

## **American Medical Association**

### **Testimony before the National Conference of Insurance Legislators Health Insurance Meeting July 8, 2005**

#### **Bringing Fairness and Transparency to Health Plan Payer Contracting and Payment Processes**

Good morning. My name is Dr. James Rohack. I am a practicing cardiologist at Scott & White Clinic in Temple, Texas and the Immediate Past Chair of the Board of Trustees of the American Medical Association (“AMA”). On behalf of the AMA and our physician members, I would like to thank the National Conference of Insurance Legislators (“NCOIL”) for inviting me to Newport to discuss the challenges that physicians face when seeking fair, open disclosure in their interactions with health plan payers. To fully detail the extensive issues facing physicians would take considerably more time than I have with you today. In fact, any one of these issues would warrant a separate presentation and that could easily consume an entire day’s discussion. I know that I am presenting an extensive agenda. However, I want you to understand the pervasive nature of the unfair business practices that I will discuss, as well as the cumulative harm these activities inflict on physician practices and on patients’ abilities to manage the financial aspects of their health care.

There are a number of factors that make it difficult for individual physicians or physician groups to tackle the issues that I am here to address.

- These unfair business practices are both increasingly sophisticated and difficult to detect and/or identify;
- There are a greater number of intermediary entities involved, making it much more difficult to trace claims and actions taken relating to them;
- Unlike insurers, physicians are restricted under antitrust laws from sharing rate information or acting collectively to address payment-related issues; and
- There are insufficient legal safeguards or state legislative and/or regulatory oversight for much of this activity. It is this legislative and regulatory vacuum the AMA calls on the NCOIL to fill.

This morning, I will outline the primary concerns that physicians across the country have in this area. In addition, I will identify solutions that will strengthen our health insurance system for everyone. The AMA believes that the NCOIL should play an important role in shaping these solutions. We are committed to working with this organization and individual state insurance departments to address these issues.

#### **I. The Underlying Problems**

There are two major problems underlying the unfair practices that I will address today.

##### **Uneven Playing Field**

The first underlying issue is the inherent disparity in bargaining power between health plan payers and physicians. While ostensibly physicians have the right to agree only to the contract

terms and reimbursement levels that benefit them, in most areas of the country, and for most physicians, this is not realistic. The root of the problem often lies in the provider contract, which is typically a form contract imposed upon physicians by health plan payers with little opportunity for amendment. Artfully drafted, these contracts and related business practices often put physicians' offices at the mercy of health plan payers in terms of reimbursement. Because of the imbalance in negotiating power between these organizations and physicians, physicians wind up forfeiting a considerable percentage of charges for services they provide.

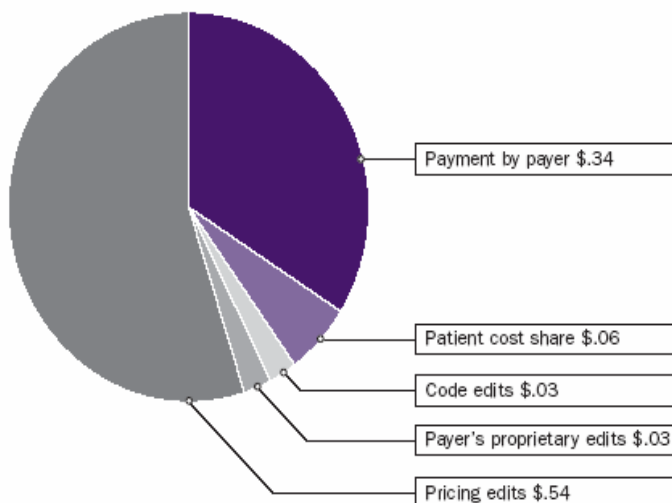
In many areas of the country, a health plan payer's market dominance makes it infeasible for a physician to not participate in the network. Moreover, health plan payers are moving aggressively to restrict reimbursement for out-of-network physicians in an effort to force these physicians to participate in their networks. As a result, physicians often feel coerced into signing provider agreements that include provisions that are inequitable and often detrimental to them and their patients. Even when egregiously treated, physicians often fail to seek redress because of the time and money involved in legal actions.

### **Lack of "Transparency" as a Cost Reduction Strategy**

The second underlying problem is the pervasive refusal by health plan payers to disclose information regarding *what* they pay and *how* they pay. This systematic effort to obfuscate payment has made it extremely difficult for physicians to dispute the amounts they are paid.

In most industries, businesses are able to set the price of the services they provide or goods they sell based on costs incurred and a reasonable profit margin. For the vast majority of physician offices, which represent a major small business interest and employer base in your respective states, reimbursement is nowhere near this straightforward. Instead it is based on a complex array of factors, most of which are largely outside of physicians' control. In recent years, physicians have faced increasingly aggressive strategies by health plan payers to contain costs through systemic reductions in reimbursement. Our data shows that physicians receive only 40 cents out of every dollar of billed charges, as reflected in the following pie chart.

