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THE FINAL REPORT OF THE SENATE STUDY COMMITTEE ON THE CONSUMER AND PROVIDER PROTECTION ACT

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District 54

Senator Burt Jones
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Prepared by the Senate Research Office
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COMMITTEE FOCUS, CREATION, AND DUTIES

The Senate Study Committee on the Consumer and Provider Protection Act was created by Senate Resolution 561 to examine the issues being addressed by Senate Bill 158. The Committee was specifically charged with studying the following:

1. Current practices and necessity for the regulation of rental networks;
2. Current practices and necessity of all-products clauses;
3. Incidence and prevalence of unilateral revisions in contracts with healthcare providers; and
4. Incidence and prevalence of incorrect data related to network adequacy.

Senator Dean Burke of the 11th served as the Committee Chair. The other legislative members included: Senator Charlie Bethel of the 54th; Senator Burt Jones of the 25th; and Senator Renee Unterman of the 45th. The Lieutenant Governor's six citizen appointees included: Mr. John Crew of Strategic Healthcare Partners; Mr. Richard Novack of Cigna; Dr. Manoj Shah, MD; Dr. Richard Smith, DDS; Ms. Angela Waller, RDH; and Ms. Cindy Zeldin of Georgians for a Healthy Future.

The Committee held four meetings: Three at the State Capitol on September 14, 2015; November 9, 2015; and December 14, 2015; and one meeting at Tifton Regional Medical Center in Tifton, Georgia on October 26, 2015.

The Committee heard testimony from the following: Mr. Marcus Downs, Director of Government Relations for the Medical Association of Georgia (MAG); Mr. Trey Sivley, Director of the Division of Insurance and Financial Oversight for the Office of Insurance and Safety Fire Commissioner; Mr. Graham Thompson, Executive Director for the Georgia Association of Health Plans (GAHP); Ms. Fatimot Ladipo, Director of Government Affairs for the Georgia Dental Association (GDA); Ms. Melana McClatchey, General Counsel for GDA; Dr. Doug Torbush, DDS, on behalf of GDA; Dr. Jim Barber, MD, on behalf of MAG; Ms. Susan Garrett, Director of Contracting for Central Georgia Health Network (CGHN); Ms. Michelle Albers, Vice President of Contracting for IMPACT, Inc.; Dr. Edward J. Green, DMD, on behalf of GDA; Mr. Allan Hayes, representing America's Health Insurance Plans (AHIP); Mr. Tom Carswell, Assistant Division Director of the Division of Insurance Product Review for the Office of Insurance and Safety Fire Commissioner; Dr. Deep J. Shah, MD, MSc, on behalf of the Georgia Chapter of the American College of Physicians (ACP); Dr. Chris Wixon, MD, on behalf of MAG; Dr. Steve Walsh, MD, on behalf of MAG; Ms. Claire McAndrew, Private Insurance Program Director for Families USA; and Meredith Gonsahn, Health Policy Analyst for Georgians for a Healthy Future.

COMMITTEE FINDINGS

Background – Consumer and Provider Protection Act

During the 2015 Legislative Session, Senator Dean Burke introduced Senate Bill 158, also known as the Consumer and Provider Protection Act, to address issues in Georgia's current healthcare provider network environment. Senate Bill 158 is a comprehensive effort to:

- Regulate "rental networks";
- Restrict unilateral changes to network contracts with healthcare providers during a contract's first year or before its renewal date;
- Prohibit "All Products Clauses"; and
- Ensure network adequacy throughout Georgia.

To achieve these ends, the Consumer and Provider Protection Act contains four Acts within itself:

- The Insurer Transparency Act;
- The Provider's Right to Choose Act;
- The Provider Stability Act; and
- The Consumer Right to Access Act.

