H.R. 2976, THE "PATIENT RIGHT TO KNOW ACT OF 1996"

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

SECOND SESSION

JULY 30, 1996

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104TH CONGRESS
2D SESSION

H. R. 2976

To prohibit health plans from interfering with health care provider communications with their patients.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 27, 1996

Mr. GANSKE (for himself, Mr. MARKEY, Mr. BARR of Georgia, Mr. BOUCHER, Mr. COBURN, Mr. DURBIN, Mr. GENE GREEN of Texas, Mr. JOHNSTON of Florida, Mr. KENNEDY of Massachusetts, Mr. KLECZKA, Ms. LOFGREN, Mr. MCDERMOTT, Mrs. MEEK of Florida, Mr. MORAN, Mr. NADLER, Mr. SANDERS, Mr. SERRANO, Mrs. SMITH of Washington, Mr. STARK, Mr. STUDDS, Mr. TRAFICANT, Mr. WAXMAN, Mr. WHITFIELD, and Mr. WISE) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committee on Ways and Means, Economic and Educational Opportunities, and Government Reform and Oversight, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To prohibit health plans from interfering with health care provider communications with their patients.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; FINDINGS.

(a) SHORT TITLE.—This Act may be cited as the "Patient Right To Know Act of 1996".

(b) FINDINGS.—Congress finds the following:

(1) Patients cannot make appropriate health care decisions without access to all relevant information relating to those decisions.

(2) Restrictions on the ability of physicians and other health care providers to provide full disclosure of all relevant information to patients making health care decisions violate the principles of informed consent and the ethical standards of the health care professions.

(3) Serious concerns have been raised about the use by health plans of contractual clauses or policies that interfere with communications between physicians and other health care providers and their patients and the impact of such clauses and policies on the quality of care received by those patients.

(4) The offering and operation of health plans affects commerce among the States, health care providers located in one State serve patients who reside in other States as well as that State, and, in order to provide for uniform treatment of health care providers and patients among the States, it is necessary to cover health plans operating in one State as well as those operating among the several States.

SEC. 2. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

(a) IN GENERAL.—

(1) PROHIBITION OF CONTRACTUAL PROVISION.—An entity offering a health plan (as defined in subsection (d)(2)) may not provide, as part of any contract or agreement with a health care provider, any restriction on or interference with any medical communication, as defined in subsection (b).

(2) PROHIBITION OF ADVERSE ACTION.—An entity offering a health plan may not take any of the following actions against a health care provider on the basis of a medical communication:

(A) Refusal to contract with the health care provider.

(B) Termination or refusal to renew a contract with the health care provider.

(C) Refusal to refer patients to or allow others to refer patients to the health care provider.

(D) Refusal to compensate the health care provider for covered services.

(E) Any other retaliatory action against the health care provider.

(3) NULLIFICATION.—Any provision that is prohibited under paragraph (1) is null and void.

(b) MEDICAL COMMUNICATION DEFINED.—In this section, the term "medical communication"—

(1) means any communication, other than a knowing and willful misrepresentation, made by the health care provider—

(A) regarding the mental or physical health care needs or treatment of a patient and the provisions, terms, or requirements of the health plan or another health plan relating to such needs or treatment, and

(B) between—

(i) the provider and a current, former, or prospective patient (or the guardian or legal representative of a patient),

(ii) the provider and any employee or representative of the entity offering such plan, or

(iii) the provider and any employee or representative of any State or Federal authority with responsibility for the licensing or oversight with respect to such entity or plan; and

(2) includes communications concerning—

(A) any tests, consultations, and treatment options,

(B) any risks or benefits associated with such tests, consultations, and options,

(C) variation among any health care providers and any institutions providing such services in experience, quality, or outcomes,

(D) the basis or standard for the decision of an entity offering a health plan to authorize or deny health care services or benefits,

(E) the process used by such an entity to determine whether to authorize or deny health care services or benefits, and

(F) any financial incentives or disincentives provided by such an entity to a health care provider that are based on service utilization.

(c) ENFORCEMENT THROUGH IMPOSITION OF CIVIL MONEY PENALTY.—

(1) IN GENERAL.—Any entity that violates paragraph (1) or (2) of subsection (a) shall be subject to a civil money penalty of—

(A) up to $25,000 for each violation, or

(B) up to $100,000 for each violation if the Secretary determines that the entity has engaged, within the 5 years immediately preceding such violation, in a pattern of such violations.

(2) PROCEDURES.—The provisions of subsections (c) through (l) of section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) shall apply to civil money penalties under this paragraph in the same manner as they apply to a penalty or proceeding under section 1128A(a) of such Act.

(d) DEFINITIONS.—For purposes of this section:

(1) HEALTH CARE PROVIDER.—The term "health care provider" means anyone licensed under State law to provide health care services.

(2) HEALTH PLAN.—The term "health plan" means any public or private health plan or arrangement (including an employee welfare benefit plan) which provides, or pays the cost of, health benefits, and includes an organization of health care providers that furnishes health services under a contract or agreement with such a plan.

(3) SECRETARY.—The term "Secretary" means Secretary of Health and Human Services.

(4) COVERAGE OF THIRD PARTY ADMINISTRATORS.—In the case of a health plan that is an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974), any third party administrator or other person with responsibility for contracts with health

care providers under the plan shall be considered, for purposes of this section, to be an entity offering such health plan.

(e) NON-PREEMPTION OF STATE LAW.—A State may establish or enforce requirements with respect to the subject matter of this section, but only if such requirements are more protective of medical communications than the requirements established under this section.

(f) CONSTRUCTION.—Nothing in this section shall be construed as—

(1) as requiring an entity offering a health plan to enter into or renew a contract or agreement with any willing health care provider, or

(2) preventing an entity from acting on information relating to treatment actually provided to a patient or the failure of a health care provider to comply with legal standards relating to the provision of care.

(g) EFFECTIVE DATES.—

(1) CONTRACTS.—Subsection (a)(1) shall apply to contracts or agreements entered into or renewed on or after the date of the enactment of this Act, and to contracts and agreements entered into before such date as of 30 days after the date of the enactment of this Act.

(2) RETALIATORY ACTIONS.—Subsection (a)(2) shall apply to actions taken on or after the date of the enactment of this Act, regardless of when the communication on which the action is based occurred.

(3) NULLIFICATION.—Subsection (a)(3) shall apply to provisions as of the date of the enactment of this Act.

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H.R. 2976, THE "PATIENT RIGHT TO KNOW ACT OF 1996"

TUESDAY, JULY 30, 1996

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 1:10 p.m., in room 1310, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
July 23, 1996
No. HL-22

CONTACT: (202) 225-3943

Thomas Announces Hearings on H.R. 2976, the "Patient Right to Know Act of 1996"

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on H.R. 2976, the "Patient Right to Know Act of 1996." **The hearing will take place on Tuesday, July 30, 1996, in room 1310 of the Longworth House Office Building, beginning at 1:00 p.m.**

Oral testimony at this hearing will be heard from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

On June 27, 1996, the Subcommittee on Health and Environment of the Committee on Commerce unanimously approved H.R. 2976. As reported by the Subcommittee, the bill would prohibit health plans from restricting medical communications between physicians and patients in their provider contracts. The introduced version of H.R. 2976 would have also prohibited plans from using standard contract language pertaining to physician compensation and incentives and non-disparagement clauses.

The rules regarding any limits on physician-patient communications by health plans, which are raised by the consideration of H.R. 2976, fall into three categories: those that restrain disclosure of treatment options; those that restrain disclosure of payment and financial incentive arrangements; and nondisparagement clauses. These limits or restraints are commonly referred to as "gag rules." Many physicians argue that contract provisions exist between health plans and providers that allegedly prohibit providers from disclosing all treatment options with patients. H.R. 2976 would prohibit such clauses. This term is being used to describe a variety of standard contract provisions including provisions protecting proprietary compensation arrangements and nondisparagement clauses. Proponents of legislation to end these rules contend that financial arrangements with individual physicians should remain proprietary, while financial incentives and compensation arrangements should be revealed at the plan level, because they argue, such arrangements can sometimes contribute to "inappropriate restraints on care." The health plans argue that provisions such as proprietary compensation arrangements and nondisparagement clauses are necessary to protect competition and prevent providers from steering patients to better paying plans.

Many States are moving forward with their own legislation in this area. Twelve States have passed some form of patient disclosure or specific rules. Other States have legislation pending and two States have defeated patient disclosure legislation.

FOCUS OF THE HEARING:

The hearing will focus on legal contracting issues involving managed health care contracts between health plans and their physicians. Key issues include: what types of provisions are contained in a managed care contract; what is the actual intent of particular provisions such as nondisparagement clauses contained in such a contract; and what practices and contract language constitute limits on physician-patient communications by health plans.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Tuesday, August 13, 1996 to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are now available on the World Wide Web at 'HTTP://WWW.HOUSE.GOV/WAYS_MEANS/' or over the Internet at 'GOPHER.HOUSE.GOV' under 'HOUSE COMMITTEE INFORMATION'.

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Chairman THOMAS. The Subcommittee will come to order.

Today's hearing focuses on H.R. 2976, as amended, that was approved by the Commerce Committee last week. This legislation would prohibit health plan contracts with providers from restricting medical communications between physicians as well as other providers and their patients.

Proponents of legislation to prohibit the use of such alleged gag clauses—and I am looking for a much better term than that and we will take nominees today—contend that these clauses undermine a physician's ability to provide his or her patients with the best possible care. Others, health plans included, argue that provisions such as proprietary compensation arrangements and nondisparagement clauses are necessary to protect competition and prevent providers from steering patients to plans simply because of their reimbursement policies.

We are going to examine this issue, hopefully, from all angles, this afternoon. Witnesses including a panel of legal experts and consultants who will shed light on what goes on in the real world regarding the drafting of managed care contracts, include what types of provisions are contained in such contracts and what practices and contract language constitute limits on physician-patient communications by health plans.

We will also hear from the NAIC on its model regulation on provider contracting and get a brief overview on what is going on in the States with regard to legislation restricting the use of certain contract language.

Finally, we will hear testimony from interested parties including representatives for health care plans, physicians, patients, and employers.

To start it off, it seemed appropriate to hear from the authors of the legislation itself, but prior to recognizing our colleagues, I ask the gentleman from California if he has any opening comments.

Mr. STARK. Thank you, Mr. Chairman. Thank you for holding this hearing. I hope that it is the first in a series on the need for consumer protections in the managed care field.

The press tells us that Dr. Ganske was promised a vote on his antigag rule bill under suspension, but I understand we may mark up the bill later. So, at least, there could be a chance for some amendments, many of which we might adopt.

There is a tremendous demand for consumer protections to stop the horror stories, anecdotal as they may be, that have accompanied this rapid growth in managed care. For example, I believe we should consider adopting utilization review reforms, timely access to care provisions, nondiscrimination laws that protect patients with serious health problems, a ban on hold-harmless clauses so that the health plans could be held accountable for their actions, join in the fun with the physicians for lawsuits and disclosure of physician financial incentives and other planned statistics, prudent layperson laws that guarantee emergency coverage, a ban on drive-through deliveries, and so forth.

If the managed care industry were wise, it would embrace these types of amendments as a way to give the public some faith and confidence in this rapidly evolving product. It is, however, kind of disappointing to see the AARP's testimony today where they seem

on one page to deny that a doctor would have the best interests of a patient at heart. And on another page, they want to keep the financial incentives to preserve a competitive advantage. They treat the patient as if he or she is not capable of understanding the financial data, while earlier in the testimony, they say the patient can understand technical medical options.

Now, managed care is sort of like the stock market crash in 1929. There are some old line blue chips like Kaiser and then there are a lot of snake oil producers. The industry could use a SEC-type system, I suppose, of consumer protections that might give patients more confidence that they are entrusting their health and lives to reputable groups that meet some minimum standards of decency. Antigag legislation is just the first step in building those protections.

As for today's hearing, Mr. Chairman, I am still inclined to support the original Ganske-Markey bill. I think it is important for patients to understand the financial pressures plans place on their doctors and I would like to hear from witnesses why we should not go back to the original bill, rather than what I consider a somewhat watered-down version.

I look forward to hearing the testimony today and inquiring with our witnesses.

Chairman THOMAS. I thank the gentleman.

If you will allow me, the reasons these televisions are here—and I do not know how your time constraint is, but I will tell the gentleman from Iowa and the gentleman from Massachusetts that, after you make your opening statements, however you may wish to inform the Subcommittee, I have an excerpt from one of those Fred Friendly seminars that we did last fall, lasting about 2½ hours. The title was "Your Money and Your Life: America's Managed Care Revolution."

There is one approximately 5-minute segment in which an exchange among Dr. Gail Povar who is a general internist at George Washington University Medical Center, the moderator, Arthur Miller and others, framed the question about as well as I have seen it. So, if you folks would make your opening statements, we will then show the approximate 5-minute video. Then we can enter into a dialog either using something from the videotape as reinforcement or as a counterpoint, as you see fit.

Perhaps, in your opening statement, you might anticipate addressing briefly the gentleman from California, Mr. Stark's comment about the original bill versus the bill that has been referred to us on sequential jurisdiction from the Commerce Committee, since it was marked up and amended in Committee.

So, with that, Hon. Dr. Ganske.

STATEMENT OF HON. GREG GANSKE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA

Mr. GANSKE. Thank you, Mr. Chairman, for the opportunity to be here this afternoon. I am looking forward to viewing this videotape and, if I may suggest to the Chairman, I also have a videotape. It is from "NBC Nightly News." It addresses this issue specifically and has some patients in it that appeared before the Com-

merce Committee. It is not very long and maybe we could view that also.

Mr. Chairman, there is significant evidence that some managed care plans are gagging their health care providers, thereby keeping patients from full and complete access to information they need to make critical decisions. These gags, whether spelled out in a contract, a written policy statement, a letter, or communicated orally, eat like a cancer at the trust between a doctor and a patient.

Earlier this year, Mr. Markey and I introduced the Patient Right To Know Act, which would prohibit the enforcement of gag rules in health care contracts. The Commerce Subcommittee on Health held a lengthy hearing in May. We explored these issues with patients, physicians, and managed care plans. The Subcommittee marked up the bill last month and I worked very hard with Members and other interested parties to address concerns about possible unintended consequences of the bill and the need for health plans to protect proprietary data from disclosure.

The result was an amendment that was approved by the Subcommittee 22 to 0 and by the Full Commerce Committee by unanimous voice vote 6 days ago. It is supported by groups like AARP, the Center for Patient Advocacy, Citizen Action, Consumer Federation of America, Consumer Union, the American Academy of Family Physicians, the American College of Surgeons, the American Dental Association, the American Nurses Association, the AMA, the American Physical Therapy Association, Podiatric Medicare, and a host of organizations. It has over 130 bipartisan supporters, including many Members of this Subcommittee.

Mr. Chairman, I want to be very clear on one point. No written contract accurately describes all the functions of a complex business enterprise. Much more occurs through policy manuals, informal practice, and oral statements. While the language of the contract can be partly instructive, the Subcommittee should directly focus, on three issues. First, how the contract language is used.

For example, a nondisparagement clause is not automatically objectionable if it is used to prevent bad-mouthing of the plan. We added into the substitute that passed something specifically to address this issue. A physician could not use this bill as a way to financially improve his situation. But, the clause is a problem if it is used to keep a doctor from telling his patient that he needs a treatment the plan is refusing to pay for.

A Tulsa neurologist was reprimanded for "disparaging the plan" when he advised a patient that she needed a test the plan was not willing to pay for.

Second, plans generally include in their contracts a provision requiring the provider to follow manuals and policy bulletins. Consider this letter from the south Florida Office of the Prudential Health Care System to participating doctors. The plan's medical director wrote: "If you believe a member may require transplantation or other sophisticated and experimental care, we request that before discussing treatment options with the member, you call us to discuss the member's eligibility for the treatment and to discuss the appropriate institution. Failure to do so may result in treatments that are not covered by benefits and, therefore, unhappy members."

What about a bulletin issued by Humana stating that: "Effective immediately, all Humana participating providers must telephone the preadmission review department before an admission occurs and before conveying the possibility of an admission to a plan member," before conveying the possibility of an admission for a plan member. It is my understanding that public scrutiny led to a change in this policy, but I think the dangers are real.

These policies restrict communications between patients and their providers, but if Congress' focus is only on the actual terms of the contract, we would be blind to these problems.

Third, oral communications. Plans often communicate orally what they do not want to put on paper, whether to retain flexibility, because it is impossible to codify everything, or perhaps because they are attempting to enforce policies they do not want to put into print.

Consider the case of Christy DeMeurers. She was diagnosed with breast cancer and eventually sought care at UCLA, where the doctor who examined her swore under oath that she was an excellent candidate for a bone marrow transplant. When her health plan discovered this, they threatened to terminate UCLA's lucrative contract as a center of excellence unless the doctor reversed his opinion about her fitness for the procedure. Faced with this tremendous economic coercion, Christy DeMeurers' doctor wrote out a deposition recommending against surgery, just 11 days after stating under oath that, "She is a candidate who may receive superior results."

Christy DeMeurers is no longer alive.

I think the ban on oral gags is particularly important. If Congress acts to ban restrictions on written medical communications only, it will ignore a significant part of the problem motivating this bill and will tacitly encourage other plans to follow the example of HealthNet. The bill passed by the Commerce Committee contained a reasonable compromise on this issue.

To prevent plans from being subjected to a "he-said, she-said" battle over alleged oral statements, the bill requires that proof of a single incident to an oral gag be made by a "preponderance of evidence," a higher legal standard than the substantial evidence test sometimes used in civil money penalty cases. This was a key component of the amendment approved by the Commerce Committee and will give health plans greater defense against spurious charges that are not backed up by any corroborating evidence.

Finally, let me be clear about what this bill will not do. It does not empower the Secretary of Health and Human Services to scrutinize every contract or to place an inspector in every doctor's office. Instead, the legislation gives the Secretary the authority to examine cases of alleged gags when they are brought to his or her attention. This is an appropriate balance that safeguards patients against efforts to limit their access to critical information.

Mr. Chairman, as passed by the Commerce Committee, the Patient Right To Know Act is a balanced bill that addresses a real problem in the health care market. I look forward to working with you and other members of the panel on this important issue and thank you very much.

[The opening statement follows:]

Statement of Rep. Greg Ganske
Hearing on Managed Care "Gag Rules"
Committee on Ways and Means
Subcommittee on Health
July 30, 1996

Mr. Chairman, thank you for the opportunity to appear before you this afternoon.

There is significant evidence that some managed care plans are "gagging" their health care providers, thereby keeping patients from full and complete access to the information they need to make critical decisions. These gags--whether spelled out in a contract, a written policy statement or letter, or communicated orally--eat like a cancer at the trust between a doctor and a patient.

Earlier this year, Congressman Ed Markey and I introduced H.R.2976, the Patient Right to Know Act, which would prohibit the enforcement of gag rules in health care contracts. The Commerce Committee Subcommittee on Health held a lengthy hearing in May which explored these issues. The panel heard testimony that gags exist and pose very real dangers.

Before the Subcommittee marked-up the bill last month, I worked very hard with Members and other interested parties to address concerns about possible unintended consequences of the bill and the need for health plans to protect proprietary data from disclosure. The result was an amendment that was approved by the Subcommittee 22-0 and by the Full Commerce Committee by unanimous voice vote six days ago.

The version of the bill adopted by the Commerce Committee represents a compromise which fairly balances the interests of patients, providers, and health plans.

Mr. Chairman, I want to be very clear on one point. No written contract accurately describes all the functions of a complex business enterprise. Much more occurs through policy manuals, informal practice, and oral statements. While the language of the contract can be partly instructive, the Committee should more directly focus on three issues:

First. How the contract language is used. For example, a non-disparagement clause is not automatically objectionable if it is used to prevent public bad-mouthing of the plan. But it is problematic if it is used to keep a doctor from telling his patient that she needs a treatment the plan is refusing to pay for. A Tulsa neurologist was reprimended for "disparaging" the plan when he advised a patient that she required a test the plan was not willing to pay for.

Second. Letters and policy bulletins. Plans generally include in their contracts a provision requiring the provider to follow manuals and policy bulletins. Consider this letter from the South Florida office of the Prudential Health Care System to participating doctors. The plan's medical director wrote, "If you believe a member may require transplantation or other very sophisticated and possibly experimental care, we request that BEFORE DISCUSSING TREATMENT OPTIONS WITH THE MEMBER, you call us to discuss the member's eligibility for that treatment and to discuss the appropriate institution. Failure to do so may result in treatments that are not covered by benefits, and therefore unhappy members."

Or what about a bulletin issued by Humana stating that, "Effective immediately, all Humana participating providers must telephone the Preadmission Review Department. . . before an admission occurs and before conveying the possibility of admission to the plan member." It is my understanding that public scrutiny led to a change in this policy, but I think the dangers are very clear.

These policies restrict communications between patients and their providers. But if Congress focusses only on the actual terms of the contract, we would not view this as a problem.

Third. Oral communications. Plans often communicate orally things that they do not want to put on paper--whether to retain flexibility, because it is impossible to codify on paper a multi-billion dollar industry, or perhaps because they are attempting to enforce policies they don't want to put in print.

Consider the case of Christy DeMeurers. She was diagnosed with breast cancer and eventually sought care at UCLA, where the doctor who examined her swore under oath that she was an excellent candidate for a bone marrow transplant. When her health plan discovered this, they threatened to terminate UCLA's lucrative contract as a Center of Excellence unless the doctor reversed his opinion about her fitness for the procedure. Faced with this tremendous economic coercion, Christy DeMeurers' doctor swore out a deposition recommending against the surgery--just eleven days after stating under oath that "she is a candidate who may receive superior results."

I think the ban on oral gags is particularly important. If Congress acts to ban restrictions on written medical communications only, it will turn a blind eye to a significant part of the problem motivating this bill and will tacitly encourage other plans to follow the example of HealthNet in its treatment of Christy DeMeurers.

The bill passed by the Commerce Committee contained a reasonable compromise on this issue. To prevent plans from being subjected to a "he said, she said" battle over alleged oral statements, the bill requires that proof of a single incidence of an oral gag be made by a "preponderance of the evidence," a higher legal standard than the "substantial evidence" test sometimes used in civil money penalty cases. This was a key component of the amendment approved by the Commerce Committee and will give health plans a greater defense against spurious charges which are not backed up with any corroborating evidence.

Finally, let's be clear about what this bill will not do. It <u>does not</u> empower the Secretary of Health and Human Services to scrutinize every contract or place an inspector in every doctor's office. Instead, the legislation gives the Secretary the authority to examine cases of alleged gags <u>when they are brought to his or her attention</u>. This is an appropriate balance that safeguards patients against efforts to limit their access to critical information.

Mr. Chairman, as passed by the Commerce Committee, the Patient Right to Know Act is a balanced bill that addresses a real problem in the health care market. I look forward to working with you and the other Members of this panel on this important issue.

Thank you. I would be pleased to answer any questions that Members may have.

Chairman THOMAS. Thank you very much. If I did not say so, obviously without objection, any written statement that either of you have will be made a part of the record.

The gentleman from Massachusetts, Mr. Markey.

STATEMENT OF HON. EDWARD J. MARKEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS

Mr. MARKEY. Thank you, Mr. Chairman, and I thank you for holding today's hearing on this important legislation.

Gag rules restricting medical communications between doctors and their patients enforce a code of silence on doctors that makes informed consent impossible. Such an attack on this most basic patient protection simply cannot be tolerated in a free society. When you are a patient, what you do not know can hurt you. That is why Dr. Ganske and I joined forces last February to introduce the Patient Right To Know Act of 1996, which protects medical communication between health care providers and their patients by banning the use of gag rules by health plans.

That is why the House must pass this bill this year and we must send it to the President's desk before the end of the session.

Our bipartisan proposal has over 140 cosponsors from both sides of the aisle and every part of the political spectrum. It is supported by a wide range of health care and consumer groups, including the American Medical Association, the American Nurses Association, the Consumer Federation of America, and the Consumers' Union. The American Association of Retired Persons and the American Heart Association both have written letters to us expressing their support for the bill as well.

Incidentally, contrary to the implication of an advertisement which ran in one of the local newspapers last week, the National Governors' Association has not taken a position on the Ganske/Markey bill. That ad, which was paid for by the managed care industry, reflected the managed care industry's view of H.R. 2976, not the position of the National Governors' Association on our bill.

My mother always told me to consider the source when I hear something I am not sure about. In this case, I would strongly urge my colleagues to do the same.

During the recent markup of this bill by the Commerce Committee, my friend from Iowa offered a substitute amendment that addressed several of the main concerns about the bill that had been raised by the managed care industry. Specifically, it protects proprietary data from disclosure, eliminates the second higher tier of civil penalties imposed by the original bill, and delays the effective date by 60 days to give plans adequate time to comply.

In addition, the substitute includes a provision explicitly stating that the bill does not protect communications made by doctors to their patients that are made solely for the doctor's own financial gain. This provision should silence once and for all those who oppose the bill for other reasons, but seek to undermine it by claiming that it is a provider protection bill rather than a patient protection bill.

I want to touch on one more point before I close. Some who have looked at this issue have focused their attention exclusively on what is written in the doctor's contract. If a clear gag clause cannot

be found there, they assume the doctor is free to speak. I would urge this Subcommittee to look deeper into this issue before drawing such a conclusion.

Dr. Rosabel Young, a Texas neurologist, was reprimanded by her HMO employer, CIGNA, for recommending a muscle biopsy to one of her patients even though it was not covered by the plan. She was told that, "It was a mistake to tell the patient about a procedure before checking to see whether it was covered." "It was as if I were a store vendor," she said "and was only supposed to advertise the products that we offered" as part of their own brand label. Clearly, CIGNA was trying to keep Dr. Young from giving her best medical advice to her patients, to gag her, not by invoking a specific provision in her contract, but by enforcing an oral policy against discussing treatment options not covered by the plan with those patients.

The Patient Right To Know Act was approved by the Commerce Committee last week by a voice vote. I am very pleased, Mr. Chairman, that you have been willing to have this hearing in such a timely fashion. Silence is not always golden. No doctor can practice good medicine in a muzzle. We must ungag the doctors and give patients confidence that nothing is preventing their doctors from telling them the truth, the whole truth, and nothing but the truth about the health of that individual or their family member. America's patients deserve no less.

I thank you, Mr. Chairman and, I look forward to the rest of the hearing.

[The prepared statement follows:]

STATEMENT OF REP. ED MARKEY
ON HR 2976, THE PATIENT RIGHT TO KNOW ACT
BEFORE THE COMMITTEE ON WAYS AND MEANS

July 30, 1996

Mr. Chairman, I want to begin by thanking you for holding today's hearing on this important legislation.

"Gag rules" restricting medical communications between doctors and their patients enforce a code of silence on doctors that makes informed consent impossible. Such an attack on this most basic patient protection simply cannot be tolerated in a free society.

When you're a patient, what you don't know can hurt you. That's why Rep. Ganske and I joined forces last February to introduce the "Patient Right to Know Act of 1996," which protects medical communications between health care providers and their patients by banning the use of "gag rules" by health plans. That's why the House must pass this bill, this year, and we must send it to the President's desk before the end of the session.

Our bipartisan proposal has over 130 co-sponsors from both sides of the aisle and every part of the political spectrum. It is supported by a wide range of health care and consumer groups, including the American Medical Association, the American Nurses Association, the Consumer Federation of America, and Consumers Union. The American Association of Retired Persons and the American Heart Association have both written letters to us expressing their support for our effort.

Incidentally, contrary to the implication of an advertisement which ran in Washington Times last week, the National Governors Association has not taken a position on the Ganske-Markey bill. That ad, which was paid for by the managed care industry, reflected the managed care industry's view of HR 2976, not the position of NGA on our bill. My mother always told me to "consider the source" when I hear something I'm not sure about -- in this case, I would strongly urge my colleagues to do the same.

During the recent mark-up of this bill by the Commerce Committee, my friend from Iowa offered a substitute amendment that addressed several of the main concerns about the bill that had been raised by the managed care industry: specifically, it protects proprietary data from disclosure, eliminates the second, higher tier of civil penalties imposed in the original bill, and delays the effective date by 60 days to give plans adequate time to comply.

In addition, the substitute includes a provision explicitly stating that the bill does not protect communications made by doctors to their patients that are made solely for the doctor's own financial gain. This provision should silence, once and for all, those who oppose the bill for other reasons but seek to undermine it by claiming that it is a "provider-protection" bill, rather than a "patient-protection" bill.

I want to touch on one more point before I close. Some who have looked at this issue have focused their attention exclusively on what's written in the doctor's contract. If a clear gag clause can't be found there, they assume the doctor is free to speak. I would urge this Committee to look deeper into this issue before

drawing such a conclusion. Dr. Rosabel Young, a Texas neurologist, was reprimanded by her HMO-employer, CIGNA, for recommending a muscle biopsy to one of her patients even though it wasn't covered by the plan. She was told that "it was a mistake to tell the patient about a procedure before checking to see if it was covered." "It was as if I was a store vendor and was only supposed to advertise the products we offered," she recalled. Clearly, CIGNA was trying to keep Dr. Young from giving her best medical advice to her patients, to gag her, not by invoking a specific provision in her contract but by enforcing an oral policy against discussing treatment options not covered by the plan with those patients.

The Patient Right to Know Act was approved by the Commerce Committee last week by a voice vote. I am pleased that the Ways & Means Committee has now turned its attention to HR 2976, and I am hopeful, Mr. Chairman, that you will schedule action on it as soon as possible.

Mr. Chairman, silence isn't always golden. No doctor can practice good medicine in a muzzle. We must ungag the doctors, and give patients confidence that nothing is preventing their doctors from telling them the truth, the whole truth and nothing but the truth. America's patients deserve nothing less.

Thank you and I yield back the balance of my time.

Chairman THOMAS. I thank the gentlemen, both gentlemen, for their comments.

As was indicated on the floor, with the legislation going to the Committees of jurisdiction, we would not in any way inhibit it. I think it is fairly evident that we are complying with that with the hearing today. It is the Chairman's intent that, although we are going out this week, the first week, no later than the second week when we come back, we would move to a markup if, in fact, there seems to be a general feeling that perhaps some language might be able to improve the legislation.

Prior to going to questions from Members, as we indicated, with your tape added, Greg, let's show—about how long is it?

Mr. MARKEY. Three or four minutes.

Chairman THOMAS. Run that tape and then run the excerpts from the "Friendly" program.

I tell everyone present, this is our small step forward in moving toward the cyber-Congress. We thought we would go high technology. [Laughter]

Obviously, Tom Brokaw does not understand the importance of mentioning sponsors of the legislation. [Laughter.]

Mark, I thought you would have that covered.

Mr. MARKEY. We have to have a gag rule at the networks on that. [Laughter.]

Chairman THOMAS. That is right.

The second tape is an excerpt from, as I said, one of those "Fred Friendly" seminars, in which Arthur Miller roams around with all the hypothetical questions—hold it. Thanks.

I need to set the setting so that, as you look at this piece, you will understand what is going on. We had in the room around the table myself and Henry Waxman, as politicians, Califano, a number of doctors, others representing hospitals, as is usually the case. He roams around, as I said, with hypotheticals.

This scenario is about a woman who was in the process of determining, under an open enrollment season, what health care option to take. She decided to take the managed care option, although there is a long discussion about the options between the managed care and the fee-for-service, about the adverse risk selection, portability, preexisting medical conditions. She makes a choice to go with the managed care option.

So, in this scenario, Miller is playing the woman who chose the managed care plan and is carrying out a discussion with the doctor. The doctor is Dr. Gail Povar, general internist at George Washington University Medical Center, as I said.

Obviously, if all of the doctors were as aggressive in terms of supporting the patients as Dr. Gail Povar seems to be, regardless of what contracts you may have signed, we would have less concern about this.

So, you get the contrast between the two tapes and I am pleased that you brought the NBC one, Greg.

Let me ask you a couple of questions which will hopefully frame it for some of us, because if you are going to be dealing with Federal regulations governing private contracts, we are all very sensitive about when and how the Federal Government is going to in-

tervene to either provide an advantage in a negotiating arrangement with one side or the other.

In addition to that, a number of States are beginning to move in this area and the legislation says no State can do legislation that is less restrictive than what we have in the bill. So, notwithstanding the agreement and the comfort level in the State, this Federal legislation may disrupt those relationships as well. So, we are very sensitive about it.

To what extent is it fair to say that contracts—you can pick some of the most egregious examples that you might in terms of what you call a gag rule—if signed by a doctor would require them to hesitate based upon their Hippocratic Oath? Are we dealing with contracts that doctors would feel, in fact, violate what they believe to be their commitment to the Hippocratic Oath?

Mr. GANSKE. I believe that you are going to get testimony that physicians in general would feel that these kinds of contracts are unethical. The situation, depending on whether a physician signs a contract with these in them or not, is something that I cannot defend. The fact is, we have ample evidence that the contracts exist and that they are affecting a patient's ability to get the information they want.

I should emphasize, Mr. Chairman, that this——

Chairman THOMAS. I guess I was trying to drive you to the most extreme position I could think of, not that it might interfere, not that it might be inconvenient, but that you would be forced to make decisions that would be inconsistent with your professional judgment as it is determined in the Hippocratic Oath.

Mr. GANSKE. I will answer that, but let me just first say, I firmly believe the primary purpose of this is not for physicians, but it is for patients. That is why groups like Citizen Action and the American Heart Association and the American Lung Association, AARP, Consumer Union have all come out endorsing this bill.