Note that the other 60 cents is eaten by authorized and unauthorized discounts and various code editing practices by health plan payers.



– SOURCE NHXS

| <b>EXAMPLE: Payer contractual allowance by edit type: per dollar</b>  |                |
|---|----------------|
| Pricing edits <sup>1</sup>  | <b>\$ 0.54</b> |
| Edits based on CPT, CCI and Medicare  | <b>\$ 0.03</b> |
| Payer's proprietary edits <sup>2</sup>  | <b>\$ 0.03</b> |
| Patient cost share payment  | <b>\$ 0.06</b> |
| Payer's payment   | <b>\$ 0.34</b> |
| <sup>1</sup> Application of fee schedule adjustments, including unauthorized discounts.   |                |
| <sup>2</sup> Application of payer specific clinical edit policy, such as the denial of a service as inclusive of another service. |                |

Some industry experts have suggested that it still takes an average of 72 days from the time a physician submits the claim to a payer to when the physician actually gets paid. According to Athena Healthcare, between 5% and sometimes 35% of claims will never be collected even though physicians spend as much as 10% of their revenue trying to collect what is rightfully owed to them for the provision of patient care. According to Todd Park, Chief Development and Chief Marketing Officer of Athena Healthcare, “[i]f you told anyone else in America, I’m going to pay you 65 days late, randomly deduct 5% of your paycheck without telling you, and make you pay me a tax of 8% to 10% of your payment, you would say its absurd.” July 2005 Fast Company.

Generally, the most onerous aspect of the relationship between health plan payers and physicians is the “black box” mentality that characterizes many health plan payers’ stance on reimbursement matters. Can you imagine any other small business tolerating not knowing how much it was going to be paid for services it renders? Other industries such as banking have long recognized the need for transparency in business transactions. However, in the health care arena, health plan payers routinely refuse to disclose any information relating to the fees that they plan to pay to physicians, claiming that the information is “proprietary.” In many cases, physicians have no way of determining how they will be paid for a given service or procedure and as a result, lack basic information needed to plan the finances of their practices. The extent of the problem is underscored by the experience of physicians in Georgia, who in 1997 successfully sued to gain access to a fee schedule and coding methodology, and have yet to have the health plan payer comply.

The AMA believes that the shroud of secrecy covering the entire health care payment process must be lifted. There is no legitimate policy rationale behind health plan payers’ refusal to provide this information to physicians and patients. It serves only as a means for health plan payers to increase profits by keeping all other parties in the dark. This includes employers, patients and physicians. It is time for states to step in to establish reasonable standards to ensure transparency in the health care payment process.

## **II. Specific Payment Reduction Strategies**

Health plan payers utilize a number of payment reduction strategies, ranging from relatively straight-forward methods to extremely complicated transactions that involve several layers of entities. In many instances, there are intermediaries that are completely unknown to the physician, but which nevertheless take a slice of the physician’s reimbursement. These practices, coupled with a “take it or leave it” stance on provider contracts and refusal to disclose payment methodologies, make it nearly impossible for physicians to manage their finances.

### **Failure to Disclose Reimbursement Schedules**

A pervasive practice that physicians face is health plan payers’ refusal to disclose their fee schedules, claiming that they are proprietary. This practice exemplifies health plan payers’ profit maximizing strategies that I discussed a moment ago.

### **Unfair Downcoding and Bundling Policies**

In addition to often lacking information regarding health plan payers’ fee schedules, health plan payers often refuse to disclose information regarding *how* they pay. This problem, which is very

difficult for physicians to address, involves “downcoding,” “bundling,” and unwarranted reassignment of AMA Current Procedural Terminology (“CPT®”) codes for procedures and services provided by physicians. These practices have a common goal and result: to increase the health plan payer’s profits by lowering or denying payment to physicians. Often, there is no rhyme or reason to these selective payer code edits. Health plan payers randomly turn edits “on” and “off.” This further confuses and disadvantages physicians and their ability to determine how a health plan payer is adjudicating claims. Making sense of how a health plan payer adjudicates claims is no easier for our patients. It has gotten so complex that deciphering an explanation of benefits (“EOB”) has become nearly impossible. Following is a hypothetical example of a complicated EOB.

