

Make Managed Care Contracts Fair & Transparent

Managed care organizations control a significant part of most physicians' practices, leaving physicians with little ability to walk away from unfair contracts. This imbalance forces physicians to sign take-it-or-leave-it contracts that are not only bad for the physician and drive up the cost of care, but can also be detrimental to patient care.

Unfair Contract Language Harms Physicians and the Patients They Serve

"... Physician agrees <Plan> may make retroactive adjustments to payments for business reasons, including claims payment errors, data entry errors, and incorrectly submitted claims. ..."

"... Such policies and procedures and other documents may be amended by <Plan> from time to time. ..."

In some cases, contract provisions may pit economic incentives for the physician against quality care for the patient. In other cases, contract provisions may attempt to nullify or ignore patient protections passed by the Legislature. Texas must modernize its statutes to bring fairness and transparency to contracts between physicians and health plans.

HB 2016 and **SB 1170** will provide disclosure of certain contract terms and prohibit unfair contracting provisions currently in practice, like hidden network arrangements and/or unilateral changes to contracts.

By providing more transparency and accountability, physicians can make informed business decisions, freeing the market to reward good health plans by making them compete for physicians on the basis of the quality of their contract terms. Otherwise, there'll be more contracts of adhesion and take-it-or-leave-it business practices, causing Texas physicians and the patients they serve to suffer.

Key Provisions of HB 2016 and SB 1170

1. DISCLOSURE

Requires health plans to disclose payment terms. Physicians need information on how the fee schedule is calculated and need all of the health plans' associated payment policies spelled out in every contract.

2. UNDERSTANDABLE TERMS

Contracts and contract amendments need to be in plain, understandable language. Physicians should not have to retain a lawyer to read all of their correspondence with health plans.

3. CATEGORIES OF COVERAGE

Currently a health plan can impose a new category of coverage on a physician. This means a physician who signs up to provide PPO or HMO service could find himself in the Workers' Compensation business without his knowledge or agreement. This bill will require an agreement on the scope of the contract.

Some Contract Language Even Strips Physicians of Protections Previously Provided by the Legislature

“... Provider agrees that <Plan> Fee Schedule contains proprietary and confidential information subject to the confidentiality provisions of this agreement. <Plan> will not make the entire <Plan> Fee Schedule available to Provider but will provide a sample listing of maximum available rates upon request of Provider. ...”

“... Our reimbursement policies and methodologies are updated periodically. ... Your reimbursement is also subject to our rules concerning retroactive eligibility, subrogation and coordination of benefits. ...”

4. RENTAL NETWORKS

Health plans often share a physicians' discounted fee schedule with third parties. This bill will require all terms of the contract (not just the fee schedule) be intact in order for a third party to enforce a discounted fee schedule.

5. CONTRACT AMENDMENTS

Contracts between managed care organizations and physicians are possibly the only setting in law where one party to the contract can unilaterally change the contract. This bill will require the provider receive notice prior to such amendments and allow the physician a period of negotiation or time to terminate the contract.

6. WAIVER OF RIGHTS

Contracts often include provisions that negate protections the Legislature has provided to physicians through statute, such as timely payment and limitations on retroactive adjustments. This bill will prohibit contractual waivers of rights.

7. PAYER MIX

This bill will allow a physician's practice to determine its own payer mix. (i.e. What percentage of his practice is with any single health plan.) Previously, health plans have dictated a physician's ability to accept patients from other health plans.

8. ENFORCEMENT

The bill allows for meaningful enforcement for both contract disputes and statute violations without imposing irresponsible penalties.

9. COMPLIANCE MONITORING

This allows a physician to share a contract with a third party for the purposes of compliance monitoring. Maintains confidentiality as set forth by the plans.

Solution: Inject Transparency Into Managed Care Contracts

HB 2016 and **SB 1170** will assure much-needed protections for physicians and their patients, provide fairness and transparency in contracts between physicians and those entities that contract for health care services, and allow physicians to serve the best interests of their patients.

The Best of the Worst: Managed Care Contract Language

“... <Plan> may amend this agreement by sending a copy of the agreement to the physician at least 30 days prior to the amendment’s effective date. The signature of the physician shall not be required. ...”

“... <Plan> reserves the right to introduce new Plans during the course of this Agreement and to designate Physician as a Participating Provider in these Plans. Physician shall accept compensation in accordance with a plan for the provision of any covered services to members under a Plan, regardless of whether Physician is a participating provider in such Plan. ...”

“... Physician agrees <Plan> may make retroactive adjustments to payments for business reasons, including claims payment errors, data entry errors, and incorrectly submitted claims. ...”

“... This is an agreement between the physician group and each company, entity, employer, or organization with which <Plan> is directly or indirectly affiliated. It is expected that additional companies, entities, employers, or organizations will choose to affiliate with <Plan>. This agreement shall become effective as to such entities upon notice. ...”

“... This agreement supersedes all previous agreements and compromises the entire agreement between Physician and <Plan>. ...”

“... Physician agrees to be obligated by all the policies, rules and regulations adopted by <Plan> and/or Payor from time to time in connection with Payor plans, as they relate to this Agreement, including amendments thereto. <Plan> will notify Physician of such policies, rules, regulations, and amendments thereto. ...”

“... Provider agrees that <Plan> Fee Schedule contains proprietary and confidential information subject to the confidentiality provisions of this agreement. <Plan> will not make the entire <Plan> Fee Schedule available to Provider but will provide a sample listing of maximum available rates upon request of Provider. ...”

“... The Program Attachments hereto are a part of this Agreement and their terms shall supersede those of other parts of this Agreement in the event of a conflict. ...”

