Uniform Plan-Provider Contracts: A Proposal to Reduce Expenses of Health Plans, Health Care Providers and the Public

By Robert N. Swidler

States, including New York, could significantly cut expenses by health plans, health care providers and the public by developing uniform plan-provider contracts without rate sheets, and requiring the use of those contracts by health plans and health care providers. Plans and providers would still negotiate reimbursement methodologies and rates, but all or most other terms would be prescribed. For some contractual matters the uniform plan-provider contracts could offer alternative terms, but with prescribed language for those alternatives. Parties could also add non-conflicting terms.

This approach would:

(i) dramatically reduce the currently significant expenditures by plans and providers in the review, negotiation and implementation of plan-provider contracts;

(ii) in New York, reduce the significant amount of NYS Department of Health (NYSDOH) staff resources devoted to reviewing such agreements,

(iii) reduce or eliminate unclear provisions, unfair provisions and non-compliant provisions that find their way into these contracts; and

(iv) make it possible for provider clinical and administrative staff to actually learn and follow requirements in plan-provider contracts, something they now cannot do when they are confronted with conflicting terms of many contracts,

(v) reduce interpretive disputes, through the development of interpretive precedents; and

(vi) help plans meet their medical loss ratio requirements under the federal health care reform law.

The potential benefit for the public is very significant. Uniform plan-provider contracts would offer a rare way to achieve significant health care savings with no diminution of quality of care or access to care. The proposal targets activity that is expensive and pervasive, yet adds little benefit for the public or the parties.

Plan-Provider Contracts

A contract between a health plan ("plan") and a health care provider ("provider") memorializes a simple bargain: the provider agrees to provide covered health care services to members of the plan, and the plan agrees to pay the provider for those services at an agreed-upon rate. Plan-provider contracts generally include two distinct parts: (i) contract terms other than rates of payment, which form the main body of the contract; and (ii) rates of payment, which usually are set forth in an appendix, sometimes called the "rate sheet."

The part of plan-provider contracts that sets forth terms other than rates of payment tends to address these topics, among others:

1. ***Definitions***—This section sets forth the definitions of key terms, including "covered service," "emergency" and "medically necessary."
2. ***Provider representations and obligations***—This usually states the provider's obligation to provide care (within provider's license) to plan members, as well as the obligation to comply with the plan's provider manual.
3. ***Plan representations and obligations***—This should state the plan's obligation to pay for services provided at the agreed-upon rates, an obligation that often is subject to the provider meeting various claims submission and other administrative requirements.
4. ***Compensation***—This sets forth the obligation of the plan to pay for covered services, and the obligation of the provider to accept as payment in full payment at the agreed-upon rate. (The rate itself typically is set forth in an appended rate sheet.) The clause may also describe the claims submission process, and the claims payment process.
5. ***Utilization review***—This sets forth requirements for prior approval of services and the process for appealing denials. Generally, it will also allow the plan to review claims retrospectively, conduct audits, and require repayment of alleged overpayments. It may also include provider rights to recover underpayments.
6. ***Coordination of benefits***—This states the rules that apply when a plan member has coverage by more than one health plan.
7. ***Constraints on provider billing members.*** This constrains the provider from billing a member in the event a claim for a covered service is denied, or in the event the plan (or another payor, if the plan acts as a third party administrator) fails to pay for some other reason such as insolvency.

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8. ***Term and termination***—This specifies when the contract expires or can be terminated, and the responsibilities of the provider for continuing patient care in the event of termination.

9. ***Confidentiality requirements***—This addresses the need for the provider to secure consent from patients to release health information.

10. ***Dispute resolution***—This generally prescribes steps that must be taken to resolve disputes either prior to litigation, or in lieu of litigation (e.g., arbitration).

11. ***Amendments***—This describes how the contract may be amended, and may give the plan certain rights to impose amendments upon notice.

12. ***Miscellaneous/boilerplate provisions***—This includes such matters as requirements to maintain liability insurance, mutual indemnification, notification procedures, governing law, subcontracting and assignment rights, and third-party beneficiary rights.

13. ***Medicare Advantage plan addendum***—This sets forth provisions required by the Center for Medicare and Medicaid Services (CMS) in its contract with the plan.

To be sure, contracts may use different titles for these sections, or address them in different order or in various combinations. They may also include provisions addressing topics beyond these standard topics. But these topics and a few others form the core of plan-provider contracts in New York.