**1**

XYZ Insurance  
123 Lane,  
Anytown, USA

Date:  
Examiner No.  
Plan No:  
Patient No:  
Claim No:  
Check Number:

**3**

US Physician Group  
PO Box 1122  
Chicago, IL 12345

Floor Mart Payer  
Benefits Department  
Schaumburg, GA 12345

**2**

| PROVIDER NAME<br>DATES OF SERVICE<br>TYPES OF SERVICE | SUBMITTED<br>CHARGES | LESS PROVIDER<br>DISCOUNT OR<br>INELIGIBLE<br>CHARGE | REASON<br>CODE<br>* | LESS<br>COPAY/<br>ENCOUNTER<br>FEE | LESS<br>DEDUCTIBLE | REMAINING<br>CHARGES | %<br>PLAN<br>PAYS | BENEFIT<br>PAID |
|---|----------------------|--|---------------------|------------------------------------|--------------------|----------------------|-------------------|-----------------|
| <b>4</b><br>9/13/00                                   |                      |  |                     |                                    |                    |                      |                   |                 |
| Outpatient Surgery                                    | 1645                 | 429  | 1                   | 0                                  | 966                | 250                  | 90%               | 225             |
| Medical Services                                      | 1500                 | 1500   | 2                   | 0                                  | 0                  | 0                    | 90%               | 0               |
| Outpatient Surgery                                    | 835                  | 125  | 1                   | 0                                  | 0                  | 710                  | 90%               | 639             |
| Outpatient Surgery                                    | 480                  | 240  | 3                   | 0                                  | 0                  | 240                  | 90%               | 216             |
| Office Services                                       | 65                   | 21   | 1                   | 10                                 | 34                 | 0                    | 100%              | 0               |
| <b>5</b>  | <b>6</b>             | <b>7</b>   |                     | <b>8</b>                           |                    |                      |                   | <b>9</b>        |
| <b>TOTALS</b>   | <b>4525</b>          | <b>2315</b>  |                     | <b>10</b>                          | <b>1000</b>        | <b>1200</b>          |                   | <b>1080</b>     |

**10**

Reason Code Description

- 1 Ineligible charge, is a Network PPO Negotiated discount; Patient Responsible
- 2 Payment is included in the allowance for the basic service/procedure
- 3 The charge was reduced due to the multiple procedure rule

TOTAL BENEFIT PAYMENT ISSUED 1080  
TOTAL PATIENT COST SHARE 120

| <b>Decoding the Explanation of Benefits</b> |   |
|---|---|
| <b>Location</b>                             | <b>Explanation</b>  |
| 1   | Plan Administrator. This is the address on the patient's health care card and usually the name entered into the practice management system. Not the name of the PPO as noted below.   |
| 2   | Payer. The entity that purchases a health care benefit from the Plan Administrator.   |
| 3   | Payee. The physician.   |
| 4   | Date of service.  |
| 5   | Type of service. Note that the CPT code from the CMS-1500 form used to submit the claim is not included on this EOB. You have to look up the claim in the practice management system to find out what CPT code was billed. This is a common but not universal practice with EOB's. CPT code 99213 was billed. |
| 6   | Billed charge. Amount billed by the physician for the procedure or service.   |
| 7   | Discount. Difference between billed charge and contracted rate. If you do the math the contracted rate with Network PPO for a 99213 is \$44.00.   |
| 8   | Patient co-payment. All contracted or allowable fees are reduced by any co-payments or deductibles.   |
| 9   | Paid amount. Equal to \$44.00 less \$10.00 co-payment = \$34.00   |
| 10  | Network PPO.  |

In the following real life example, according to a NHXS analysis, a physician's office was paid 12 different rates for the same service. Look at PPO F as an example. Here, the office submitted 17 claims for the same service to PPO F and was paid four different rates. This is a perfect example of how confusing the practice environment has become for physicians and how difficult it is for physicians to determine the actual payment for the provision of health care services.

| <b>Physician Group ABC<br/>STATEMENT OF ACCOUNTS<br/>Plan Administrator</b>                     |                       |                         |
|---|-----------------------|-------------------------|
| <b>Physician Contract Discount<br/>Applied to CPT Code 99213<br/>– Established Office Visit</b> | <b>Actual Payment</b> | <b>Number of Claims</b> |
|   |                       |                         |
| Network PPO A   | \$ 77.42              | 3                       |
| Network PPO B   | \$ 43.65              | 1                       |
| Network PPO C   | \$ 48.99              | 15                      |
|   | \$ 53.00              | 2                       |
| Network PPO D   | \$ 42.00              | 1                       |
| Network PPO E   | \$ 42.00              | 2                       |
|   | \$ 43.10              | 6                       |
|   | \$ 48.99              | 1                       |
| Network PPO F   | \$ 37.73              | 4                       |
|   | \$ 44.38              | 1                       |
|   | \$ 46.78              | 1                       |
|   | \$ 51.00              | 11                      |

As illustrated in the previous EOB diagram, the EOB received by the physician group may not have included references to the source for the discounted rate. Therefore, the physician group would not have the information necessary to make an accurate assessment of the appropriateness of the payment received from the payer, or to dispute the payment amounts.