Are there situations where the economic forces in the market could place an exceedingly heavy load on a physician to sign one of those contracts? I think that there are. There are situations developing where consolidation has occurred in the managed care industry where a few players have a very large share of the market. It may mean whether a physician can stay in that locale, as to whether they sign a contract or not.

So, there definitely can exist a very significant conflict of interests, both in terms of fulfilling your Hippocratic Oath, but also in terms of whether you are going to practice in that community where your kids are going to school and where you may have set down roots 20 years ago.

Chairman THOMAS. On the NBC tape and the Fred Friendly tape, it was primarily focused on physicians. Your comments are focused on physicians and quite rightly the end result is informing the patient, as you indicate with the findings. The very first finding you have in the bill is the patient's right to know.

But in the bill, you define health care provider—the term health care provider means anyone licensed under State law to provide health care services. The scope of that definition is obviously, I think we all agree, far broader than physicians. It would extend to not only physicians' assistants, but nurses, nurse practitioners,

nurse midwives, therapists, dieticians, dental hygienist, social workers, certain medical records employees, and so forth, who would come under a number of States' definition of health care provider.

Do you believe it is essential to have it as broad as that?

Mr. GANSKE. I do. I have had personal communications from members of the nursing and physical therapy professions that they are experiencing the same types of problems with these types of gag clauses.

Chairman THOMAS. OK. Then when you have medical communication defined in the amended bill—in this section, the term medical communication means a communication made by a health care provider with a patient of the provider, with respect to the patient's physical or mental condition or treatment options—it does not indicate that the health care provider show any expertise by virtue of the license they receive in the State or knowledge about the area in which they could make comments—it could be physical, mental or treatment options.

How do you deal with a ophthalmologist making a statement to a patient about the mental health aspect of the provision or a dietician making a comment about some physical treatment aspect? Do you see what I am talking about? Given the broad definition and the fact that you do not restrict the comment to the expertise, either by licensure or employment, contract employment, of the individual making the statement, that you provide blanket protection for anybody to make any comment about any aspect of the plan, whether they have expertise or not.

Mr. GANSKE. Well, the matter of expertise, I think, is adequately handled by the State licensing boards. If individuals are making recommendations outside of their area of expertise, they are going to be subject to the usual sanctions.

Chairman THOMAS. Well, no, not making recommendations, making comments about the health plan's provisions. They are criticizing the health plan's provisions in areas in which they have no expertise. They are making comments about it. They are protected under this bill in the communications with the patient or with the people who are provided with the plan and they are making "a medical communication." They could be commenting about any of the physical or mental provisions or treatment options in the plan and it could be anybody, including one of the medical records employees.

Mr. GANSKE. I would just say that if a treating surgeon who is a licensed physician has a concern about a patient's severe depression and recommends to the patient that they obtain a consultation from a psychiatrist, I think they are operating within the bounds of what would traditionally be seen as a pertinent part of their treatment of that medical condition. I think the——

Chairman THOMAS. I obviously have little or no quarrel with the example that you gave. Do you see how I could provide you with an example based upon how you define health provider under the law and the provision in which they could make a comment on the plan, that I could provide a number of extreme examples in which people could clearly be seen to be meddling or making disparaging remarks about a plan with no clear intent to assist the patient in

their right to know on the basis of physical or mental condition or treatment options.

This is just an area that you need to look at and think about. As we move toward the potential markup, I would like to have some conversations in terms of the scope and the extent to which folk who I believe probably have no professional expertise could make comments and be protected under the very broad umbrella. I understand you need to create a broad umbrella. I am just questioning, perhaps, maybe it is broader than it needs to be.

Mr. GANSKE. Mr. Chairman, I worked with Congressman Burr, and also worked with various interested parties on this legislation. We came to an understanding of sorts and had a colloquy on this. I think this would be an appropriate issue for report language, especially in terms of just exactly what a medical communication is. I believe that it is basically any test, consultation or treatment option, any risks or benefits associated with them in any variation and quality among health care providers or institutions providing such services, as an example of, I think, the type of language that I would be happy to work with you on.

Chairman THOMAS. I appreciate that. I am currently representing an interest group of one on this issue. It may or may not extend beyond that, but that is the group I am looking out for right now.

Does the gentleman from California wish to inquire?

Mr. STARK. Thank you, Mr. Chairman. I have been trying to sort out the differences between the original bill and the bill before us. I guess the easiest way would be to ask the witnesses if they could just give me a quick summary of what was dropped from the original bill and if there was any reason other than political expediency to get a bill passed. If there was a technical reasons for dropping it, maybe you could tell us. Maybe there was no reason other than votes, that is a pretty good reason.

Could you run through quickly and give us an idea——

Mr. MARKEY. I can, if you want, just summarize——

Mr. STARK. Yes.

Mr. MARKEY [continuing]. The changes that were made. The most significant change was the deletion of language in the base bill that listed a series of adverse actions that are prohibited. Instead the——

Mr. STARK. The doctor, the termination to renew a—a refusal to renew a contract, that section?

Mr. MARKEY. Right, exactly.

Mr. STARK. OK.

Mr. MARKEY. Instead, the substitute does make clear that plans may not gag their providers. Plans that attempt to impede free communications between providers and patients would still be punished even if they have taken no retaliatory actions. The substitute contains a more focused definition of protected medical communications, deleting a long list of terms that appeared in the base bill.

The substitute includes a provision that makes clear that providers may not use the protections of this bill solely for the purpose of steering patients into a competing health plan which pays them better. That is based on language from the gag clause ban which passed the Assembly of California by a 72 to 0 vote.

Finally, the substitute narrows the focus of the bill to the core patient protections. The substitute protects only medical communications between providers and patients. This represents a change from the base bill which also protected statements made by providers directly to the health plan and to State or Federal regulators. Significant questions were raised about possible unintended consequences of these provisions and the substitute deletes them. As Dr. Ganske mentioned in his statement, we changed the test from substantial to a preponderance of the evidence as well.

Finally, we wanted to get a bill passed, too. That was also one of the reasons.

Mr. STARK. The part that addresses making statements by providers to the health plan or to the State or Federal regulators, we have a couple of lawsuits in California now where plans are refusing to give information to the State as required by State law. These changes would affect that kind of restriction, so the physicians would not be able to discuss this with State regulators. Is that one of the things that was dropped out?

Mr. GANSKE. I think that providers under an inquiry from a State or a Federal regulator, if the Secretary made an inquiry, would still be able to provide information as it relates to the gag clauses. I mean, this specifically deals with banning gag clauses.

Mr. STARK. In other words, the State would have to get the information from the plan? They could not get it from one of the physicians working in the plan, in effect? Your original bill would have allowed them to do that and, as I see it, this newer version is silent on that.

Thank you. Thank you, Mr. Chairman.

Chairman THOMAS. Does the gentleman from Nebraska wish to inquire?

Mr. CHRISTENSEN. No.

Chairman THOMAS. Does the gentleman from Washington wish to inquire?

Mr. MCDERMOTT. Yes, thank you, Mr. Chairman. I have a question. Why do you think you need a Federal law to do this? Why don't you let the insurance commissioners do it in the 50 States?

Mr. GANSKE. Well, if I may answer that, I think we need a Federal law because about 50 to 60 percent of people with employee provided insurance are not covered by State law. We are talking primarily about ERISA plans. I do feel that managed care is a legitimate option for people to have. I think that the ERISA law was set up to provide uniform standards for certain reasons. Health was folded into those pension issues. There should be a minimal, I believe, level playingfield.

I would argue, quite frankly, that the established HMO plans may find themselves at a disadvantage to a more entrepreneurial type of managed care plan which has these types of restrictions in it, because you can increase your profit line basically by decreasing the care. These gag clauses can function to do that. So, quite frankly, it is very similar to, I think, legislation we passed in the Commerce Subcommittee on telecommunications.

I think there is a role for some minimal level of regulation, particularly when you run into some egregious examples like we have

seen. So, the short answer is, because the State insurance plans do not regulate a lot of the plans.

Mr. MCDERMOTT. Well, let me just walk you through an example. One day, I was flying home to Seattle and I was sitting next to a woman who was the manager of an office for a neurologist out in Vienna, Virginia. I asked her if she had anything to do with these managed care contracts and she said, Oh yes, we have signed 70 of them. I said, Well, you have signed them, have you read them all? Do you know all the provisions that are in them? She said, Are you crazy? I could not possibly do that. She said, We have to sign all of these so that we can get paid.

Now, suppose she were to find that there was a clause or the doctor was to find that there was a clause in one of those contracts that was restrictive, a gag clause, and they wanted to deal with this. Under your bill, what would be the mechanism by which that individual neurologist could go after the particular company he had signed this contract with? Would all managed care contracts have to be reviewed by the Justice Department before they could be used by insurance companies or——

Mr. GANSKE. No.

Mr. MCDERMOTT [continuing]. Would the doctor have an individual cause of action against the insurance company because they have an illegal provision in their contract? Explain to me how that would work. I would like to know, as a physician, when I am back out there practicing after this election. What steps do I have to take under the provisions of this bill to deal with this kind of stuff?

Mr. GANSKE. Well, I do not know whether you will be back practicing after this election. [Laughter.]

The way that I would see this working is, the bill, if it is signed into law, outlaws or bans those gag clauses. Upon information of them, the Secretary of HHS could levy a $25,000 fine.

Now, let us say that you are a practicing provider, whether you are a nurse practitioner, a physical therapist, or whatever. You get a communication from the medical director of the plan. It says, "You have recommended a treatment that we are not covering. I would remind you that you have in your contract a clause that says you may not discuss treatment options unless you first get an OK from us. If this behavior persists, we will take you off our plan."

That raises some concern for that practitioner so the practitioner, I think, would then initiate a complaint and point out to the management that, under the Patient Right To Know Act, this restriction is not legal and if you persist in enforcing it, then I could bring this to the attention to the Secretary of HHS. It does not mean that the Secretary is going to look at every contract around the country. It simply provides a mechanism whereby these would be limited.

Mr. MCDERMOTT. So, it would be the general counsel of HHS who would get these cases as they came from individual practitioners, who have received a communication that they are going to be dropped because there is a clause that limits them?

Mr. GANSKE. That would be how I would envision it.

Mr. MCDERMOTT. Mr. Markey.

Mr. MARKEY. The regional HHS office, yes.

Mr. MCDERMOTT. OK.

I was listening to your answer to the Chairman about the issue of breadth of the bill versus narrowness. I think I would have answered that question a little differently or a little bit more emphatically, that you want a broad bill if you are on the side of the patient. If you are on the side of the HMO industry, you want a narrow bill. So, only psychiatrists can make referrals about psychiatric issues and only belly surgeons can talk about belly issues and neurologists only about nerves. Nobody can stray out of their very narrow constraints.

The problem, it seems to me, in trying to write any definition that gets narrow is going to be that, you have nurse practitioners and you have physicians' assistants who are operating in broad areas as well as, physicians who operate in broad areas. I think if you try to narrow this, I would be very careful in any kind of negotiations you make in terms of narrowing, because you will always take away information from the patient that they do not know about.

Even if it is a physical therapist who says, Well, I saw a case like this once and I thought this worked. Then the patient goes to the plan and says, Well, why cannot they do this. I think this might make my back feel better or whatever.

That information that comes from whatever level of practitioner is for the patients—at least gives the patient a little bit more understanding of what is going on. I would be—in your negotiations the Chairman is talking about, I would be wary of narrowing the definition.

Thank you, Mr. Chairman.

Chairman THOMAS. Does the gentleman from New York wish to inquire?

Mr. HOUGHTON. Yes, just a very quick question.

Gentlemen, it is great to see you. Thanks very much for being here and pushing this bill.

New York has just passed a bill, just about a week or so ago, doing the same thing, prohibiting gag clauses. I am not quite sure of two things, one, how your bill will fit into that. Maybe you do not know what the bill is. The other thing is, Is there a difference between written and oral communications here?

Mr. GANSKE. Well, let me answer that. I think that this bill is needed, because even if New York passes this law, about 50 percent of the residents in New York with health insurance will not be covered, because they are covered by ERISA plans that would be exempted from State regulation.

I believe that it is very important to leave oral communications in this bill, because we had ample testimony that it is not just the written contract that is a problem. It is a phone call from the medical director not recorded on paper that says, "If you keep making these referrals for this type of treatment, you are off the panel."

Picture your wife with a breast cancer and she has a lump in her breast and she goes in to her physician and he has signed one of these contracts with these gag clauses. He does her history and physical exam and there are four commonly accepted treatments. He says, Excuse me, and he leaves the room and gets on the phone and says, Can I tell the patient about these four types of treatment for this breast lump? That is what we are talking about in this bill.

Your wife or your loved one needs to know what their options are in order to make informed consent in order to get the best treatment.

Now, if that plan has in their contracts that they are not going to cover a type of treatment, let's say, bone marrow transplants, that is fine. The patient should know whether a bone marrow transplant is an option for them and then they can take up the issue of whether this is authorized or not with the company.

Chairman THOMAS. In the legal advice provided by the gentleman from Washington and your negotiations on the legislation, all of the examples that were used were fairly obvious in terms of types of doctors being able to make broad-based recommendations. Even in the example of the therapist, I think it makes some sense. I just think when you use the definition—and I am trying to explore all of the folks who are covered by that very expansive definition—you reach a point where you are in the chair with a dental hygienist cleaning your teeth and they are talking about something they read in People Magazine. It seems to me, that is a bit far afield in terms of what would be protected in this kind of legislation, based upon the gentlemen's concerns and the continued, repeated examples, including the one that he just gave.

In fact, I found it interesting. In my preparation for this, I read a number of booklets that are now being prepared to advise doctors on how to deal with contracts with managed care organizations or MCOs, as this one book called them, the "Legal Analysis of Managed Care Contracts." I do want to underscore, because I believe, Dr. Ganske, you said in your opening comments that you do not intend for this legislation to cover someone who might make disparaging remarks.

For example, in this document, "Legal Analysis of Managed Care Contracts," on page 11, they talk about marketing issues. They talk about how some contracts include provisions that prohibit you from encouraging any member to disenroll and from making disparaging remarks about any physician participants in the plan or the plan itself. "I would recommend that you get an MRI, but your health care plan is too cheap to pay for it." Then in offset type it says—this is the contract language. "Provider shall not make and shall not use his best efforts to insure that no employer of the provider or subcontractor of the provider makes any derogatory remarks regarding HMO to any member."

That is not your intent as I understand the provisions in your bill; is that correct?

Mr. GANSKE. Mr. Chairman, that is specifically the issue of a conflict of interests in terms of a provider bad-mouthing a plan in order to move a patient into a plan where their fee schedule may be better. It is a valid concern and that is why we added language to the bill that specifically preempts that.

Chairman THOMAS. I wanted to get that on the record.

Then on page 12, they go on in advice to doctors in——

Mr. GANSKE. Mr. Chairman, what are you referring to?

Chairman THOMAS. This is a Legal Analysis of Managed Care Contracts, Managed Care 2000, from Astro Merck [phonetic], a series of family practice management monographs developed through an educational grant from Astra Merck. It is sponsored by the

Family Practice Management. I looked at a number of these booklets that outline do's and don'ts.

For example, read the contract is the first thing that they say. Understand that there are supportive documents to the contract; read those, too. When you look at words, do not assume you know what they mean. If they are capitalized, you need to understand the definition. It is that kind of advice that they are giving. They then give examples, in fact, they have a sample contract.

I was just trying to understand what level of information was being provided to doctors on do's and don'ts. I found on page 12 of this particular document a recommendation from the attorneys that doctors do not sign any contract requiring you to provide the highest quality or best care. It says, "Do not sign any contract requiring you to provide the highest quality or best care." Perhaps, we need to, at a different time, spend some time finding out why folks are so concerned about making sure that the Patient Right To Know Act covers the physician or the medical provider's ability to communicate to the patient but that all of the documents in fairly bold language say do not sign a contract requiring the doctor to provide the highest quality or best care available. I need to know and understand that provision.

Have you had a chance to look at the bill that Mr. Markey referred to in his comment to the gentleman from Washington, the legislation that has passed both the assembly and the Senate and is on Governor Wilson's desk? It is recommended that he sign it. I wanted to call your attention to section D, which I believe, in reading this section—and on line 16, the last word there is peer, peer review. I believe if your legislation became law, this would not be allowed to go into effect in California.

I would like your reaction, either in terms of why it would weaken your legislation or why you would recommend that it not be included in your legislation since it passed both the assembly and the Senate in California and probably will go into effect in California if Governor Wilson signs the bill.

Mr. GANSKE. Well, Mr. Chairman, I have just briefly looked this over.

Chairman THOMAS. I understand.

Mr. GANSKE. I need to review it in more detail. It appears to me that this is not a prohibition against economic credentialing, and that is also protected in my bill. It also appears to allow sanctions of providers who fail to follow legal standards. That is also consistent with H.R. 2976.

Chairman THOMAS. Well then, I would very much like to sit down, with some more time available to us and, review this California legislation to see where it is in conflict or would be less stringent in protecting, as you would say, the patient's right to know so that we could use that as an example. My information is, the Governor is about ready to sign it.

Does the gentleman from California wish to——

Mr. STARK. Yes, thank you, Mr. Chairman. I want to go back, Mr. Markey and Hon. Dr. Ganske, here for 1 minute. Mr. Markey, in the statement you made about the major changes, the original bill protected statements made by providers directly to State or Federal regulators. I am picking the words out there.

Now, in an Los Angeles Times article, it says here that there is a court case with Pacific Care Health Systems with 11,000 complaints. Pacific Care is resisting a demand by the State Department of Corporations to access the internal records of their health plan. The department, the State's regulator of health HMOs says it sought the records after the enrollees complained.

Now, in your bill, the original bill, you talk about protecting communications—and I am jumping—but it says, with any State or Federal authority who is responsible for licensing or oversight. What I guess is, by taking that out, what you are saying is, any doctor, let's say, who talked to a State regulator or a Federal regulator could be fired. Ought they not to be protected?

I suppose a State could go in and subpoena them under a criminal action, but we are trying to get away from that. We are trying to get some interim control both at the State level and at the Federal level where you do not have to go for a criminal action to put somebody under subpoena.

Would it not be a good idea to free up the physician's ability to communicate with regulators?

Mr. GANSKE. Well, Mr. Stark, if I may address this. When we dropped a couple of those provisions, first, I think there were some concerns about communications back and forth between a provider and the health plan and it was not essential for the bill. The second part which was about whether there could be communications between Federal and State regulators was—well, we did not have any examples of plans trying to prevent that. So, if you have information on that, I would be interested in knowing about it. Since we had not really seen that as a problem, we just decided to delete the language and simplify the bill.

Mr. STARK. I guess, and I do not know if we want to get into the State issue, but it would seem to me that if there is going to be future—if we are going to look at this both through Medicare, Medicaid or through the insurance regulations, we would not want to provide a screen behind which a plan administrator could say to all of the physicians, shut up or you will get fired. Then you have to go through a whole legal routine to get testimony from them. It is something we can discuss later.

If that was not a particular issue you were concerned about in changing the bill, I would suggest that maybe we revisit that.

Thanks very much.

Mr. MARKEY. If I may——

Mr. STARK. Yes.

Mr. MARKEY. In the same way that the gentleman from California is raising issues as the gentleman from Washington and you, this is not the Magna Carta yet. [Laughter.]

Mr. STARK. That is an oak tree you are sitting under.

Mr. MARKEY. We will have the next 5 weeks at least to walk through. If you have a real life example where you think that, for example, there is a significant harm that would be created by our inability to be able to extend this law into areas where we have not, then I clearly would like to hear it. At the same time, we are not withholding any protections that already exist. We have expanded, we think, at this point as far as we could go realistically in our Subcommittee at this time.

However, we are not at all—I am, at least, not adverse to moving it on further if you want to give additional communications protections. Understand, we did it in the context of the Commerce Committee as it existed circa 1996. We think that this is a very good bill in terms of at least giving the patient the ability in their conversations with their doctor to be able to have their rights fully protected. If I could go further, of course, I would have gone further. That is a limitation. I accepted it.

Mr. STARK. I appreciate the answer from both of you.

Thank you very much, Mr. Chairman.

Chairman THOMAS. The gentleman from Washington.

Mr. MCDERMOTT. Mr. Chairman, I have always believed that everything good or bad starts in California. [Laughter.]

So, when you bring me an assembly bill, I would call to your attention——

Chairman THOMAS. We are pleased that water runs downhill and we really do look forward to Washington's water.

Mr. MCDERMOTT. So far, the Columbia has not.

In the bill from the assembly, they use the term "the ability of a physician, surgeon, or other licensed health care provider." I think the breadth of that is basically the breadth that is used in this bill. I think that is primarily because most States have a licensure law under which you have about one hundred things licensed these days.

Chairman THOMAS. I understand that. Even pulling out specific titles from the general health care provider, I think, does give an emphasis that we may want to talk about, notwithstanding the list both being universal. The way in which they describe it at least places an emphasis in terms of importance of role, perhaps. It is an area to discuss.

I want to thank both of you. Normally, as you know, members come, make a statement and there is almost a silent understanding that you would not subject them to any questions about their own legislation. We feel fairly comfortable in doing that, one, because obviously the gentleman is not only knowledgeable from a theoretical point of view, but he is also very knowledgeable from a realistic point of view. The gentleman from Massachusetts has been involved in this area for some time.

In addition to that, if we are going to go with sequential referral and the bill originated in your Committee, given the shared jurisdiction that we have, I think it is extremely important and valuable for us to talk with each other from the two Committees in a way in which we can inquire of a substantive nature.

So, I want to thank both of you, not only for making the historically usual visit, but also for allowing us to ask you some questions, which I think will help us in framing how we may approach the bill from our Subcommittee's jurisdiction.

Mr. MARKEY. May I say, Mr. Chairman, I understand and appreciate the fact that congressional expert is an oxymoron, if we are describing a Congressman. The next panel is one of real experts and I have just had the good fortune, however, of testifying with someone who happens to also have the benefit of being an expert and a Congressman at the same time on this subject.

Chairman THOMAS. We thank both of you for your contribution.

Mr. GANSKE. Thank you, Mr. Chairman.

Chairman THOMAS. The next panel is described as a panel of legal experts, Dr. Peter Kongstvedt, who is partner and national practice director of the Managed Care Strategy and Medical Management Section of the Managed Care Group of Ernst and Young; Joel Stocker from Greenberg Traurig, Miami, Florida; and Mark Rust, a partner in Kamensky and Rubinstein law firm in Chicago.

I would tell each of you that your written testimony will be made a part of the record. You may proceed to inform the Subcommittee in any manner you see fit in the timeframe that you have available. We will begin with Dr. Kongstvedt and move to the rest of the panelists.

Doctor.

STATEMENT OF PETER R. KONGSTVEDT, M.D., PARTNER AND NATIONAL PRACTICE DIRECTOR, MANAGED CARE STRATEGY AND MEDICAL MANAGEMENT SECTION, MANAGED CARE GROUP, ERNST AND YOUNG, LLP

Dr. KONGSTVEDT. Thank you, Mr. Chairman. My name is Peter Kongstvedt. I am a board-certified physician of internal medicine and a fellow in the American College of Physicians. I appreciate your introduction.

On behalf of Ernst and Young, LLP, I would like to thank you for inviting me to testify.

In the popular press, the issue at hand has been labeled the gag rule or the gag clause. Many groups charge that HMOs and PPOs have sought to restrict or gag what a contracting provider may or may not discuss with a health plan member, including discussions related to the provision of patient care and to the health plan's business secrets.

Using the technique of orchestrated outrage, the issue has been brought to the public's attention, using such examples as the cover of a widely circulated news magazine featuring the photo of a model wearing surgical scrubs and mask, ostensibly to represent a gag physician. Using another technique known as the identifiable victim, others have used anecdotes to describe the issue in terms of a misfortune that has occurred to an individual, ascribing that misfortune to the provision in the contract between the health plan and the physician.

In Ernst and Young's dealings with a broad representation of the health care industry, predominantly on the provider's side, we have not actually seen evidence of the gag rule being an issue. The issue at hand does appear to be somewhat difficult to surface. In all honesty, I can say that I have not personally seen such a gag clause in its most restrictive format, but it is possible that such a contract does exist, because I certainly cannot claim to have seen every contract in existence.

At the same time, there are indeed clauses in these contracts that serve to control certain aspects of communication between physicians and members of health plans, as illustrated in the attachment to my testimony. The three common forms of such clauses include those related to business secrets, those related to the plan's market position and those related to compliance with the plan's medical management program. It is common in contracts

between physicians and health plans to require the physicians to respect and maintain the confidentiality of the business secrets of the health plans, the most common example being fee schedules and capitation schedules and, in some cases, also secrets of third-party vendors.

Clauses related to the health plans's market position are designed to prevent a contracting physician from taking actions or making statements that would harm the business interests of the health plan. The most common example are restrictions on a physician from encouraging patients to join a competing plan for whatever reasons, but primarily because the other plan pays better.

The clause also encompasses the possibility that the health plan terminates its contract with the physician. The physician then encourages patients to switch to a plan that does continue to cover the services of that physician. Both of these positions are very easily understood and obviously easy to defend, but they are primarily economic. The health plan wishes to maintain its membership base. The physician wishes to maintain his or her patient base. It is difficult to state which party in any given event may have the better economic case.

Contracts between health plans and physicians commonly contain language contractually requiring physicians to comply with the medical management program. Such medical management programs, which are the hallmark of managed care, usually focus on utilization management and quality management. Problems may arise when the physician and the health plan disagree about a course of treatment or when the physician or health plan want to use a particular provider or hospital but the health plan does not use that provider or hospital.

I personally know of no health plans that deliberately and/or systematically deny medically necessary services to members, although the ongoing debate about the definition and, therefore, coverage of experimental investigational medical services makes this issue an ever changing one. It is not in the best business interests, to say nothing about the moral, ethical and legal interests of either a health plan or the physicians that it contracts with to deny truly needed care. If care is truly needed and not provided, the patient gets sicker and is likely to become more expensive to treat in the future.

In addition, if either the plan or the providers engage in such systematic or deliberate behavior, the effect on the market and sales would ultimately be very detrimental.

Health plans usually have contract clauses that expressly state that the health plan is not in the practice of medicine and the physician is obligated to undertake the proper clinical course of action. Health plans routinely include such clauses for several reasons, not the least of which is to lower their exposure under joint and several responsibility or respondeat superior. A gag clause would undermine the risk management aspect of that clause in the contract.

The conflict between providers and health plans may not be legal or contractual, but rather lie in the implementation of those contractual terms. I will be the first to acknowledge that it is more than possible that some health plans and some medical directors are inept at carrying out their functions, whatever the actual policy

and the position of the health plan is. In those cases, it is possible that an incompetent medical director could communicate an adverse coverage ruling in such a way as to make the network provider perceive a threat or, worse yet, actually threaten the provider with termination from the plan, despite having no sound contractual or policy grounds for such a threat.

Likewise, it is possible that there are some who are using this issue to resolve by legislative means the problems that they cannot resolve in the marketplace. It is always a risk, when Congress contemplates legislative action, that there will be unintended consequences, particularly when there is a high talk to reality ratio. Some examples, which have been discussed, include increasing litigation based on creative interpretation of the law, lobbying patients under the guise of medical communications about health plan movement for reasons that may be detrimental to the competitive process and the creation of a precedent that, when business disputes arise between physicians and health plans, the Congress will be required to pass ever more detailed laws controlling the management of health plans and physicians.

Mr. Chairman, to answer some of the questions surrounding these issues, Ernst and Young, LLP does have a proposal to submit for your consideration. We would consider undertaking an examination of a representative sampling of nongroup, nonstaff model HMOs to validate the process in the contractual relationship between providers and health plans to determine this relationship's impact on physician-patient communications. This would encompass various aspects and, Mr. Chairman, if you will allow me 30 more seconds, I will conclude.

Including the legal aspects, does the health plan have clauses in place in their provider contracts which constitute the commonly accepted definition of the gag clause, that is, restrictions and discussions by a contracting provider with the health plan member regarding the full range of treatment options available, regardless of what is covered and behavior? Does the plan exclusively promote through its legal and QA processes open full communications between providers and patients? If such communications are indeed hindered, is the problem surrounding the gag issue at the plan systemic or individual in nature?

We are pleased to offer our services on a pro bono basis with the cooperation of the providers and the health plan industry.

Mr. Chairman, thank you again for the opportunity to testify.

[The prepared statement and attachments follow:]

STATEMENT OF
PETER R. KONGSTVEDT, M.D., FACP, PARTNER
ERNST & YOUNG LLP

Introduction

My name is Peter R. Kongstvedt, M.D., F.A.C.P. I am a board-certified physician of Internal Medicine and a Fellow of the American College of Physicians. I am a partner in the Washington, DC office of Ernst & Young LLP, where I serve as the National Practice Leader for Managed Care Strategy and Medical Management for the firm's Managed Care Group. Professionally, I lead and assist in the development of health care quality and cost-containment strategies for a variety of health care clients, including providers, integrated delivery systems, and health plans. I also serve as one of Ernst & Young's leaders in the research and development of issues impacting managed care systems. I am the editor and principal author of *The Managed Health Care Handbook, 3rd Edition*, published by Aspen Publishers. This text, and its companion text, *The Essentials of Managed Health Care*, are the leading texts on managed care in the country today and are in use in a large number of graduate programs in health care administration.

Mr. Chairman, on behalf of Ernst & Young LLP, I would like to thank you for allowing me the opportunity to share with this committee our observations and experiences regarding the nature of physician/health plan contracting and how this relationship impacts patient care.

The Issue

There are largely two issues before the committee today: the physician/health plan relationship and what communications, if any, should be considered to be "protected medical communication" between a contracting physician and a health plan member. By their very nature, contractual arrangements between providers and health plans are complex. These arrangements encompass numerous issues, including compensation, plan protocols, and the provision of medical care. As is apparent in Attachment 1 (reprinted with permission from *The Managed Health Care Handbook, 3rd Edition)*, there are a great many contractual terms in most legal agreements between physicians and health plans. In the popular press, this issue has been labeled the "gag rule" or "gag clause." Some groups have charged that health plans, including health maintenance organizations (HMOs) and preferred provider organizations (PPOs), have sought to restrict, or "gag," what a contracting provider may and may not discuss with a health plan member, including discussions related to the provision of patient care and to the health plan's business secrets. To remedy these alleged restrictions, some groups are advancing legislation, including H.R. 2976, "The Patient Right to Know Act," sponsored by Representatives Greg Ganske (R-Iowa) and Edward Markey (D-Mass.), which would define what physician/patient communications may be considered to be protected medical communications and provide penalties for health plans who violate these protections. Using the technique of Orchestrated Outrage, this issue has been brought to the public's attention using such examples as the cover of a widely circulated news magazine featuring a photo of a model wearing surgical scrubs and a surgical mask, ostensibly to represent a "gagged" physician. Using another technique known as The Identifiable Victim, others have used anecdotes to describe this issue in terms of a misfortune that has occurred to an individual, ascribing that misfortune to this alleged "gag" provision in the contract between the health plan and the physician.

The Reality

Quite frankly, in Ernst & Young's dealings with a broad representation of the health care industry, we have not seen evidence of the "gag rule" being an issue. The issue at hand appears to be the Sasquatch of managed care: it is large, ugly, hairy, and scary, however, producing the actual thing has proven to be quite difficult. Despite the public discussion, there have been few concrete examples of unedited contracts that support the claim that such inappropriate "gag" rules actually exist. In all honesty, I can say that I have never seen such a clause, despite having reviewed personally several hundred such contracts in the course of my career. Nonetheless, health plans appear to be sensitive to even the perception that they "gag" their physicians. In at least one well publicized case, a health plan was accused of having a "gag clause." While the plan denied that it was their intent to "gag" providers, they changed the clause anyway.

At the same time, there are indeed clauses in these contracts that serve to control certain aspects of communication between physicians and members of health plans. As illustrated in Attachment 1, there are three common forms of such clauses:

- those related to business secrets
- those related to the plan's market position, and
- those related to compliance with a health plan's medical management program

Business Secrets

It is common in contracts between physicians and health plans to require the physician to respect and maintain the confidentiality of the business secrets of the health plan. In some cases, these business secrets are the property of the health plan; the most common example of such secrets are fee schedules or capitation schedules (i.e., the financial terms or payment terms between the health plan and the physician). In other cases, the business secrets are the property of a third party vendor with which the health plan has contracted. A common example of such an arrangement would be clinical management protocols licensed from a medical management or disease management organization. These business secrets are generally considered to be proprietary because they foster competition between health plans -- competition which has been found in many surveys both to lower overall health care costs and maintain or improve the quality of care provided.

The Health Plan's Market Position

Clauses related to a health plan's market position are designed to prevent a contracting physician from taking actions or making statements that would harm the business interests of the health plan. These clauses have no bearing on the provision of care. A common example of these clauses would be a plan restricting a physician from encouraging patients to join a competing health plan ostensibly for reasons of quality, but in fact because the competing health plan pays better.[1]

This clause also encompasses another possibility: in the uncommon event a health plan terminates its contract with a physician, the physician may then encourage patients covered by that health plan to change coverage to another plan that will continue to cover services of that physician. Both positions are quite understandable: the health plan wishes to protect its membership base, while the physician wishes to protect her or his patient base. In both cases, the reasons for doing this are primarily economic and it is thus harder to clearly state which party is more deserving economically.

[1] In the case of sophisticated providers with equity positions or other forms of incentives, this might include encouraging only healthy patients/members to switch plans, leaving the sick ones behind. This is generally referred to as Adverse Selection.

