without regard to the financial interests of either the HMO or the doctor. On the other hand, if the review board has to use the health plan's definition of "medically necessary," there is no such guarantee.

In response to the growing body of case law and their own need to demonstrate profitability to shareholders, insurers are now writing contracts that threaten even this minimal level of consumer protection. They are writing contracts in which standards of medical necessity are not only separated from standards of good practice but are also essentially not subject to review. Here is one example, of many, of a health plan's definition of "medically necessary services."

> "Medical necessity means the **shortest, least expensive, or least intense level** of treatment, care or service rendered, or supply provided, as determined by us (the health plan), to the extent required to diagnose or treat an injury or sickness. The service or supply must be consistent with the insured person's medical condition at the time the service is rendered, and is not provided primarily for the convenience of the injured person or doctor." (emphasis added)

Contracts like this demonstrate that some health plans are manipulating the definition of medical necessity to deny appropriate patient care by arbitrarily linking it to saving money, not the patient's medical needs.

On the surface, some may say, "So what's wrong with the 'least expensive treatment'?"

Here's just one example out of the thousands I could cite: as a reconstructive surgeon, I treated children with cleft palates. "Clinical standards of care" would determine that the best treatment is surgical correction, but under this HMO's definition, the plan could limit coverage to a piece of plastic to fill the hole instead. After all, this plastic obturator would be cheaper. However, instead of condemning children to a

lifetime of using a messy prosthesis, the proper treatment--reconstruction using the child's own tissue--would give that child the best chance at normal speech and a normal life.

Paradoxically, insurers stand to benefit from misguided legislative changes that displace case law! Last year, legislation that passed the House and the GOP bill in the Senate would have granted insurers the explicit power to define medical necessity, without regard to current standards of medical practice. This would have been accomplished by allowing them to classify as medically unnecessary any procedures not specifically found to be "necessary" by the insurer's own technical review panel. The Senate bill would have even given insurers the power to determine what evidence would be relevant in evaluating claims for coverage and would have permitted insurers to classify some coverage decisions as exempt from administrative review.

I know that many of our colleagues who supported those bills last year had no idea of the implications of the medical necessity provisions in them.

Specifically, insurers now want to move away from clinical standards of care applied to particular patients to standards linking medical necessity to "population studies." On the surface this may seem "scientific" and rational. However, as a former medical reviewer myself who worked with many insurers large and small, let me explain why I think it is critical that we stick with medical necessity as defined by clinical standards of care:

- First, sole reliance on broad standards from generalized evidence isn't good medical practice;
- Second, there are practical limits to designing studies that can answer all clinical questions; and
- Third, most studies aren't of sufficient scientific quality to justify overruling clinical judgment. Let me explain these points further (I also recommend the article on these shortcomings by Rosenbaum, et al, in the January 21, 1999 edition of the New England Journal of Medicine).

First, while it may sound counter-intuitive, it isn't good medicine to solely use "outcome-based" studies of medical necessity, even when the science is rigorous. Why? Because the choice of the outcome is inherently value-laden. The medical reviewer for the HMO is likely, as shown by the above mentioned contract, to consider cost the essential value. But what about quality?

As a surgeon I treated many patients with broken fingers simply by reducing the fracture and splinting the part. For most patients this would restore adequate function. But for the musician who needs a better range of motion, surgery might be necessary. Which outcome should be the basis for the decision about insurance coverage: playing the piano or routine functioning? My point is this—taking care of patients involves much variation.

Definitions of medical necessity must be flexible enough to take into account the needs of each patient. "One size fits all" outcomes make irrelevant the doctor's knowledge of the individual patient and is bad medicine, period.

Second, there are practical limitations on basing medical necessity on "generalized evidence," particularly as applied to HMO's. Much of medicine is the result of collective experience, and many basic medical treatments haven't been studied rigorously. Furthermore, aside from a handful of procedures that are not explicitly covered, most care is not specifically defined in health plans because the number of procedures and the circumstances of their application are limitless.

In addition, by their very nature many controlled clinical trials study treatments in isolation, whereas physicians need to know the benefits of one type of treatment over another. Prospective, randomized comparison studies on the other hand are expensive. Given the enormous number of procedures and individual circumstances, if coverage is limited to only those that have scientifically sound generalized outcomes, care could be denied for almost all conditions. Come to think of it, maybe that is why HMO's are so keen to get away from prevailing standards of care!

Third, the validity of HMO guidelines and how they are used is open to question. Medical directors of HMOs were asked to rank the sources of information they use to make medical decisions. Industry guidelines generated by the trade associations representing health plans ranked ahead of information from national experts, government documents, and NIH consensus conferences. The most highly ranked respected source—medical journals—was used less than 60% of the time!

Industry guidelines are frequently done by Milliman and Robertson, a strategy shop for the HMO industry. This is the same firm that championed "drive through deliveries" and outpatient mastectomies. Many times, these practice guidelines aren't grounded in science but are cookbook recipes derived by actuaries to reduce health care costs. Here are two examples of the errors of their guidelines:

- A National Cancer Institute Study released in June found that women receiving outpatient mastectomies face "significantly higher" risks of being re-hospitalized and have a higher risk of surgery-related complications like infections and embolisms.

- A 1997 study published in the Journal of the American Medical Association showed that babies discharged within a day of birth faced increased risk of developing jaundice, dehydration, and dangerous infections.

Objectivity of medical decision making requires that the results of studies be open to peer review. Yet much of the decision-making by HMO's is based on unpublished, "proprietary," and unexamined methods and data. Such secret and potentially biased guidelines simply can't be called scientific.

This is not to say that outcomes-based studies don't make up a part of how clinical standards of care are determined. They do. But we are all familiar with the ephemeral nature of new "scientific" studies such as those on the supposed dangers of alar!

Clinical standards of care do take into account valid and replicable studies in the peer-reviewed literature, as well as the results of professional consensus conferences, practice guidelines based on government funded studies, and guidelines prepared by insurers that have been determined to be free of any conflict of interest. But most importantly, they also include the patient's individual health and medical information and the clinical judgment of the treating physician.

Congress should pass legislation defining this standard of medical necessity because: 1) ERISA shields plans from the consequences of most decisions about medical necessity, 2) under ERISA, patients generally can only recover the value of benefits denied, and 3) even this limited remedy is being eroded by insurance contracts that give insurers the authority to make decisions about medical necessity based on questionable evidence. And to ensure these protections, Congress must provide patients with a speedy, external review of all coverage decisions, not merely those that insurers decide are subject to review.

It is time for Congress to defuse the "smart bomb" of HMO's.

Sincerely,

Greg Ganske
Member of Congress

AUG 11 1998

Malpractice Liability Assessment Model

Estimates of the Cost Impact of Managed Care Accountability Legislation

Prepared by William M. Mercer, Incorporated
and the
American Medical Association

August 1, 1998

WILLIAM M. MERCER

American Medical Association
Physicians dedicated to the health of America