Rental Networks and the Insurer Transparency Act

Traditionally, under a managed care plan, an intermediary (plan) forms a network of healthcare providers and connects the healthcare providers to third party payers such as insurance companies, employers, and third party administrators (payers). The providers offer their services to the plan at a discounted rate because they expect payers to steer patients to them, resulting in an increase in patient volume. The healthcare providers that are on the plan's panel of providers are "in-network," and because of the negotiated discounts, patients who go to them for services pay less than they pay for similar services offered by healthcare providers who are not on the plan's panel, or "out-of-network."

This arrangement is undermined if, for example, a PPO fails to market the provider's services as "in-network," or if the PPO makes the discounts available to payers that are not part of the provider's marketing plan – that is, the PPO "rents out" the provider's discount without the provider's knowledge or consent. The latter is known as a "rental network" and sometimes referred to as a "Silent PPO." When this happens, providers find themselves providing services to individuals for which they expect to receive a certain reimbursement amount, only to find out at the time of payment that the individual's payer has accessed a discount without notifying the provider.

In essence, under a rental network, a PPO with which a physician contracts to be on a PPO panel makes the discounts the physician negotiated with that PPO available to other payers and without the physician's consent. However, occasionally a physician unwittingly agrees to make the negotiated discounts available to other payers in a PPO's rental network because the physician fails to thoroughly read or understand the contract proposed by the PPO.

Currently, Arkansas, California, Colorado, Connecticut, Florida, Indiana, Kentucky, Louisiana, Maryland, North Carolina, Ohio, Oklahoma, South Carolina, Texas, Virginia, and the Federal Employee Health Plan limit, prohibit, or otherwise closely regulate the practice of renting out provider networks.[1] Georgia's Insurance Commissioner, however, possesses no direct oversight over rental networks.[2]

Mr. Marcus Downs of MAG testified that his organization is not seeking to outlaw rental networks, but rather that rental networks should be regulated more closely. Specifically, MAG is seeking the following:

1. Disclosure of rental networks;
2. Notify physicians when a network has been sold/purchased;
3. Honor the existing contract with the physician;
4. Require rental networks to register with the Commissioner of Insurance; and
5. Allow the Commissioner to revoke any non-registered or unapproved networks.[3]

To be fair, nothing in current law prohibits a physician from declining a contract that includes a rental network. However, a physician tries to avoid this because it interrupts patient care and ultimately causes the greatest harm for those in need of care. MAG contends that this underscores the challenge of rental network agreements.[4]

Although Mr. Graham Thompson, representing GAHP, acknowledged that more transparency and disclosure are necessary when the provisions of a contract are altered, he indicated that a handful of bad players are responsible for the negative experiences encountered by providers and consumers.[5] Dr. Doug Torbush, DDS, testifying on behalf of GDA, acknowledged firsthand experience with rental networks. Dr. Torbush testified that he will no longer participate in rental networks after encountering negative experiences with Sun Life Financial, which had been rented out to United Concordia, involving unknown reimbursement rates and poor customer service.[6]

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[1] Testimony presented by Mr. Marcus Downs, Director of Government Relations for MAG; September 14, 2015.
[2] Testimony presented by Mr. Trey Sivley, Director of the Division of Insurance and Financial Oversight for the Office of Insurance and Safety Fire Commissioner; September 14, 2015.
[3] Testimony presented by Mr. Marcus Downs, Director of Government Relations for MAG; September 14, 2015.
[4] Ibid.
[5] Testimony presented by Mr. Graham Thompson, Executive Director for the Georgia Association of Health Plans (GAHP); September 14, 2015. Although Mr. Thompson identified Beach Street and MultiPlan as rental networks, he did not specifically identify them as bad players.
[6] Testimony presented by Dr. Doug Torbush, DDS, on behalf of GDA; September 14, 2015.