A few states are attempting to break open this “black box” mentality. In my home state of Texas, for example, we are working tirelessly with our Department of Insurance to improve upon our state prompt payment law. In 2003, we supported legislation that was enacted that requires health plans and other entities to provide a description and copy of coding guidelines, including any underlying bundling, recoding, or other payment process and fee schedules as they apply to specific procedures.

Additionally, a health plan’s claims payment processes must use nationally recognized, generally accepted CPT codes, notes and guidelines including all modifiers and be consistent with nationally recognized, generally accepted bundling edits and logic.

To date, the Texas Department of Insurance has not adopted regulations specifying nationally recognized, generally accepted bundling edits and logic because the stakeholders have reached a deadlock on a bundling system that is “generally accepted.” We believe that standardization is critical for both physicians and health plans and will cut down on any accidental coding or claims processing errors.

Without transparency of information, physicians are left wondering what more needs to be done in order for a claim that has been determined to be deficient of information by the health plan to be processed and paid appropriately.

We are hopeful that the Department’s oversight will provide more clarity to the entire claims processing and payment environment.

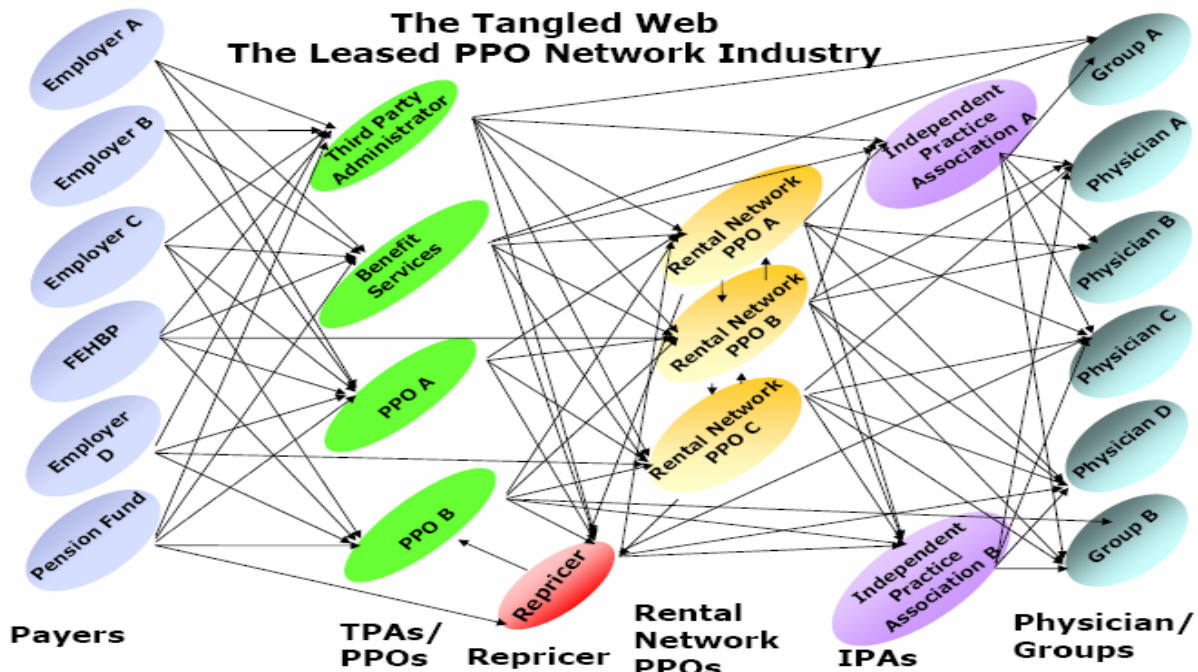
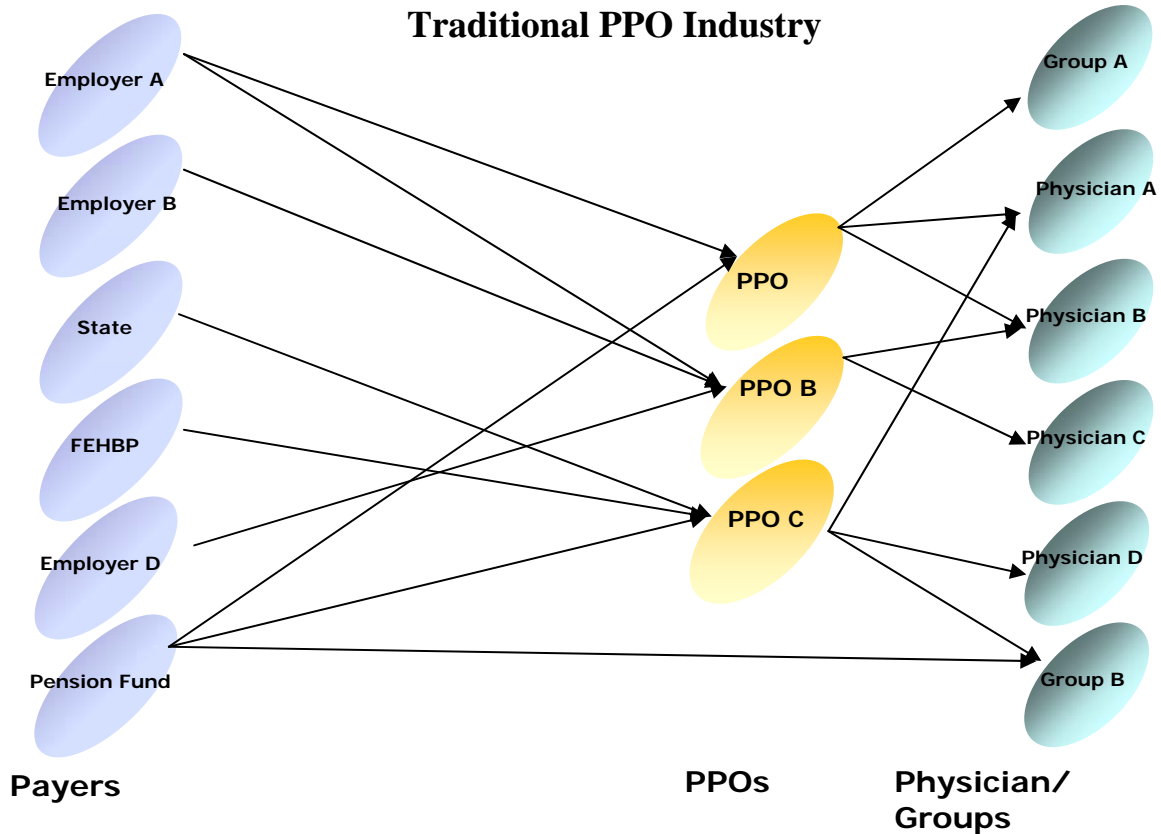
### **An Unregulated Secondary Discount Market**