Compliance With Medical Management Programs

Contracts between health plans and physicians commonly contain language contractually requiring the physician to comply with the plan's medical management program. Such medical management programs, which are the hallmark of managed care, usually focus on utilization management and on quality management. It is perhaps in this area that much of the confusion by both physicians and health plans occurs.

This clause (or section of the contract) may be broadly defined, leaving the specifics of the medical management program to an appendix or a policy and procedure manual. The clause may be specific, such as requiring a physician to contact the health plan prior to authorizing a referral or an admission. In a similar fashion, the contract may be specific with regards to requirements under the quality management program such as credentialing criteria or allowing the health plan to have access to clinical records for peer review.

Where problems may arise is when a physician and a health plan disagree about a course of treatment, or when a physician or patient want to use a particular provider or hospital, but the health plan does not use that provider or hospital. In those cases, the physician is most likely to tell the patient that the health plan has not approved a particular provider or hospital (for payment only, of course; the health plan cannot control what the patient actually does, only for what the health plan will pay). Most well-run health plans have rapid dispute resolution policies to resolve these disagreements in a timely manner, but it is possible and likely that some health plans do not carry out that activity with alacrity.

I personally know of no health plans that deliberately and/or systematically deny medically necessary services to members, although the ongoing debate about the definition (and therefore coverage) of experimental and investigational medical services makes this issue an ever-changing one. It is not in the best business interests – to say nothing about the moral, ethical, and legal interests -- of either a health plan or the physicians it places "at risk" to deny needed care: if care is truly needed and not provided, the patient gets sicker and is likely to become more expensive to treat in the future. Additionally, if either the plan or its providers engage in such systematic or deliberate behavior, the effect on their marketing and sales would be quite detrimental – something that managed care plans can ill-afford in this current environment of intense market competition. Many employers have used managed care to reduce their exposure to spiraling health care cost increases. These employers are holding health plans accountable for the quality of the services they provide. Indeed, many employers require health plans to adhere to strict quality guidelines, such as those developed by the National Committee for Quality Assurance (NCQA), an independent, not-for-profit organization which credentials HMOs. With respect to "gag clauses," the NCQA Accreditation Standards specifically prohibit managed care organizations from placing any "restrictions on the clinical dialogue between practitioner and patient."[2]

Health plans, as illustrated in Attachment 1, usually have contract clauses that expressly state that the health plan is not in the practice of medicine, and that the physician is obligated to undertake the proper clinical course of action. In other words, if a dispute cannot be resolved, the physician must take appropriate clinical action. The physician and health plan can argue the financial issues later without involving the patient. Health plans routinely include such clauses for several reasons, not the least of which is to lower their exposure under Joint and Several Responsibility and/or Respondeat Superior. A "gag clause" would undermine that risk-management aspect of the contract.

Moreover, the conflict between provider and health plan may not be legal or contractual, but rather lie in the *implementation* of mutually agreed upon contractual terms. I would be the first to acknowledge that it is more than possible that some health plans and some medical directors could be inept at carrying out their functions, whatever the actual policy and position of the healthplan is. In those cases, it is possible that an incompetent medical director could communicate an adverse coverage ruling in such a way as to make a network provider perceive a threat to their status as a contracting provider, or worse yet, actually threaten a provider with termination from the plan despite having no contractual or policy grounds for such a threat.

Likewise, it is more than possible that there are some physicians who are using this issue to try and solve via legislative means what they cannot solve in the marketplace. There are certainly some physicians who do not like managed care in any form, and who do not wish to see any organization involved in changing the way they practice medicine – even if the care they provide is not appropriate treatment, is not performed in the right setting, is of questionable quality, and is ultimately unaffordable. It is also possible that there are some physicians who are hearing what is *not* being said about managed care or who are very worried about the emergence of managed care, even if they have not actually experienced it themselves.

Lastly, the health care marketplace is witnessing the rapid growth of provider-based integrated delivery systems. These organizations seek not only to provide medical care, but to manage the financial aspects of that care as well. In these systems, this very same issue of "gag clauses" and provider/patient communications arises. However, it is not the health plan that is managing the communications, it is the providers themselves. These systems have the very same needs for compliance with medical management programs, protection of business secrets, and protection of their market share. The needs of these provider-sponsored systems will create these same issues being discussed here today. In fact, one increasingly popular approach for many large and sophisticated health plans is to capitate globally integrated delivery and financing systems, and have those systems manage these aspects of the plan.

Unintended Consequences

There is always risk when Congress contemplates legislative action, especially when that action is taken to deal with something that has a high talk-to-reality ratio. Global responses to discreet and scattered problems raise the possibility of unintended consequences. I respectfully caution Members of this committee that the potential for these unintended consequences is both *real* and *genuine*. Examples germane to this discussion could include (depending on the type of legislation being considered):

- Increased litigation by physicians, members, and others based on a "creative" interpretation of the law;
- Physicians may "lobby" patients under the guise of "medical communications" about health plan selection for reasons that may be self-serving to the physician, and detrimental to the health plan;
- A reduction or removal of incentives for physicians to comply with medical management policies of health plans;
- Physicians who have been terminated from the health plan (which is not common, but clearly does occur; not every one of the over 650,000 physicians in the U.S. is going to be a good physician or be able to practice in a managed care
- environment) would be permitted to claim that the only basis for termination was communications -- a claim that could easily be created by the physician simply talking at great length to their patients about the physician's complaints;

[2] 1996 NCQA Review Guidelines, *Members Rights and Responsibilities* standard 1.1.3.

- Provider Sponsored Organizations (envisioned under many Medicare Reform initiatives, and actively sought by most provider organizations) would find it more difficult to carry out effectively medical management activities for the same reasons that would apply to health plans; and

- The creation of precedent that when business disputes arise between physicians and health plans, Congress will be required to pass ever-more detailed laws controlling the management of health plans and physicians – a direction with which the nation as a whole is not comfortable.

A Proposal

As the health care marketplace continues to evolve, pressures to provide accountable, high-quality, and cost-effective health care based upon the best medical practices and outcomes will only increase. As a condition of enrolling in a health plan, many employers are moving to seek comparative "report cards" and other standardized quality information about health plans. Additionally, government actions may also change the health care landscape. In the coming years, these market and government pressures will only intensify.

Against this backdrop, the controversy surrounding "gag" clauses is being debated. It is my understanding that this hearing is being held to address many questions, including:

- What *is* the problem surrounding the perception by providers that they are being "gagged?"

- If there is indeed a problem, what is the scope of the problem? Is it system-wide or does it rest largely with a few "bad apples" in the managed care industry?

- How can an assessment be made of the issues surrounding physician/health plan contracting and physician/patient communication?

- What systemic processes do health plans have in place that balances the concerns of providers and health plans and the patients they serve? If a health plan does not have a system *in* place, should that absence be taken as a measure of the plan's overall quality?

Mr. Chairman, to answer many of the questions surrounding these concerns, Ernst & Young LLP would like to submit for your consideration the following:

Ernst & Young LLP would consider undertaking an examination of a representative sampling of non-group and non-staff model HMOs to validate the process begetting the contractual relationship between providers and health plans and to determine this relationship's impact on physician-patient communication.
This examination would encompass the various aspects of the physician/health plan relationship and its impact on patient care, including:

- ***Legal.*** **Does the health plan have clauses in place in their provider contracts which constitute the commonly accepted definition of "gag clause" – that is, restrictions on discussions by a contracting provider with a health plan member regarding the full range of treatment options available to the member, regardless of whether is it covered by the plan?**

- ***Behavior.*** **Does the plan explicitly promote, through both its legal and QA processes, open and full communication between providers and their patients? *If such communications are indeed hindered* is the problem surrounding the "gag" issue at the plan systemic or individual in nature?**

Mr. Chairman, Ernst & Young LLP is pleased to offer our services on a *pro bono* basis and would collaborate with industry associations and plans. We would develop a survey technique that would allow the plan to demonstrate its management practices with regard to this issue.

Mr. Chairman, thank you again for the opportunity to testify. In the coming months, I look forward to working with you, other Members of the committee, and organizations represented here today to answer the questions surrounding the "gag" issue. At this time, I would be happy to answer any questions you may have about either the "gag" issue or our proposal.

THE MANAGED Health Care Handbook

Third Edition

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Legal Issues in Provider Contracting

Mark S. Joffe

The business of a managed health care plan is to provide or arrange for the provision of health care services. Most managed health care plans, such as health maintenance organizations (HMOs) and preferred provider organizations, provide their services through arrangements with individual physicians, independent practice associations (IPAs), medical groups, hospitals, and other types of health care professionals and facilities. The provider contract formalizes the managed health care plan–provider relationship. A carefully drafted contract accomplishes more than mere memorializing of the arrangement between the parties. A well-written contract can foster a positive relationship between the provider and the managed health care plan. Moreover, a good contract can provide important and needed protections to both parties if the relationship sours.

This chapter is intended to offer to the managed health care plan and the provider a practical guide to reviewing and drafting a provider contract. Appendixes 55–A and 55–B are a sample HMO–primary care physician agreement and a sample HMO–hospital agreement, respectively. These contracts, which have been provided solely for illustrative purposes, have been annotated by the author. Although these agreements are used by an HMO, most provisions have equal applicability to other managed care plans.

Contracts need not be complex or lengthy to be legally binding and enforceable. A single-sentence letter agreement between a hospital and a managed health care plan that says that the hospital agrees to provide access to its facility to enrollees of the managed health care plan in exchange for payment of billed charges is a valid contract. If a single-paragraph agreement is legally binding, why is it necessary for managed health care plan–provider contracts to be so lengthy? The answer is twofold. First, many terms of the contract, although not required, perform useful functions by articulating the rights and responsibilities of the parties. As managed care becomes an increasingly important revenue source to providers, a clear understanding of these rights and responsibilities becomes increasingly important. Second, a growing number of contractual provisions are required by state licensure regulations (e.g., a hold-harmless

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clause) or by government payer programs (e.g., Medicare and Medicaid).

An ideal contract or contract form does not exist. Appropriate contract terms vary depending on the issues of concern and the objectives of the parties, each party's relative negotiating strength, and the desired degree of formality. Although the focus of this chapter is explaining key substantive provisions in a contract, the importance of clarity cannot be overstated. A poorly written contract confuses and misleads the parties. Lack of clarity increases substantially the likelihood of disagreements over the meaning of contract language. A contract not only should be written in simple, commonly understood language but also should be well organized so that either party is able to find and review provisions as quickly and easily as possible.

The need for clarity has become more important as contracts have become increasingly complex. Many managed health care plans may act as an HMO, a preferred provider organization, and a third party administrator. Those health care plans will frequently enter into a single contract with a provider to provide services in all three capacities. In addition, this single contract may obligate the provider to furnish services not only to the managed health care plans enrollees but to enrollees of a number of affiliates of the managed health care plan.

The following discussion is designed to provide a workable guide for managed health care plans and providers to draft, amend, or review contracts. Much of the discussion is cast from the perspective of the managed health care plan, but the points are equally valid from the provider's perspective. Most of the discussion relates to contracts directly between the managed health care plan and the provider of services. When the contract is between the managed health care plan and an IPA or medical group, the managed health care plan needs to ensure that the areas discussed below are appropriately addressed in both the managed health care plan's contract and the contract between the IPA or medical group and the provider.

GENERAL ISSUES IN CONTRACTING

Key Objectives

The managed health care plan should divide key objectives into two categories: those that are essential and those that, although not essential, are highly desirable. Throughout the negotiation process, a managed health care plan needs to keep in mind both the musts and the highly desirables. Not infrequently, a managed health care plan or a provider will suddenly realize at the end of the negotiation process that it has not achieved all its basic goals. The managed health care plan's key objectives will vary. If the managed health care plan is in a community with a single provider of a particular specialty service, merely entering into a contract on any terms with the provider may be its objective. On the other hand, the managed health care plan's objectives might be quite complex, and it may demand carefully planned negotiations to achieve them.

"Must" objectives may derive from state and federal regulations, which may require or prohibit particular clauses in contracts. Managed health care plans need to be aware of these requirements and make sure that their contracting providers understand that these provisions are required by law.

Beyond the essential objectives are the highly desirable ones. Before commencing the drafting or the negotiation of the contract, the managed health care plan should list these objectives and have a good understanding of their relative importance. This preliminary thought process assists the managed health care plan in developing its negotiating strategy.

Annual Calendar

Key provider contracts may take months to negotiate. If the contemplated arrangement with the provider is important to the managed health care plan's delivery system, the managed health care plan will want to avoid the diminution of its

bargaining strength as the desired effective date approaches.

The managed health care plan should have a master schedule identifying the contracts that need to be entered into and renewed. This schedule should include time lines that identify dates by which progress on key contract negotiations should take place. Although such an orderly system may be difficult to maintain, it may protect the managed health care plan from potential problems that may arise if it is forced to operate without a contract or negotiate from a weakened position.

Letter of Intent Compared with a Contract

The purpose of a letter of intent is to define the basic elements of a contemplated arrangement or transaction between two parties. A letter of intent is used most often when the negotiation process between two parties is expected to be lengthy and expensive (e.g., a major acquisition). A letter of intent is a preliminary, nonbinding agreement that allows the parties to ascertain whether they are able to agree on key terms. If the parties agree on a letter of intent, the terms of that letter serve as the blueprint for the contract. Some people confuse a letter of intent with a letter of agreement. Because a letter of intent is not a legally binding agreement, regulators will not consider them in evaluating whether a managed care organization meets availability and accessibility requirements. Therefore, the use of a letter of intent should be limited to identifying the general parameters of a future contract.

Negotiating Strategy

Negotiating strategy is determined by objectives and relative negotiating strength. Depending on the locale or market dynamics, either the managed health care plan or the provider may have greater negotiating strength. Except in circumstances in which the relative negotiating strength is so one-sided that one party can dictate the terms to the other party, each party should identify for itself before beginning negotiations the negotiable issues, the party's initial position on each issue, and the extent to which it will compromise. Because a managed health care plan may use the same contract form as the contract for many providers, the managed health care plan needs to keep in mind the implications of amending one contract for the other contracts that use the same form.

A recurring theme presented at conference sessions discussing provider contracting and provider relations is the need to foster a win–win relationship, where both parties perceive that they gain from the relationship. The managed health care plan's objective should be fostering long-term, mutually satisfactory relationships with providers. When managed health care plans have enough negotiating strength to dictate the contract terms, they should exercise that strength cautiously to ensure that their short-term actions do not jeopardize their long-term goals.

CONTRACT STRUCTURE

As mentioned above, clarity is an important objective in drafting a provider contract. A key factor affecting the degree of clarity of a contract is the manner in which the agreement is organized. In fact, many managed health care plan contracts follow fairly similar formats. The contract begins with a title describing the instrument (e.g., "Primary Care Physician Agreement"). After this is the caption, which identifies the names of the parties and the legal action taken, along with the transition, which contains words signifying that the parties have entered into an agreement. Then, the contract includes the recitals, which are best explained as the "wherein" clauses. These clauses are not intended to have legal significance but may become relevant to resolve inconsistencies in the body of the contract or if the drafter inappropriately includes substantive provisions in them. The use of the word *wherein* is merely tradition and has no legal significance.

The next section of the contract is the definitions section, which includes definitions of all key contract terms. The definitions section pre-

codes the operative language, including the substantive health-related provisions that define the responsibilities and obligations of each of the parties, representations and warranties, and declarations. The last section of the contract, the closing or testimonium, reflects the assent of the parties through their signatures. Sometimes, the drafters of a provider contract decide to have the signature page on the first page for administrative simplicity.

Contracts frequently incorporate by reference other documents, some of which will be appended to the agreement as attachments or exhibits. As discussed further below, managed health care plans frequently reserve the right to amend some of these referenced documents unilaterally.

The contract's form or structure is intended to accomplish three purposes: to simplify a reader's use and understanding of the agreement, to facilitate amendment or revision of the contract where the contract form has been used for many providers, and to streamline the administrative process necessary to submit and obtain regulatory approvals. Clarity and efficiency can be attained by using commonly understood terms, avoiding legal or technical jargon, using definitions to explain key and frequently used terms, and using well-organized headings and a numbering system. The ultimate objective is that any representative of the managed health care plan or the provider who has an interest in an issue will be able to find the pertinent contract provision easily and understand its meaning.

Exhibits and appendixes are frequently used by managed health care plans to promote efficiency in administering many provider contracts. The managed health care plan, to the extent possible, could design many of its provider contracts or groups of provider contracts around a core set of common requirements. Exhibits may be used to identify the terms that may vary, such as payment rates and provider responsibilities. This approach has several advantages. First, it eases the administrative burden in drafting and revising contracts. Second, if an appendix or exhibit is the only part of the contract that is being amended and has a separate state insurance department provider number, the managed health care plan need only submit the amendment for state review. Third, when a contract is under consideration for renewal and the key issue is the payment rate, having the payment rate listed separately in the appendix lessens the likelihood that the provider will review and suggest amending other provisions of the contract.

COMMON CLAUSES, PROVISIONS, AND KEY FACTORS

Names

The initial paragraph of the contract will identify the names of the parties entering into the agreement. It is always a good idea to ensure that the parties named in the opening paragraph are the parties that are signing the agreement. If a managed health care organization is signing the agreement on behalf of affiliates, the provider may want to have the signing party represent and warrant that it is authorized to sign on behalf of the nonsigning party. If the nonsigning party is much stronger financially than the signing party, it would be worthwhile to have a representation directly from the nonsigning party that the signing party may enter into the agreement on its behalf. In reviewing a contract, providers should be particularly sensitive to the responsibilities of nonparties to the agreement and the ability of the provider to enforce these responsibilities. For example, if a managed care organization is offering services to self-insured employers, is the self-insured employer a party to the agreement? If not, what assurances does the provider have that the self-insured employer will fulfill its responsibilities?

Recitals

A contract will typically contain, in rather legalistic prose, a series of statements describing who the parties are and what they are trying to accomplish. These recitals should be general statements. Periodically, however, contract

drafters insert substantive requirements in the recitals section. Contract reviewers should be sensitive to this possibility.

Table of Contents

Although a table of contents has no legal significance, the reader will be greatly assisted in finding pertinent sections in a long contract by referring to the table of contents. One common failing in contract renegotiations is neglecting to update the table of contents after the contract has been amended.

Definitions

The definitions section of a contract plays an essential role in simplifying the structure, and the reader's understanding, of a contract. The body of the contract often contains complicated terms that merit amplification and explanation. The use of a definition, although requiring the reader to refer back to an earlier section for a meaning, simplifies greatly the discussion in the body of the agreement. A poorly drafted contract will define unnecessary terms or define terms in a manner that is inconsistent with their use in the body of the agreement.

Defined terms are frequently capitalized in a contract to alert the reader that the word is defined. Definitions are almost essential in many contracts, but their use may complicate the understanding of the agreement. Someone who reads a contract will first read a definition without knowing its significance. Later, when he or she reads the body of the contract, he or she may no longer recall a term's meaning. For this reason, someone reviewing a contract for the first time should read the definitions twice: initially and then in the context of each term's use. Definitions sections tend to err on the side of containing too many definitions. A term that is used only once in a contract need not be defined. On the other hand, a critical reader of a contract will identify instances in which the contract could be improved by the use of additional definitions.

In reviewing a contract, managed health care organizations and providers should not underestimate the importance of definitions of the parties' responsibilities.

An occasional defect in some contracts is that the drafter includes substantive contract provisions in the definitions. A definition is merely an explanation of a meaning of a term and should not contain substantive provisions. This does not mean that a definition that imposes a substantive obligation on a party is invalid. In reviewing a contract, if a party identifies a substantive provision in a definition, the party should ensure that its usage is consistent with the corresponding provision in the body of the contract.

Terms that are commonly defined in a managed care context are *member*, *subscriber*, *medical director*, *provider*, *payer*, *physician*, *primary care physician*, *emergency*, *medically necessary*, and *utilization review program*. Some of these terms, such as *medically necessary*, are crucial to a party's understanding of its responsibilities and should be considered carefully in the review of a contract. In many managed care agreements, payers and not the managed health care organization are responsible for payment under the contract. In this case, who is a payer and how a payer is selected and removed become important to the provider. The definition of *member* or *enrollee* is also important. The contract should convey clearly who is covered under the agreement, but it should be clear as to whom the managed health care organization can add in the future. The managed health care plan and provider should ensure that these terms are consistent, if appropriate, with those in other contracts (e.g., the group enrollment agreement).

Provider Obligations

Provider Services

Because the purpose of the agreement is to contract for the provision of health services, the description of those services in the contract is important. As mentioned above, the recitation of

services to be furnished by the provider could be set out either in the contract or in an exhibit or attachment. An exhibit format frequently allows the party more flexibility and administrative simplicity when it amends the exhibited portion of the agreement, particularly when the change requires regulatory approval.

Contracts may use the term *provider services* to denote the range of services that is to be provided under the contract. Managed health care organizations frequently adapt physician contracts to apply to ancillary providers. In so doing, the managed health care organization may not revise language that is applicable only to physicians and apply it to an ancillary provider. Nonphysician providers should consider this issue in reviewing a contract.

The contract needs to specify to whom the provider is obligated to furnish services. Although the answer is that the provider furnishes services to covered enrollees, the contract needs to define what is meant by *covered enrollee*, explain how the provider will learn who is covered, and assign the responsibility for payment if services are furnished to a noncovered person. Managed health care organizations and providers frequently disagree on this issue. The providers' view is frequently that if the managed care organization represented that the individual was covered, the managed care organization should be responsible for payment. In contrast, the managed care organization frequently asserts that it should not be responsible for the costs of services provided to noncovered enrollees and that the provider should seek payment directly from the individual. This issue is oftentimes resolved based on relative negotiating strength.

Provider contracts should also cover adequately a number of other provider responsibilities, including the provider's responsibilities to refer or to accept referrals of enrollees, the days and times of days the provider agrees to be available to provide services, and substitute on-call arrangements, if appropriate. Provider contracts may also specify the qualifications necessary for the provider of back-up services when the provider is not available. Some of these functions may be prescribed as conditions of participation in public programs, such as the Medicare risk-contracting program.

If the provider is a hospital, the contract will include language identifying the circumstances in which the managed health care plan agrees to be responsible or not responsible for services provided to nonemergency patients. A fairly common provision in hospital contracts states that the hospital, except in emergencies, must as a prerequisite to admit have the order of the participating physician or other preadmission authorization. The hospital contract also should have an explicit provision requiring that the managed health care plan be notified within a specified period after an emergency admission. A related policy and contracting issue is whether the hospital should be entitled to reimbursement for performing the initial screen that is required when a patient goes to the emergency department.

A good provider contract must be supplemented by a competent provider relations program to ensure that problems that arise are resolved and that the providers have a means to answer questions about their contract responsibilities. Providers will frequently be given the opportunity to appeal internally claim denials and decisions of non-medical necessity by the managed care organization.

Nondiscriminatory Requirements

Provider agreements frequently contain clauses obligating the provider to furnish services to the health care plan's patients in the same manner as the provider furnishes services to non-managed health care patients (i.e., not to discriminate on the basis of payment source). In addition, a clause is used to prohibit other types of discrimination on the basis of race, color, sex, age, disability, religion, and national origin. Government contracts may require the use of specific contract language, including a reference to compliance with the Americans with Disabilities Act. As an alternative, the managed care organization and provider may want to add a second contract clause that requires compliance

with all nondiscrimination requirements under federal, state, and local law. These obligations may also apply to subcontractors of the provider.

Compliance with Utilization Review Standards and Protocols and the Quality Assurance Program

The success of the managed care organization is dependent on its providers being able and willing to control unnecessary utilization. To do so, the providers need to follow the utilization review guidelines of the managed health care plan. The contract needs to set out the provider's responsibilities in carrying out the managed health care plan's utilization review program. The managed health care plan's dilemma is how to articulate this obligation in the contract when the utilization review program may be quite detailed and frequently is updated over time. One option used by some managed care organizations is to append the utilization review program to the contract as an exhibit. A second option is merely to incorporate the program by reference. In either case, it is important for the managed health care plan to ensure that the contract allows it to amend the utilization review standards in the future without the consent of the provider. If the managed health care plan does not append a cross-referenced standard, the managed health care plan should give each provider a copy of the guidelines and any amendments. Without this documentation, the provider might argue that it did not agree to the guidelines or subsequent amendments.

The contract needs to inform providers of their responsibilities to cooperate in efforts by the managed health care plan to ensure compliance and the implications of the provider not meeting the guidelines. Contracts differ on whether the managed health care plan is seeking the provider's cooperation or compliance. The current Health Care Financing Administration (HCFA) guidelines for provider contracts require that the provider cooperate with and participate in the managed health care plan's quality assurance program, member grievance system, and utilization review program. Providers generally favor an obligation to cooperate with these programs rather than one to comply because a requirement to comply with the programs decisions seems to preclude the right to disagree.

The same basic concepts and principles apply to the provider's acceptance of the managed health care plan's quality assurance program. Some managed health care plans tend to equate their utilization review and their quality assurance programs. This attitude not only reflects a misunderstanding of the objectives of the two programs but is likely to engender the concern or criticism of government regulators, which view the two programs as being separate. In the last several years, as managed health care plans have placed greater emphasis on their quality assurance/quality improvement programs, provider compliance responsibilities have increased correspondingly. To provide some guidance on the nature of these responsibilities, some managed health care organizations have appended summaries of these quality programs to the contracts to give providers a better idea of their responsibilities.

The contract should include a provision requiring the provider to cooperate both in furnishing information to the managed health care plan and in taking corrective actions, if appropriate.

Acceptance of Enrollee Patients

A provider contract, particularly with a physician or physician group, will need a clause to ensure that the provider will accept enrollees regardless of their health status. This provision is more important when the risk-sharing responsibilities with the providers are such that the physician has an incentive to dissuade high utilizers from becoming part of his or her panel. Most provider contracts with primary care physicians also include a minimum number of members that the physician will accept into his or her panel (e.g., 250 members). The contract should also include fair and reasonable procedures for allowing the provider to limit or stop new members from being added to his or her panel (at a point after the provider has accepted at least the minimum number of members) and a mecha-

nism to notify the managed health care plan when these changes take place. The managed health care plan needs to have data regarding which providers are limiting their panel size to comply with regulatory requirements.

The contract should also specify the circumstances in which the provider, principally a primary care physician, can cease being an enrollee's physician. Examples may be an enrollee's abusive behavior or refusal to follow a recommended course of treatment. This contract language would need to be consistent with language in the member subscriber agreement and in compliance with licensure requirements, which frequently identify the grounds on which a physician may end the physician–enrollee relationship.

Enrollee Complaints

The contract should require the provider to cooperate in resolving enrollee complaints and to notify the managed health care plan within a specified period of time when any complaints are conveyed to the provider. The provider should also be obligated to advise the managed health care plan of any coverage denials so that the managed health care plan can anticipate future enrollee complaints. To the extent that governmental payer programs require special enrollee grievance procedures, the language in the contract should be written sufficiently broadly to ensure provider cooperation with those procedures.

Maintenance and Retention of Records and Confidentiality

Provider contracts should require the provider to maintain both medical and business records for specified periods of time. For example, these agreements could provide that the records must be maintained in accordance with federal and state laws and consistent with generally accepted business and professional standards as well as whatever other standards are established by the managed health care plan. If the managed health care plan participates in any public or private payer program that establishes certain specific records retention requirements, those requirements should be conveyed to the providers. The contract should state that these obligations survive the termination of the contract.

The managed health care plan also needs a legal right to have access to books and records. The contract will want to state that the managed health care plan, its representatives, and government agencies have the right to inspect, review, and make or obtain copies of medical, financial, and administrative records. The provider would want the availability of this information to be limited to services rendered to enrollees, after reasonable notice, and during normal business hours. The cost of performing these services is often an issue of controversy. If there are no fees for copying these records, the contract should so state. When the managed health care organization is acting on behalf of other payers, it is desirable to have language acknowledging that the other payers have agreed to comply with applicable confidentiality laws.

In addition to the availability of books or records, the managed health care plan might also want the right to require the provider to prepare reports identifying statistical and descriptive medical and patient data and other identifying information as specified by the managed health care plan. If such a provision is included in the contract, the managed health care plan should inform the provider of the types of reports it might request to minimize any future problems. Finally, the provider should be obligated to provide information that is necessary for compliance with state or federal law.

An often neglected legal issue is how the managed health care plan obtains the authority to have access to medical records. Provider agreements periodically contain an acknowledgment by the provider that the managed health care plan is authorized to receive medical records. The problem with this approach is that the managed health care plan might not have the right to have access to this information, and, if it does not, an acknowledgment of that right in the contract has no legal effect. Some state laws give

insurers and HMOs, as payers, a limited right of access to medical records. This right may arise if the managed health care organization is performing utilization review on behalf of an enrollee. Managed health care plans should review their state law provisions on this issue and their procedures for obtaining the appropriate consents of their members to have access to this information. Many managed health care plans obtain this information through signatures that are part of the initial enrollment materials. These consents could also be obtained at the time health services are rendered.

Managed health care organizations frequently include provisions in contracts in which the provider acknowledges that the managed health care organization has the right of access to enrollee records. The provider should be reluctant to agree to this provision without consulting state law. Although the clause acknowledging the right of access may make it easier to persuade a reluctant provider to release an enrollee's medical records, the managed health care plan needs to remember that that statement, or for that matter similar statements in the group enrollment agreement, do not confer that right. Finally, the contract should state explicitly that the provisions concerning access to records survive the termination of the agreement.

A related provision almost always included in provider contracts is a requirement that the provider maintain the confidentiality of medical records. A common clause is a provision that the provider will only release the records in accordance with the terms of the contract, in accordance with applicable law, or upon appropriate consent. State law will frequently allow disclosure of information without patient identifiers for purposes of research or education. Managed health care plans and providers need to be sensitive to confidentiality concerns with regard to minors, incompetents, and persons with communicable diseases for which there are specific state confidentiality statutes governing disclosure of information.

A medical record issue may arise when a managed health care plan wants the right to perform certain medical tests outside the hospital before an enrollee's admission. The contract between the managed health care plan and the hospital may allow for such tests and the inclusion of the test results into the hospital's medical record. The hospital may insist that the results of the tests be in a format acceptable to the hospital's medical record committee, that the laboratory results be properly certified, and that the duties performed shall be consistent with the proper practice of medicine.

Payment

The payment terms of the agreement often represent the most important provision for both the provider and the managed health care plan. As mentioned earlier, the payment terms are frequently set forth in an exhibit appended to the contract and are cross-referenced in the body of the agreement. A number of payment issues should be covered in the contract. For example, who will collect the copayments? If the managed health care plan pays the provider on a fee-for-service basis, a provision needs to state that unauthorized or uncovered services are not the responsibility of the managed health care plan. To avoid members' receiving unexpected bills from providers for noncovered services, contracts may say that the provider must inform the member that a service will not be covered by the health plan before providing the service. In addition, the contract may preclude the provider from ever billing an enrollee when the managed health care organization has determined that the service is not medically necessary.

From the provider's perspective, he or she needs a clear understanding of what is necessary for a service to be authorized. If the provider submits claims to the managed health care plan, the contract should set out the manner in which the claim is to be made and either identify the information to be provided in the claim or give the managed health care plan the right to designate or revise that information in the future. If the contract specifies the information to be included in a claim, the managed health care plan

should also have the unilateral right to make changes in the future.

The agreement should also obligate the provider to submit claims within a specified period and obligate the managed health care plan to pay claims within a certain number of days. The latter requirement should not apply to contested claims. Also, special provisions will apply to claims for which another carrier may be the primary payer. A common way to address this issue in a balanced manner is to allow a 2-month period for collection from the purported primary carrier. If unsuccessful, the managed health care plan would pay while awaiting resolution of the dispute.

At issue is the time in which the managed health care organization is required to pay on claims. Contracts frequently identify a specific time period (e.g., 30 to 60 days) during which payment on clean claims is to be made. Provider contracts rarely impose an interest penalty for late payment, reflecting the greater bargaining strength of the managed health care organization. Some contracts require the managed health care organization to make a good faith effort to pay within a specified period. From the provider's perspective, the weakness of this provision is that a good faith standard is probably too ambiguous to be enforceable. Some states have laws requiring insurers and HMOs to pay interest on late claims.

The contract needs also to address reconciliations to account for overpayments or underpayments. To avoid these issues from lingering for an inordinately long period of time, some managed health care plans limit the adjustment period to a specified period (e.g., 6 months). Also, some managed health care plans use contract provisions that do not allow for a reconciliation if the amount in controversy falls below a specified amount.

The most complex aspects of provider contracts are often the risk-sharing arrangements (see Chapters 9, 12, and 14). Risk can be shared with providers in significantly varying degrees depending on the initial amount of risk transferred, the services for which the provider is at risk, and whether the managed health care organization offers stop-loss protection. Risk pools with complicated formula: determining distributions are frequently used both when services are capitated and when payments are based on a fee schedule. Although the primary objective of these arrangements is to create incentives to discourage unnecessary utilization, the complexity of many of these arrangements has confused providers and engendered their distrust when their distribution falls below expectations. Some managed health care plans that had complex risk-sharing arrangements are now realizing that simpler, more understandable arrangements are preferable. If the arrangement designed by the managed health care plan is somewhat complex, the provider's understanding will be greatly enhanced by the use of examples that illustrate for providers the total payments they will receive in different factual scenarios.