Increasingly, New York state statutes and regulations impose requirements that impact contract terms. For instance, prompt pay requirements narrow the ground for differences in clauses on the timing of payment.[1] Also, in New York, most plan-provider contracts are required to include "Standard Clauses for HMO and IPA provider Contracts"—a set of mandatory terms largely aimed at protecting the rights of patients in these arrangements.[2] The federal health care reform act will impose additional requirements, narrowing differences in other provisions.[3] But the growing realm of legal requirements has not reduced the need for constant, tedious, time-consuming, expensive drafting, review and negotiations over the provisions identified above, or for expensive disputes over the meaning of such customized terms.

The Development, Review, Negotiation and Implementation of Terms Other Than Payment

Generally a health plan will develop a series of standard contracts. It may need more than one contract both because it contracts with different types of providers (e.g., hospitals, physicians, home care) and because it offers different product lines (e.g., its commercial managed care plan, its third party administrator plan, its Medicare Advantage Plan). The development of these contracts by attorneys and health plan contracting departments requires significant administrative expenditures by plans.

In New York, managed care contract terms, and significant modifications of approved terms, must be approved by NYSDOH.[4] Accordingly the next step for the plan is to forward its contracts to NYSDOH for its review and approval—a process which may involve some back-and-forth with the plan.

The health plan will then send the applicable contracts to each health care provider that it seeks to include (or continue to include) in its network. The provider must then devote significant resources, including its contracting and/or finance staff and its in-house or outside attorneys, to carefully review the contract.

Then comes the hard part. A provider, if it has the resources and any negotiating ability, will identify provisions that are disadvantageous to it and seek to change them. For instance, it may object to a clause that would allow the plan to pay "the lesser of" negotiated rates or published charges. It may object to provisions that obligate it to comply with changes in the plan's "provider manual" but do not give the provider practical notice of such changes. It may object to a provision that allows the plan to amend the contract unilaterally, upon notice to the provider and the provider's failure to object within a notice period.

The plan and the provider will then have to devote significant resources to painstakingly negotiate each of the disputed terms. This process will require further time and effort of contracting staff and/or in-house or outside attorneys. If the negotiations result in significant modifications to the contract, it may be necessary for the plan to submit the modifications to NYSDOH again.

Once a plan-provider contract is agreed-upon and signed, variations among contracts will continue to impose expenses on both plans and providers. A provider will find it difficult to train its staff to understand and implement the requirements of the contract, which are likely to differ from the requirements in its contracts with other plans. A plan will find it difficult to learn and implement any unique changes that a provider secured through negotiations.

This burdensome process of contract development by a plan, contract review by NYSDOH, contract review by the provider, negotiation by both parties, approval of modifications by NYSDOH, and implementation of variations by both parties is not an isolated or occasional event. A hospital or health system will have to go through this same process with twenty, thirty, or maybe fifty or more contracts. A plan will to go through this process with

hundreds, perhaps thousands of contracts. Accordingly, plans and providers in New York are devoting enormous resources each year to developing, reviewing, negotiating, and striving to implement these contracts.

It is difficult to discern significant value to health plans, providers or the public from this activity. To be sure, in each individual negotiation, a plan or provider may gain some incremental advantage over the other party, or over competing plans or providers. But in the aggregate there is probably not a great deal of difference in these contract terms from plan to plan. The enormous resources devoted to this process could be spent more productively on the provision of health care, or not spent at all.

The Uniform Plan-Provider Contracts (UPPCs)

New York should consider developing a series of "Uniform Plan-Provider Contracts" (UPPCs) and mandate their use by health plans and health care providers. These contracts would accomplish wholesale what is now being done retail at enormous transactional expense. Specifically, state-mandated uniform contracts would reduce expenditures:

- by plans for contract development
- by the NYS Department of Health for contract review
- by providers for contract review
- by plans and providers for contract negotiations
- by plans and providers for implementation of unique terms
- by plans and providers, in interpretive disputes

Plans and providers would continue to negotiate rates, as well as other terms that do not conflict with the UPPC terms.