Senate Bill 158's Insurer Transparency Act attempts to bring more clarity and transparency to rental networks by defining them and requiring them to register with the Insurance Commissioner within 30 days of commencing business in Georgia, unless the entity is already licensed by the Commissioner as a health insurer.[7]

The Commissioner is authorized to revoke the registration of a rental network if it is discovered that the network provider has:

- Knowingly accessed or utilized a medical provider's contractual discount without a contractual relationship; or
- Leased, rented, or otherwise granted to a third party access to a provider network contract, unless that third party accessing is:
    - A payer or third-party administrator;
    - A preferred provider organization or preferred provider network; or
    - An entity engaged in electronic claims.

Amending Provider Contracts and the Provider Stability Act

Under current law, insurers in Georgia are permitted to modify the terms of their contracts with medical providers – including reimbursements – in the middle of a contract without the provider's consent. These unilateral changes often result in a physician receiving less money for the same services, while undermining standard contract law where changes to contracts are forbidden without the mutual consent of both parties. It was noted that when modifying the terms of the provider agreement, many insurers will avoid undermining contract law by leaving the contract itself untouched, and instead modifying the policy and procedure manual.[8] Beyond the financial impact on providers, changing the terms of an agreement prior to its expiration date: makes it difficult for the provider to determine a patient's network status; negatively impacts the patient through higher out-of-pocket costs; and impacts the provider's relationship with the patient who may believe that the provider is purposely overcharging out-of-network fees when in fact, it is discovered later that the patient is indeed in-network.[9]

To address this issue, Senate Bill 158 requires health insurers to honor the terms of their contracts with physicians for the full duration of the agreement. Specifically, it prohibits a health insurer from effecting a unilateral material change to a contract without the express agreement of the provider during either the first year of the contract or the initial term of the contract, whichever is longer.[10] After that period, the health insurer may only execute a unilateral material change with the express agreement of the provider on the stipulated renewal date of the contract or the anniversary of the effective date of the contract, whichever is longer. A violation of this provision will result in a civil penalty from $500 to $2,000. Currently, this provision has yet to be adopted by any State Legislature.[11]

All-Product Clauses and the Provider's Right to Choose Act

Health plans sometimes invoke what is known as an "all-product clause" that essentially forces physicians contracted in a particular payer plan to participate in all of the plans offered by that payer in the state and surrounding areas, including those offered through the exchanges. They are sometimes invoked in Georgia and other states because some plans are having difficulty getting enough physicians to voluntarily sign up for the plans, putting them at risk of not meeting adequate network thresholds. The Affordable Care Act (ACA) requires that Medicaid and exchange plans provide "adequate networks" that meet the needs of the plan holders. An all-products clause can be troublesome to providers because contracts generally require the provider to participate in all current and future networks/products. Often, these contracts are in excess of 25 pages and written in a way that even a doctor has difficulty understanding. In these instances, physicians are being forced to agree to terms and rates which they have not seen.[12] The Committee is unaware of any other business model that requires a party to accept an all-products-like clause for the present and future, while also having to accept the terms of a contract that can be unilaterally changed in the future.

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[7] The legislation uses the term "Rental preferred provider network," which means a preferred provider network that contracts with a health insurer or other payor or with another preferred provider network to grant access to the terms and conditions of its contract with medical physicians. Such contracts are often referred to as "renting" or "leasing" the network.

[8] This was pointed out twice by Dr. Jim Barber, MD, on behalf of MAG; and Ms. Susan Garrett, Director of Contracting for Central Georgia Health Network (CGHN); October 26, 2015.

[9] Testimony presented by Ms. Michelle Albers, Vice President of Contracting for IMPACT, Inc.; and Dr. Edward J. Green, DMD, on behalf of GDA; October 26, 2015.

[10] Although he conceded that it is an arbitrary figure chosen by MAG, Mr. Downs explained that a "material change" is considered a decrease in fees or payment in excess of 7 percent.

[11] Testimony presented by Mr. Graham Thompson, Executive Director for GAHP; October 26, 2015.

[12] Testimony presented by Dr. Jim Barber, MD, on behalf of MAG; October 26, 2015.