The most significant trend in provider payment arrangements has been the growth of arrangements where physician–hospital organizations (PHOs) or other integrated delivery systems are willing to accept a percentage of the managed health care plan premium as compensation for the services they provide (see Chapter 4 and 5). An important, related issue is the extent to which state regulators will want to oversee these arrangements directly or indirectly through licensure requirements applicable to the licensed entities to which the PHOs contract (see Chapter 53). The PHO assumes the role of a super-IPA as it becomes responsible for providing, or arranging for the provisions of, all or almost all the managed health care plan's services for enrollees assigned to it. In fact, the PHO does not typically provide services itself; the PHO arranges for the health services through affiliated hospitals, physician groups, and other health care providers. In developing its relationships with a managed health care plan, the PHO must be mindful of how it is transferring the obligations to provide services to its subcontractors.

The compensation arrangements typically provide that the PHO will receive a specified

percentage of the amount that the managed health care plan or other payer receives. To reduce the risk of inappropriate adverse or favorable selection, the payment amounts may be adjusted to account for expected utilization based on demographic factors, such as age, sex, and other predictors of health care utilization. Also, the amount of risk assumed by the PHO might be limited until the number of enrollees assigned to the PHO reaches a critical size. The amount of compensation received by the PHO would be reduced to reflect the cost of services that the PHO does not assume responsibility for or stop-loss coverage that is provided by the managed health care plan.

Another issue to consider is whether the managed health care plan will have the right to have the services performed by other providers if it is not satisfied with the contracted provider's performance. Because the PHO is assuming virtually all the risk for the defined population, the PHO needs to consider carefully the assumptions that have been made regarding the demographics and health needs of the covered population.

In recent years, as providers gain more experience with managed health care plans, they are becoming more sophisticated in analyzing and evaluating payment arrangements and are more aware of the ability or inability of managed health care plans to produce the volume promised. A growing number of contracts are being renegotiated in light of the actual volume of patients that a managed health care plan is able to deliver to the provider. Contracts are also now beginning to allow volume as a factor affecting payment amount.

Some of the payment-related issues that should be addressed in a contract are as follows: What if services are provided to a person who is no longer eligible for enrollment? What if services are provided to a nonenrollee who obtained services by using an enrollee's membership card? Who has the responsibility to pursue third party recoveries? What are the notice requirements when the nonresponsible party finds out about a potential third party recovery? Some managed health care plans allow their providers to collect and keep third party recoveries, whereas others will require that the information be reported and the recovered amount deducted (see Chapter 32). One sensitive issue is the potential liability of a managed health care plan if a provider collects from Medicare inappropriately when another carrier under the Medicare secondary payer rules had primary responsibility. Under the regulations of the HCFA, the managed health care plan is legally responsible and may be forced to pay back the HCFA even if the payment was received by the provider without the knowledge of the managed health care plan. Managed health care plans should include a contract provision transferring the liability to the provider in this circumstance.

Another issue that should be addressed in the contract is the responsibility of the managed health care plan as a secondary carrier if the provider bills the primary carrier an amount greater than the amount the provider would have received from the managed health care plan. From the managed health care plan's perspective, it will want a contract provision relieving the managed health care plan of any payment responsibility if the provider has received at least the amount that he or she would have been entitled to under the managed health care plan–provider contract.

Hold-Harmless and No Balance Billing Clauses

Virtually all provider contracts contain a hold-harmless clause, under which the provider agrees not to sue or assert any claims against the enrollee for services covered under the contract, even if the managed health care plan becomes insolvent or fails to meet its obligations. A no balance billing clause is similar (and may be used synonymously) and states that a provider may not balance bill a member for any payment owed by the plan, regardless of the reason for nonpayment; the provider may bill the member for any amount that the member is required to pay, such as copayment or coinsurance, or for

services not covered under the schedule of benefits (e.g., cosmetic surgery). Many state insurance departments (or other agencies having regulatory oversight in this area) will not approve the provider forms without inclusion of a hold-harmless clause containing specific language. HCFA also has adopted recommended model hold-harmless language applicable to federally qualified HMOs that was approved by the National Association of Insurance Commissioners.

Relationship of the Parties

Provider contracts usually contain a provision stating that the managed health care plan and the provider have an independent contractual arrangement. The purpose of this provision is to refute an assertion that the provider serves as an employee of the managed health care plan. The reason is that, under the legal theory of respondeat superior, the managed health care plan would automatically be liable for the negligent acts of its employees. Although managed health care plans frequently include a provision such as this in their provider contracts, it has limited value. In a lawsuit against the managed health care plan by an enrollee alleging malpractice, the court is likely to disregard such language and to focus on the relationship between the managed health care plan and the provider and the manner in which the managed health care plan represented the provider in evaluating whether the managed health care plan should be vicariously liable.

A related clause frequently used in provider contracts states that nothing contained in the agreement shall be construed to require physicians to recommend any procedure or course of treatment that physicians deem professionally inappropriate. This clause is intended, in part, to affirm that the managed health care plan is not engaged in the practice of medicine, an activity that the managed health care plan may not be permitted to perform. Another reason for this clause is to protect the managed health-care plan from liability arising from a provider's negligence.

Use of Name

Many provider contracts limit the ability of either party to use the name of the other. This is done by identifying the circumstances in which the party's name may or may not be used. Contract clauses may allow the managed health care plan the right to use the name of the provider for the health benefits accounts, the enrollees, and the patients of the participating providers. Otherwise, the party needs the written approval of the other party. The use applies not only to the name but also to any symbol, trademark, and service mark of the entity. The managed health care plan and the provider will want to ensure that proprietary information is protected. The contract should require that the provider keep all information about the managed health care plan confidential and prohibit the use of the information for any competitive purpose after the contract is terminated. With medical groups frequently switching managed care affiliations, this protection is important to the managed health care plan.

Notification

The managed health care plan needs to ensure that it is advised of a number of important changes that affect the ability of the provider to meet his or her contractual obligations. The contract should identify the information that needs to be conveyed to the managed health care plan and the time frames for providing that information. For example, a physician might be required to notify a managed health care plan within 5 days upon loss or suspension of his or her license or certification, loss or restriction of full active admitting privileges at any hospital, or issuance of any formal charges brought by a government agency. Although specific events should be identified in the contract, a broad catch-all category should also be included, such as an event that, if sustained, would materially impair the provider's ability to perform the duties under the contract. The contract should require immediate

notification if the provider is sanctioned under the Medicare or Medicaid programs. If the managed care organization is contracting with a provider who has been sanctioned, the organization may no longer be eligible to receive Medicare and Medicaid funds.

In a hospital contract, the corresponding provisions would be when the hospital suffers from a change that materially impairs its ability to provide services or if action is taken against it regarding certifications, licenses, or federal agencies or private accrediting bodies.

Insurance and Indemnification

Insurance provisions in contracts are fairly straightforward. The obligations in the contract may be for both professional liability coverage and general liability coverage. The managed health care plan wants to ensure that the provider has resources to pay for any eventuality. The contract will state particular insurance limits, provide that the limits will be set forth in a separate attachment, or leave it up to the managed health care plan to specify. A hospital agreement may require only that the limits be commensurate with limits contained in policies of similar hospitals in the state. From the managed health care organization's perspective, it will probably want a specific requirement to ensure adequate levels of insurance. There also should be a provision requiring the provider to notify the managed health care plan of any notification of cancellations of the policy. Another needed notification in a physician context is notification of any malpractice claims.

Cross-indemnification provisions, in which each party indemnifies the other for damages caused by the other party, are common in contracts. One weakness of the clause is that some professional liability carriers will not pay for claims arising from these clauses because of general exclusions in their policies for contractual claims. Although these clauses are frequently used, this limitation and the fact that a provider should still be liable for his or her negligent acts suggest that these indemnification clauses are not essential.

Term, Suspension, and Termination

One section of most contracts identifies the term of the contract and the term of any subsequent contract renewals. Many contracts have automatic renewal provisions if no party exercises its right to terminate. Both managed health care plans and providers should give careful thought to the length of the contract and the renewal periods.

Some contracts give a right of suspension to the managed health care plan. In suspension, the contract continues, but the provider loses specific rights. For example, if a provider fails to follow utilization review protocols a specified number of times, the provider will not be assigned new HMO members or perhaps will receive a reduction in the amount of payment. The advantage of a suspension provision is that total termination of a contract might be counterproductive for the managed health care plan, but a suspension might be sufficiently punitive to persuade the provider to improve.

Termination provisions fall into two categories: termination without cause, and termination with cause. The value of having a provision that allows the managed health care plan to terminate without cause is that the managed health care plan need not defend a challenge by the provider on the substantive issue of whether the grounds were met. A 90-day period is fairly common. If the managed health care plan has the right to terminate without cause, frequently the provider will also be given that right. A regulatory issue to be aware of is that some state laws require providers to continue to provide services for a specified period of time after their contract has terminated. These requirements relate to the state's requirements for the managed health care plan to have protections against insolvency and have to be reflected in the contract.

Terminations with cause allow the health plan to terminate faster and should be used in situa-

tions where the managed health care plan needs to act quickly. The contract might establish two different categories: one for immediate termination and another for termination within a 30-day period. Many contracts give either party a period of time to cure any contract violations. This time period, although useful to the managed health care plan if it has allegedly violated the agreement, extends the period of time in which it can terminate the contract. Grounds for termination for cause may be suspension or revocation of a license, loss of hospital privileges, failure to meet accreditation and credentialing requirements, failure to provide services to enrollees in a professionally acceptable manner, and refusal to accept an amendment to the contract agreement. A general clause also allows for termination if the provider takes any actions or makes any communications that undermine or could undermine the confidence of enrollees in the quality of care provided by the managed health care plan. This last clause has been variably interpreted by health plans and has been the subject of some state regulation. The clause should make clear that a physician is free to make medical recommendations, but is not free to disparage the plan.

The contract should be clear that a provider, upon termination, is required to cooperate in the orderly transfer of enrollee care, including records, to other providers. The provider also should cooperate in resolving any disputes. Finally, the provider should continue to furnish services until the services being rendered to enrollees are complete or the managed health care plan has made appropriate provisions for another provider to assume the responsibility. The contract should also be clear that the provider is entitled to compensation for performing these services.

In general, too little consideration has been given to preparing for contract terminations. When the provider and the managed health care plan enter into a contract, little thought is given to what will occur when the contract ends. Often, relationships end acrimoniously, and it is in both parties' best interest to consider how their interests will be protected in the event that the contract is terminated.

Declarations

In declarations, the parties provide answers to a number of "what if" questions. These clauses are common to all contracts.

A *force majeure* clause relieves a party of responsibility if an event occurs beyond its control. In a provider contract, this instance is more likely to arise if the provider is no longer able to provide services. In considering *force majeure* clauses, the parties need to distinguish between events that are beyond a party's control and those that disadvantage a party but for which the party should still be obligated to perform the contract's responsibilities.

A choice of law provision identifies the law that will apply in the event of a dispute. Absent a violation of public policy in the state in question, a court will apply the agreed-upon law. Frequently, lawyers draft contracts using the state in which their client is located without consideration of the advantages and disadvantages of the underlying law. In provider contracts where the managed health care plan and the provider are located in the same state, this clause has little relevance.

A merger clause specifies that only the language in the agreement shall constitute the contract. Such a clause prevents a party from arguing that oral conversations or other documents not included in the contract modify the contract's terms.

A provision allowing or not allowing parties to assign their rights is frequently included in contracts. Provider contracts usually prohibit a provider from assigning its rights under a contract. Some contracts are silent on the right of the managed health care plan to assign the contract. Silence would allow the managed health care plan to assign the contract. An option is to allow the managed health care plan to assign the contract only to an affiliate or a successor without the written consent of the provider.

A clause identifying how the contract will be amended is almost always included in a provider contract. A contract will frequently give the managed health care plan the unilateral right to amend the contract absent an objection by the provider. This procedure is necessary when the managed health care plan has a large provider panel and it is administratively difficult to obtain the signatures of all the providers.

A severability clause allows the contract to continue if a court invalidates a portion of the contract. This is a common provision in a contract, but it is unlikely that the problem will arise.

Contracts also set forth a notice requirement identifying how notices are provided to parties and to whom. The manner in which notice is provided is important. If a notice requirement that the communication be conveyed by certified mail with return receipt requested, an alternative form of delivery is not valid. Parties should consider what is administratively feasible before agreeing on how notice will be given.

Closing

Both parties need to confirm that the parties identified at the beginning of the contract are the parties that sign the contract. Also, if a corporation is one of the parties, the signatory needs to be authorized on behalf of the corporation to sign the agreement.

CONCLUSION

The provider contract establishes the foundation for the working relationship between the managed health care plan and the provider. A good contract is well organized and clearly written and accurately reflects the full intentions of the parties. In drafting and reviewing provider contracts, the managed health care plan and the provider need to keep in mind their objectives in entering the relationship, the relationship of this contract to other provider contracts and agreements, and applicable regulatory requirements.

Chairman THOMAS. Do we have the next speedreader coming on? [Laughter.]

Mr. Stocker.

STATEMENT OF JOEL STOCKER, SHAREHOLDER, GREENBERG TRAURIG, MIAMI, FLORIDA

Mr. STOCKER. Mr. Chairman, I am Joel Stocker. I am a lawyer and shareholder with Greenberg Traurig. Greenberg Traurig is a law firm with 270 lawyers in Florida, New York, and Washington.

I have practiced for over 20 years, concentrating on health care transactions and regulations. I have negotiated and defended contracts on behalf of individual physicians, hospitals managed care companies and group practices, including for-profit and nonprofit entities.

Today, my written testimony focuses on contract terms, various relationships between physicians and physicians' managed care companies and hospitals. Today, I will center my oral testimony on two key points.

First, I urge you to focus on the purposes of contract terms and on the importance of the business matters they protect. Contracts between physicians and purchasers of physicians' services contain many terms that could be interpreted to impact physician-patient communication. However, these terms are designed to protect business interests: HMOs are concerned that physicians will convince patients to switch HMOs in order to further the physician's economic interests.

Second, this legislation broadly defines a physician-patient communication and, at least, in my opinion, it will have unintended consequences, impacting business interest provisions as well as medical care communications. Physicians today contract with various entities, hospitals, group practices, physician networks, and managed care companies. Attached to my written testimony is a chart describing these contracts.

While physician agreements with different entities contain many differences, they are similar in several respects. The physician is required to provide professional services, but also has obligations to the entity contracting with the physicians. The following are contract term basics: Provisions requiring the delivery of physicians' services; the physician is required to provide services according to the rules and ethics of the physician's profession; provisions on the scope and price of services; provisions regarding the term of the contract and its termination; provisions requiring compliance with quality and other regulations, and provisions protecting the business interests of both parties.

Because it is the physician who develops a direct personal relationship with the patient, the physician often has the ability to influence health care purchasing decisions. This ability to influence decisionmaking is sometimes exercised for medical reasons, but also has been used for personal gain.

Examples include a physician who wants to leave a group practice for a better offer or who has a better contract opportunity with a different managed care company. Consequently, the managed care entity, network, or group practice will include a business in-

terest protection provision that restricts a physician's ability to move to one plan or location and take away patients.

Combining professional and business obligations sometimes creates tension in a business relationship. However, in my experience, it is generally understood that physicians must exercise their professional medical judgment in providing health care services. They must abide by the rules of their profession. Parties to these contracts generally understand and abide by that principle. However, as Congress examines contract terms and provider relationships, it is important to distinguish between communication about business relationships and communications about medical care.

I personally have never seen a term in a contract that restricts communications applied to medical care options. That is not to say that examples do not exist. However, these provisions are generally written to protect business interests and are applied in that way.

Let me describe a few provisions that I consider business interest terms of a contract. They include noncompetes, antidisparagement and confidentiality of business information. Such terms include restrictions on disparagement in the solicitation of members. Group practices, managed care companies and networks attract patients to their groups, plans and networks and want to protect these relationships. For that reason, they include similar provisions in their agreements with physicians. These provisions are developed to keep physicians from aggressively discrediting the managed care companies and moving large numbers of patients to other plans.

Confidentiality provisions protect managed care companies, groups and networks from having other companies and providers know what they pay for their services. It protects their member lists and it protects their unique methods of doing business. These terms are generally not directed at controlling the flow of medical information between doctor and patient.

Medical care is changing and physician agreements are also changing. Sometimes changes have positive and negative results. The doctor-patient relationship is probably not as intimate as it once was and it is certainly not as unfettered. The decision before you is whether this competitive health care market calls for more Federal regulation or whether the market, bound by professional ethics, malpractice considerations, accreditation requirements, customer satisfaction and the good faith of professionals is enough to prevent significant abuse.

Thank you.

[The prepared statement and attachments follow:]

STATEMENT OF JOEL STOCKER
on behalf of
GREENBERG TRAURIG

Introduction

Mr. Chairman, I am Joel Stocker, a lawyer and shareholder with Greenberg, Traurig. Greenberg Traurig firm with over 270 lawyers in Miami, West Palm Beach, Orlando, Ft. Lauderdale, Tallahassee, New York City, and Washington, D.C. I am a heal care lawyer and have practiced for over 20 years, concentrating in health care transactions and regulation. I have negotiated and defended contracts on behalf of individual physicians, hospitals, managed care companies, and group practices including both for-profit and non-profit entities. My experience enables me to provide members of the Committee with an understanding of the rapidly changing health care environment, the growth of contracting between various providers and entities, and some of the practical considerations of provider relationships.

When I started practicing law the doctor-patient relationship was much simpler. Most health care plans were indemnity products where physicians were paid their charges, and where patients were responsible for high co-payments and deductibles. In an indemnity plan, the patients makes a claim on an insurance policy and the physician has no relationship to the insurer.

Then premiums began to rise. Employers found it increasingly difficult to pay for the cost of health care, and began to offer managed care plans to their employees. Managed care typically involves employed or contracted physician services where physicians have a direct or indirect contractual relationship with a managed care company.

Change has also occurred in the way physicians practice medicine. Physicians are increasingly employed by either other physicians, physician service companies, hospitals or managed care companies Physician contract relationships with these entities deal with many of the same issues that exist in the managed care contracting arena.

The health care system has changed, and the role of physicians in supervising and defining health care services for patients is evolving. Physicians no longer make independent decisions regarding the care for a patients without considering of the price of the care. Patients now select physicians not only based on reputation of that individual physician, but also on the reputation of the physician group and the health plan network. Physicians are often employees with employment contracts; are joined with other physicians in a network or group practice; or have multiple contractual relationships with a variety of health care plans. As a result of these changes, the contractual relationship between physician and those to whom they provide services has become increasingly important. Through those contract relationships, decisions on how, when, and where health care is provided is shared between the patients, the physician and the contract entity.

Today, my testimony will describe various types of contracts, including an examination of contract terms, when they are used, and the impact they have on medical care for patients. I will center my discussion on four key points:

(1) Although there are several types of contracts that physicians have with managed care companies, physician group practices, physician networks, and hospitals the terms of the contracts tend to be similar.

(2) Many of the contract terms between physicians and these other entities relate to business matters, not to physician - patients communications.

(3) Most of the business contract terms are designed to protect against a physician taking or moving a block of patients for economic, not medical reasons.

(4) Medical decision making is governed by ethics, state licensing, accrediting bodies, medical liability, and customer satisfaction.

Relationship to Patients

Physicians today contract with various entities: hospitals, group practices, physician .etwc 'xs, and/or managed care companies.[1] These entities are modeled in various fashions:

Group Practice/Physician Company

These entities provide physician services, generally by hiring physicians. The entities then contract with managed care companies, IPAs and other Service Provider Networks to provide physician services. Physicians contract with these entities either as employees or independent contractors. Although a physician may have an ownership interest in one of these entities, increasingly, they are large companies that employ physicians.

IPAs/Networks

These are entities that contract with physicians and physician companies to provide services throughout a geographic area. These companies may be physician, hospital, or investor owned. While some such entities are single specialty providers, (e.g. surgical IPA), many provide comprehensive services in wide geographic areas, contracting with multiple managed care plans. They often contain their own credentialing, utilization review/quality assurance, provider and member relations functions, and claims administration functions.

These large scale entities often resemble managed care companies, without the marketing and regulatory compliance functions (they rely on the managed care company for those services). By **not** being directly competitive with managed care companies, they are able to sell their services to multiple managed care services (often for a percentage of the managed care company's total premium).

The IPA/network typically enters into provider contracts with physician groups, IPA/network agreements tend to be very much like physician provider agreements with managed care companies. This is because they ultimately sell services to managed care companies and also because they have similar business interest to protect; provider agreements typically contain non-competition, non-disparagement provisions, etc. These intermediary entities then contract with managed care companies, by providing physicians and services.

Managed Care Companies

Managed care companies, such as HMOs, EPOs, and PPOs, enter into provider agreements with physicians, physician groups, physician service companies, and IPAs/networks. These provider agreements enable managed care companies to provide physician and other health care goods and services to the public. Managed care companies are also able to control the price and quality of the services they render through the provider agreements. Managed care is different from traditional indemnity or fee-for-service care. Managed care controls price through negotiated agreements. Such agreements set a contract price for services, and, ensure quality by selecting providers and monitoring the care provided. Managed care companies are regulated (typically on the State and Federal levels) and , consequently, provider agreements contain provisions to assure regulatory compliance. In addition, provider agreements contain typical business provisions.

Increasingly, managed care companies prefer to contract with larger scale physician entities (group practices, practice companies, IPA/networks), rather than individual physicians. They do this for several reasons: 1) larger entities become involved in the care management process and often share risk with the managed care company; 2) there is less administrative cost in contracting with larger groups; and 3) by aggregating volume, better pricing for services can be negotiated, thereby lowering overall premium costs.

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[1] See Attachments

Contract Terms

Physicians have a variety of relationships with these entities. Sometimes physicians are employed and provide their services to a single entity (physician or group practice); and sometimes they are independent contractors that have contracts with multiple managed care companies, hospitals, networks and/or IPAs. While there are a lot of differences between the types of contracts that are underwritten, they all cover certain basic contract terms.

Scope and Price of Services

These contract sections describe the services the physician is responsible for and how much the physician is paid. There is a greater variety in provisions governing the scope of services and the method of payment. Approaches vary depending on the structure of the provider network and the capabilities and objectives of the parties. We are seeing creative approaches to these issues being proposed by both physician groups and managed care companies. These approaches often include bundling services (physician, hospital and other services) and risk sharing.

Term and Termination

These contract provisions set forth the duration of the agreement and the conditions under which the agreement can be terminated. Some agreements contain no set term -- they are terminable at will. However, others contain a term of one or more years. Early termination covers such issues as material breach, loss of license, etc.

Protection of Business Interests

These provisions protect the relationship of the contracting party with the physician. Generally, the contracting party, rather than the physician, is responsible for obtaining the patient. For example: A patient is generally insured as a result of the marketing efforts of a managed care plan to an employer group. Because the physician develops a direct, personal relationship with a patient, the physician often has the ability to influence health care purchasing decisions. This ability to influence decision making is sometimes exercised for medical, but has often been used for personal gain - the physician wants to leave a group practice for a better offer or has a better contract opportunity with a different managed care company. Consequently, the contracting party (group practice, IPA, managed care company, etc.), includes contract provisions to restrict the physician's ability to move and take the patient.

Quality, Regulatory Compliance and Other Issues

Agreements contain a wide variety of requirements to ensure compliance with quality, licensing requirements, and other regulations. These terms vary depending upon the nature of the agreement. For example, physician provider agreements between managed care companies and IPAs/networks generally contain numerous provisions to ensure quality and regulatory compliance. Physician employment agreements with hospitals often contain provisions regarding licensing and board certification.

Similarities Between Agreements

While physician agreements with different types of entities contain many dissimilarities, they also are becoming remarkably similar in certain respects: the physician is becoming more like other professionals that are employed by large enterprises, such as large scale law, accounting and engineering firms. The physician continues to provide professional services (and is bound by the ethics and rules of the physician's profession), but also has obligations with which the physician contracts. The entity retaining the physician has developed a business, and business relationships with third parties (consumers and other purchasers of health care services) and has an interest in protecting those relationships.

Professional and business obligations sometimes create tension in a business relationship. However, in my experience, it is generally understood that physicians must abide by the constraints of their profession and with community standards of care. The business that contracts with time respects and supports [illegible] 's not to say that problems don't exist, but they are the exception rather than the rule.

Current legislation by Congress focuses on contract terms that protect the business relationship and terms that describe termination of contractual agreements. More specifically, the legislative focus is on health plans and contracts with providers. The following describes how contract terms among the variety of contracts work in practice.

Communications between Patient and Physician

As Congress examines contract terms and provider relationships, it is important to distinguish between communication about business relationships and communications about medical care. I have never seen a term that restricts communication with respect to medical care options. While there are some examples of communication restrictions, they are generally not used in the context of medical care options. There are clauses, however, that are written to protect business interests.

Contract Terms Protecting Business Interests

There are a variety of contract provisions that are used to protect the business of the group practice, managed care company, or hospital network. Provisions include non-competes, anti-disparagement, and confidentiality of business information.

Managed care companies often include restrictions on disparagement and solicitation of members. Managed care companies and networks attract employers and patients to their plans and networks, and have an interest in protecting these relationships. Managed care companies use these provisions to keep physicians from moving large numbers of patients to other managed care companies, and from aggressively discrediting their business or company.

Managed care companies also use confidentiality provision that prohibit the disclosure of confidential information. Such provisions are intended to protect information about the managed care company with respect to that company's costs or fees to physicians, the company's member lists, and information about the company's business methods. Confidentiality provisions are not generally directed at controlling the flow of information between doctor and patients.

In addition, some agreements contain provisions prohibiting a physician or physician network from entering into similar agreements with other managed care companies. In my experience, these provisions tend to be enforced only in egregious cases.

These terms are enforced via threat of termination or legal proceedings. Physicians and group practices generally use non-competes and anti-disparagement clauses to protect the patient base and the reputation of the group. Whether we like it or not, these entities entering into agreements have become big businesses and the contracts involve millions of dollars. We should not think that these agreements focus on a particular patient's relationship with that patients' personal physician.

Termination Clauses

When relationships deteriorate, parties begin to think about contract termination. The issues range from getting out of a bad or undesirable relationship to what happens when the agreement is terminated. Commonly used concepts include the following:

> **Termination without cause**
> This allows a party to terminate an agreement for no reason. Generally the right to terminate without cause is mutual -- either party can exercise it. Physician employment agreements with group practices or physician service companies are

often terminable without cause.

Termination following the end of a term
Agreements often for a term of one or more years. The trend in managed care agreements is a one-year term. At the end of the term, either party can elect to renew, renegotiate or terminate the agreement. This gives the parties the certainty of a one-year agreement, but the ability to move away from it if conditions change.

Termination with cause
This allows a party to terminate if the agreement is materially breached. Most contracts contain these provisions. Generally, a party can terminate an agreement "for cause" on limited, or without any, notice. Where a breach is curable, contracts often provide for a cure period. The breaching party corrects the problem and the contract continues. Where there is a major problem, such as endangerment to the safety of patients, agreements can generally be terminated immediately.

Non-competition and confidentiality
A non-compete term/clause will typically restrict a physician from practicing within a geographic area (1 mile to several counties) of the former employer for a period of time (one year to several years). The scope of these restrictions is often limited by state law. Non-competes and confidentiality provision often continue after the end of an agreement. However, sometimes non-compete provisions bind a party only in certain circumstances. For example, a non-compete may not bind a party if the other party has materially breached the agreement.

These types of continuing obligations appear in both employment and independent contractor agreements. The most restrictive provisions are often used by group practices and physician services companies. When a physician is terminated, the physician must leave the geographic area because of non-compete requirements, and must often resign medical staff privileges at the hospital. Physician groups and medical practice companies view their relationship by requiring physicians that they terminate to leave the patient behind.

Managed care provider agreements may also use these types of continuing obligations. However, their use tends to be more limited than in the physician employment contract.

Medical Care Decisions
Physician contracts also contain provisions that require the physician to abide by ethical standards, remain licensed, be board certified, etc. However, these provisions often mirror governmental and accrediting body requirements. They give the right to terminate the agreement if the physician fails to meet professional standards. A physician must continue to abide by professional standards and requirements: physicians, managed care companies, and the courts recognize this as an overriding principal. Consequently, communications between doctors and patients are required to meet ethical standards. These communications are generally respected by those who contract for physician services.

Medical care decisions are also influenced by malpractice litigation. Physicians are obligated to provide services that meet community standards of care, and physicians are legitimately focused on practicing defensive medicine. A physician's obligation to practice according to community standards often influences decision making and will cause a physician to "do the right thing." This may be a communication to a patient or a referral to a specialist. In my experience, managed care companies will not "go after" a physician for making decisions according to community standards. Managed care companies may not cover the cost of service, but they will typically not "punish" the physician for making the communication or advocating for the patient.

Lastly, both physicians and the entities with whom they contract with are influenced by customer and public opinion of quality and service. In a competitive health care environment, no provider or managed care company wants to be known as a company that gives bad or inadequate care. Consumers and their employers increasingly make health care

purchasing decisions based upon publicly disclosed evaluations, accreditation ratings and adverse news reporting. These important factors tend to keep both physicians and especially managed care companies in check. Without a good quality reputation, employers and their employees will simply choose another plan or another physician.

Conclusion

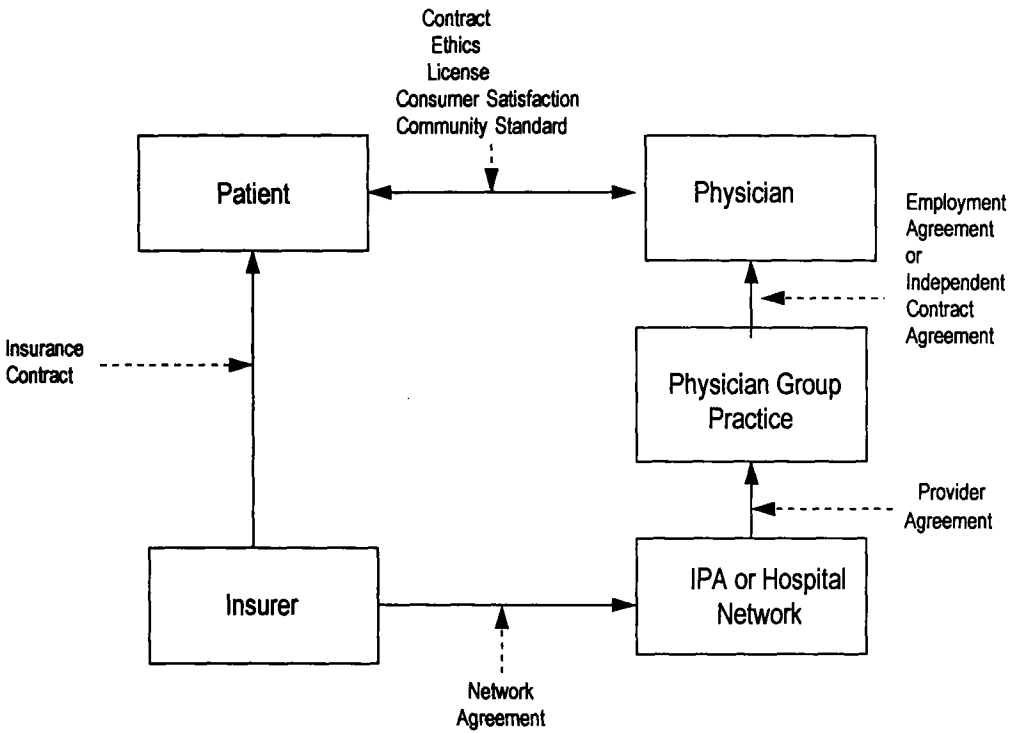
Medical care is changing, and physician agreements are also changing. Sometimes, changes have both positive and negative results. The doctor-patient relationship is probably not as intimate as it was, and it certainly is not as unfettered. Many health care markets are moving in the direction of managed care provided by large scale organizations that contract with physicians. This is a firmly established trend. The issue before you is whether the situation calls for more federal regulation, or whether the market, as influenced by professional ethics, malpractice considerations, accreditation requirements, customer satisfaction, and the good faith of professionals, can prevent significant abuse.

Attachments

Managed Care Network Requirements

- Members restricted to use network
- Managed care company obligated to assure quality & availability
- Managed care company must negotiate competitive price for medical services & limit over utilization of care

Determining Which Contract Applies



Term and Termination

	Employer	Managed Care	IPA/Network	Hospital Network
Termination at will	+/-	—	√	√
Term of Years	√	√	√	—
For Cause	—	√	√	√
Due Process	√	√	√	√

Protecting Business Relationships

	Employer	Managed Care	IPA/Network	Hospital Network
Non-Solicitation	√	√	√	√
Non-Compete	√	—	√	—
Non-Disparagement	—	√	√	√
Confidentiality	√	√	√	√
Resignation of Staff Privileges	√	—	—	—

Chairman THOMAS. Mr. Rust.

STATEMENT OF MARK E. RUST, PARTNER, KAMENSKY AND RUBINSTEIN, CHICAGO, ILLINOIS

Mr. RUST. Thank you, Mr. Chairman and Subcommittee Members. I am pleased to testify before you today and I commend the Subcommittee and Chairman Thomas for holding this important hearing on an issue of great concern to physicians and their patients.

My name is Mark Rust and I am a partner in the law firm of Kamensky and Rubinstein in Chicago and Lincoln Wood, Illinois. We represent some 3,000 physicians throughout the country, either individually or in groups. I might also add that, I am the former chair of the American Bar Association's Medicine and Law Committee, in the tort and insurance practice section. Accordingly, I have had the opportunity to review a wide variety of managed care arrangements.