The process for developing UPPCs. It is not difficult to envision a process to develop UPPCs in New York. The most straightforward approach would be for NYSDOH or the NYS Insurance Department (NYSID) or both, after securing authorizing legislation, to develop UPPCs and promulgate them as regulations. But health plans, health care providers, and consumer groups may question the ability of those agencies to recognize and protect their interests when performing this task. A better approach would be for the empowered state agency to convene a task force, with representatives of health plans, health care providers, and consumers, to develop and propose draft UPPCs to the agency. The Task Force should require a consensus, or at least a supermajority, before recommending any draft UPPC. Thereafter the agency could consider those recommendations and, if it agrees, mandate the UPPC by regulation. Participation by competing plans and competing providers in this process would likely be protected from antitrust exposure under the Noerr-Pennington doctrine, which protects persons who advocate for laws and regulations even if the laws and regulations would have an anticompetitive effect.[5]

The process of developing a series of complete UPPCs may be long and difficult. However, it will not take very long, or be very difficult for a UPPC Task Force to agree upon discrete, simple clauses, and achieve some quick accomplishments. For example, if the UPPC Task Force were to agree upon a coordination of benefits clause, by that step alone it would free up enormous resources now required to draft, review, negotiate and implement these clauses (which, incidentally, are especially taxing to read). A standard Medicare Advantage Addendum should also be a relatively easy, noncontroversial task that will reduce custom drafting, review and negotiation work. With each new series of agreed-upon clauses, the Task Force would remove more costs, and come closer to achieving the goal of creating complete UPPCs. The UPPC Task Force could continue to meet to review and recommend modifications to UPPCs as necessary.

Alternative uniform clauses. In many instances, it will be reasonable to offer the contracting parties alternative uniform clauses. For example, the UPPC could allow the parties to choose between a compensation clause that requires payment at "the rates set forth in Appendix A" or an alternative clause that requires payment "at the lesser of the rates set forth in Appendix A or provider's published charges." Even if a UPPC were to offer choices such as this, it would still achieve most of the advantages noted previously: it would relieve the parties of drafting and reviewing unfamiliar language. The presence of optional clauses would create some additional items for negotiation, but the negotiation would be greatly simplified: the choices would be fixed, limited and clear. And as a result, the parties would be better able to recognize the financial implications of each alternative, and the relationship between the selection and the negotiated rates.

Need for legislation. Legislation would be necessary to facilitate the development and implementation of UPPCs. Even if DOH or SID could claim regulatory authority to convene task forces and create UPPCs, they clearly do not have the authority to mandate the exclusive use of such contracts.

Judicial interpretation. Currently, a court decision that interprets a disputed clause in a plan-provider contract has little precedential value; it is not relevant to other contracts that have different terms. But a court decision interpreting a disputed clause in a UPPC will operate as a precedent, and reduce the potential for future disputes and lawsuits on that same term.

Through this process, plans and providers would be liberated from the expensive, low value task of developing, reviewing, negotiating, implementing, and disputing the meaning of plan-provider contract terms.

Possible Objections to UPPCs

Various objections to UPPCs can be anticipated.

1. *UPPC terms would unduly favor plans or unduly favor providers.* Both health plans and providers are apt to fear that the process described above will result in contracts that are unfavorable to them. But the UPPC Task Force process would provide ample protection against contracts that are skewed toward one side or the other—especially if it requires a consensus or supermajority for recommendations. Moreover, the value of standardization would more than make up for the presence of provisions that are less-than-optimal from a plan or provider's standpoint.

2. *Opposition to government interference in plan-provider negotiations.* Persons who oppose any increase in government involvement in health care will object to this proposal, because it undeniably increases government involvement in what are now private negotiations. But those willing to look beyond mere form will see that in this instance government will be helping the parties achieve their own aims more efficiently, which coincides with the public interest in reducing health care costs. This is similar to government's role in mandating electronic data interchange protocols for plans and providers.[6] It is even more closely akin to state government's role in adopting uniform commercial codes, which benefit both sides in private contracting.[7] And like the uniform commercial code, the UPPC leaves untouched the heart of the commercial negotiation—rates of payment. In this regard, this proposal is wholly unlike a call for the return to NYPHRM,[8] where the state displaced the very heart of plan-provider negotiations by setting commercial rates of payment for providers.

3. *Health care reform will eliminate the need for UPPCs.* The Patient Protection and Affordable Care Act (PPACA)[9] strives in many ways to push plans and providers away from contracting on a fee-for-service basis, and toward other reimbursement mechanisms that reward providers for value. A key delivery model envisioned to achieve this shift is the accountable care organization (ACO), a collaboration of providers who strive to control costs and improve quality of care for a defined population. In all likelihood, plan-ACO contracts will look very different from UPPCs, which will reflect today's largely fee-for-service environment.