Dr. Edward Green, an Albany dentist, testified on behalf of GDA about an existing contract he has with an insurance company in Georgia. Because of his geographic location, he treated patients who reside in Alabama and billed those patients for out-of-network services since he had not signed any Alabama contract. He was later informed that an all-products clause contained in his contract with the Georgia network required him to accept patients of the insurer's Alabama affiliate as in-network. He and his staff were then required to spend many hours making corrections to the bills and mending the relationship with those who felt that he purposely and unscrupulously overcharged them. Dr. Green further testified that if all-products clauses were prohibited, providers would no longer be surprised with the almost infinite list of insurance plans carefully hidden in the lines of insurance contracts that they are contractually obligated to accept and treat as in-network.[13]

Mr. Graham Thompson testified that none of GAHP members use all-products clauses in their provider contracts, while arguing that prohibiting all-products clauses would allow providers to cherry-pick higher profit plans.[14] However, Mr. Trey Sivley testified that while insurance companies may not explicitly refer to them as "all-products clauses," they are able to accomplish the same result by different means and wording.[15]

Senate Bill 158 prohibits all-product clauses under the "Provider's Right to Choose Act." Specifically, it prohibits health insurers from requiring a provider to provide services under all health plans offered or sponsored by, or affiliated with, the insurer, or to participate in all of its provider network arrangements. In addition, a health insurer may not terminate any contractual relationship with a provider on the grounds that the provider did not agree to participate in a provider network arrangement.

Network Adequacy, Network Accuracy, and the Consumer Right to Access Act

Network adequacy refers to a health plan's ability to deliver the benefits promised by providing reasonable access to a sufficient number of in-network primary care and specialty physicians, as well as other healthcare services included under the terms of the contract. Insurers generally have the ability to define and adjust the number, the qualifications, and the quality of providers in their networks. Insurers may also limit the number of providers in their networks as a means of lowering costs or coordinating care, which often narrows their provider networks to an extent that consumers may have limited options when choosing providers, or may not have access to necessary specialists at all.

Georgia currently reviews managed care plan networks for adequacy (i.e., reasonable access), including HMOs, PPOs, POSs, and all other managed care products, under Code Section 33-20A-5. A managed care entity must demonstrate that its plan:

1. Makes benefits available and accessible to each enrollee electing the managed care plan in the defined service area with reasonable promptness and in a manner that promotes continuity in the provision of healthcare services, including continuity in the provision of healthcare services after termination of a physician's contract;
2. When medically necessary, provides healthcare services 24 hours a day and seven days a week;
3. Provides payment or reimbursement for emergency services and out-of-area services; and
4. Complies with the provisions of Code Section 33-20A-9.1 relating to nomination and reimbursement of out-of-network healthcare providers and hospitals.

A managed care plan must also have arrangements, established in accordance with regulations of the Commissioner, for an ongoing quality assurance program for healthcare services it provides to such individuals that provide for a utilization review program which, in addition to the requirements of Chapter 46 of Title 33:

1. Stresses health outcomes;
2. Provides for the establishment of written protocols for utilization review, based on current standards of the relevant healthcare profession;
3. Provides review by physicians and appropriate healthcare providers of the process followed in the provision of such healthcare services;
4. Monitors and evaluates high-volume and high-risk services and the care of acute and chronic conditions;
5. Evaluates the continuity and coordination of care that enrollees receive; and
6. Has a mechanism to detect both underutilization and overutilization of services.

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[13] Testimony presented by Dr. Edward J. Green, DMD, on behalf of GDA; October 26, 2015.

[14] Testimony presented by Mr. Graham Thompson, Executive Director for GAHP; October 26, 2015. The six GAHP members are Aetna; BlueCross BlueShield of Georgia; Cigna; Humana; Kaiser Permanente; and UnitedHealthcare.

[15] Testimony presented by Dr. Edward J. Green, DMD, on behalf of GDA; October 26, 2015.