Mr. Chairman, the managed care contract, when running between an MCO and an individual physician or a small physician group, is a virtual contact of adhesion. It is between two parties of grossly unequal bargaining power. Further, the contract is filled with arcane jargon. Physicians rarely ask their attorneys to review these agreements prior to signing them. They perceive that there is little likelihood that the MCO will be willing to change anything but the most minor items. In my experience, that expectation is reasonable.

As a result, these agreements contain a variety of clauses to which most sophisticated commercial parties would never agree. I describe them more fully in my written statement in order to illustrate why physicians are in no position to spot, much less negotiate out provisions that might negatively affect their patients.

In addition to clauses that allow an MCO to terminate for a breach, such as a gag clause, virtually every such agreement with physicians has a clause that allows the MCO to terminate a physician without explanation on short notice. Given the existence of the without-cause termination provisions, the relative rarity of the crude clause that gags the physician from fully communicating to his or her patient is not striking. The existence of a single such clause generates emotion in the physician community because it articulates what physicians perceive the be the unwritten policy of certain MCOs to punish those physicians who discuss with patients the economic limitations on their treatment options.

Given the power virtually all plans have of terminating the physician on 60-days notice for no reason, physicians fear the existence of a gag policy in each MCO relationship whether the ban is explicit or implicit. Sometimes, such policies are explicit, though not nearly as bold as those that have recently been reported and that we have seen just a moment ago.

One common example is the provision that forbids a physician from counseling a member to sign up with another plan. At first blush, this clause sounds commercially reasonable. Consider, however, this dilemma. When a patient asks her physician whether the physician will be able to provide cutting edge cancer treatment in the event the tests show the patient has breast cancer, how should

the physician respond. If she tells her patient that the plan might not pay for such treatment, the patient will ask, which plan does pay? In that conversation the physician will likely breach her agreement with the MCO, because the net effect of her answer to her patient may be that the patient switches into another plan.

Even when such a policy is not contained in an agreement, an MCO may mean such physician/patient communications reason enough to terminate the physician without cause. I believe the without cause termination provision was employed recently in one midwestern city to chill patient communications. The MCO accounted for approximately 25 to 30 percent of patients in the city. It decided unilaterally that it would switch all of its obstetricians and gynecologists from fee-for-service individualized capitation payment.

Most physicians do not feel they could afford to lose 30 percent of their practice. Even if they could, their loyalty to their patients prevented them from leaving the plan. But, many physicians informed their patients of the new compensation policy of the MCO. Because it was open enrollment season for most employers, the MCO began to notice an immediate loss of customers.

In response, the MCO contacted many of those obstetricians and advised them that it could end the relationship shortly without having to state a reason. It appeared from my observation that the advice had its desired effect, the obstetricians discontinued discussing the matter with patients.

Nothing could be more appropriate than a physician fully disclosing to a patient that he or she now has a financial incentive to not treat rather than to treat. Nothing could be more appropriate than a gynecologist advising her patient in advance of a pregnancy that her plan provides only for a 24-hour stay at the hospital after labor and delivery.

The commercial result of such communication, however, may be that the patient switches plans. In such an event, a physician should not fear retaliation and in case retaliation occurs, she should not be left on why it occurred.

Physicians should not be exempt from the normal rules of contract, but written and unwritten policies, whether communicated directly to the physician or not that chill communication between physician and patient should be disfavored in the law.

When patients are confused by the relentless news of new therapies and new methods of medical payment, they will inevitably try to sort these issues out by talking with the party they trust most, their physician. They should have that right.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF MARK E. RUST
PARTNER, KAMENSKY & RUBINSTEIN
CHICAGO, ILLINOIS
TO THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIONS
RE: PATIENT RIGHT TO KNOW ACT OF 1996
JULY 30, 1996

MR. CHAIRMAN:

My name is Mark E. Rust. I am an attorney who concentrates his practice in health law, representing primarily physicians and physician groups throughout the midwest. I also am the former Chair of the American Bar Association's Medicine and Law Committee of the Tort and Insurance Practice Section. In addition, I am a member of the Standing Committee on Legislation of the Illinois State Bar Association, which will be considering a measure similar to the one before the Subcommittee for recommendation to the Illinois legislature this fall.

I am a partner in the law firm of Kamensky & Rubinstein in Chicago and Lincolnwood, Illinois. We represent some 3,000 physicians, either individually or in groups of varying size. Accordingly, I have had the opportunity to become quite familiar with a vide variety of managed care contracts and have gained an understanding of the difficulties physicians encounter under such contracts. I am pleased to have the opportunity to testify before you today about managed care contracting arrangements that have the effect of inhibiting physician-patient communications. I commend the Subcommittee and Chairman Thomas for holding this important hearing on an issue that is and has been of great concern to physicians and their patients.

I understand that H.R. 2976 is intended to help resolve the so-called "gag clause" controversy in managed care/physician contracting. I would like to describe for the Committee why enactment and enforcement of laws banning the prohibition on free communication between physician and patient, whether those prohibitions are written or unwritten, is so important to physicians. As a preliminary matter, however, it may be helpful to explain the general nature of contracts between managed care organizations, which I will call MCOs, and physicians from the perspective of an attorney who represents physicians.

The managed care contract, when running between an MCO and an individual physician or a small physician group, is a virtual contract of adhesion. I am well aware that, because it is between two sophisticated parties, the contract is unlikely ever to be deemed a contract of adhesion as a matter of law. But in most other respects, it is. It is between two parties of grossly unequal bargaining power. With managed care penetration at an all time high and rising, most physicians can ill afford to reject offers to join MCO plan panels. Further, the contract is filled with arcane jargon. Interpretation of the finer points of these agreements can be difficult for attorneys who do not specialize in health care law, and virtually impossible for physicians reading the agreement on their own. The non-price terms are rarely brought to the physician's attention after execution. Accordingly, most such agreements remain in file drawers, unexamined, for years.

Physicians rarely ask their attorneys to review these agreements prior to signing them. They perceive that it is not worth paying the fees associated with such reviews because there is little likelihood that the managed care organization will be willing to change anything but the most minor, ministerial items. In my experience, that expectation is reasonable. Further, most physicians do not have attorneys who understand a great deal about managed care. It follows that what little legal advice they do obtain is unhelpful.

As a result, these agreements are filled with a variety of clauses that most reasonably sophisticated commercial parties would never agree to. Methods of payment are often stated to be at a certain rate, subject to change on little or no notice in the sole discretion

of the MCO. Physicians are required to abide by rules and regulations incorporated by reference and contained in a booklet that the physician never receives. Further, those rules are usually subject to change on little or no notice and violation of the rules are cause for material breach. Indemnity clauses are common. These clauses require the physician to pay all awards and costs associated with any liability suit brought against the MCO that was prompted by the physician's alleged negligence. Physicians are unaware that their voluntary agreement to this clause will cause them to be held personally liable for the full amount of such awards and costs: malpractice insurance will not cover such voluntary obligations. Most agreements provide that in the event a payor fails to pay or goes bankrupt, the physician -- who is already obligated to refrain from seeking payment from the patient -- will simply assume the loss on all such patients.

I am well aware that this Committee is uninterested in the plight of physicians with respect to the commercial terms routinely forced on them by MCOs. I simply recount a handful of them here for your examination as background in explaining why physicians are in no position to spot -- much less negotiate out -- provisions that might negatively affect their patients, such as prohibitions or inhibitions on free communication with patients in written policy or in practice.

But before I turn to that subject, let me describe a related subject. It is the single most important non-fee related commercial term that most physicians do understand in their agreements: the "without cause" termination provision.

Virtually every managed care agreement with physicians has a clause that allows the managed care organization to terminate a physician without cause and without explanation on short notice. This clause appears to be reciprocal in the sense that the physician may also terminate on 60 or 90 days notice, but usually the physician is prevented from such termination if the MCO is experiencing difficulty in replacing him or her. Even without that restriction on the physician's ability to terminate, the physician would be prevented ethically and under the common law from discontinuing seeing the patients covered under the MCO in the event the MCO failed to pay and could not replace the physician.

This clause is relevant to our discussion today on "gag" policies even when those policies are not stated directly in the contract. In most cases, the physician lives in constant fear of being terminated without cause for the same reason he or she feels compelled to initially enter into the agreement: many MCOs control a large market share of patients, and such a termination might overnight wipe out a large percentage of the physician's practice. Worse, most MCO credentialing applications ask whether the physician has ever been terminated from a plan. An affirmative answer to this question can be fatal to the application. And since a without cause termination never requires an explanation by the terminating party, no explanation can be given for this blot on his or her career when the physician next applies to participate on an MCO panel.

Given these facts, the relative rarity of the crude, overt clause that "gags" the physician from fully and freely communicating to his or her patient is not striking. When such a clause is noted by investigators and held up to scrutiny in the press, as it has been in recent months, the question naturally arises: How common are such clauses? And: Are they ever enforced? In my experience, the answers are: probably not very, and probably not often.

But the reason the existence of a single such clause generates such a groundswell of emotion in the physician community is that it perfectly articulates what physicians believe to be the real policy of certain unscrupulous, profit-driven, market-share motivated MCOs: terminate those physicians who don't "play ball". They believe MCOs will punish those physicians who fully discuss with patients the economic limitations on their treatment options under their managed care plan. When combined with the option virtually all plans have of terminating the physician on 60 days notice without the necessity of providing a reason, physicians have good reason to fear the existence of a gag clause in each such MCO relationship, whether the ban is explicit or implicit.

Sometimes, such clauses are explicit, though not nearly as direct and bold as those that have recently been reported. For example, I would put the following clause, which is fairly common, in the category of "gag clause" because of its chilling effect on communication between physician and patient:

> "During the term of this agreement, provider shall not advise or counsel any member to disenroll from the HMO, and will not directly or indirectly solicit any member to enroll in any other HMO or PPO or similar health care service plan or insurance program."

At first blush, this clause sounds commercially reasonable to one not sensitive to the physician-patient relationship. Naturally, the HMO wishes to protect what it perceives to be an economic property interest in its patients. In consideration for allowing the physician to intrude into the relationship it maintains with those patients, it desires to prevent her from providing any advice to the patient that would have the effect, directly or indirectly, of causing that patient to switch out of the HMO and into a standard indemnity insurance plan.

It sounds reasonable, that is, until you consider the predicament of a physician at the conclusion of her patient examination. When the patient asks her whether she will be able to provide cutting edge cancer treatment in the event that tests show the patient has breast cancer, how do you suppose the physician will respond?

If the physician answers fully -- that the patient's plan might not pay for such leading edge treatment -- the conversation will logically progress to plans or programs that would. In that conversation, the physician will likely materially breach her agreement with the MCO, because the net effect of her answer to the question may be that the patient switches into an indemnity or other plan to be sure of coverage in the future. In short, the physician may have effectively counseled the patient to disenroll from the HMO

Despite its otherwise commercially reasonable appearance, this clause prohibiting such free communication between physician and patient is unreasonable in practice when applied to the relationship between patient and physician. No party to this agreement should have a proprietary interest in a human being -- the patient -- that is subject to the application of commercial law. The MCO is first and foremost an insurer. The patient has simply chosen it to manage the provision of care and provide coverage, as inexpensively as possible, from the risk of loss associated with that care.

Neither does the physician have a proprietary interest in the patient. The physician does, however, have duties to the patient that are well settled in law and provide the foundation of what we refer to as the physician-patient relationship. The physician has the duty to diagnose and recommend a course of treatment to the patient. The physician has the duty to treat and not abandon the patient. And she has the duty to fully inform her patient, free of commercial concerns, of all relevant treatment options.

Even when such a clause is not contained in an agreement, an MCO may deem the physician-patient communication described above, which results in a patient leaving the MCO's plan, as reason enough to terminate the physician "without cause". In the past 24 months I have witnessed many occasions of physician clients terminated without cause and without explanation. In each case the physician suspects that the termination is the result of over-aggressive patient advocacy, but it is impossible to test the theory because no explanation need be given.

It is virtually impossible to bring an action against the MCO to discover the reason for the termination under the current state of the law. In one freak circumstance, where we were able to properly threaten an action because of a unique set of facts, the MCO relented and provided the reason for the termination. The physician had apparently been unhappy with the processing of patient claims and the MCO feared he was discussing the subject with

patients. The MCO acknowledged that it, like other MCOs, terminate only when a provider no longer meets their selection and retention criteria, which are extra-contractual and not shared with the physician or the public. In this case, apparently, the retention guidelines called for the dismissal of physicians who complained too loudly about claims processing for fear they may share their frustrations with their patients.

I have also been involved recently in a situation where the "without cause" termination provision was employed to chill patient communications that a plan thought was injurious to its commercial health. This incident occurred in a midwestern city of significant size. A managed care organization that accounted for approximately 25%-30% of patients in the city decided unilaterally that it would switch all of its obstetrician and gynecologist providers from fee-for-service to capitation payment. The payment was to be provided to each obstetrician and gynecologist individually, rather than through a legitimate network that could accept actuarial risk. (As you are no doubt aware, capitation is a single payment, per member per month, made to a provider to cover all services required by a patient population in a given month. If services provided are few, the provider makes more money. If services are great, he loses.)

Most physicians did not feel they could afford to lose 30% of their practice. Even if they could, their loyalty to their obstetrical patients prevented them from doing so. As a result, most continued to be providers. But many physicians fully informed their patients of the new compensation policy of the MCO.

Because it was open enrollment season for most employers at that time, and because women inevitably drive the decision to choose a health care plan on behalf of themselves and their family, the MCO began to notice an immediate loss of customers.

In response, the MCO, through its agents, contacted large numbers of those obstetricians and advised them of the possibility that the MCO could end the relationship shortly without having to state a reason. It appeared from my observation that the advice had its desired effect. The obstetricians and gynecologists discontinued discussing the matter with patients.

That was a good illustration of how an MCO can use its power to terminate without giving a reason, thereby stifling what I believe to be legitimate physician communication with patients. Nothing could be more appropriate than a physician fully disclosing to a patient that he or she now has a financial incentive to not treat, rather than to treat, a patient. Nothing could be more appropriate than an obstetrician advising her patient in advance of a pregnancy that her plan provides only for a 24 hour stay at the hospital after labor delivery. The commercial result of such communication, however, may be that the patient switches plans. In such event, a physician should not fear retaliation; and in case retaliation occurs, she should not be left to speculate on why it occurred.

With that in mind, I would support, at a minimum, passage of H.R. 2976. However, while it provides some protection for the physician-patient relationship, it does not address all of the concerns I have expressed in this testimony. I will note, for the record, three significant defects the Committee may wish to consider.

First, the prohibition on restricting medical communication between a health care provider and patient or guardian is limited only to those restrictions that are part of a written or oral communication made to the provider. This does not cover the concerns of a vast number of physicians, who believe they might be terminated for violating an internal MCO policy on physicians who speak too freely with patients, which policy was never communicated to the physician. This concern could be alleviated by simply deleting the phrase "to such a provider" contained at lines 15 and 17 (Section 2(a)(1)(B) and (C)).

Second, the definition of "medical communication" provided in Section 2(b) is not broad enough. Using this definition, a physician who fully disclosed to a patient the capitated method by which she is paid and its possible impact on the patient's care, would

not be engaged in a protected communication. If such communication had the effect of causing the patient to disenroll from the MCO and enroll in an indemnity plan, the physician could be in breach of her agreement to not "directly or indirectly" cause such an occurrence.

Third, enforcement through civil monetary penalties, although helpful, is not, in my view, sufficient. Providing physicians with a private right of action to enforce those restrictions as private attorneys general will force MCOs to be conscious of their obligations to not interfere in the physician-patient relationship. It would give the physician the right to ferret out the reasons for her termination and the motivation to determine its legitimacy.

Physicians should not be exempt from the normal rules of contract law. But the provider agreement between an MCO and a physician is not a normal contract. It has a direct and profound effect on a human being who is not a party to it -- the patient. Throughout this century, state and federal laws have focused on the protection of patients, given the commercial realities of our private health care system. Such concerns are evident in restrictions on fee splitting and the corporate practice of medicine. The latter concept is analogous to the regulation of MCO agreements as they affect patient care, in that both seek to shield the doctor-patient relationship from purely commercial concerns, divorced from common law duties and medical ethics.

In addition, to the degree that such contracts are indeed similar to contracts of adhesion, there is ample legal precedent for legislative oversight, much as is common in policies of insurance and landlord/tenant relationships.

In conclusion, written and unwritten policies, whether communicated directly to the physician or not, that have the effect of chilling communication between physician and patient should be disfavored in the law. This is especially true in an age when managed care organizations, through acquisition, merger, or otherwise, are controlling an increasingly larger portion of the patient population. When patients are being barraged with shrill commercial claims by such plans, and confused by the relentless news of new therapies and new methods of medical payments, they will likely try to sort these issues out by talking with the party they trust most: their physician. They should have that right.

Mr. ENSIGN. I would like to thank the panel.

We will just take a couple of questions here real quick with all of you.

First of all, could you maybe just go down the line and tell me what, say, three or four top concerns that you see that physicians have when they're negotiating their contracts with managed care.

And if each of you would respond.

Dr. KONGSTVEDT. That question is a very moving target, because the old world of individual solo practitioners in small groups negotiating is rapidly giving away to large organized systems of care, through physician hospital organizations, MSOs, management service organizations, vertically integrated, integrated systems and so forth.

There is very rapid movement toward global capitation in which the providers are now receiving a large global capitation and the very issues being debated today are now becoming internal to the provider system and external to the HMOs.

So, it is very difficult to answer that question because those concerns are rapidly moving. Answers that are germane to solo practitioners who are not moving into integrated systems will be very, very different than that answer for physicians who are part of a large, integrated delivery system.

Mr. ENSIGN. OK. Well, why don't you then answer what are the group versus the individual, primary concerns?

Dr. KONGSTVEDT. In my experience on the side of the solo and small group practices, the large concerns are the issue raised that managed care organizations are unlikely to change substantial terms in a contract for one physician and that is true. They will not do so.

The payment provisions are generally whatever they are. It is very common, as has been said, that physicians may or may not read the contract. They rarely do employ a lawyer to review all of the terms to do so.

On the large group side, the large integrated systems, the issues of negotiation involve the level of the global capitation and who will do what function in utilization management, credentialing, quality management and so forth. The more that these processes are moved out to the integrated delivery system, the more these issues are between the individual physicians and the physician leadership of that integrated delivery system.

Mr. ENSIGN. OK. Mr. Stocker.

Mr. STOCKER. My experience is similar. We are seeing a significant movement in south Florida toward very large-scale physician organizations where the physicians are becoming much more sophisticated in negotiating these contracts, and where they have a lot more bargaining power than individual physicians.

In my experience, what they are concerned with is the amount of payment and, frankly, these large groups are encouraging the managed care companies to move to a global cap, some sort of a global cap arrangement.

The role of the physicians in care management, what they are attempting to do is to move a lot of the functions that you typically see in an HMO into the physician arena and, frankly at least in

my view, I see that as a very positive thing because physicians are in a good position to manage care.

And what we are seeing is a redundancy, a deliberate redundancy required in those functions so that the HMO can exercise its responsibility and the physicians can effectively manage the care and control the costs. And also, they want to know to whom payment is going to be made, you know, on what basis. Risk pools, the issue of risk pools, the issue of stop loss insurance and those kinds of economic terms.

Mr. ENSIGN. OK. Mr. Rust.

Mr. RUST. My experience has been very similar. In individual contracts, it is virtually impossible to negotiate particularly the important legal issues that exist there. If it is a ministerial item, you've got the name of my group wrong or it is with me, individually, and I am really in a group of four, they're willing to go ahead and do that. But there's no negotiation otherwise, and physicians do not usually try to, other than what I referred to as hit-and-run tactics where, for example, they do not like the indemnity clause so they strike it out, initial it, sign it, throw it into the hopper, and hope the MCOs do not really notice it.

With respect to larger groups, there is negotiation but, as the other speakers have suggested, usually it is about price-type terms. When you see various kinds of clauses that tend to inhibit what physicians can say and they are put into a commercially sounding, reasonable context, you have to understand most of these groups are relatively newly formed and they are very fearful that they will even be able to get the contract to begin with. Sometimes they put a great deal of capital into building this organization and they do not have much experience. it is not the kind of thing they normally really focus on negotiating.

Mr. ENSIGN. Would you, like to comment on the difference between the way that primary care physicians versus specialists or subspecialists view this negotiating phase? And actually the way that they view the whole idea of this patient protection the gag rule.

Mr. RUST. If I can take a stab at that, Mr. Chairman.

That's a very important distinction because the groups that we are talking about—and it was just referred to a moment ago that we are seeing more large group contracting, as opposed to individuals—are by and large primary care driven, gatekeeper model type groups. And those are the people who are negotiating these contracts and being very concerned about capitation.

Specialists are often times, still even in that environment, entering into contracts individually and they still have the same problem as any of the individual physicians have, it is impossible for them to negotiate these things.

Mr. STOCKER. At least in my experience when you're talking about these larger groups, the physicians that are running these groups have very similar ideas about confidentiality provisions, antidisparagement provisions, and noncompete provisions that the managed care companies do. And they typically put the same kinds of provisions in their contracts with other physicians because both of these types of entities are trying to protect the same thing, the business reputation of their company. And these physician compa-

nies are just like managed care companies in that respect, they have a business interest to protect.

So, the interesting thing about it is that when you see physicians getting together in these arrangements, they behave pretty much the way managed care companies behave.

Dr. KONGSTVEDT. I would echo that. I have been struck by how rapidly providers of care—hospital executives, physicians, and other providers of care—do change their attitude regarding some of these types of provisions. Any willing provider, open access, other types of contractual terms, when they become globally capitated and it is now their business risk.

Mr. ENSIGN. Thank you.

The gentleman from California, Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

I just want to hop ahead here. we are going to hear later from the AMA, but I think they say it properly. They say the very first fundamental element of the patient/physician relationship—and this is a section of some major issue of ethics published by the AMA's Code of Medical Ethics—the patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their physicians as to the optimal course of action.

Now, in addition, their council on ethical and judicial affairs, the AMA entity responsible for maintaining the Code of Medical Ethics and providing authoritative interpretation stated that, "The physician's obligation to disclose treatment alternatives to patients is not altered by any limitations in the coverage provided by the patient's managed plan. Patients cannot be subject to making decisions with inadequate information. That would be an absolute violation of the informed consent requirements. If these clauses"—and they are referring here to gag clauses—"are carried out and the physicians are subject to sanctions, a reduction of patient quality of care will result."

Now, that's what the doctors are saying. Dr. Kongstvedt, you would suggest, I think in your closing, that we should trust the professional managers with these things. And they probably are not the recipient of your consulting. So, the Prudential Life Insurance Co. that has stolen over $3 billion from their investors, has had over $300 million in fines, and has been convicted as a corporation and its top executives of felonies, do you think we should trust that company to manage care? No way, you just cannot. You're putting the fox into the hen house.

And there is more than just good faith. When the incentives are skewed, as I think Mr. Rust suggests, that the doctors judgment is pushed.

So, the question today is, How can we handle this. If its a Medicare contract, then aren't we all paying the bill? So, we have a real right to see that the beneficiaries get what they're entitled to. And what they're entitled to is the level of care, which is far higher under an indemnity plan because there are no restrictions on it, as there are in indemnity plans. Even the best managed care plan far more restrictions than an indemnity plan. Just by definition, indemnity plans are better when it comes to choice of quality care that's available.

And what we are trying to find here is a way so that the doctors are not being kicked out or coerced, directly or indirectly, into pushing one kind of treatment.

We will get into what PacifiCare did about withholding vaccine or what another group did in Florida by pushing men to be castrated rather than getting treated by pharmaceuticals that would reduce the growth of testosterone when they got prostate cancer, just because it saves $8,000 on average to have them castrated rather than give them expensive pharmaceuticals.

That's criminal, that's obscene. And none of the witnesses are old enough to get close to having to make that choice. But I want to tell you it is not a choice that you want to be flim-flammed on by some doctor who is being pushed by his health care plan.

So, I hope that you can help us find a way to solve this. The managed care plans aren't going to suffer if they are doing it right. And it is the doctors who are going to lose their jobs. So, Mr. Rust, I think you're heading in the right direction. And I would hope if we take up Dr. Kongstvedt's CPA firm's offer of free help, that we end up with contracts that will protect the patients and not your clients.

Thank you, Mr. Chairman.

Dr. KONGSTVEDT. Mr. Chairman, may I respond, please?

Mr. ENSIGN. Certainly.

Dr. KONGSTVEDT. Mr. Congressman, regarding the issue of Prudential, certainly the legal problems that they had had no relation to their health plans, it was their investment service.

Mr. STARK. The same chief executive officer runs the whole show. When you lie down with skunks, you smell.

Dr. KONGSTVEDT. And in the case of that organization they have voluntarily sought and secured NCQA accreditation and NCQA accreditation rules are very clear that they prohibit such gag clauses.

Mr. STARK. They were in the NASD, too, but that didn't stop them from stealing the money.

Dr. KONGSTVEDT. Well, the only last statement I can make is that our firm actually represents more health care providers than we do payors. Our offer of free assistance is, in fact, we believe a balanced one. We are advocating neither one position nor the other and we, in fact, do not do business with Prudential at this time. They are not a client of mine.

Mr. ENSIGN. The gentleman would be reminded that veterinary services do take care of certain medical procedures that he talked about earlier. [Laughter.]

Mr. ENSIGN. The gentleman from Nebraska.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. Rust, in your testimony you state that you represent 3,000 physicians. I want to find out more information about the size of the practice that you represent or if it is all sizes, all kinds?

Mr. RUST. It is a lot of individuals, many of them formed into small to medium groups. And by that, I would say everything from 2 to 10 people. And increasingly these days it is larger organizations of joint venturing physicians who are forming networks to do managed care contracting that range in size from 30 to 150.

Mr. CHRISTENSEN. What would you say is the predominant scope of your practice, the large or the individual size?

Mr. RUST. It has traditionally been the individual and group size, but in the last 2 years, it has become increasingly the large size because of the tremendous activity that was set off a couple of years ago with the introduction of the national health bill.

Mr. CHRISTENSEN. It was either you or Mr. Stocker who made the comment that it is almost impossible to negotiate individual contracts?

Mr. RUST. That's correct.

Mr. CHRISTENSEN. Would you extrapolate on that, please?

Mr. RUST. Yes. Well, first of all, most physicians, as I believe Dr. McDermott mentioned, do have 70 contracts in their office which they never have reviewed because they perceive that they will not get anywhere. And in the few instances where physicians do attempt to do that, there is really only one of two ways to approach it.

Either I am going to write a set of comments on the agreements which I try to limit just to those things which are really reasonable that the other side can focus in on, and the physician can send them off to the managed care organization and say, Look if you will make these changes, I will sign it, or they can ask me to call the attorney directly for the other plan.

In both cases, the managed care organization takes the position that we just do not change any of the things that we consider material to the contract. And what they consider material to the contract is virtually everything but the names of the parties and certain kinds of boilerplate.

Mr. CHRISTENSEN. What I am really interested in is your negotiation on behalf of the large groups versus the small groups.

How does that differ when it comes to actual substance within the contract? I mean don't you see that nondisparagement clauses end up in the large group practice, as well as your individual group practice? Aren't they almost identical?

Mr. RUST. When you say, they end up, what do you mean?

Mr. CHRISTENSEN. As far as the contract language within the agreement between the providers?

Mr. RUST. Actually, I have not yet seen—well, excuse me, I have seen once or twice that kind of nondisparagement language and I counseled the administrator, the executive officer who was negotiating it as to what the problems were and that it should come out. And he took the view that that was a lesser priority than some other issues and it never came out.

Mr. CHRISTENSEN. So, you're saying that in your practice, the predominant representation that you have given to your clients is that there is not a nondisparagement type of clause in the individual practices, would that be correct?

You're shaking your head.

Mr. RUST. I am not understanding you.

Mr. CHRISTENSEN. Would you say that there is predominantly not a nondisparagement clause in the individual practices?

Mr. RUST. I would say you see nondisparagement clauses about one out of every five contracts. They do not all have them.

Mr. CHRISTENSEN. Mr. Stocker, how would your practice and your experience with this differ from Mr. Rust's?

Mr. STOCKER. First of all, you probably think that Florida is—tourism is a big industry there, but really health care is the big industry in Florida, and we see a lot that sort of is advanced guard stuff there.

And one of the things we are seeing is that health plans really do not want to contract with individual physicians very much any more. It is too costly for them to do that, and they cannot get the care management and some other things that they want.

So, more and more we are seeing them contracting with groups, specialty groups and large IPAs, and PHOs and all these other things. And we do see nondisparagement provisions with respect to business types of terms. But I have never seen a gag rule. I have never seen a contract provision that prohibits a physician from discussing treatment options.

That's just in my range of experience, but I see a lot of these things.

Mr. CHRISTENSEN. I have got one last quick question. I just wanted to find out, Mark, it looks like you were also chair on the legislation for the Illinois State Bar as well as the chair of the American Bar's Medicine and Law Committee——

Mr. RUST. I am on the standing committee for legislation.

Mr. CHRISTENSEN [continuing]. Tort and Insurance Practice Law. Where did you come down on, earlier this year when we were trying to put together malpractice reform legislation for the medical community?

Mr. RUST. The Illinois State Bar Association just had a tort reform bill passed, or Illinois just had a tort reform bill passed the previous term. And there were a number of pieces of legislation that arose to reverse those so-called tort reform provisions, and the Bar Association was in favor of reversing those tort reform provisions but that didn't happen.

Mr. CHRISTENSEN. And on the American Bar, as far as the overall—that was on the Illinois side?

Mr. RUST. That was on the Illinois side, that's correct.

Mr. CHRISTENSEN. What about the position that the American Bar has taken?

Mr. RUST. The American Bar Association has been opposed to tort reform, by and large.

Mr. CHRISTENSEN. Yes, unfortunate.

Thank you.

Mr. RUST. That was not my personal opinion, and I am not here to testify for the American Bar Association.

Mr. CHRISTENSEN. Thank you.

Mr. ENSIGN. Does the gentleman from Washington wish to inquire?

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I wish I could get a debate going between the three of you about this whole issue because I am sure there are no gag clauses. There is no contract that says, thou shalt not say, XY or Z. It is much more subtle than that. And it seems to me that from my own experience watching television I saw a classic example of a gag clause. That was on "Chicago Hope." A doctor came into a managed care operation bringing his patients with him. Well, when I got out of

medical school nobody ever thought of ever selling your practice to a hospital or some kind of managed care operation.

But that's what's happening today. There is a major revolution. I do not have to tell you that. This doctor brought his patients in assuring them that they will get the same kind of care in the managed care operation that they got when he was in private practice.

He treated an elderly woman, she was about 75 years old. Later he had to tell her that he could no longer see her, he had been fired by the managed care operation because he did not deliver care according to the standards of that managed care company.

Now, there is a tearful scene with the 75-year-old woman standing there saying, "You mean I am going to have to start with a new doctor and I am going to have to explain my whole life to these people? And there is an ethical dilemma here that this bill is a kind of a blunt instrument trying to reach at but there is going to be something passed out of the Congress. You are going to get treatment du jour or medicine du jour from the Congress and the State legislatures because of the issue that that illustrates.

And that is the question of when the physician is standing there, knowing that he or she is going to be fired by the managed care operation if they do something that is implicit or explicit or in the contract or whatever, then they are going to make decisions for their patients which are based simply on money, not on quality of care.

Now, doc, I want to say doctors are all great people, we are, and we try, but there are a few that will be impacted by money. And the American public is not protected when the physician's livelihood is on the stake. And my question to you is, in these cases or in these situations, number one, Does the doctor have an appeal process that really allows him or her to go back to the managed care operation and say, You cannot fire me, you cannot terminate this contract?

And second, the malpractice questions. Some, one of you commented—I read your written testimony—that doctors are supposed to indemnify the plan. So, if I make a decision and there is a lawsuit has anybody ever put forward their contract and said, Well, my managed care contract said I could not do that or was prohibited from doing it and, therefore, I am not committing malpractice. it is the managed care operation that is committing malpractice.

I would like to hear some talk about that issue, because the doctors feel caught in the squeeze between their livelihood and doing what they think and always knowing that there is this hammer that can come in the darkness.

So, any one of you or all of you?

Mr. STOCKER. Well, first of all, and again, there may be examples of it, but I do not see a situation where a managed care company is going to fire somebody for making a comment to a patient. In a typical managed care network you have several thousand doctors and they're doing things and the managed care company is doing things. And it is only when an issue rises to a very high level that there's some action taken.

But also you have got to look at the structure of the profession and the industry now. You are getting more large-scale organizations and you're having doctors who are working for other doctors

who are working for doctor networks, who are working for very large-scale organizations.

So, there are a number of different levels between the managed care company and the doctor. To me, the gag rule issue isn't nearly as significant an issue as the basic issue of managing care and looking at how doctors are performing with respect to economics and with respect to quality?

And these issues are looked at and will be looked at irrespective of whether you pass any legislation with respect to gag rules or not. So, if a doctor is down there and he's making a lot of referrals for a lot of expensive things that are not medically necessary, he may very well be fired, irrespective of a gag rule.

Because if you are going to manage care, you are going to have to manage care and, at some point or another, somebody is going to have to do it in order to keep the costs down.

It is a different reality I think than the reality we are talking about where you have got a doctor who has no bargaining power, who has this managed care contract that is shoved in front of him. The way I see it, that's not the reality that we are dealing with today.

Mr. MCDERMOTT. If that's not the reality why have, whatever it is, some 17 or 20 legislatures plus the U.S. Congress passed laws against drive-by babies, drive-by baby delivery? And said that managed care contracts cannot prevent women from staying in a hospital overnight after childbirth?