In recent years, the health care market has spawned a secondary market in physician discounts that has exacerbated physicians’ ability to manage their practices. The lack of regulatory oversight in the preferred provider organization (“PPO”) industry in general has resulted in the proliferation of entities that are engaged in the extremely lucrative business of developing health care provider panels and then leasing the panels *and* associated provider discounts to various health plan payers.

These entities are often called “rental network PPOs” or “lease network PPOs.” When the physician discount is shared without authorization from the physician, the arrangement is often referred to as a “silent PPO.”

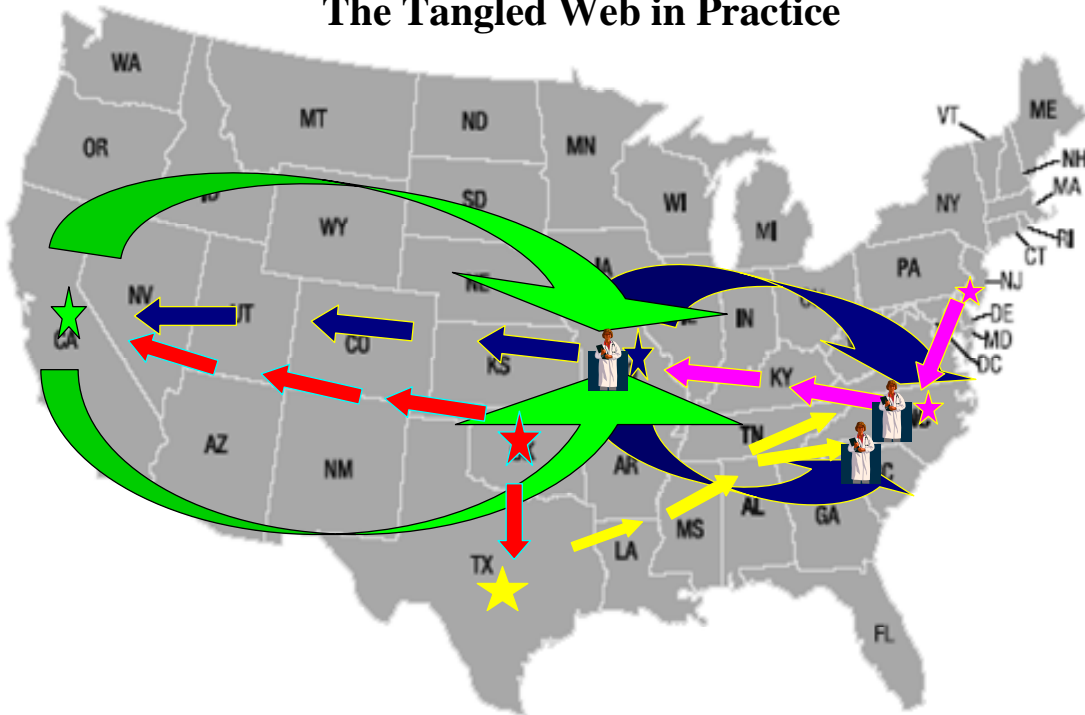
There are also entities called “repricers” whose sole purpose is finding and applying the lowest discounted rate for its clients, often without authorization from the physician. The activities within this market, and the entities engaged in these activities, are virtually unregulated in the vast majority of states.