“... Our reimbursement policies and methodologies are updated periodically. ... Your reimbursement is also subject to our rules concerning retroactive eligibility, subrogation and coordination of benefits. ...”

“... Upon termination of this Agreement, Provider shall continue to treat Members until the earlier of: (i) the completion of their course of treatment; or (ii) <Plan> has made arrangements to have their treatment provided by another provider. In addition, Provider shall continue to treat Members, upon request of any Member or Payor, until the anniversary date of such Member or Payor’s Health Benefits Plan or for one (1) calendar year, whichever is less. ...”

The Truth About House Bill 2016

Health Plans Claim: Government Should Not Intervene in Contractual Issues Between Physicians and Health Plans

Truth: In a perfect world, the state would not be involved with contract issues between physicians and health plans, but we don't live in a perfect world. The increased consolidation of the health insurance industry has created a health care market that is dominated by a few investor-driven managed care plans, which control a significant part of most physicians' practices. These health plans dictate ambiguous contract terms, and those terms impact every aspect of a physician's practice.

There are serious public policy ramifications when such disparity in bargaining power occurs between physicians, who take care of patients, and health plans, which are only accountable to their shareholders. Physicians have little choice but to sign whatever contract is offered by health plans. Most physician practices find it nearly impossible to sacrifice a significant part of their patient base to make a stand against untenable contract provisions the plans offer.

House Bill 2016 is a modest approach to ensuring managed care contracts are fair and transparent. It provides disclosure of certain uniform contract provisions, prohibits certain unfair contract provisions like unilateral contract changes, and will relieve some administrative pressure and costs.

Health Plans Claim: HB 2016 Shouldn't Apply to ERISA Plans

Truth: ERISA plans, or self-insured plans, comprise the majority of the Texas health insurance market. The health plans try to confuse what is a straightforward bill that provides for fairness and transparency in their contractual relationships with physicians by raising the all too familiar argument that ERISA preempts any state law that they don't like.

This, however, ignores settled ERISA law. Courts have clearly defined the scope of ERISA preemption, and case law laid out by the US Supreme Court and federal appeals courts informs us that a state has the authority, as well as the traditional role of regulating health care contracts. This bill falls squarely within the state's traditional regulatory power.

The US Supreme Court has said that the ERISA preemption is subject to "the starting presumption that Congress does not intend to supplant state law," and that "unless congressional intent to preempt clearly appears, ERISA will not be deemed to supplant state law in areas traditionally regulated by the states." Contract law is traditionally regulated by the states.

ERISA says to employers that if you self-insure, you can structure your benefit packages for your employees anyway you want to without state laws interfering with the design or administration of those plans. So states can't tell self-insured plans that they have to cover this service or that procedure. If House Bill 2016 is enacted into law, ERISA plans will remain free to design and administer their benefits as they wish.

In case after case, courts have held that state laws that have an indirect impact on ERISA plans do not trigger preemption. Moreover, courts have allowed physicians to assert state law contract claims against payers, finding that ERISA does not intend to govern those relationships. The courts reason that the physicians are not a "party to the ERISA bargain struck between plan and plan participants by Congress. Instead, these parties' relationships flow from and are governed by contracts." The same reasoning applies to the validity of HB 2016, since it focuses on the contracts between health plans and physicians, not on the terms or structures of an ERISA benefit plan.

Any effort by health plans to amend HB 2016 to provide an ERISA exemption is tantamount to saying the Texas Legislature does not have the right to legislate in the area of contract law between health plans and physicians.

The Health Plans Claim: HB 2016 Mandates Specific Contract Terms

Truth: There is nothing in the language of the bill that requires health plans to adopt specific or standardized contract language. Health plans are free to continue to execute individual, unique contracts with physicians and other health care professionals. All HB 2016 proposes is to require health plans to provide physicians with information they need to make an informed business decision, like payment terms.

Providing more transparency and accountability in managed care contracting will free the market to reward good health plans by making them compete for physicians on the basis of the quality of their contract terms.

Health Plans Claim: They Compete for Physicians' Services

Truth: This claim is patently false. In Texas today, a few very large investor-driven health plans dominate the health care market. This imbalance forces physicians to sign take-it-or-leave-it contracts that are not only bad for the physician, but can be detrimental to patient care. Texas' health care market is not an equal playing field

Those few health plans control a significant part of most physicians' practices, leaving physicians with little ability to walk away from unfair contracts. What incentive does a plan have to agree to any request from a physician, when the plan has the ability to remove that physician from their network for not agreeing to the terms of their contract and effectively denying that physician's patients access to his services?

The Health Plans Claim: HB 2016 Will Increase Costs

Truth: Same song, fourth verse. Every session we hear this same Chicken Little defense – anything the Legislature attempts to do on managed care reform will increase costs. Given the healthy profits the for-profit health plans have posted over the past several years, not to mention the mind-boggling compensation packages their senior executives have received, the questions must be asked, how will disclosing contract terms to physicians raise costs?

HB 2016 does not require health plans to re-write existing contracts and only requires health plans to comply with the disclosure requirements for contracts entered into or renewed on or after Jan. 1, 2008.

Health Plans Claim: Existing State Law Addresses the Provisions of HB 2016

Truth: Texas has been at the forefront of managed care reform and has strong, comprehensive statutes in place, which govern managed care practices. Unfortunately, state law and Texas Department of Insurance regulations apply only to a small portion of Texas' health insurance market, as self-insured ERISA plans are exempt from most state oversight. This patchwork of oversight creates confusion in the market by holding health plans to different standards.

HB 2016 applies consistent standards to all health plans and requires them to comply with existing state law, disclose certain uniform contract terms and prohibit unfair contracting provisions. Health plans should not be opposed to HB 2016 as it simply applies existing state law to all health plans.