The benchmark for network adequacy is the current National Association of Insurance Commissioners' (NAIC) Model Act, which requires that a network maintain "sufficient in number and types of providers to assure that all services will be accessible without unreasonable delay."[16] Likewise, the current definition in Georgia is similar: "A network that is sufficient in numbers and types of providers to assure that all required services will be accessible without unreasonable delay."[17]

The NAIC Model Act was recently revised and adopted by NAIC at the end of 2015. The benchmark for network adequacy in the revised model has been updated and is now defined as a network that is:

> "Sufficient in numbers and appropriate types of providers, including those that serve predominately low-income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults, will be accessible without unreasonable travel or delay."[18]

Working hand-in-hand with network adequacy is the concept of network accuracy, which refers to the correctness of network directories that provide consumers with a list of in-network physicians. For consumers, accurate provider directories are critical when shopping for coverage, so that consumers can make comparisons among different health plan options and find the plan that best meets their health needs and will protect them from unnecessarily high out-of-pocket costs for care.[19] If directory information is inaccurate, consumers might buy a plan that actually does not provide access to the types of providers, services, and facilities they need. Accurate directories are also important for consumers once they already have insurance since enrollees need accurate information about which providers, hospitals, and other facilities are in their network when they do need care.[20] Moreover, accurate directories are important for regulators when ensuring that health plans have enough of, and the right variety of, providers and facilities in-network to meet consumers' needs and fulfill the contracts that insurers have with consumers to deliver covered benefits. Inaccuracies can mask network adequacy problems resulting in regulators mistakenly approving inadequate networks.

Potential Drawbacks to the Current Network Adequacy Standards

Current network adequacy standards put a premium on the number of providers in a plan's network, but they rarely address whether those in-network providers are high quality or offer expanded access. The Committee learned, however, that there is no universal definition for "quality" and that the term can vary from insurer to insurer.[21] Network adequacy standards also do not define quantitative time and distance standards, or standards for how long consumers should have to wait to get an appointment with primary care and specialty providers. For example, in the state of Washington, consumers are guaranteed appointments with primary care providers within 10 business days and with specialists within 15 business days for non-urgent services. New Jersey requires that people should be able to get mental health and substance use care within 20 miles or 30 minutes average driving time. The federal government also outlines these types of standards for Medicare Advantage.[22]

In addition, standards usually do not address whether contracted providers are taking new patients, which can create barriers to access for consumers seeking care. Exchanges have an opportunity to confront this problem. Under the ACA, Qualified Health Plan (QHP) Issuers are required to submit a copy of their provider directory to the Exchanges, and to potential enrollees in hard copy upon request, and the directory must identify whether those providers are taking new patients.

Consumer Right to Access Act

In an effort to safeguard network adequacy and ensure accurate provider directories, Senate Bill 158's Consumer Right to Access Act requires each health insurer to:

1. Maintain a network that is sufficient in numbers and types of providers to ensure that all services will be accessible without unreasonable delay. Emergency services must be available 24 hours per day;
2. Report annually to the Commissioner the number of enrollees and the number of participating in-network healthcare providers; and

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[16] http://www.naic.org/documents/committees_b_rftf_namr_sg_exposure_revised_draft_proposed_revisions_mcpna_model_act.pdf
[17] Georgia GID-PPA-1
[18] http://www.naic.org/store/free/MDL-74.pdf
[19] Testimony presented by Ms. Claire McAndrew, Private Insurance Program Director for Families USA; November 9, 2015.
[20] Testimony presented by Dr. Chris Wixon, MD, on behalf of MAG; November 9, 2015.
[21] Testimony presented by Mr. Allan Hayes, representing America's Health Insurance Plans (AHIP); November 9, 2015.
[22] Testimony presented by Ms. Claire McAndrew, Private Insurance Program Director for Families USA; November 9, 2015.