The following diagrams depict the industry before and after the rise of intermediaries and leased networks. The first diagram represents the PPO industry as we all knew it to be: straightforward and uncomplicated. The second example portrays the tangled web that exists today - created by the complex array of entities engaged in this secondary discount market and their various relationships to one another.



The complexity of the tangled web are staggering and confounding for both physicians and patients. The following map and the associated stars, arrows, and physicians depict the tangled web in practice. Believe it or not, this “zig zag” of relationships and arrangements between leased networks, third party administrators and other entities to access physician discounts are not uncommon. Oftentimes, they are even more complex than this map, involving multiple entities wedged between the physician and the patient.

### The Tangled Web in Practice



Discounted fee schedule arrangements are the heart of most modern managed care. In a PPO arrangement, physicians agree to accept for reimbursement a percentage of billed charges, in exchange for the benefit of the PPO including the physician in its participating provider list, thus steering a higher volume of patients to the physician. When entered into with full information regarding fees, reimbursement policies and other policies affecting patient care, the physician or physician group can assess the value of the increased volume against the lower reimbursement rate, and make an informed decision about whether to contractually agree to a given discount rate.

Increasingly, the activities within this secondary discount market render the bargain underlying the PPO agreement meaningless. Many of these entities provide no value whatsoever to the physician, but exist for the sole purpose of trafficking in provider discounts. They are intermediaries between a plan and physician whose sole function is to apply the lowest discount a physician has accepted with any health plan payer, thus depriving the physician of the reimbursement that would otherwise apply.

A common scenario arises when a physician enters into a contract with a rental network PPO based on its contractual arrangement with one or more large health plans. Unknown to the

physician, the rental network PPO rents or leases the physician's discount information to downstream entities for a profit. It may be hard to imagine, but it is actually possible for one rental network PPO to have hundreds of other health plan payers and affiliates to whom it leases various provider panels and associated discounts. What is equally egregious is that in many cases, entities that have accessed discounts refuse to adhere to the terms of the underlying contract, including provisions relating to prompt pay, payment methodologies and policies, and other provisions that protect the rights of physicians and patients.

Patients also suffer from this secondary market activity. If the health plan payer reimburses the physician at a lower rate based on a non-negotiated discount while the beneficiary pays the portion of billed charges set forth in their subscription agreement, the patient may shoulder a disproportionate financial burden.

The AMA receives many questions and complaints regarding the legitimacy of these types of entities. Not surprisingly, it is very difficult to discern between legitimate entities and "fly-by-night" outfits that are little more than a website. Given the huge amount of health care resources these entities are siphoning from the system, it is extremely troubling that they function with little to no oversight. We believe that this entire secondary discount market must be carefully scrutinized and regulated.

We feel strongly that it is critical for states to shine a light on this stealth discounting that is unknown to most physicians, their patients and the regulators of the individual states.

### **Private Sector Activity**

The AMA has long addressed these activities through the work of the Private Sector Advocacy unit, which focuses on bringing fairness to contracting and payment processes for physicians and their patients. This is being accomplished through ongoing discussions with national health plan associations and individual health insurers, as well as through the development of educational and instructional materials for physicians and their office staff. These resources and services are designed to assist physicians and their office staff in strengthening their practice management while navigating the ever changing maze that is the health insurance market.

### **Multidistrict Litigation ("MDL")**

In the past few years, high profile physician class action lawsuits against many of the nation's major managed care organizations have attempted to address many of these payment practices. This multidistrict litigation ("MDL") alleged that these health plans employed improper reimbursement and other business practices designed to delay and deny payments to physicians. The alleged unfair business practices included bundling and downcoding of CPT codes, failure to recognize CPT modifiers, lack of full disclosure of fee schedule information, and breach of state prompt pay laws. In short, the same problems that I am here today to ask you to address.

