

**OFFICE OF THE HEALTH INSURANCE COMMISSIONER**  
**PROFESSIONAL PROVIDER HEALTH PLAN WORKGROUP**  
**Occasional Contract renegotiations and Impact of Silent PPOs**  
**June 2008**

**Statutory expectations §42-14.5-3**

“To establish and provide guidance and assistance to a subcommittee (“The Professional Provider-Health Plan Work Group”) of the advisory council created pursuant to subsection (c) above, composed of health care providers and Rhode Island licensed Health Plans. This subcommittee shall develop a plan to implement the following activities:

(vii) By December 1, 2007, a report to the legislature on the temporary credentialing of providers seeking to participate in the plan's network and the impact of said activity on health plan accreditation;

**(viii) By February 1, 2008, a report to the legislature on the feasibility of occasional contract renegotiations between plans and the providers in their networks.**

**(ix) By May 1, 2008, a report to the legislature reviewing impact of silent PPOs on physician practices.**

**Overview**

The Professional Provider Health Plan Workgroup is comprised of professional provider representatives, billing agents, physician group leaders and the three major Rhode Island Health Plans: UnitedHealthcare of New England, Blue Cross and Blue Shield of Rhode Island and Neighborhood Health Plan of Rhode Island. The members for this initiative are: Steve DeToy- Rhode Island Medical Society; Christopher Dooley- Women & Infants PHO; Lorraine Roberts- Lighthouse MD; Paul Carey-RI Urological Specialties; Joel Kaufman M.D.- Lifespan/Physicians PSO; Charlene Denton-Lifespan PSO. Health Plan representatives are Robert Cambio- BCBS; Beverly Jane Perry- UnitedHealthcare of New England; Maureen Brousseau- Neighborhood Health Plan of Rhode Island.

The Workgroup met in April 2008 to discuss the final two items identified in the statute; the ability of providers to renegotiate and the impact of silent PPOs on physician practices in Rhode Island.

**Discussion-Contract renegotiations**

The Workgroup discussed the current managed care contract negotiation process and the general dissatisfaction the provider community has with the ability to negotiate with health plans. Providers, especially individual practitioners, believe they do not have the “leverage” that the larger provider groups have when dealing with the local payers.

Providers do not like being in what they feel is a “take it or leave it” contracting position. The provider’s concerns regarding their contracts go beyond their inability to negotiate fees. The physicians want to discuss in advance the plans’ administrative changes like increased utilization review requirements, specialty pharmacy rules and high deductible plans. These administrative changes have significant impact on provider’s offices that they believe is overlooked by the plans.

The health plans explained that they have to have some uniformity in the network for ease of administration and that these operational changes need to be uniform. BJ Perry and Bob Cambio representing the plans indicated that their provider contracts do allow providers to express their desire to re-negotiate the provider contract at any time. The contracts also allow for the plans to make administrative changes with notice.

The ability of providers to negotiate with health plans has been a topic that this office recently addressed as part of the mandated Special Legislative Commission to develop recommendations for strengthening the role of the state's primary care physicians. This Commission also considered enacting legislation to empower primary care providers to jointly negotiate with health insurers. The OHIC chaired this special commission last fall and delivered its findings to the legislature earlier this year. This Workgroup discussed the Commission’s report.

## **Conclusions and Findings**

The Workgroup understands that despite the provider’s frustrations, individual contract rate negotiations are up to the discretion of the health plans. Additionally, they understand that antitrust laws prohibit the ability of providers to join together to negotiate with health plans.

However, the Workgroup concurred with the recommendation of the Special Commission that it may be appropriate to have more input from the provider community prior to implementation of material contract modifications or significant administrative changes to the network. Ideally, the physician community wants meaningful bilateral dialogue with the health plans prior to implementation of any material contract change.

The Workgroup concurred with the recommendation that the Office of the Health Insurance Commissioner or the Department of Health Office of Managed Care Regulation establish more specific regulations with which to measure the impact of proposed contract modifications prior to implementation. These regulations would include guidelines to monitor the impact of the modification on patient safety, the administrative burden to the practice and impact of change on health care system as a whole.

## **Discussion – Silent PPOs**

The Workgroup also addressed the impact of Silent PPOs on the physician's practices. Physicians agree to participate in a health plan's network and accept that health plan's members at the fees in their contracts. In silent PPO arrangements, access to these contracted rates are "rented" or "leased" to payers who are not party to the original contract. This is very confusing to the physician's office as they often do not know that these contracted rates are being applied until after the claim has been processed and it is indicated on the explanation of benefits. There is often no indication on the patient's ID card that they are members of the network.

Ideally providers need to know to whom these contracted rates apply in advance. They need more clear communication from the contracted plans if they are marketing their networks to others. The providers often are put in a position of agreeing to payment policies of these contracted entities and of which they have no prior knowledge.

## **Conclusions and Findings**

Silent PPOs are problematic to the provider community. These arrangements are an administrative burden the provider's offices. The patients are not properly identified at the time of service. The explanation of benefits indicates that the discount has been taken. The payment and utilization rules vary and the provider has no direct contract with this entity and has little or no recourse.

It was stated that the health plan networks selling their contracted provider rates are primarily located outside the state of Rhode Island. Some of the companies that sell or rent their networks have contracted discounted fee for service arrangements with the providers and the providers generally find this reimbursement acceptable.

Steve Deto of the Rhode Island Medical Society will look into statutes passed in other states on this issue and will evaluate introducing legislation in Rhode Island as appropriate.