   But the emergence of ACOs, if it occurs, will actually enhance the need for UPPCs. As providers form ACOs, and as plans and providers move more members into that structure, it will become even more inefficient to expend resources on developing, reviewing and negotiating fee-for-service contracts on a contract-by-contract basis: contracting-related costs will be spread over a shrinking base. In sum, health care reform, rather than eliminating the need for UPPCs, makes them essential, and makes the retail approach to plan-provider contracting untenable.

   Moreover, PPACA will place additional pressure on plans to reduce administrative expenses in order to meet new medical loss ratio requirements. The UPPC could prove quite helpful to plans in that regard.

   As an interesting aside, some conservative groups that oppose PPACA argue that access to care would be improved more, and costs would be controlled more, by allowing individuals to buy health insurance "across state lines," i.e., from any state, without regard to the insurance laws of the state of their residence.[10] That may or may not be true. But if that approach were adopted, New York health care facilities would start seeing more and more patients with insurance from plans licensed in places like Utah, Kentucky or Guam. The need for each New York facility to participate in burdensome contract and rate negotiations would jump from twenty or thirty localized instances to thousands of nationwide instances. Plans would face a similar exponentially increased contracting burden. It is hard to envision accomplishing this without UPPCs or some variation.

4. *The UPPC would disrupt standardization of a plan's contracts across states.* Plans that operate in several states have an interest in using the same contract, or as close to the same contract as possible, in all those states. To the extent the plan is required to use a New York specific contract, that requirement will disrupt standardization from its perspective. This is true, but it is fair to say that New York laws and regulations already require plans to prepare a lengthy appendix of special clauses, as well as many other provisions do not appear in their contracts in other states. The UPPC is an incremental extension of that process.

5. *State laws cannot require ERISA plans to use UPPCs.* This is probably correct: ERISA's pre-emption clause constrains state efforts to regulate health insurance operated by employee benefit plans subject to ERISA.[11] But state insurance laws are efficacious within their sphere. Moreover, if UPPCs prove valuable for state-regulated plans, federal policymakers should consider a similar initiative for ERISA-regulated plans.

Certainly other objections will be identified. But absent some significant new concern not identified here, it seems on balance the advantages of implementing UPPCs far outweigh the objections.

Accordingly, health care policymakers in New York should start to consider the merits of developing a series of Uniform Plan-Provider Contracts (UPPCs) and mandate their use by health plans and health care providers. The use of UPPCs promises to cut significantly expenditures by health plans and health care providers associated with developing, reviewing, negotiating, and striving to implement plan-provider contracts. Those expenditure reductions will advance the public's compelling interest in controlling health care costs, with no impact on quality of care or access to care.

Endnotes

1. NY Public Health Law § 3224-a.
2. See http://www.nyhealth.gov/health_care/managed_care/hmoipa/appendix.htm.
3. See, e.g., Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act, 75 Fed. Register 43330 (July 23, 2010).
4. See Provider Contract Guidelines for MCOs and IPAs. http://www.nyhealth.gov/health_care/managed_care/hmoipa/guidelines.htm See also 10 NYCRRR § 98-1.13 Assurance of access to care. (a) All covered services must be directly provided or arranged for within the approved provider network pursuant to written contracts developed and maintained in a form and manner prescribed by the commissioner, except that when services are unavailable within the provider network, such services must be arranged for outside of the approved provider network.
5. See *Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127, 135 (1961); *United Mine Workers v. Pennington*, 381 U.S. 657, 670 (1965).
6. See, e.g., Health Insurance Reform: Standards for Electronic Transactions, 65 Fed. Register 50312 (August 17, 2000).
7. NY Uniform Commercial Code.
8. New York's Prospective Hospital Reimbursement Methodology (NYPHRM) regulated hospital rates for all in-patient care, except for services provided to Medicare beneficiaries. N. Y. Pub. Health Law § 2807-c (McKinney 1993). It was allowed to expire on December 31, 1996.
9. The Patient Protection and Affordable Care Act (the Affordable Care Act), Public Law 111–148, was enacted on March 23, 2010; the Health Care and Education Reconciliation Act (the Reconciliation Act), Public Law 111–152, was enacted on March 30, 2010.
10. See, e.g., "Let Health Insurance Cross State Lines, Some Say," NY Times, Feb 13, 2010, available at http://prescriptions.blogs.nytimes.com/2010/02/13/let-health-insurance-cross-state-lines-some-say/.
11. See *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers*, 514 U.S. 645 (1995).

Robert N. Swidler is General Counsel to Northeast Health in Troy, NY, and is Editor of the NYS Bar Association *Health Law Journal*.

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