In 2003, Aetna, Inc. and CIGNA Healthcare agreed to settlements with a national class of physicians. Recently, Health Net, Inc. and Prudential Insurance Company of America entered into a settlement as well. Pursuant to the settlements, these companies agreed to change their business practices to more fairly deal with physicians in a number of areas, including disclosure of fee schedules and related payment policies and methodologies to physicians in advance or upon request. In addition, the settlements include standards for complying with CPT codes,

guidelines and conventions. Where divergences from these standards are permitted, they must be shared with the physician.

The settlements also include prompt pay standards, which apply unless a stronger state standard exists. These settlements are significant because these payers have agreed to alter their policies to address many of the problems that I am discussing today. Moreover, these settlements clearly demonstrate the ability of private payers to comply with these requirements regarding transparency in their relationships with physicians, without impairing their ability to make a profit.

We at the AMA are very mindful that these settlements are of a limited duration. We believe that it is critical that the agreements contained in these settlements not only become permanent, but also apply to all health plan payers and intermediaries. To ensure this, we need individual state legislators and state insurance commissioners to exercise their leadership in regulating insurance to seek broader application of these settlement standards to all health plan payers and contracting intermediaries.

### **III. The Need for State Action in Addressing Unfair Business Practices**

Now that we have outlined what the AMA believes to be the problem with respect to these unfair business practices, we want to discuss some of the solutions.

The AMA believes it is imperative that states move to address, through legislation, regulation and oversight, the systematic efforts of health plan payers to utilize insidious practices to minimize reimbursement to physicians. The NCOIL has a distinguished record of developing strong policy and model state legislative standards for health insurance. We believe that this organization would contribute significantly to improving the transactional aspects of this market that are not functioning properly. We ask the NCOIL to develop standards that require transparency and equity in interactions between health plan payers and physicians. In addition, we call upon individual state legislators to play a more aggressive role in addressing these issues in the states.

The AMA and the nation's state medical associations have a strong record of leadership in advocacy in the states on issues involving fair business practices in the health care industry. In fact, we were primary proponents of state "patient protection" legislation, which resulted in nearly every state legislature enacting laws that provide patients with better information, clarified and strengthened their ability to appeal adverse determinations, and gave them more choices.

Late pay is another practice that organized medicine's advocacy has catalyzed states to address decisively. We appreciate the leadership demonstrated by the nation's legislatures and insurance commissioners in that effort. This enforcement has resulted in over \$54 million of fines levied against health plans that have violated individual states' laws. State medical associations, working closely with the AMA, advanced the case for prompt pay standards with data regarding the extent of the problem, facilitated in many cases by physician surveys. Now, nearly every state has enacted some form of prompt pay law. Our experience with that tenacious problem is that health plan payers are finding ways to circumvent state laws through aggressive use of "retrospective audits," which result in unfair returns of payments already processed and approved by the health plan payer *and* "pending claims," which work to delay payment and place claims in limbo. We ask that individual state legislators, with NCOIL's guidance go back to

their individual states and tighten their respective prompt payment statutes by (1) preventing continued delays in payments by defining and distinguishing between denied and “pending” claims and (2) restricting “retrospective audits” and reviews, as well as other forms of look-backs and take-backs, preventing their use to circumvent existing state prompt payment laws.

We believe that similar focus needs to be placed on other payment practices. Again, we turn to you for leadership and direction. We will support your efforts in any way possible.

A major hurdle to our advocacy efforts on these issues is the perception that physicians do not need protection on so called “pocketbook” issues. However, it is important for state policymakers like yourselves to recognize that physicians, as small business owners, are facing unprecedented costs of professional liability insurance and the threat of substantial reimbursement cuts from the public sector, as well as dramatically increasing technology costs. Physician offices are important employers in your states. Access to health care services in many areas is at risk, as physicians are squeezed from increasing practice costs and lower public and private reimbursement.

Another hurdle is that federal Employee Retirement Income Security Act (“ERISA”) law is viewed by a majority of state regulators as tying their hands with respect to regulation of self-insured ERISA plans. The AMA has closely tracked court rulings on preemption issues. We believe that these rulings have clarified that states have greater authority to regulate the activities of entities that contract with self-insured ERISA plans through the insurance regulation exception to ERISA preemption.

### **Solutions:**

#### *1. Develop Model Requirements Promoting Payment Transparency*

To address the industry’s “black box” reimbursement policies, we ask that the NCOIL develop model standards that require health plan payers and any other intermediary organizations involved in the claims paying process (all referred to as “entities” in this section) to disclose fee schedule information and payment policies, including any coding methodologies used in reimbursement process. These standards would promote transparency by including the following:

- Entities must disclose fee schedule information to the physician *prior to* contract execution and/or renewal.
- Entities must disclose any software used for reimbursement determination purposes and related information.
- Entities must notify the physician in advance of any modifications to any claims processing information referenced in the provider contract, including information not attached to the contract itself.
- Physicians must have the right to request certain claims payment information in addition to fee schedules, e.g. payment methodologies and coding and bundling rules or processes.
- Physicians must have the right to terminate the contract with the entity after the receipt of any claims payment information.
- Coding methodologies must adhere to AMA CPT codes, guidelines and conventions.