Explain to me what's going on that all over the country in legislative bodies people are jumping up and doing that kind of thing?

Mr. STOCKER. Well, first of all, drive-by babies have nothing to do with gag rules. The issue with drive-by babies—and I think it is a very legitimate issue—is what level of care, what standard of care should be common, I mean should be the baseline?

And that's a different issue from gag rules.

Mr. MCDERMOTT. But it gets back to the question of what level of care is expected and using a managed care contract as a defense against malpractice.

Mr. STOCKER. Well, irrespective of whether there's a gag rule or not, every physician and I think at this point, managed care companies, as well if they are telling physicians what to do, are bound by community standards of care. I mean that will be the standard. And, if an HMO is directing a physician to do something that is below community standards, my view of it would be that the HMO would wind up being liable and probably if the physician went along with it, he would be, too.

I would never counsel a client, HMO, or a physician client, to provide any services below the community standard of care.

Mr. MCDERMOTT. Have you defended any physicians who have been dropped off the panel?

Mr. STOCKER. I represent both physicians and HMOs and other kinds of—and I haven't had that come up ever.

Mr. MCDERMOTT. Have you, Mr. Rust?

Mr. RUST. I am sorry, what was the question?

Mr. MCDERMOTT. Have you ever represented anybody who has been dropped off the panel by an HMO?

Mr. RUST. Oh, yes, certainly.

Mr. MCDERMOTT. And what kind of success?

Mr. RUST. Absolutely zero and the reason is that no plan in their right mind would ever tell the physician the reason they were terminating them. Every time a managed care plan wishes to terminate a physician, they exercise the without clause provision. Whether or not it has to do with gag clause, bad care, rotten whatever, it just does not make any sense for them to do otherwise, because they have the legal power to do it. And they would have to be absolutely crazy not to.

Let's talk about the reality for a moment. Let's assume, as my colleagues are suggesting, that the managed care organizations are a bunch of very sophisticated players who would never do something like this or exercise a gag clause. But, at the same time, they're turning over that responsibility to large organizations of physicians. And that's happening.

So, now, we are going to have provider agreements under the large group of physicians. Now, we all know that physicians are a bunch of greedy yahoos, so, what do you think the physicians are going to do if they have these clauses? They're going to enforce them.

And the fact is that this bill would also make that illegal with respect to the physician organization just the same way it would be illegal with respect to the managed care organization. In either case, it is important to have and, possibly even more importantly, it is important to have in a situation where you are now shifting all this responsibility from our sophisticated chief executive officers of the managed care organizations to the unsophisticated physicians sitting on the board of their large groups.

You asked about two issues specifically. Is there an appeal mechanism? There always is an appeal mechanism but it only exists when you are terminated for a breach or for some reason. So, it is never used.

If a physician is terminated without cause, it is virtually impossible to find out the reason unless you have, as I have had before, the freak circumstance of something else going on where you can pressure the organization to tell you why they did what they did.

With respect to the malpractice indemnity issue, this is the way it works. Now, under this language that most human beings cannot possibly read, much less, comprehend, it basically says that if the HMO ever finds itself as a defendant in a malpractice action, because of some events that involved the alleged negligence of a physician, the physician will indemnify and hold harmless the managed care organization.

Now, at first that sounds kind of reasonable for a physician to say, OK, I do not commit malpractice so if that happens, I do not care; besides that, I have insurance. What they do not understand is that their insurance never covers them for that liability. They are bare with respect to that indemnification under virtually all malpractice policies.

So, when the issue actually arises that there is a lawsuit and the HMO has a great deal of fees and costs and possible awards to be lodged against it and finds itself, as a defendant, sitting along side the physician, the managed care organization will use that as a

club to tell the physician how his defense should operate, what he should say and what he should do.

And that is why that indemnity provision is important.

Mr. MCDERMOTT. My time has expired.

I think this is an issue we are going to come back to.

Thank you.

Mr. ENSIGN. I would like to thank the panel. I think that we have a couple of goals in common and it is a difficult issue to determine how we get to those goals. One is that we want the best quality of medical care that we can give to everybody.

Managed care has come into being because there was nothing out there controlling costs in the marketplace and so, it was a legitimate niche that managed care came into being. Now, you have to negotiate that delicate balancing act of controlling costs with providing the best quality medical care, and we can see the difficulties in doing that.

I would like to thank the panel and call up the next panel.

I would like to welcome our next panel. Dr. Nelson representing the American Medical Association and Dr. Nelson is an obstetrician-gynecologist and a deputy director of the Department of Health, Salt Lake City, Utah and a member of the Board of trustees of the American Medical Association. Dr. Chris Jagmin is vice president and medical director of Health Affairs, PacifiCare in the Southwest, Dallas, Texas, on behalf of the American Association of Health Plans.

Gentlemen, if you would, please keep your statements to 5 minutes. And the yellow light means that you have about 1 minute to go.

So, please proceed, Dr. Nelson.

STATEMENT OF JOHN C. NELSON, M.D., DEPUTY DIRECTOR, DEPARTMENT OF HEALTH, SALT LAKE CITY, UTAH; AND MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. NELSON. Thank you, Mr. Chairman.

My name is John C. Nelson, M.D., and I am a practicing obstetrician-gynecologist from Salt Lake City, Utah. I also serve as a member of the Board of Trustees of the American Medical Association and as part-time deputy director of the Utah Department of Health.

I am a participant in several managed care plans. I see all comers. I am a participating physician in Medicare and am pleased to see Medicaid patients, as well. We commend, of course, the Subcommittee for holding this important hearing on H.R. 2976 about gag clauses but also about gag practices.

Mr. Chairman, gag clauses strike at the heart of the patient-physician relationship. They present an inherent ethical conflict of interest.

As AMA's CEJA, Council on Ethical and Judicial Affairs recently stated, "The physician's obligation to disclose treatment alternatives to patients is not altered by any limitations in the coverage provided by the patient's managed care plan. Patients cannot be subject to making decisions with inadequate information. That would be an absolute violation of the informed consent require-

ments. If these clauses are carried out and physicians are subject to sanction, a reduction of patient quality of care will result."

Patients must be able to trust and rely on information that physicians provide to them. Physicians have an ethical as well as a legal duty to ensure that their patients are fully informed of all options. Gag clauses place a wedge between patients and their physician. They wear away at the most fundamental element of the healing process, trust.

Although gag clauses fall into many categories, they are all designed to control physician behavior and limit patient access to information. I point out, of course, that the legal responsibility continues to lie, however, with the physician.

Some in the managed care industry have stated that there aren't any gag rules. We strongly disagree. The media has documented a number of written and, more importantly, unwritten gag practices.

For example, last week's Washington Post reported about a gag practice by the Washington area's largest operator of managed health care known as Mid-Atlantic Medical Services or MAMSI. MAMSI recently told its doctors, "Effective immediately, all referral from Primary Care Physicians to Specialists may be for only one visit." Continuing on in bold print, "We are terminating the contracts of physicians and affiliates who fail to meet the performance pattern for their specialty."

In another example, a recent bulletin regarding preadmission guidelines stated, and this is at Humana, "Effective immediately all Humana participating providers must telephone the Preadmission Review Department—before an admission occurs and before conveying the possibility of admission to the plan member." Mr. Chairman, we call those plan members, patients.

Although a followup memo blamed "poor wording" for any "misinterpretation" of that bulletin as a restriction of communication, we think the effect of the announcement clearly is chilling.

Some health care plans, such as U.S. Health Care and Blue Cross/Blue Shield of Kansas City, have voluntarily removed gag clauses in response to the AMA's urging last January.

We believe these managed care organizations should be commended. Clearly, more is needed. As noted in a recent editorial in the "L.A. Times," "Today HMOs are less likely to require physicians to sign restrictive contracts than to simply fire them for referring too many patients to expensive specialists."

The AMA is on record supporting the Patient's Right To Know Act. We are encouraged by the Commerce Committee's unanimous vote on the Senate version of the bill. We are concerned, however, about attempts to dampen support for that bill. These efforts include advertising by the managed care industry that falsely suggests that the National Governors' Association is opposed to H.R. 2976. The NGA has assured us that they have taken a position on H.R. 2976 and do not intend to do so. My own Governor, whose wife is my patient, Mike Levitt of Utah, told me yesterday the same thing.

The term "gag clause" should not be viewed in an overly narrow or restrictive manner. We encourage the Subcommittee to resist narrowing the bill's gag clause protections. The Commerce Committee bill would go a long way toward restoring the patient-physician

relationship. If patients are to be truly free to make informed medical decisions, the bill should be strengthened to resemble more the original measures introduced.

Responding to the loud public outcry against gag clauses, States have begun to enact "antigag clause" legislation. Given the number of States moving forward, we expect some to ask, Is the Federal antigag clause necessary? We say, emphatically, yes, because even if all the States enacted similar measures, not all health plans will be reached by the State law. Consequently, Federal legislation is necessary to make all the gag clauses null and void.

In conclusion, the AMA maintains gag clauses and, more importantly, gag practices create an unacceptable ethical conflict of interest for physicians. It is simply bad medicine. We will continue to work to support H.R. 2976 and help physicians and our patients fight gag clauses. The AMA stands ready to work with you; we will do all we can to help and I am certainly willing to take questions.

Thank you very much.

[The prepared statement follows. The attachments are being held in the Subcommittee files.]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Ways and Means

U.S. House of Representatives

RE: H.R. 2976, the "Patient Right to Know Act of 1996"

Presented by John C. Nelson, MD

July 30, 1996

INTRODUCTION

My name is John C. Nelson, MD. I am a practicing obstetrician and gynecologist from Salt Lake City, Utah. I also serve on the Board of Trustees of the American Medical Association (AMA) and as part-time Deputy Director of the Utah Department of Health. On behalf of the 300,000 physicians and medical students of the AMA, I am pleased to have this opportunity to testify before you today about so-called "gag clause" provisions and practices that are commonly found in many of today's managed care contracts and H.R. 2976, "The Patient Right to Know Act of 1996," a bill that would prohibit managed health insurance organizations from restricting patient-physician communications. We commend the Subcommittee Chairman Bill Thomas for holding this important hearing.

As you may know, recent estimates suggest that over 58 million Americans are enrolled in health maintenance organizations. In addition, another 81 million receive care through some type of managed care arrangement. To date, almost 80 percent of the AMA's members maintain some form of managed care contract. Many observers believe that the near-term result of this trend has been a marked decrease in the rate of health care inflation. A number of studies have suggested that managed care provides care at least equal to that provided in fee-for-service medicine. Other studies, press accounts, anecdotal evidence, and a growing wave of public opinion, however, have begun to point out that needed care may be denied because of the financial pressures put on physicians and other health care providers to reduce costs to the detriment of their patients. We believe that a patient's needs must come first.

The AMA believes that "patient protection" and "antitrust relief" provisions similar to those contained in the House-passed Medicare reform package of last year should be enacted. As you know, the AMA supported these Medicare reforms and although the President vetoed the final bill we believe that, now more than ever, "anti-gag clause" legislation should be enacted not just for Medicare, but across the board to encompass all health benefit plans. We also believe that only in this way will some of the more egregious examples, in which physicians have been prevented from providing relevant information to their patients, be addressed.

"GAG CLAUSES" DISTORT THE PATIENT-PHYSICIAN RELATIONSHIP

"Gag clauses" strike at the heart of the patient-physician relationship because they present an inherent ethical conflict of interest. The AMA's *Code of Medical Ethics*, which lays out the guiding principles for the entire medical profession, is very specific on this point. In it we find a very important section entitled *Fundamental Elements of the Patient-Physician Relationship*. The very first "*Fundamental Element*" is as follows:

"The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patient should receive guidance from their physicians as to the optimal course of action."

In addition, the AMA's Council on Ethical and Judicial Affairs, the AMA entity responsible for maintaining the *Code of Medical Ethics* and providing authoritative interpretations of its contents, has recently stated that:

"The physician's obligation to disclose treatment alternatives to patients is not altered by any limitations in the coverage provided by the patient's managed care plan...Patients cannot be subject to making decisions with inadequate information. That would be an absolute violation of the informed consent requirements. If these clauses are carried out and the physicians are subject to sanction, a reduction of patient quality of care will result" (see attachment).

The AMA staunchly believes that patients must be able to trust and rely on the information their physicians provide to them regarding appropriate medical treatment and care. In short, physicians, as providers of health care, have an ethical and legal duty to ensure that their patients are fully informed of their options regardless of cost or potential treatment limitations. Unfortunately for patients, "gag clauses" create a real or perceived potential conflict of interest for physicians by placing a wedge between them and their physician. "Gag clauses" and "gag practices" wear away at a most fundamental element of the healing process -- trust.

WHAT ARE "GAG CLAUSES"

The Subcommittee's "Hearing Advisory" suggests that "gag clauses" fall into three categories:

1.) Those that restrain disclosure of treatment options;

2.) Those that restrain disclosure of payment and financial incentive arrangements; and,

3.) Disparagement clauses.

We would respectfully add two other types of "gag clause" provisions:

4.) Those that prohibit communicating with patients in the event the physician is "deselected" (raising concerns of continuity of patient care); and,

5.) Those that prohibit physicians from referring patients to other specialists or facilities not participating in the plan.

Assuming that medical communications are being made in good faith by a physician to a patient, these contractual provisions are designed and implemented with the intent to control physician behavior and to limit a patient's access to the full range of information that is needed to make informed decisions and provide informed consent about the proper course of medical treatment. While we acknowledge a legitimate business interest in attempting to control costs and to avoid unjustified disparagement of a plan's operations, we firmly believe that such efforts should not undermine the quality of care received by patients. To be sure, not all health plan contracts contain written "gag clauses," yet some in the managed care industry have stated that "there are no gag rules" in managed care contracts. While we strongly disagree with this latter statement, we do agree with the recent editorial in the *Los Angeles Times* which states "today HMOs are less likely to require physicians to sign restrictive contracts than to simply fire them for referring too many patients to expensive specialists" (see attachment).

WRITTEN AND UNWRITTEN "GAG CLAUSES"

Recent media reports in *Time Magazine*, *USA Today*, *The New York Times*, *Chicago Tribune*, NBC Nightly News, *Newsweek*, National Public Radio, *Boston Globe*, CNN, *Newsday*, AP, and the *San Francisco Examiner* have documented a number of written and unwritten "gag" practices. While all differ in detail, most tell a story of health insurance programs that value

cost containment and financial gain for shareholders over the well-being of members and policyholders. Although these reports are anecdotal, they are, nevertheless true and indicative of a widespread problem. Written contract provisions continue to be of great concern. **However, a number of physicians have also become concerned about the more subtle, unwritten, plan policies and procedures that are used to impede physicians from discussing treatment options if the plan does not cover those treatments.**

One example of "gag" practices was reported in last week's *Washington Post* regarding the Washington area's largest operator of managed health care known as Mid Atlantic Medical Services (MAMSI). In a recent letter, the health plan, also known as M.D. IPA, Alliance, Optimum Choice and MAPSI, told participating physicians that "effective immediately, all referrals from Primary Care Physicians to Specialists may be for only one visit." The letter continued, in bold type, **"we are terminating the contracts of physicians and affiliates who fail to meet the performance patterns for their specialty"** (see attachments).

In another example, a recent plan bulletin regarding preadmission review guidelines stated that **"effective immediately, all Humana participating providers must telephone the Preadmission Review Department...before an admission occurs and before conveying the possibility of admission to the plan member."** Although a follow-up memorandum blamed "poor wording" in the original announcement for any "misinterpretation" of the bulletin as a restriction of communication between physicians and patients, the AMA maintains that the original effect of the announcement is clearly chilling (see attachments).

Another "gag clause" example is provided in the following physician contract provision with Aetna: "Upon notice of termination or nonrenewal, Consulting Physician shall cooperate fully with Aetna and comply with Aetna's procedures, if any, in the transfer of Members to other Providers. In addition, upon notice of termination or nonrenewal, at Aetna's option, Members shall not be permitted to select Consulting Physician as their provider of health care services" (see attachment). The AMA believes such contract provisions are harmful to patients. This particular provision raises important concerns regarding patient choice and continuity of care issues. We believe that in instances where the patient-physician relationship is severed by the plan for non-clinical reasons, there should be rules providing for the continuity of care for some reasonable period of time to allow for a smooth and satisfactory transition. These are only a few "gag clause" examples. The AMA would be pleased to provide further examples of other "gag clauses" and practices.

NOT ALL HEALTH PLANS CONTAIN "GAG CLAUSES"

Some health care plans, such as U.S. Healthcare, Blue Cross/Blue Shield of Kansas City, ChoiceCare and Health Net of Missouri, have voluntarily removed onerous "gag clauses" in response to the AMA's urging to do so last January. We also note that the American Association of Health Plans, the Washington representatives of the managed health care industry, adopted a non-binding statement of purpose which suggests that the industry should "encourage physicians to share information with patients on their health status, medical conditions, and treatment options." The Association of Managed Healthcare Organizations also recently issued a statement in support of "a patient's right to full clinical information about the physician's recommended treatment and other options for care." Finally, the National Committee for Quality Assurance (NCQA) issued a clarification of their standard for Members' Rights and Responsibilities which states that "at a minimum, the organization has a written policy that recognizes the following rights of members to: participate in decisionmaking regarding their health care and prohibits restrictions on the clinical dialogue between practitioner and patient." We believe these managed care organizations should be congratulated for understanding the importance of this issue. Clearly, however, more is needed.

"PATIENT RIGHT TO KNOW ACT OF 1996" (H.R. 2976)

The AMA is on record in firm support of H.R. 2976, the "Patient Right to Know Act of 1996," a bipartisan measure sponsored by Representatives Greg Ganske (R-IA) and Edward Markey (D-MA). While we are encouraged by the Commerce Committee's recent and

unanimous vote on the amended version of this important measure, we are concerned about attempts by the for-profit managed care and insurance industries to pare back this legislation to the point where it may become unrecognizable from the bill as originally introduced. These efforts include placing advertisements in well read publications that falsely suggest that the National Governors' Association (NGA) has taken a position in opposition to H.R. 2976. We urge Congress to be cautious not to mistake these calculated attempts by the managed care industry to leverage the reputation of a prominent group such as the NGA. In fact, the NGA has assured us that they have not taken a position on H.R. 2976, the "Patient Right to Know Act" and do not intend to do so in the near future (see attachment).

In general, the AMA believes that the term "gag clause" should not be viewed in an overly narrow, legalistic or restrictive manner. The AMA maintains that a more common sense approach to this issue should prevail because of the fact that "gag clauses" often go beyond the mere elements of contract law and include a pattern of practice that is limiting to physician-patient communications. We encourage the Subcommittee to resist the urge to narrow the definition of "gag clause" protections. The AMA believes that narrowing the important provisions of the bill would allow plans to neglect those concerns reported by physicians and others in the actual delivery and practice of health care. While we are confident that, in the end, we would also prevail on the merits of such provisions, narrowing these provisions at this time would affect patient care in the interim.

We believe that the bill passed by the Commerce Committee would go a long way toward restoring the patient-physician relationship, which has been damaged by "gag clauses." We also believe, however, that if patients are to be truly free to make informed medical decisions, the legislation should be strengthened to reflect the following concerns:

"GAG" CONTRACTS AND PRACTICES SHOULD BE BANNED. The legislation should be amended so that health plans would no longer be allowed to "gag" their physicians through policies and other unwritten conduct, which intimidate physicians and interfere with a patient's right to receive essential medical information. As reported from the Committee on Commerce, Section 2 (a)(1) is both unclear and potentially harmful to patients. In short, this provision would merely prohibit health plans from including written or oral "gag clauses," thus leaving it questionable whether those well documented cases in which a physician has been "gagged" by a plan's own internal procedures would, indeed, be prohibited by the bill. Patients need to be protected from plans retaliating against their doctors for advocating on their behalf and following ethical medical practices;

THE DEFINITION OF "MEDICAL COMMUNICATIONS" SHOULD BE EXPANDED. The Amendment's definition of "medical communications" is narrow and limits what patients should be allowed to know. For example, the original "Patient Right To Know Act" expressly stated that physicians would be free to inform patients about the "basis or standard for the decision of [a health plan] to authorize or deny health care services or benefits." The original bill also specifically protected medical communications between physicians and patients regarding "the process used by [a health plan] to determine whether to authorize or deny health care services or benefits." Physicians should be free to inform patients if and when certain health services will be covered by the plan. The definition of "medical communication" contained in the original "Patient Right To Know Act" should be restored; and,

HEALTH PLANS SHOULD NOT GET MORE THAN ONE BITE AT THE APPLE. Another provision in the Substitute bill would let health plans off the hook if they only occasionally use gag clauses. Under the amended version, civil money penalties could be leveled against a health plan only if the physician has been "gagged" as a part of a "pattern" or practice of the plan. Thus, a plan that gags physician communications on "an occasional" basis would be immune from punishment. The effects of "gag clauses " are too dangerous to the health, safety and welfare of patients to be allowed more than one bite at the apple.

Although we would prefer that the amended "Patient Right To Know Act" be restored to its original form, we are pleased that the amended bill would set the ground rules for physician-patient communications and would cover all health plans, including self-insured "ERISA"

plans. The AMA has worked closely with the sponsors of H.R. 2976 in developing this bill and maintains that it is a necessary first step to rid the health system of these egregious contract provisions without unduly interfering with the legitimate business practices of managed care companies.

STATE/FEDERAL INTERPLAY NECESSARY TO CORRECT "GAG" PROBLEMS

In reaction to the loud public outcry caused by local cases where physicians have been "gagged," thereby threatening patients, a number of states have begun to enact "anti-gag clause" legislation. For example, legislatures in Massachusetts, Colorado, Maryland, Georgia, Indiana, Virginia, Maine, New Hampshire, Rhode Island, Tennessee, Vermont and Washington have all passed such measures. Another twelve states currently have similar proposals pending while a number of other states have chosen to address this issue through regulation. Finally, the National Association of Insurance Commissioners (NAIC) recently adopted a non-binding model bill that would, in part, ban plans from contracting to limit or prohibit a participating physician from discussing treatment options with patients regardless of the health carrier's position on the treatment options, or from advocating on behalf of patients within a utilization review or grievance process.

Given the number of states moving forward with legislation, the NAIC's model bill and various private sector activities to educate the public about these provisions and practices, we expect some to pose the question, "is federal anti-gag clause necessary?" The AMA believes the clear and simple answer is "yes!" Even if all the states enacted similar "anti-gag clause" measures, not all health plans can, nor will, be reached by state law. Consequently, federal legislation is necessary to make "gag clauses" null and void in all health plans. Although the courts have yet to speak on this issue, we believe waiting for the courts to render their final judgment could, in the interim, prove harmful -- if not fatal -- for many patients.

In addition, an increasing number of Medicare beneficiaries have begun to join managed care plans. Because this population often uses a greater number of specialists, managed care "gag clauses" could pose especially acute problems for unsuspecting Medicare beneficiaries. Although the path for Congressional reform of Medicare remains uncertain, we would expect efforts to change the system to include an even greater role for managed care plans in the immediate future. Federal legislation covering all private and public sector health plans is, therefore, needed in order to ensure that every patient is adequately protected from these contractual provisions and practices.

CONCLUSION

In conclusion, the AMA maintains that "gag clauses" and "gag practices" should be made unenforceable and null and void. Toward this end, we support both private and public sector efforts to prohibit "gag clause" provisions and practices. The AMA maintains that such practices are an unreasonable burden on physicians and create an unacceptable ethical conflict of interest, as well as being "bad medicine." In addition, to our support of the "Patient Right To Know Act of 1996" (H.R. 2976), we will continue to work to support physicians fighting against such practices and provisions. The AMA stands ready to work with you, Mr. Chairman and Members of the Subcommittee, on this important issue. I would be pleased to answer any questions you may have at this time. Thank you.

Mr. ENSIGN. Dr. Jagmin.

STATEMENT OF CHRIS L. JAGMIN, M.D., MEDICAL DIRECTOR, PACIFICARE IN THE SOUTHWEST, DALLAS, TEXAS; ON BEHALF OF AMERICAN ASSOCIATION OF HEALTH PLANS

Dr. JAGMIN. Thank you, Mr. Chairman.

Mr. Chairman, and Members of the Subcommittee, I am Chris Jagmin, medical director at PacifiCare in the Southwest. Today, I am testifying on behalf of PacifiCare and the American Association of Health Plans. PacifiCare and the American Association of Health Plans believe that physicians must be free to discuss all appropriate treatment options with their patients. We believe this information should be complete, unbiased, and presented to patients in a language they can understand.

PacifiCare uses no contract clauses which limit a physician's ability to discuss treatment options with his or her patients. PacifiCare in the Southwest is a network model HMO. We have 290,000 members and 75,000 Medicare members. We are the largest Medicare risk contractor in Texas and Oklahoma. Of our 8,200 contracting physicians, approximately 1,800 are primary care physicians and 6,400 are specialists.

Because of our strong commitment to the patient-physician relationship, PacifiCare does not use contract clauses that limit a physician's ability to discuss treatment options with his or her patient. Contracts with physicians and other providers are a key feature of network-based care. Contracts enable plans to hold physicians accountable, set out physician and plan roles and responsibilities and set payment arrangements. They protect all the parties involved.

Legislation prohibiting so-called gag clauses is unnecessary because, despite all the recent headlines and news articles, available information suggests that health plans rarely, if ever, use provider contracts to restrict communications on patient care.

Although some may find this surprising, it is fully consistent with the plans' strong incentive to encourage, not stifle, such communications.

Legislation regulating provider contracts is unwise because it would launch the Federal Government down the long and unprecedented road of deciding what private contracts may or may not contain. This will almost certainly produce unintended consequences.

There has been a lot of confusion around the issue of what is a gag clause and I would like to address two types of clauses that have been erroneously labeled as gag clauses—antidisparagement clauses and proprietary information clauses.

The purpose of an antidisparagement clause is simply to prevent a physician from involving patients in disputes and disagreements between physicians and health plans. Patient care, not a physician's disagreement with the plan, should be the focus of a member's encounters with the health delivery system.

As a medical director, I believe that a physician who has some knowledge or understanding of the system in which he or she works has an obligation to work within the system to correct it. At PacifiCare, a member physician can pursue a number of avenues. First, a physician can bring the concern to the attention of the medical group's or IPA's medical director or administrator. If the

problem is still not resolved, then the doctor may appeal directly to PacifiCare's physician advisory committees. PacifiCare also has a separate provider appeal mechanism available to physicians in the network.

Proprietary information clauses protect information such as the specific financial arrangements between the plan and physicians, whose release of this information would undermine competition among plans.

Disclosure of precisely how much a physician is paid per member per month, which I note can be an incomplete and misleading measure of payment, will do little to help patients answer the question that is foremost in their minds: Am I receiving the health care services needed for my disease or illness? Both antidisparagement and proprietary clauses in no way restrict physicians from discussing treatment options. And, in fact, are commonly found in many other professional and business agreements.

In addition, even though the Commerce Committee bill was narrowed in scope, the legislation still includes language that would bar a health plan from including "any provision that prohibits or restricts" any medical communication in contracts with health care providers.

The vagueness of this term opens the doors to broad interpretation by the Secretary of HHS. The bill also bans a health plan from prohibiting or restricting medical communication as part of an oral communication. Including oral communication that would change longstanding rules of contract law which have relied on written agreements between two parties.

Regulating the terms of contractual agreements between providers and health plans is not the way to ensure that patients receive the information that they need about their care, nor is it the way to ensure that physicians put patient interests first.

Quality improvement systems and holding physicians accountable for patient satisfaction are more effective. At PacifiCare physicians, along with senior management, lead our commitment to quality through our quality improvement council. Each market in our region has a physicians' advisory committee composed of practicing physicians in our network. These physicians perform peer review activities, as well as design studies in collaboration with PacifiCare to improve our members' health.

We currently have 52 practicing physicians, including specialists, who actively participate in our monthly quality improvement activities. We have targeted quality improvement activities in clinical areas such as congestive heart failure, diabetes, early detection of breast cancer, depression, and pediatric asthma.

These measurement and improvement activities will allow us to improve the care and outcomes for our members. HMOs and other integrated networks provide the unique vehicle for systematic quality improvement that is not readily available in fee-for-service arrangements.

What PacifiCare and other plans understand is that if you offer high quality care at an affordable cost, members will remain in your plan. While the record of network-based care in terms of the quality of choice and affordability is impressive, we are always striving to better fulfill our aim. Together we make lives better.

Thank you very much for this opportunity to be a part of this hearing. I would be pleased to respond to any questions that you and other Members of the Subcommittee have.

[The prepared statement follows:]

STATEMENT OF CHRIS L. JAGMIN, M.D.
MEDICAL DIRECTOR
PACIFICARE IN THE SOUTHWEST

Mr. Chairman, members of the Committee, my name is Chris Jagmin, M.D. I am the Medical Director of PacifiCare in the Southwest, and today I am testifying on behalf of PacifiCare and the American Association of Health Plans (AAHP). AAHP (formerly GHAA/AMCRA) represents more than 1000 HMOs, PPOs, and similar health plans. AAHP member companies are dedicated to a philosophy of health care that puts the patient first by providing coordinated, comprehensive health care. AAHP plans care for more than 100 million Americans.

PacifiCare is a network model HMO, which means we provide services through a network of contracted medical groups and Independent Practice Associations (IPAs). I appreciate the opportunity to address you today and hope my comments will be helpful to you. **Let me say at the outset that PacifiCare uses no contract clauses which limit a physician's ability to discuss treatment options with his/her patient. Also, AAHP and its member plans are committed to a policy of unrestricted communication between physicians and their patients with respect to diagnosis, treatment, and other information affecting the course of patient care.**

My testimony will highlight three areas:

1. Describe PacifiCare in the Southwest and how we work collaboratively with our physicians.

2. Review our activities to increase the value of health care, improve the quality of care/services provided, and improve health outcomes for our membership.

3. Discuss health plan contracting issues and related proposed legislation.

PacifiCare in the Southwest is a network model HMO, as noted above. We have 290,000 members including employees from small to very large companies, union trusts, and individuals. Our senior risk plan for Medicare beneficiaries (Secure Horizons) has over 500,000 members nationally and over 75,000 members in the Southwest. We are the largest Medicare risk contractor in Texas and Oklahoma. There are 58 medical groups/IPAs with 8200 physicians in our network. Of these, approximately 1800 are primary care physicians and 6400 are specialists.

Our providers include small primary care offices of one or two physicians, as well as large multi-specialty medical groups. We also contract with academic medical centers such as the University of Texas Medical Branch in Galveston and the University of Texas Health Science Center in Houston.

This large network provides our membership a wide choice of physicians. Members may change physicians within their medical group freely or may change medical groups on a monthly basis. With such a wide choice, members are encouraged to select the physician who best meets their needs and preferences. Our medical groups take both quality of care and customer service seriously. This is reinforced by medical groups' intense competition with one another for patients. A medical group that responds to patients' needs will be successful. In contrast, medical groups that are not sensitive to individual patient needs will lose patients and will not thrive.

PacifiCare in the Southwest is driven by our corporate aim: "Together we make lives better." We take great pride in our relationships with our medical providers. We have worked collaboratively over the years to ensure that physicians have the tools they need for improving care and service. Our "Art of Caring Program" was developed five years ago to improve service. It consists of intense one-to-two day training programs for physicians, nurses and office staff, focused on improving customer service and enhancing patient satisfaction. We have also funded two-day training programs to promote better communication between patients and their physicians. We have invested in our physicians' commitment to quality by giving practicing physicians the opportunity to attend intense, four-week courses in quality improvement.

Quality Improvement and Continuous Improvement are two values we believe in deeply. Along with physicians, senior management leads our commitment to quality through our Quality Improvement Council. Each market in our region has a Physician's Advisory Committee composed of practicing physicians in our network. These physicians perform peer review activities

as well as design studies in collaboration with PacifiCare to improve the health of our members. We currently have 52 practicing physicians -- including specialists -- actively participating in our monthly quality improvement efforts.

A major objective of our quality program is to assure that each of our members receives the best, most appropriate care for his or her particular case. As you may know, there is a great deal of variation in physician practice across the country, with the residents of some areas being two or three times more likely to receive a particular treatment -- such as an angioplasty -- than those in other parts of the country. These variations strongly suggest that, under fee-for-service medicine, some patients are receiving treatment that is inappropriate for their case. A Rand study, for example, reports that 25% of carotid endartectomies and coronary artery bypass surgeries are probably unnecessary or inappropriate. PacifiCare's quality improvement mechanisms are designed to assure that patients are not over-treated or under-treated -- that they receive the care they need. Working with physicians to develop and refine practice guidelines and utilization management techniques, we have been able to reduce the incidence of inappropriate care and its associated risks. In one case, for example, heart bypass surgery successfully averted the need for a more serious and risky heart transplant; in another, a patient whose physician initially recommended a kidney transplant was found instead to need a more complex -- and costly -- kidney-pancreas transplant.

It is likewise important to note that there may be several treatments available for the same diagnosis. Prostate cancer is an example. Current treatments include radical surgery, standard radiation therapy, brachytherapy (seed implants), cryoablation (freezing), hormonal therapy, or watchful waiting. Choice of treatment must be based upon the full clinical picture -- the stage of cancer, its aggressiveness, the age of the patient, and the values or preferences of the patient. In these, and in fact all circumstances, we believe that patients need the most complete, unbiased information available to assist them in making the right choices for them. We do not believe in limiting physicians' discussion of patients' choices or of other information important to helping patients make decisions about their care. We do not believe either that physicians are always unbiased in their treatment recommendations. It might be unusual, for example, for a radiation oncologist to recommend surgery to a prostate cancer patient. He/she would be much more likely to recommend radiation therapy. Our approach is to encourage patients to make these choices when all the information has been provided to them.