3. Maintain a network directory on a website, mobile app, or other electronic means, through which a provider or enrollee may obtain a listing of all participating providers within each network.

The Insurance Commissioner is required to assess the provider network adequacy of each health insurer and the assessment is to be done annually at the time of license renewal or at the time of initial licensure. In assessing provider network adequacy, the Commissioner must consider, but is not limited to:

1. Provider-covered person ratios by specialty;
2. Primary care provider-covered person ratios;
3. Geographic accessibility;
4. Geographic population dispersion;
5. Waiting times for visits with participating providers;
6. Hours of operation;
7. The volume of technological and specialty services available; and
8. The availability and accessibility of appropriate and timely care provided to disabled enrollees in accordance with the Americans with Disabilities Act.

If the Commissioner determines that a plan is unsatisfactory, the Commissioner must set forth the reasons for the determination and may set forth proposed revisions which will render the plan satisfactory. The insurer must then prepare a revised plan within 45 days. If the revised plan is rejected, the insurer will have the right to request a hearing within 45 days.

Finally, health insurers are prohibited from excluding any appropriately licensed type of healthcare provider as a class from their provider networks and each provider network must be adequate to meet the comprehensive needs of the enrollees.

RECOMMENDATIONS

Rental Networks
A consensus has been reached by the Committee that more complete definition of rental or "shadow" networks is needed in the Georgia Code. There is a consensus that there may be an opportunity to delegate to, and further define, the powers of the Georgia Department of Insurance in promulgating further regulation and authority to improve transparency for both consumers and providers in this area.

Provider contracting
Much testimony was heard on the issue of an imbalance in the contracting process with small providers. (solo or small groups) The financial stability of many providers is placing many small practices/providers in jeopardy is also of grave concern.

It is apparent, however, that there is significant disagreement between the health insurance industry and the healthcare provider community on the definition of "all products clauses" and required affiliation agreements in provider contracting.

There is also disagreement on the extent to what constitutes "material" contract changes. The amount, type, and timing of notification of changes to contract/reimbursement terms and the possible significant financial implications to the provider are also persisting issues.

There is also disagreement on whether the use of provider manual changes that may have a significant impact on the substance of a provider contract that may alter the "spirit" of the initial agreement in financially significant ways between contract initiation and expiration should result in further regulation.

The Committee consensus is that further dialog between all parties, keeping the citizens of Georgia's health and financial well-being as the focus of the discussion, is warranted. The financial stability of the provider network, especially in rural areas, should also be considered. Continued monitoring of what is being done in other states to deal with this area of contention is also recommended.

Mechanisms, whether regulatory or legislative, to improve the financial stability of the provider network in the State of Georgia should be investigated. The risks of substantial loss of providers and subsequent access due to financial pressures cannot be overstated. This effort should also be balanced as to the ability of the insurance industry to provide insurance products that are fiscally acceptable to an individual companies' own need for financial stability as well as the public's need for affordable, easily accessible products with as much choice in coverage options as possible. The complexity of federal regulations, including those surrounding the Affordable Care Act, also cannot be understated.

Health Provider Network Adequacy
The Georgia consumer's need for healthcare provider network adequacy, network transparency, and adequate and up to date network directories was clearly shown during testimony. The Committee recommends a careful review of model legislation recently promulgated by the National Association of Insurance Commissioners concerning these issues. This review should determine whether legislation, further regulation, and or additional appropriations for the Georgia Department of Insurance is needed to protect or provide an appropriate level of access to healthcare of the citizens of the State of Georgia. This review should involve the input of all stakeholders in the process, including consumer advocates, the insurance/payer industry, provider industry, the Georgia Department of Insurance, other State of Georgia health related departments/divisions and the Georgia State Legislature.

Respectfully Submitted,

THE SENATE STUDY COMMITTEE ON THE CONSUMER AND PROVIDER PROTECTION ACT

Senator Dean Burke – Chair
District 11