- Medically indicated patient services, such as consultations and diagnostic procedures provide by physicians on the same day, must be paid on a separate basis in conformity with CPT codes, guidelines and conventions. Entities cannot be allowed to inappropriately downcode, bundle and/or reassign these physician services and procedures.
- Retrospective audits – Entities cannot be allowed to retrospectively audit or recover payment of claims after 180 days have lapsed from the date of submission by the physician. Once these 180 days have lapsed, payments must be deemed final.
- Entities cannot include language in provider contracts that waives these requirements.

In the area of disclosure of fee schedule information, as well as code editing information, do not be convinced by arguments that disclosure equates to rate setting. Plain and simple, most physicians cannot sustain viable medical practices without information on how and how much they will be paid.

## 2. *Develop “Fair Contracting” Model State Legislation and/or Regulations*

In recent years, a few states have enacted fair contracting legislation. By developing model fair contracting legislation, the NCOIL would help advance and guide efforts by other states that seek to address these issues. Again, in this section, we define “entities” as health plan payers and any other intermediary organizations involved in the claims paying process.

We believe that this legislation should provide the following standards:

- Entities *and* physicians must agree to any contract amendments.
- Provider contracts must include notice and equity provisions regarding contract termination.
- Entities must disclose contract, policy, and reimbursement information to the physician *prior to* contract execution and/or renewal.
- Entities cannot reserve the right to retain absolute discretion in contractual matters.
- Physicians must have the right to a private cause of action, including a claim for actual damages, attorney’s fees and costs.
- Entities cannot include language in provider contracts that waives these requirements.

The AMA has a model managed care contract that expands upon these requirements. The most current version of this contract is available on the AMA website ([www.ama-assn.org](http://www.ama-assn.org)) or upon request.

## 3. *Develop Model Standards to Regulate the Secondary Discount Market*

The AMA asks that the NCOIL move to shine a light on this covert and unscrupulous business conduct. This insidious practice is perhaps the most difficult for individual physicians to combat. Several states have passed legislation in this area. For example, the AMA commends the work of the California legislature as it continues to grapple with its existing law that addresses these practices.

We would like NCOIL to join us in addressing the seriousness of this unregulated activity by developing model state legislation or regulation that would send a signal that it opposes this practice. We believe that this legislation or regulation should require the following:

- Physicians must be allowed to affirmatively opt in and out of any agreement to buy or lease the provider panel and associated discounts.
- A contract between a rental network PPO or similar entity and a physician must contain the following provisions and assurances:
  - All material terms of the contract are consistent with a state's applicable law, including but not limited to a state's prompt payment and claims processing statutes;
  - All payers to which it has sold or leased its provider panel and associated discounts will (1) comply with the underlying contract between the rental network PPO and the physician and (2) pay the provider pursuant to the rates and methodologies of payment set forth in the underlying contract; and
  - Any payer to which a panel has been sold or leased will not sell or lease the panel to any other payer.
- Where a rental network PPO sells or leases its panel to another entity and that entity violates the terms of the underlying contract, the burden is on the rental network PPO to either take reasonable action to ensure compliance with the underlying contract or to assume direct responsibility for payment of the submitted claim.
- A rental network PPO cannot sell or lease its provider panel (and associated discount) to an entity that is not a payer.
- A rental network PPO's contract with a physician must include a copy of its fee schedule.
- Once a provider terminates a provider contract, the rental network PPO, as well as any other entities it has sold or leased its panel to, must cease to apply the discounted rate agreed to in the underlying contract.
- Payers must clearly identify on an EOB, remittance advice, etc., the entity assuming financial risk for services and the identity of the rental network PPO through which the discounted rate is claimed.
- Rental network PPOs and similar entities cannot include language in provider contracts that waives these requirements.

#### **IV. Conclusion**

You will undoubtedly hear significant opposition to the concerns we have laid out before you today from the numerous health insurance lobbyists who participate in your meetings. We do not ask that the NCOIL require health plan payers to disclose truly "proprietary" information to physicians. Rather, we ask that the NCOIL use its unique role to establish fair standards for states to adopt in the area of provider contracting and transparency of health care interactions, claims, processing and payment. Use the momentum started by the MDL settlements to address these unfair business practices. You will strengthen our health care system by doing so.

To conclude, we hope that this will be just the beginning of a continuing dialogue with you, the nation's state legislators, on these important issues. Thank you.