PacifiCare believes that we need to be accountable for these activities. To that end we have published HEDIS data for three years. We have targeted quality improvement activities ongoing in the following clinical areas:

- Congestive Heart Failure
- Diabetes
- Pediatric Immunization
- Mammography
- Pap smears
- Depression (study in collaboration with the Rand Institute)
- Pediatric Asthma

These measurement and improvement activities will allow us both to improve the care and outcomes of these populations and to report our results. A GHAA survey of 125 HMOs in 1994 indicated that 96 of them have implemented programs to improve childhood immunizations -- even though immunization rates already are higher in HMOs than in fee-for-service. Others have programs in asthma, arthritis, and other diseases. These efforts are in addition to other quality improvement initiatives which might be directed at improving record keeping systems, developing missed appointment tracking systems, or improving follow up of abnormal lab/x-ray results.

In this way, HMOs are organized systems for financing and delivering health care. They provide a vehicle for systematic quality improvement that is not as readily available in more episodic financing arrangements such as fee-for-service plans, because HMOs combine a number of interrelated features that foster a comprehensive approach to quality. These include:

- Selection of a defined, fully credentialed network of providers who can work together on delivery and quality issues.

- Delivery of comprehensive services across the spectrum of inpatient and outpatient settings, providing a full range of quality interventions.

- Clinical and fiscal accountability for the health care of a defined population -- allowing population-based data collection, analysis, intervention, and monitoring -- and establishing accountability for health plan performance.

A comprehensive review of the literature published from 1980-1994 appeared in the May 18, 1994 Journal of the American Medical Association. It analyzed 167 studies comparing quality of care in HMOs with care provided to similar populations in other settings. The study concluded that HMO quality is better than or equal to the fee-for-service results on 14 of 17 measures. People cared for in HMOs consistently receive more preventive care -- such as breast, pelvic, rectal and general physical examinations -- as well as more health promotion counseling. Some specific examples of studies on quality of care in HMOs are outlined below.

- Elderly HMO members with cancer are more likely to be diagnosed at an early stage than those in the fee-for-service system, according to a HCFA study that compared Medicare records for 12 different types of cancer. Breast, cervical and colon cancers, along with melanomas, were diagnosed significantly earlier in HMOs than fee-for-service. The largest difference was for cervical cancers: almost 60 percent of HMO members were diagnosed at the earliest stage, compared with just 39 percent of fee-for-service patients (American Journal of Public Health, October 1994).

- Women in HMOs were more likely to obtain mammograms, pap smears and clinical breast exams than women in fee-for-service settings. For example, 62 percent of women HMO members age 50-64 had a mammogram within the past year, compared to 50 percent of women with fee-for-service coverage (CDC/NCHS Advance Data No. 254, August 3, 1994).

- Finally, HMO members -- elderly and non-elderly -- are more satisfied overall with their health plan than fee-for-service enrollees. For example, a survey of 19,000 elderly Americans by the National Research Corporation found those enrolled in HMOs had higher satisfaction levels than traditional fee-for-service Medicare enrollees for every level of health status.

At PacifiCare we measure member satisfaction in several ways. One measure is the Member Satisfaction Tracking System (MSTS). This program involves a telephone survey of a statistically valid sampling of members for each of our contracted medical groups/IPAs. For example, the most recent results for 4 months ending 5/96 show that 97% of Secure Horizons members in San Antonio are satisfied on an overall basis and 98% said they would recommend PacifiCare. Also, the survey results indicate that 100% of Secure Horizon members of Tulsa are likely to continue coverage.

The second measure of satisfaction (or dissatisfaction) is the number of complaints. This has consistently been low, and currently is less than 5 complaints per thousand members per year for all complaints related to clinical care or service. In 1995, we estimate there were over 1,000,000 doctor-patient visits in our system. During this same period, there were less than 500 complaints related to quality issues (less than .05% of visits). Of these, less than 50 were found to represent true quality-of-care issues. This represents less than .005% of visits. All complaints are carefully reviewed and action plans developed when appropriate. Unlike fee-for-service, HMOs have systems in place to address problems with the objective of preventing their recurrence.

Perhaps a more important indication of satisfaction than enrollment rates is disenrollment rates. People can join a plan, but that means very little if they disenroll in a short period of time due to dissatisfaction. According to a recent study based on Health Care Financing Administration (HCFA) data, only 4% of Medicare beneficiaries enrolled in HMOs return to fee-for-service plans.

Contracting Issues

Before commenting on H.R. 2976, Mr. Chairman, we want to underscore one vital point. We firmly believe that there should be open communication between health professionals and their patients about health status, medical conditions, and treatment options. Such communication is key to prevention and early treatment, which AAHP member plans have long emphasized as an integral part of network-based care. Likewise, the full participation of patients in decisions affecting their treatment helps to assure that they receive quality, cost-effective care. Viewed from this perspective, such communication is in the best interests of the patient, the physician, and the health plan.

Federal legislation regulating the contractual relationships between physicians and health plans is both unnecessary and unwise. Contracts with physicians and other providers are a key and distinguishing feature of network-based care, ensuring that most of the services their enrollees need are provided through selected panels of providers. Contracts are how our plans hold these providers accountable, how they make clear the respective roles and responsibilities of the provider and the plan, and how they codify the payment arrangements between the provider and the plan. As such, they protect all of the parties involved.

Legislation prohibiting so-called "gag" clauses in these contracts is unnecessary because -- despite all the recent headlines and news articles -- available information suggests that health plans rarely -- if ever -- use provider contracts to restrict communications on patient care. Although some may find this surprising, it is fully consistent with plans' strong incentive to encourage -- not stifle -- such communications.

Provider Contracts

Legislation regulating provider contracts is unwise because it would launch the federal government down the long and unprecedented road of deciding what private contracts may and may not contain -- and in a sector of the economy that is so complex and rapidly changing that any efforts to ban specific arrangements will almost certainly produce unintended consequences. *As introduced*, for example, H.R. 2976 would effectively nullify two types of contractual provisions -- "anti-disparagement" clauses and confidentiality clauses -- that in no way restrict treatment-related communications between doctor and patient. Because these types of clauses have been misconstrued as "gag clauses," I would like to briefly discuss them.

Anti-disparagement clauses

The primary purpose of an anti-disparagement clause is simply to prevent a provider from involving patients in disputes and disagreements between physicians and health plans. Patient care -- not a physician's disagreements with the plan -- should be the focus of a member's encounters with the health care delivery system. If a provider disagrees with a health plan decision, he or she should seek to resolve the matter directly with the plan, not by enlisting patients to do the job. Such disputes do not belong in the examining room. These types of disputes relate to communication between a provider and a plan, not a provider and a patient.

Anti-disparagement clauses are also designed to assure that a provider who has contracts with more than one health plan does not use his or her position to encourage patients to switch from one plan to another simply because that plan's contract is more advantageous to the physician. It is important to remember that many physicians are affiliated with multiple health plans with quite different compensation arrangements.

As a medical director, I believe that a physician who has some knowledge or understanding of the system in which he/she works has an obligation to work within the system to correct it. The system -- within network-based plans -- has a number of avenues that a physician can pursue. First, a physician can bring the concern to the medical group or IPA's medical director or administrator. If the individual problem still cannot be resolved, then individual doctors may utilize an appeal mechanism directly to PacifiCare. PacifiCare engages its physician providers at a variety of levels to permit this to happen. Concerns may be brought to the Physician Advisory Committees. PacifiCare also has a separate provider appeal mechanism available to physicians in the network.

Permitting physicians to criticize the health plan irresponsibly is unacceptable. Protecting physicians making incorrect and misleading statements is not a rational solution, and in fact, would undermine the premise that patients should be given complete, accurate and unbiased information. Further, such protection would be unprecedented, and would afford health care providers protection not available to any other contractors.

Disclosure of Proprietary Information

When used, confidentiality clauses are intended primarily to protect against disclosure of proprietary information. We believe that patients should be informed about how their health plan works, and why, in their specific case, particular treatment options are appropriate or inappropriate. Likewise, patients should be fully informed about how their health plan made a decision about whether a particular service was covered, how to appeal that decision, and in general terms what the plan's financial arrangements are with the health professionals who provide patient care.

Health plan contracts with providers often contain legitimate requirements that providers not disclose proprietary information, such as specific protocols and specific compensation amounts. Restricting the disclosure of such financial information is appropriate. First, competition among health plans is intense, and the release of such information about one plan can give its competitors an unfair advantage, erode any competitive advantage it has achieved, and eliminate the incentive to find more effective methods for delivering care. Second, plans themselves are often bound by contract not to disclose coverage decision procedures and other protocols that are licensed by companies that have developed them as commercial products. Preventing plans from requiring their affiliated providers to respect this confidentiality will make it difficult, if not impossible, to comply with such obligations and to protect intellectual property appropriately.

Releasing proprietary decision procedures will do little to help patients understand the particulars of their case. These documents are frequently highly complex, sometimes voluminous, and almost always involve extremely technical terminology. More importantly, disclosure of precisely how much a physician is paid per member per month will do little to help patients answer the question that is foremost in their minds: Am I receiving the appropriate health care services needed for my disease or illness?

As a recent article in the New England Journal of Medicine points out, network-based health plans have developed highly sophisticated mechanisms for paying physicians -- mechanisms that take into account patient satisfaction and other measures of quality, as well as practice profiles, in order to avoid both under- and over-utilization of services.[1] The article reports, for example, that "more than half of the group or staff model HMOs and the network or IPA HMOs adjusted payment [physician compensation] on the basis of patients' complaints and measures of the quality of care." Thus, simply telling a patient that her plan pays a physician $X per month for her care fails to tell the whole story. In fact, it can be misleading if the patient does not understand that the plan is also paying the physician a similar amount each month for an entire group of patients, many of whom do not need any care -- or if the patient does not know that the physician has "stop-loss" protection for high cost cases, as is frequently true. **However, patients should know how the decisions affecting their care are made and how they can appeal any decisions with which they disagree.**

PacifiCare and "Gag Clauses"

PacifiCare believes categorically that physicians must be free to discuss all appropriate treatment options with their patients. We believe that this information should be complete, unbiased, and sensitive to the patient's own values. Patients should have information presented to them in ways they can understand and in language that they can understand.

As a medical director, I'd like to point out that not all physicians may be aware of all treatment options. There is much changing in the practice of medicine and new treatments are available all

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[1] Gold, Hurley, Lake, Ensor, and Berenson, "A National Survey of the Arrangements Managed Care Plans Make with Physicians," New England Journal of Medicine, vol. 333, No. 25 (December 21, 1995), pp. 1678-83.

the time. Nonetheless, PacifiCare encourages our doctors to discuss all treatment options, including those which may not be covered.

PacifiCare agrees with the statement: "Patients cannot make appropriate health care decisions without access to all relevant information relating to those decisions". This information should include an understanding of whether the treatments are covered by the plan as this information may be very relevant. **Our PacifiCare Provider Contract does not contain a clause limiting a physician's ability to discuss treatment options.**

Over the years, PacifiCare has enjoyed substantial growth, a high level of member satisfaction, a low level of disenrollment, and a high mutual regard with our medical providers. Regulation of our provider contracts is not necessary and could potentially impair the communication between the doctor and the patient.

Legislating Contracts – H.R. 2976
The Committee on Commerce made significant changes to the *introduced version* of H.R. 2976. Changes include a shorter definition of medical communication with the addition of a specific reference to oral communication; a change in the amount of civil money penalties; deletion of the "prohibition on adverse action by a health plan"; and redrafting of the rule of construction.

While the scope of H.R. 2976 has been improved since it was first introduced, we still have serious problems with the bill. Today I am going to address two areas of concern.

"Restricting" Communications
We believe that the intention of H.R. 2976 is to protect patient care by assuring unrestricted physician-patient communication regarding medical diagnosis and treatment options. Unfortunately, this bill could actually place patient care at risk by interfering with our health plans' quality assurance initiatives. H.R. 2976 includes language that would bar a health plan from including "any provision that prohibits or *restricts*" any medical communication in contracts or agreements, written statements, or oral communications with health care providers. The vagueness of the term "restricts" opens the door to broad interpretation by the Secretary of Health and Human Services and the federal courts, leading to extensive government micro management of health care delivery.

Some health plans and physician group practices currently require physicians to refer to clinical practice guidelines or practice protocols before discussing diagnoses and treatment options with their patients. For example, some require physicians to check with the plan before recommending an organ transplant, to make sure the doctor knows about the plan's use of centers of excellence for transplant surgery. If broadly interpreted, such practices, designed to ensure high-quality care, could be deemed "restrictive." Other health plans and medical group practices require physicians to discuss complex cases with their peers, i.e., doctor-to-doctor, to assess the medical appropriateness of a course of treatment for a particular patient, prior to discussing treatment options with their patients. These discussions focus on the tough cases for which a clear-cut treatment may not be obvious. H.R. 2976 could prohibit this quality improvement practice. These types of quality improvement activities do not interfere with plans' commitment to free and open communication or their commitment to placing no restrictions on discussion of medical treatment options.

Limits on "Oral Communications"
We are concerned that H.R. 2976 not only bans a health plan from including any provision that prohibits or restricts medical communication as part of a written contract or written statement, but also as part of an "oral communication." The inclusion of "oral communication" in H.R. 2976 is unnecessary as the relationship between a plan and its providers invariably is governed by a written agreement.

The purpose of written contracts is to assure that all parties involved have a clear understanding of what is expected of them. Currently contracts are enforced on the basis of mutually agreed to *written* terms and conditions, precisely because oral communications are easily subject to misinterpretation. H.R. 2976, which permits disputes to be based on undefined oral

communications between health plans and physicians, creates several problems. First, the bill would create the potential for litigation based on a provider's misinterpretation of a casual comment. Second, the bill does not make clear who is a "representative" of the health plan or who is responsible for the plan's oral communications. Is the representative solely a health plan administrator, or do physicians also speak as representatives of the plan? If a physician suggests to one of his colleagues that he should conduct more tests before revealing a diagnosis to a patient, would this be interpreted as prohibited communication under this bill?

Further, in a dispute on the issue between a plan and a provider, it would be the language of the written agreement between them which would govern. Oral statements made by a plan to a provider which restricted or prohibited medical communication would violate the written contract.

Finally, regulating "oral communications" would force health plans to document all oral communications that they have with providers to protect themselves from future litigation. Informal conversations about medical care, for example between a medical director and a plan physician would be difficult, as remarks would have to follow an approved script. Maintaining daily records of every interaction would be tremendously laborious and administratively burdensome. Moreover, it would inhibit the free flow of information between medical professionals that is vital to providing high quality care.

Concluding Comments

While the record of network-based care in terms of quality, choice, affordability, information, partnership and prevention is an impressive one, we certainly recognize that there is always room for improvement. Due to the complexities of modern medicine, the best outcome is not always achieved in every circumstance -- regardless of the type of delivery system. Press reports critical of HMOs and other network-based health plans focus on anecdotes without even mentioning the numerous studies reporting that quality of care in network-based plans is equal to or better than care in fee-for-service plans. It is this evidence -- and not anecdotes -- that should drive our policy discussions. Moreover, such stories fail to acknowledge that the very same problems can and often do occur in fee-for-service plans.

We intend to continue to support efforts for continuous quality improvement, to encourage dissemination of comparative plan data, and to respond promptly to identified problems. At the same time, we urge those who have the responsibility for public policy-making to reject legislation or regulation that would reduce network-based care plans' ability to deliver quality, affordable care. Regrettably, all too often opponents of HMOs, PPOs and other similar plans have tried to use legislation to unnecessarily burden health plans and thereby limit consumers' choices.

We know there are tens of millions of very satisfied consumers enrolled in PacifiCare and other AAHP member plans. What they illustrate is that as Americans have direct contact with network-based care plans, they recognize and appreciate the advantages these plans provide. Each and every day our member plans focus on improving or maintaining the health of their patients as well as making health care more affordable. HMOs, PPOs and other network-based plans have been at the center of efforts to reform our health care system for decades and as study after study shows, they have done it with high quality at lower costs and with high levels of patient satisfaction.

Thank you very much for this opportunity to be a part of this hearing. I would be pleased to respond to any questions that you or other members of the Committee may have.

Mr. CHRISTENSEN [presiding]. Thank you, Dr. Jagmin.

Dr. Nelson, earlier one of the panels talked about the insurance commissioners taking a look at this and letting it be handled at the State level. In your opinion, what would be wrong with allowing us to go that route as we are in, six or seven States now and growing, rather than, as Dr. Jagmin has stated, down that slippery slope of Federal regulation?

Dr. NELSON. Thank you, Mr. Chairman.

One of the roles I have in Utah, as being the deputy director of our State Health Department—and there are many groups which would not fall under that group—there are about 60 percent or more of individuals who are insured by employer-owned insurances which simply do not come under the regulation for a State insurance commissioner.

Further, there are many patients also in Federal programs, specifically Medicaid or the State programs. So, a tremendously large number of individuals would not be affected by that.

Mr. CHRISTENSEN. Dr. Jagmin, I wanted to find out under PacifiCare how autonomous are the doctors under PacifiCare's managed care plans?

Dr. JAGMIN. When you talk about autonomous, I assume you mean clinical decisionmaking processes?

Mr. CHRISTENSEN. Correct.

Dr. JAGMIN. We delegate medical necessity and the determination of clinical decisions to physicians in our network.

Mr. CHRISTENSEN. So, do they have to get approval every time they are presented a case scenario versus a specialist, that type of situation?

Dr. JAGMIN. Physicians in our network do not call the health plan for approval. We delegate utilization management to provider physician groups. Now, within their medical group, the physicians may have set up mechanisms where they call each other for approval, but we do not maintain a 1–800, call a nurse program, or anything like that.

Mr. CHRISTENSEN. Do they lose money if they refer, as a primary care giver, if they refer out of the network or to a specialist within the network?

Dr. JAGMIN. Providers lose money if they refer inappropriately.

Mr. CHRISTENSEN. What is determined inappropriately?

Dr. JAGMIN. The physician who is taking care of the patient determines what is inappropriate. If a patient needs care and the plan's physician or whoever is contracted to take care of the patient does not take care of the patient, they will become sicker, they are going to require more resources, they are ultimately going to cost the system more. So, the emphasis in good managed care plans is to determine illness, discover it early, and treat it early.

Mr. CHRISTENSEN. How do the HMOs and, specifically PacifiCare, encourage doctors to discuss all the possible alternatives with the patient?

Dr. JAGMIN. Sometimes the health plans have to raise all the possible alternatives with the patient and the physician. The PruCare issue we were talking about earlier is a good example—PruCare has centers of excellence that they use for transplants. When a member has an unusual disease that requires a transplant,

they can go to a center of excellence. Involving a national center broadens the range of choice and opportunities.

In my particular case, I have a friend in San Antonio who is an attorney whose daughter has cystic fibrosis. At age 26, she is still alive and required a lung transplant. PruCare arranged for them to go to Barnes, in St. Louis, which is one of the best programs and they were very happy with the outcome of that care.

Mr. CHRISTENSEN. Should a patient have the right to know financial arrangements and incentives that doctors have with managed care organizations?

Dr. JAGMIN. Yes. I think patients should have a right to know incentives. I do not think they should know proprietary information and I will give you an example.

When I was practicing in my group, we put out a letter to our patients and said, you've joined our practice. You should know if you are a PacifiCare patient, we are paid by capitation. We are accountable for your health care and here is how we are reimbursed.

We found that to be a fair and equitable way to be reimbursed. We did not tell them our capitation rate is x dollars and cents per member per month because that would be proprietary information.

Dr. NELSON. Mr. Chairman, it is so much more subtle than that. Let me tell you about a real live patient not too long ago and I will do it as briefly as I can. Just to tell you the bind we are in.

I am an obstetrician-gynecologist and I see high-risk patients. I hope they do not become high risk because they come to me but high risk in the first place. This is a patient I had not rendered care for before, who had five previous cesarean deliveries. She was pregnant for the seventh time, having had a miscarriage. It was about 33 weeks out of 40 gestation. She was in preterm labor.

Now, the question is, what do we do? Every once in a while at 33 weeks, a patient will be mature enough that if her baby were delivered it might do very well, with intensive care but very expensive intensive care. If the baby were not mature, if we simply kept it in the womb a little bit longer it could become mature relatively rapidly with not much difficulty.

In this particular case, it also meant an expensive operation which, of course, puts the patient at some risk. Now, what do we do? Because of my training I did what I thought I was supposed to do: I called an expert. A colleague of mine who is a perinatal doctor, a person specializing in high-risk obstetrics.

We agreed together that the appropriate thing to do was to do an amniocentesis and remove a small amount of fluid from the womb, analyze that and see if the baby were mature and make our decision based upon that. As I had the abdomen prepped, the patient reminded me that she was a member of XYZ corporation. Of course, I took my sterile gloves off and called XYZ. I do not know where the people came from, and I am sure the person I talked to did graduate from high school, but not much more.

That person could not spell amniocentesis, could not tell me if it was covered or not, and could not find a supervisor who could tell me. I was finally told, after many minutes on the phone, that this was not a covered benefit. Now, what am I supposed to do?

Am I supposed to allow my patient to go into labor, maybe let her baby die and, at any rate, cost thousands and thousands of dol-

lars if I make the wrong judgment? Or do I go ahead and try to keep the baby in utero which if I do inappropriately could make the uterus burst and she could lose her life?

Oh, by the way, all these young folks are making these decisions in a cavalier fashion on the telephone some place in a clandestine place, never having seen my patient. I am the one who takes the medical-legal hit. If there were a problem, I am the one who has to go to court.

What did I do? I did what was right, I prayed and I did the amniocentesis. I ate the cost of it. I ate the cost of the test which was several hundred dollars, found out that my patient was not mature, kept her on tributelene or medication to make her not contract and successfully delivered her several weeks later of a term infant.

What was my thanks? A letter of reprimand for telling my patient something she should not have been told, even though I provided good care.

So, it is not just, Mr. Chairman, what's written in the contract, it is the implementation and the subtleties, the vagaries, the regulations, and so forth, that come out. It was very difficult.

Mr. CHRISTENSEN. Would you be able to give a copy of that letter of reprimand to the Subcommittee?

Dr. NELSON. I am sure I can find it.

Mr. CHRISTENSEN. I would be interested in seeing that.

[The information was not available at the time of printing.]

Mr. CHRISTENSEN. Dr. Jagmin, Dr. Nelson earlier talked about a Humana contract that he recently testified from. Would you consider that a gag clause?

Dr. JAGMIN. If I am remembering the contract correctly, it was an issue about informing the patient.

Mr. CHRISTENSEN. Dr. Nelson, do you have that, would you reread that?

Dr. NELSON. Right here. This is the Physician Bulletin 96001–5896. And it says, "Effective immediately, all Humana participating providers must telephone the preadmission review department at 1–800, before an admission occurs and before conveying the possibility of admission to plan member."

Now, it talks about many group contracts that specify a 50-percent penalty for not getting preadmission review authorization.

Dr. JAGMIN. I think the issue of the particular quote, before conveying the possibility of admission to the plan member, is wrong. And I think Humana subsequently said that that was a wrong statement, that there was an inappropriate person who issued it. That is inappropriate behavior, clearly.

Now, the issue of what is covered under a benefit is definitely in the plan's purview. Something may be medically necessary and not covered in the plan's benefit. So, it is important for physicians to notify patients that you need to have this done, and now we are going to figure out if your plan covers it or not. I am going to call the plan to see if I can do it. I think we are starting to confuse medical necessity with benefit plan coverage issues.

Mr. CHRISTENSEN. And under the association you are representing, the medically necessary words, would be, something that under Dr. Nelson's scenario would have been covered?

Dr. JAGMIN. Now, in PacifiCare, Dr. Nelson or the physician involved in this Humana issue, would not have called me or anybody else for approval to do the procedure.

Mr. CHRISTENSEN. OK. Dr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I would like to follow that line of questioning. If the physician delivers the care, at some point you are going to go after Dr. Nelson if he does too many amniocentesis. Ultimately, your computer printout is going to come out that he does one on practically every case he has.

Now, what's the penalty for that in your organization?

Dr. JAGMIN. The penalty for being an outlier is not a penalty. I learned from Brent James of Inter-Mountain Health Care in Salt Lake City, and I am sure that Dr. Nelson knows, the fact that a physician is in variation compared to his or her peers does not mean they are wrong. It means there is a variation and we should investigate it and explain it.

It may be that the patients who went to Dr. Nelson were truly sicker, truly did require those procedures. That every one of them was justified. Fine. Variance is explained.

It may be that there is a learning opportunity for Dr. Nelson to learn what the rest of his colleagues are doing. It may be that Dr. Nelson is doing the right thing and all the other doctors should be doing more amniocentesis.

Mr. MCDERMOTT. Well, you puzzle me because obviously Dr. Nelson thinks there is a situation of subtle kind of gag or subtle restriction on his practice. You say it does not exist. I do not understand why your organization would oppose this bill, since you say you rarely use this, I think that the language you actually used in your testimony rarely, if ever, use these kinds of antidisparagement or any other kind of clause, why would you resist this being in the law?

Dr. JAGMIN. Physician health plan contracts are very complicated. And what we really oppose is the Federal regulation of that contract and that interaction. This is only one example that once we get started into we are going to be micromanaging every detail of that relationship. We are all going to be unhappy, both providers and health plans.

Mr. MCDERMOTT. But I said to the last witness, as I think you may have heard, I suspect that Dr. Nelson's going to win in the end, because his story is much more compelling than your kind of rational presentation of this. You got billions of dollars, I mean you got the front page of Time magazine last December with a doctor, with a mask in his mouth, being gagged. When you have got that going on out there, I cannot understand why you, on a business basis, would resist something that you say you rarely, if ever, use and there would be no penalty on Dr. Nelson. You would never, ever deduct anything out of his paycheck if he did an amniocentesis on everybody.

Dr. JAGMIN. Let me give you an example where I think we have problems with the language of the bill. Theoretically now some of the communications that happen between a medical director and a physician in the plan I would consider would be a restriction.

For instance, if we know a patient's having a certain procedure done at a particular hospital, and I know from dealing with other patients that hospital B over in this other city has a much better success rate. If I call that physician and say, Did you know this?, am I gagging that physician?

We read that potential communication as a gag and it is very much up to the whim of the Secretary in determining that. I am concerned about that.

Dr. NELSON. If I may, I take exactly the opposite approach. I say how can anybody be opposed to it? The groups like PacifiCare that are doing a good job, do not have anything to fear. The ones who are doing a bad job are the ones that need to fear. It is so subtle, Dr. McDermott, so subtle. Within the last 2 weeks I received from one of my groups I have worked with for 13 or 14 years now, a new way in which I will be paid. There are four tiers. I happen to hit tier three, so I am going to be paid a little bit more but not as much as if I were to hit tier four.

Now, the way this was determined is that they took the number of dollars I spent for my patients and compared the number of dollars I spent to my patient to the number of other doctors, all specialties, and divided it by the number of doctors.

Mr. MCDERMOTT. All specialties, not just——

Dr. NELSON. Yes.

Mr. MCDERMOTT. You weren't compared against obstetricians?

Dr. NELSON. No, sir. All doctors.

Mr. MCDERMOTT. So, that's kind of a universal salary schedule?

Dr. NELSON. Correct. So, what they got was an average. And 0.3 was the average and I was 0.4, some small number. I said to the person explaining this, Does that mean I am a better doctor or worse doctor? We do not know was the answer.

Well, if I am a better doctor, you should pay me more, not less. The fact you are paying me less makes me believe you think I am a worse doctor. No, sir, we do not know. Well, then why are you paying me less? Well, because you spent more than average and it went around like that.

The sum and substance of it was, well, if, in fact, I am doing the correct thing, maybe you should be paying me more, maybe all the other guys are wrong. Maybe I am the worst doctor in history and I need to repent but the point is you cannot tell me and, yet, I am being treated as if I were the person who is not doing it well.

So, these are the things that are really happening right now.

Mr. MCDERMOTT. What's the differential between tier 1, 2, 3, and 4?

Dr. NELSON. It is about 5 or 7 percent. Among a large number of patients in a capitated plan that could be more.

Mr. MCDERMOTT. Five percent each tier?

Dr. NELSON. Roughly.

Mr. MCDERMOTT. So, you could be making 20 percent more if you were at the top?

Dr. NELSON. It is 15 to 20 percent, I am sorry I do not remember the numbers exactly but I could get them for you.

But it is a different percent per tier.

Mr. MCDERMOTT. I think it would be useful for the Subcommittee to see how that actually operates.

Dr. NELSON. I would be very happy to submit that.

[The information was not available at the time of printing.]

Mr. MCDERMOTT. One of the things about this that is very difficult to talk about in detail but it is on television and that's why we get the term gag clause. There are no obvious gag clauses. But there are these subtle pressures on people which I find very hard to believe that a managed care operation is not using one way or another.

You say you are not. So, I think you make a very serious error in coming here on a business basis and allowing all this bad publicity to continue going because you resist having a law in place which prevents the use of gag rules.

Thank you, Mr. Chairman.

Mr. CHRISTENSEN. Mr. Cardin.

Mr. CARDIN. No questions.

Mr. CHRISTENSEN. Dr. Nelson, I just have a couple of other questions. First of all, the bill that passed the Commerce Committee applied to all providers not just physicians. How does the AMA or yourself, personally, feel about the free communication of medical advice not just from a physician but also, say, from hospital nurses and other medical personnel?

Dr. NELSON. I suppose, Mr. Chair, it would have to do with intent. We would think that information from any source is beneficial. A very simple example. If you were to have the misfortune to have adult respiratory distress syndrome, a very serious disease which kills lots of people, you would hope that that happened to you in Salt Lake City, because we have the best outcomes in the world, literally.

But the fact is that when rounds are held—the rounds are conducted by the attending physician, the resident physician, the intern physician—the nurse, the nurse specialist, the physical therapist, the respiratory therapist, the occupational therapist, the social worker, the clinical pharmacist, and so forth, we do everything as a team. So, if anyone of those members found a problem with the process we would want that information.

Mr. CHRISTENSEN. OK.

I have no further questions. I would add, Dr. Jagmin, I think you have a very difficult position. I mean I think you are in a bit of a quandary. In one aspect I understand the position you are taking, because I understand, you know, the group that you also work for. But, I also believe that this is an area that needs to be addressed and investigated. It is tough for you to have to be in the position that you are in.

I appreciate your testimony.

Dr. JAGMIN. I understand, Mr. Chairman, there is one point I would like to clear up from Congressman Stark's comments earlier.

Mr. CHRISTENSEN. Yes, sir.

Dr. JAGMIN. California was requested by the State government to supply over 50,000 patient charts for review of complaint issues in California, which run a little bit less than 5 per 1,000 members per year. Those 50,000 charts included 39,000 members who had never complained about the health plan.

Imagine having your personal chart put into the hands of the State government where we know that confidentiality is not always

observed. So, the judge who ruled on that case in California agreed with PacifiCare. PacifiCare ultimately did provide the charts for which there were complaints documented for which there were concerns.

Dr. NELSON. There are a lot of other ways to handle it. In the State of Utah, where the health department does have access, we are so incredibly careful about confidentiality that we cannot trace the chart back to the patient or to the doctor.

But we certainly have the information. it is by that information that we can improve the quality of care.

Mr. CHRISTENSEN. Thank you both for your testimony.

The next witnesses, please, come forth.

Josephine Musser, vice president of the National Association of Insurance Commissioners; Diane Archer, executive director of Medicare Rights Center; and Lisa Craft from the Blue Ridge Regional Health Care Coalition.

STATEMENT OF DIANE ARCHER, EXECUTIVE DIRECTOR, MEDICARE RIGHTS CENTER, NEW YORK, NEW YORK

Ms. ARCHER. My name is Diane Archer, and I am the executive director of the Medicare Rights Center, a national nonprofit organization that works to ensure equitable access to quality health care for seniors and people with disabilities on Medicare. I thank the Subcommittee on Health for inviting me here to testify on the Patient Right To Know Act.

The Medicare Rights Center, under a contract with the New York State Office for the Aging and with funding from the Health Care Financing Administration, operates a telephone hotline that provides direct assistance to more than 6,000 people each year who have health insurance questions and problems.

More than 20 percent of our cases concern HMOs. Most of these cases are from clients who want to know whether they should remain in fee-for-service Medicare or switch to an HMO, or which HMO to choose and how to distinguish among them.

Our staff spends considerable time studying the HMOs in New York State but we are still unable to offer much guidance. HMOs do not disclose the basic information our clients need to know to make informed health care choices.

In particular, they do not disclose the specialist to whom patients will have access for a particular health condition, or the circumstances under which they will cover particular treatments for cancer, heart disease, stroke, and other costly and complex illnesses. To compound the problem, many HMOs do not allow their network physicians to disclose two crucial types of information that their patients need to know in order to make informed health care choices.

First, some HMOs prohibit their doctors from disclosing treatment options which the HMO will not authorize even when the doctors believe these treatments may be in their patient's best interest. While HMOs might have good reason to regulate the care that network doctors deliver, permitting HMOs to prevent full disclosure of all medically appropriate treatment options serves no public interest.

Indeed, many of our clients, and I suspect a large number of HMO enrollees, currently choose their HMO because their doctor is in the network. They believe that they can trust their doctor to disclose their best health care options and they should be able to trust their doctor without fear that their medical advice has been censored by the HMO.

Second, many HMOs prohibit providers from disclosing financial incentives that may influence provider decisions about the care they deliver. Without information about physician financial incentives, patients cannot make informed choices about their health care.

While a patient may choose an HMO because it covers a particular treatment, HMO financial incentives may discourage physicians from providing this care in all but the rarest of instances. Medical practice is a regulated industry analogous in some ways to the distribution of pharmaceuticals. As a matter of longstanding public policy, the government requires comprehensive warnings to accompany the sale of pharmaceuticals in order to ensure that consumers understand the risk they are taking when they use particular drugs.

The medical policies and practices of HMOs merit similar scrutiny because they have a direct bearing on people's health and well-being. At the very least, a Patient Right To Know Act should protect the ability of physicians to disclose how HMO financial incentives can discourage delivery of costly specialty care.

While constraints on physician disclosures may serve HMO business interests, none serve any legitimate health care interest. They only undermine consumer choice about which HMO to join and what kind of care they need. None of these constraints have any place in our health care system and, indeed, many States already outlaw one or more of them.

If Congress sincerely wants informed consumer choice, it should pass H.R. 2976, as originally introduced, and outlaw HMO constraints on physician disclosure about treatment options and financial incentives, as well as nondisparagement clauses in HMO contracts.

However, even this legislation will not serve its purpose unless Congress addresses the ability of HMOs to terminate physician contracts for any reason. You have heard testimony earlier today about this issue. Even if Federal law forbids HMOs from restricting some or all types of physician communications, HMOs can, nonetheless, terminate doctors because of their communications. This ability to terminate physician contracts without cause has perhaps the greatest chilling effect on patient-physician communications.

In order for the Patient Right To Know Act to achieve its desired objective, informed health care decisionmaking, in order for patients to take responsibility for their health care, Congress must forbid HMOs from terminating physicians for disclosing treatment options, financial information, and any other information that bears on the quality of care the HMO delivers.

In conclusion, the Patient Right To Know Act, as originally introduced, is an excellent first step to helping patients take responsibility for their health care. But, in order for consumers to make informed choices about their health care, Congress will need to mandate far greater disclosure from HMOs. Most importantly, HMOs will need to disclose their medical protocols, including the terms under which they pay for particular treatments and the conditions under which they disallow care. Without these additional HMO disclosures, consumers cannot assess the nature of the care HMOs deliver, cannot make informed choices about their HMOs, and cannot take responsibility for their health care.

Thank you.

[The prepared statement follows:]

Testimony of Diane S. Archer, Executive Director, Medicare Rights Center

I am the Executive Director of the Medicare Rights Center, a national not-for-profit organization that works to ensure equitable access to quality health care for seniors and people with disabilities on Medicare. I thank the Subcommittee on Health for inviting me to testify today on the Patient Right to Know Act.

The Medicare Rights Center, under a contract with the New York State Office for the Aging, with funding from the Health Care Financing Administration, operates a telephone hotline that provides direct assistance to more than six thousand people each year who have health insurance questions and problems. More than 20% of our cases concern HMOs. Most of these cases are from clients who want to know whether they should remain in fee-for-service Medicare or switch to an HMO or which HMO to choose and how to distinguish among the HMOs. Our staff spends considerable time studying the HMOs in New York State, but we are still unable to offer much guidance. HMOs do not disclose the basic information our clients need to know to make informed health care choices. In particular, they do not disclose the specialists to whom patients will have access for a particular health condition or the circumstances under which they will cover particular treatments for cancer, heart disease, stroke and other complex and costly illnesses.

To compound the problem, many HMOs do not allow their network physicians to disclose two crucial types of information that their patients need to know in order to make informed health care choices.

First, some HMOs prohibit their doctors from disclosing treatment options which the HMO will not authorize even when the doctors believe these treatments may be in their patients' best interest. While HMOs may have good reason to regulate the care network doctors deliver, permitting HMOs to prevent full disclosure of all medically-appropriate treatment options serves no public interest. Indeed, our clients and, I suspect, a large number of HMO enrollees, currently choose their HMO because their doctor is in the network. They believe that they can trust their doctor to disclose their best health care options; and they should be able to trust their doctor, without fear that their medical advice has been censored by the HMO.

Second, many HMOs prohibit providers from disclosing financial incentives that may influence provider decisions about the care they deliver. Without information about physician financial incentives, patients cannot make informed choices about their health care. While a patient may choose an HMO because it covers a particular treatment, HMO financial incentives may discourage physicians from providing this care in all but the rarest of instances. Medical practice is a regulated industry analogous in some ways to the distribution of pharmaceuticals. As a matter of long-standing public policy, the government requires comprehensive warnings to accompany the sale of pharmaceuticals in order to ensure that consumers understand the risks they are taking when they use particular drugs. The medical policies and practices of HMOs merit similar scrutiny because they have a direct bearing on people's health and well-being. At the very least, a Patient Right To Know Act should protect the ability of physicians to disclose how HMO financial incentives can discourage delivery of costly specialty care.

While constraints on physician disclosures may serve HMO business interests, none serve any legitimate health care interest. They only undermine consumer choice about which HMO to join and what kind of care they need. None of these constraints have any place in our health care system and, indeed, many states already outlaw one or more of them. If Congress sincerely wants informed consumer choice, it should pass HR 2976 as originally introduced and outlaw HMO constraints on physician disclosure about treatment options and financial incentives as well as non-disparagement clauses in HMO contracts.

However, even this legislation will not serve its purpose unless Congress addresses the ability of HMOs to terminate physician contracts for any reason. For example, even if federal law forbids HMOs from restricting some or all types of physician communications, HMOs can nonetheless terminate doctors because of their communications. This ability to terminate physician contracts without cause has perhaps the greatest chilling effect on physician-patient communications. In order for the Patient Right to Know Act to achieve its desired objective -- informed health care decision making -- Congress must forbid HMOs from terminating physicians for disclosing treatment options, financial information and any other information that bears on the quality of care the HMO delivers.

In conclusion, the Patient Right to Know Act as originally introduced, is an excellent first step to helping patients take responsibility for their health care. But, in order for consumers to make informed choices about their health care, Congress will need to mandate far greater disclosure from HMOs. Most importantly, HMOs will need to disclose their medical protocols, including the terms under which they pay for particular treatments and the conditions under which they disallow care. Without these additional HMO disclosures, consumers cannot assess the nature of the care HMOs deliver, cannot make informed choices about their HMOs and cannot take responsibility for their health care. Thank you.

Mr. CHRISTENSEN. Thank you, Ms. Archer.
Ms. Craft.

STATEMENT OF LISA BRITTS CRAFT, EXECUTIVE DIRECTOR, BLUE RIDGE REGIONAL HEALTH CARE COALITION, ROANOKE, VIRGINIA; ON BEHALF OF NATIONAL BUSINESS COALITION ON HEALTH

Ms. CRAFT. Mr. Chairman, Members of the Subcommittee, good afternoon. I am Lisa Craft, executive director of the Blue Ridge Regional Health Care Coalition, a business group on health representing 80 employers in the Blue Ridge Mountains of Southwest Virginia.

I am here today to represent the interests of many employers, all members of health care coalitions across the United States with regard to H.R. 2976. Health care coalitions nationally include more than 7,000 employer members and represent more than 35 million employee lives.

Because of the many negative implications to employer sponsored health plans and managed care, I strongly oppose this legislation and any legislation that does not provide for uniformity in the rules affecting benefit plans. The bill is intended to protect communication between patients and providers regarding available treatment options from undue contractual restrictions and employers do not oppose this. I repeat, employers do not oppose the intent of this bill.

As written, however, the bill reaches far beyond this purpose to affect written agreements and oral communications between health plans and providers. H.R. 2976 poses a serious threat to managed care contracting, as well as to the delivery of high-quality affordable health care.

Employers are opposed to this bill for many reasons, but I will focus on three. Implications to ERISA, communication issues, and erosion of managed care from both quality and cost standpoints.

First, H.R. 2976 does not provide for any uniformity in the rules affecting health benefit plans that contractors have agreements with any type of provider, comparable to uniformity provided by ERISA. H.R. 2976 fails to ensure uniformity by granting States authority to impose their separate and mutually inconsistent standards. Since ERISA does not supersede other Federal laws, this effectively modifies the ERISA preemption in a manner that is unacceptable to employer plan sponsors.

In addition, the bill also creates a new enforcement role for the Department of Health and Human Services, a role which we do not feel HHS is prepared to fulfill.

Health and Human Services will determine violations and impose civil penalties on health plans which could affect a broad range of the various provisions, terms, and other requirements of an employee welfare benefit plan and third party administrator.

Second, the overly broad prohibitions on health plan communications create ambiguities which will lead to increased litigation. Health plans support open discussion of treatment options by providers with patients. However, this bill subjects more than the terms and agreement of the contract to the prohibition on protected medical communication. The bill includes any provision of a con-

tract, statement, or oral communication that prohibits or restricts protected patient/provider communication. The term "restricts" can be interpreted to mean limiting, confining, affecting, or may apply to such communication as utilization review.

Currently, contracts are enforced on the basis of written terms and conditions. Employers, health plans, and providers come to the bargaining table as business partners to negotiate the terms and conditions, setting forth the obligations of the parties. This bill provides Federal statutory rules that allow disputes to be based on all communications between the provider and the health plan.

Communications could include direct verbal statements, impressions, conversations, and so forth. If the government is to monitor all these communications, including reports, memos, newsletters, educational materials, and all conversations to and with participating network providers, costs will surely increase because each communication will have to be scrutinized by the health plan to ensure they are not interpreted or perceived as prohibiting, limiting, or confining protected communications.

In addition, this bill will open up a new arena of litigation relating to communication with at least two new types of evidence. One, showing a pattern of oral communication violations; and two, demonstrating a preponderance of oral communication violations. How these patterns and preponderances are proven is uncertain and may be subject to fabrication.

Third, the bill will erode managed care and the higher quality and lower costs associated with managed care. Employers have used managed care arrangements in order to lower costs and maintain quality health benefits for employees. Many managed care options include performance guarantees and information requirements which allow employers to include contract provisions aimed at assessing and maintaining the quality of health care services delivered. Without the ability to contract in this manner, employers will have no incentive to continue the managed care relationships.

With the return to traditional indemnity coverage, we will see cost increases and decreased quality initiatives. Not only is this a negative for employers, the erosion of managed care will be identical for public plans, including Medicare and Medicaid, Indian Health Services, and Federal and State government employee plans.

In addition to the erosion of managed care and associated cost increases, this bill will drive up administrative expenses by requiring plans to renegotiate contracts, review all contracts, written statements, oral communications, and greatly increase medical costs by favoring fee-for-service options as a means to avoid HHS micromanagement.

In conclusion, employers are opposed to H.R. 2976 because of its negative impact on employer provider contracting, thus minimizing the positive effects of managed care. The communication regulations created by the bill and the regulatory function created for Department of Health and Human Services is an additional layer of unnecessary burden and expense. These provisions also greatly diminish ERISA and create new liability for employer sponsored plans and third-party administrators.

Thank you.

Mr. CHRISTENSEN. Ms. Musser, we are going to have to go and vote. We have two votes and it is going to be 25 minutes or so. If you would go ahead and start your testimony and if we have to break off and come back for questions, that's what we will do.

So, we are pleased to hear your testimony at this time.

STATEMENT OF JOSEPHINE MUSSER, VICE PRESIDENT, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS; AND CHAIR, SPECIAL COMMITTEE ON HEALTH INSURANCE; AND COMMISSIONER, OFFICE OF THE COMMISSIONER OF INSURANCE, STATE OF WISCONSIN

Ms. MUSSER. Thank you, Mr. Chairman, and Congressman Cardin.

My name is Josephine Musser, and I am the vice president of the National Association of Insurance Commissioners and the chair of the NAIC special committee on health insurance. I am also commissioner of insurance for the State of Wisconsin.

Celebrating its 125 anniversary this year, the NAIC is the Nation's oldest association of State government officials. Its members are the chief insurance regulators from the 50 States, the District of Columbia, and the 4 U.S. territories. On behalf of Governor Thompson and the NAIC, I thank you for the opportunity to address you here today.

H.R. 2976 addresses the important issue of communication between patients and their doctors. As you may know from my background biography, in one of my former lives I was a nurse, a patient advocate, an educator. My ethics are ingrained with informed consent and patients bill of rights.

Consumers need reassurance that a provider will discuss all treatment options with them, even when a plan's policy might not cover that treatment. The NAIC Managed Care Plan Network Adequacy Model Act proposes to protect these communications and offers other consumer protections.

As always, the NAIC encourages the inclusion of provisions allowing for State flexibility. We are pleased to see this proposed legislation give States the authority to establish or enforce more stringent requirements.

Further, we applaud the fact that the bill applies to both State-licensed and ERISA-governed plans, thereby, creating in fact a level playingfield with respect to its requirements.

The advantage of State flexibility highlights the strength of State-based insurance regulation. My home State of Wisconsin, for example, has a different experience and a different managed care climate than many other States.

For example, we enacted a statute more than 20 years ago that has the effect of prohibiting restrictions on provider communications. We have a very sound managed care market; 53 percent of our insured market is enrolled in managed care. This is due, in part, to the development of a strong relationship between providers and insurers, and the large number of provider-based plans. In Wisconsin, 19 of the 27 HMOs in Wisconsin were founded and owned by providers. And Wisconsin is the only State which requires HMOs to be licensed as insurers. This regulatory approach is different from other States' approaches.

For example, my office reviews all contracts between HMOs and providers. We would know if an HMO was contractually implementing a gag rule. As this debate began to grow nationally, I requested that my Market Regulation Bureau review the history of complaints and market conduct exams, searching out operational gag rules in addition to contractual gag rule provisions.

Not only have no HMOs implemented a gag rule in Wisconsin, but also we have received no complaints from providers or consumers on the issue. Obviously, this approach works for Wisconsin.

In fact, our State has the lowest uninsured rate in the country, according to the U.S. Census Bureau. I am proud of the climate of innovation fostered by Wisconsin Governor Tommy Thompson, who has helped our State advance significant small employer insurance reform, as well as Medicaid managed care. Working together, we have created a regulatory structure that works for Wisconsin, and we have a thriving managed care industry.

Managed care simply does not seem to get the headlines that Governor Thompson's welfare and education reforms get.

Mr. CHRISTENSEN. Ms. Musser, at this time, I am going to have to go and vote. I will come back and we will finish this off and give you ample time to finish your testimony and have some questions.

So, at this time, the Subcommittee stands in recess.

[Recess.]

Mr. CHRISTENSEN. Ms. Musser, we will let you finish up your testimony. We will give you a couple of extra minutes to finish up and then go into some questions.

Ms. MUSSER. Thank you.

As I was saying, my office reviews all contracts between HMOs and providers. And we would know if an HMO was contractually implementing a gag rule. But, as was mentioned earlier today and as the debate began to grow nationally, I requested that my Market Regulation Bureau review the complaints and market conduct exams searching out an operational gag rule, in addition to any contractual provisions that might exist.

Not only have no HMOs implemented a gag rule in Wisconsin, but also, we have received no complaints from providers or consumers on this issue.

Obviously, this approach works for Wisconsin. In fact, our State has the lowest uninsured rate in the country, according to the U.S. Census Bureau. Among the NAIC members, the gag clause has been discussed at great length as we have worked to develop managed care standards. Knowing this issue is of critical importance to consumers, our proposed Managed Care Plan Network Adequacy Model Act includes a provision similar to the provision in H.R. 2976 relating to medical communications.

During the past year, 17 States have taken legislative or regulatory action to prohibit gag clauses. Another 10 States have considered the issue. And of course, as I mentioned before, the great State of Wisconsin took action more than 20 years ago.

The NAIC Model Act suggests ways to bolster existing State requirements and to strengthen consumer safeguards in the rapidly evolving marketplace. The NAIC has either adopted or is developing models in the following areas: Quality assessment and improvement, utilization review, provider credentialing, managed care plan

network adequacy, data reporting, confidentiality, and grievance procedures.

In addition, the NAIC's CLEAR, Consolidated Licensure of Entities Assuming Risk, initiative seeks to promote a more competitive marketplace by ensuring that managed care providers are subject to a level regulatory playingfield.

As another example of the progress the States are making is Ohio's proposed Managed Care Uniform Licensure Act. This legislation would comprehensively rewrite existing managed care laws. Ohio, like other States, is engaged in an intensive effort to define the role and scope of the new provider organizations which are being created everyday.

Ohio's bill includes financial quality and utilization review requirements. It streamlines financial regulation and oversight of all managed care operations, placing them all under one chapter law. These organizations, of course, include HMOs, PPOs, provider sponsored networks, and multiple employer welfare arrangements or MEWAs.

I would like to return for just a moment to the subject of ERISA. The NAIC has stressed repeatedly that all consumers of health coverage should have the benefit of crucial consumer protections. In our white paper, "ERISA: A Call For Reform," and in testimony before Congress, we have emphasized that a significant portion of the health care market, including the managed health care market, is outside the jurisdiction of State law.

In previous testimony I have discussed my State's and all the States' inability to assist the thousands of consumer complaints we receive each year—from those covered by ERISA plans who do not know that they are covered by ERISA plans, and those who have no recourse or effective due process.

We recommend that when the opportunity arises, you consider additional protections for consumers of such plans in order to afford similar levels of security.

Again, let me urge you to maintain the States' ability to implement innovative and effective protections for the reform of the health insurance market. By doing so, in H.R. 2976, you have recognized the expertise of the States in regulating the health insurance market and in dealing with health insurance reform.

I want to thank you for the opportunity to testify, and I would be pleased to answer any of your questions.

[The prepared statement follows:]

STATEMENT OF JOSEPHINE W. MUSSER
VICE PRESIDENT, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS
CHAIR, SPECIAL COMMITTEE ON HEALTH INSURANCE
COMMISSIONER OF INSURANCE, STATE OF WISCONSIN

Introduction

Good morning Mr. Chairman and members of the Subcommittee, my name is Josephine Musser. I am the Vice President of the National Association of Insurance Commissioners (NAIC) and the Chair of the NAIC's (EX) Special Committee on Health Insurance ("the NAIC Committee"). I am also Commissioner of Insurance for the State of Wisconsin. I have had the pleasure of meeting with you, Mr. Chairman and several other members of this subcommittee concerning various health insurance-related measures over this past year. It is a pleasure to return to testify before you today to discuss H.R. 2976, the "Patient Right To Know Act of 1996", and the issues of health care provider contracting and managed care regulation and to inform you of recent NAIC and state-level efforts in these areas.

The NAIC, the nation's oldest association of state public officials, is composed of the chief insurance regulators of the fifty states, the District of Columbia, and the four U.S. territories. This year, we are celebrating our 125th anniversary. The NAIC's (EX) Special Committee on Health Insurance is a committee composed of 38 of our members. The NAIC established this special committee a few years ago as a forum to discuss the many health care reform proposals and to provide technical advice on a nonpartisan basis to all who sought our expertise.

On behalf of the NAIC Committee, I would like to thank you for providing me with the opportunity to address you this afternoon at this hearing. My testimony will focus upon H.R. 2976, some of the legislation in place in Wisconsin and other states in this area, and the efforts underway at the NAIC to update and expand upon the NAIC's model state laws in the area of managed care. I will highlight provisions within certain proposed NAIC models that address the critical issues of provider-patient communications, health plan-provider communications and contracts, and other protections for enrollees and providers within managed care health plans.

Background

On July 27, 1995, the NAIC provided a statement for the record of a joint hearing held by the Subcommittee on Health of the Committee on Ways and Means and the Subcommittee on Health and Environment of the Committee on Commerce regarding standards for health plans providing coverage in the Medicare program. In this testimony, we provided some background information about state regulation of managed care organizations and NAIC efforts in this area, which I will update and expand upon today.

States currently regulate managed care organizations through a variety of statutes and regulations governing health maintenance organizations (HMOs), preferred provider organizations (PPOs), Blue Cross and Blue Shield plans, indemnity health insurance plans with a managed care component, and limited prepaid service organizations, among other types of organizations. Many states also regulate organizations that perform certain managed care functions, including free-standing utilization review organizations.

As you may know, the states, through the NAIC, have developed, and continue to develop, model state laws and regulations in the health care area. The NAIC's model HMO Act has been adopted with some variation in a majority of states and has served a pivotal role in promoting certain state-level protections. The NAIC also has a model addressing preferred provider arrangements and prepaid limited service organizations. These models are discussed in more detail herein.

H.R. 2976, the "Patient Right To Know Act of 1996"

The House Committee on Commerce has approved H.R.2976 and the Committee on Ways and Means is considering it on sequential referral. As adopted by the Committee on Commerce, the bill would prohibit health plans, both state-licensed and those governed by the federal Employee Retirement Income Security Act ("ERISA"), from prohibiting or restricting any medical communication as part of either a written contract or agreement with a health care provider, a written statement to such a provider, or an oral communication to such a provider. The bill also covers third-party administrators having responsibility for contracts with health care providers under the plan. The bill defines "medical communication" as "a communication made by a health care provider with a patient of the provider (or the guardian or legal representative of such patient) with respect to the patient's physical or mental condition or treatment options." We note and applaud the fact that H.R. 2976 applies to both state-licensed and ERISA governed health plans -- thereby treating both types of plans on a "level playing field."

As discussed below, the provisions of this bill are similar to a provision within the NAIC's proposed Managed Care Plan Network Adequacy Model Act that restricts health carriers from prohibiting participating providers from discussing treatment options. This model also addresses issues not discussed within the proposed legislation that relate to consumer, provider, and health plan rights and obligations.

The NAIC Committee appreciates that the proposed legislation specifically allows states to "establish or enforce requirements with respect to the subject matter of this section" as long as the requirements are "more protective" of medical communications than the requirements established under this section. In the course of commenting on federal health insurance reform legislation, the NAIC Committee has encouraged the inclusion of provisions allowing for state flexibility, such as in this

provision. The advantage of allowing each state some flexibility highlights the strength of state-based insurance regulation.

For example, Wisconsin has a different experience and a different managed care climate than that in many states. We have had language in our laws that equates to a restriction on gag rules for over 20 years. As this debate began to grow nationally, I requested that my market regulation bureau review the history of complaints, market conduct exams, and provider contracts for gag-rule provisions. In Wisconsin, not only have no HMOs implemented a gag rule in Wisconsin, but we have received no complaints from providers on this issue.

Obviously, this approach works for Wisconsin. In fact, our state has the lowest uninsured rate in the country, according to the U.S. Census Bureau. I am proud of the climate of innovation fostered by Wisconsin Governor Tommy Thompson, who has helped our state advance significant small employer insurance reforms. Working together, we have created a regulatory structure that works for Wisconsin and we have a thriving managed care industry.

Wisconsin's experience, however may be the exception and not the rule. Many key factors in the development of our managed care industry may have affected the relationship between HMOs and providers in our state. As a bit of background, Wisconsin does have a very sound managed care market. HMOs cover 53 percent of the states's insured group business, and cover an even higher percentage in urban areas. Nineteen of our 27 HMOs were founded by providers, creating a tradition of a strong relationship between providers and insurers. In addition, Wisconsin is the only state that requires HMOs to be licensed as insurers, which offers a different regulatory focus than most states where HMOs fall under a separate insurance licensure structure.

Our regulatory structure has worked for Wisconsin, and managed care has thrived with high satisfaction levels. That does not mean that our structure would work well in other states. The strength of state regulation is that each state is able to adapt to its environment and establish strategies most likely to work. H.R. 2976 recognizes that strength and enhances it.

On a technical note, the NAIC Committee recommends clarifying the scope of the preemption language by replacing the term "subject matter of this section" with the specific topics intended, such as "medical communications and health plan requirements relating to such communications." Such a clarification would assure that the scope of the provision is not construed to include subject matter not intended to be affected by the legislation.

The enforcement of H.R. 2976's requirements is to occur through the imposition of federal civil money penalties. However, as noted above, the preemption language also clarifies the states' ability to enforce more stringent requirements. In the past, the NAIC Committee has supported certain federal minimum standards relating to insurance, as long as state flexibility and the states' role as primary regulators and enforcers of insurance law is maintained. The NAIC Committee commented favorably upon the portability provisions within H.R. 3103, as adopted by the House and Senate respectively, and appreciated Congress' retention of the states' role as prime regulators of insurance within those sections of the bills. The NAIC Committee would recommend a similar division of enforcement authority within this bill, with federal enforcement for plans regulated by ERISA and state enforcement for those regulated under state law. Therefore, even in states which choose to not adopt standards that are more stringent than the requirements of the bill, the states' role as primary enforcers of insurance law should be retained. Such a division of authority may have been intended by the legislation, in which case we would simply recommend clarifying language

State Laws Addressing "Gag Clauses" and Utilization Review

The proliferation of so-called gag clause legislation around the country this year is one indication of tremendous public attention to issues raised by the growth of managed care. The term "gag clause," which refers to clauses in the contracts that managed care plans have with providers, particularly physicians, is used to describe at least four distinct situations. The term most commonly refers to clauses that prohibit or impede a provider from discussing with a patient all possible medical treatments, including those not covered by the plan. This type of gag clause is addressed by H.R. 2976 and by most enacted state laws. The second meaning of the term refers to limitations on a provider's freedom to discuss the compensation and other financial arrangements that the provider has with the patient's managed care plan. A particularly sensitive issue is the extent to which a provider's compensation can be adversely affected by hospitalizations of their patients, referrals to specialists, and the prescribing of expensive diagnostic tests or treatments. A third meaning of the term refers to contractual provisions prohibiting a provider from revealing a plan's proprietary information or trade secrets. Finally, the term is sometimes used to mean a broader contractual provision preventing a provider from making disparaging remarks about the specific plan or about HMOs and managed care in general.

H.R. 2976 and most state legislation are directed primarily at eliminating any constraints on the provider's ability to discuss all treatment options with the patient, regardless of the plan's policy with respect to coverage of that treatment. However, the public's concern about full and fair disclosure of all available treatment options is a symptom of the more general concern that managed care creates incentives for plans and providers to withhold necessary health care services.

At least 13 states have enacted legislation addressing the gag clause issue, and a fourteenth state has addressed the issue by administrative action. Bills were introduced during the 1995-1996 legislative session in an additional 12 states, but were not enacted. During the past year, then, at least 26 states moved to address this issue, and 14 have taken action. These figures are necessarily approximate because there is not always agreement about whether the provisions of a bill meet the definition of gag clause legislation and because, in some states, more than one bill may address this topic.

In general, these state statutes make clear that providers may not be contractually impeded from furnishing a patient with information that is relevant to the patient's medical condition, including information about treatment options that are not covered by the plan. The language used to achieve this objective varies from state to state; in some cases the statutory language also protects the provider's right to advocate on behalf of the patient who seeks reconsideration of a plan's decision. The issue of a provider's financial arrangements with the plan is less frequently addressed, although the language of some statutes is sufficiently broad to prohibit a managed care plan from impeding discussions of this subject between patient and provider. Relatively few states explicitly address the issues of protection of trade secrets or contractual prohibitions of disparaging remarks, but the state legislation addressing these subjects appears to uphold the right of managed care plans to prevent providers from revealing trade secrets or from making maliciously critical statements that could harm the carrier.

The NAIC discussed at some length the gag clause issue in the course of developing our proposed Managed Care Plan Network Adequacy Model Act. The provision in our model addressing this issue was drafted after much discussion and reflects the experience of regulators from very diverse states. The NAIC's effort reflects our recognition that this issue is of critical importance to consumers.

At least 33 states already regulate organizations and entities that conduct UR, and some additional states considered UR legislation during this past session. In 22 of these states, the insurance commissioner has the regulatory authority. In the remaining states, the health commissioner is usually the state official having jurisdiction over UR organizations. In rare instances a state official other than the insurance commissioner or the health commissioner has the regulatory authority.

The NAIC's "CLEAR" Initiative and Its Proposed Model State Laws Governing Managed Care Plans

Managed Care Plan Standards

Over the past two and a half years, the NAIC, in a public process, has been developing reasonable standards to suggest ways to bolster existing state requirements. The NAIC has either adopted, or is developing, models in the following areas relating to managed care: quality assessment and improvement, utilization review, provider credentialing, managed care plan network adequacy, data reporting, confidentiality, and grievance procedures. At this point, the NAIC members have adopted two of these models, one relating to provider credentialing and one relating to quality assessment and improvement. The full NAIC, at its Fall National Meeting in September, will consider three of these models, in the areas of utilization review, managed care plan network adequacy, and grievance procedures. In general, the NAIC has drafted these standards to apply to all plans performing managed care functions. In some cases, the provisions apply to other health carriers as well.

"CLEAR"

The NAIC's Regulatory Framework Task Force (the "Task Force") has been charged with the development of the above-mentioned model laws. The Task Force formed the Health Plan Accountability Working Group (the "working group") to undertake the initial drafting. The working group held numerous public meetings to discuss these models. At the NAIC's June 1995 Summer National Meeting, the working group recommended to its parent committee that the current NAIC model laws governing health carriers and other health care organizations be reviewed with an aim toward increased use of common definitions and common regulations of similar functional and risk-sharing/risk-transferring characteristics among health plans. The working group further recommended that the NAIC's existing models should be expanded to include, at a minimum, the health plan accountability standards under development by the working group, and that the effort be coordinated with other NAIC committees, such as the Health Organizations' Risk-Based Capital Working Group, and the Blanks Task Force. This comprehensive effort has been denominated as "CLEAR," or "Consolidated Licensure for Entities Assuming Risk," and seeks to promote a more competitive marketplace by ensuring that entities performing the same or similar functions are subject to a level regulatory "playing field." In addition, this effort seeks to clarify that the wide array of entities performing managed care functions fall within the scope of state regulation.

When we complete work on the health plan standards, the first priority will be to analyze the NAIC's other current models and begin the process of recommending ways to consolidate existing health models and incorporate the new standards.

Risk-Based Capital

The NAIC's Health Organizations Risk-Based Capital Working Group (HORBC) is developing a risk-based capital formula for all health organizations. These requirements seek to provide more flexible and sound requirements for plans' fiscal soundness, taking into account organizations' unique

characteristics. The American Academy of Actuaries ("AAA") is providing the technical assistance in developing a formula that is effective, but does not impose onerous data requirements. The results of this effort will be incorporated within the "CLEAR" effort.

There are four principal risk elements inherent in the insurance function:

C-1 Asset Risks: Risk that existing assets will decline in value and erode surplus as a result of that decline.

C-2 Pricing and Obligation Risks: Risk of any mispricing in the determination of premium rates or deviations between assumptions and experience in the payment of claims liabilities. This is the predominant risk for health carriers.

C-3 Interest Rate Risks: Risk of loss due to unforeseen changes in interest rate levels.

C-4 General Business Risks: Catch-all category that includes general business risk. Includes risk of assessments, administrative expense overruns, and environmental changes such as health care reform.

For health plans, regulators are principally concerned with C-2 risks. This is the risk that insurers may not have adequate funds available to cover insurance risks.

In December 1994, AAA presented to the HORBC a proposed model reflecting the variability inherent in health care coverages. The model applies factors to various asset, premium, and reserve items and contains credits for actions taken by an entity which reduce risk and loads for actions taken which increase risk. An example is managed care credits for activities or payment arrangements which reduce risk. The model also attempts to capture the impact of regulatory activity on an entity. An example is state rate approval requirements which may increase risk.

HORBC asked AAA to develop a simplified formula which maintained the formula's precision while at the same time minimized the costs to the health organization in collecting the data. The simplified formula must meet the following criteria:

specific — to the extent possible, the data should come directly from the annual statement or a supplemental blank (or be added to the annual statement) or from other specifically referenced source for all reporting organizations.

auditable — to the extent possible, the data should be included in the annual statement information that is electronically captured by the NAIC and that it be easily measured for consistency and quality through cross-checks with other annual statement data.

available — the data should be relatively easy for health organizations to obtain without substantial modifications of current reporting systems. One organizational form should not bear excessive data-gathering costs relative to another organizational form.

The AAA has submitted its proposed simplified formula to the HORBC working group. The working group will commence testing of the formula this summer and fall, and anticipates providing a detailed report by the end of the year. The results of the survey will determine what types of modifications to the formula will be required and whether another survey will be necessary.

State Activity in the Area of Consolidated Licensure

As I mentioned, Wisconsin is the only state to regulate HMOs as insurers, having always done so. This strategy of regulation allows a high level of flexibility and monitoring. For example, Wisconsin requires a business plan to be filed by HMOs which include a detailed description of provider access. My office reviews these plans to assist HMOs in creating a structure that will provide adequate levels of provider access. Also, by reviewing this plan and by requiring provider contracts to be filed with my office, we can monitor emerging changes in the managed care industry and develop the proper oversight strategies. This flexible approach contributed to a managed care climate that allowed Governor Thompson to lead the country in implementing managed care for AFDC recipients.

Other states have made significant progress. The state of Ohio is considering proposed legislation that seeks to accomplish many of the same goals as the NAIC's CLEAR effort. Ohio's Managed Care Uniform Licensure Act proposes to rewrite comprehensively existing managed care laws. This effort is the result of an intensive effort to define the role and scope of risk-assuming entities. The bill includes financial, quality, and utilization review requirements and would streamline the financial regulation and oversight of all operations of managed care insurance organizations and place such regulation within one chapter of law. These organizations include HMOs, PPOs, provider-sponsored networks, and multiple employer welfare arrangements.

NAIC Proposed Health Plan Standards

In undertaking the development of health plan standards, the NAIC recognized that the delivery of health care services was evolving away from fee-for-service insurance arrangements to managed care arrangements of many types. In light of the fact that most state insurance departments have a principal role in regulating managed care entities, and have therefore observed the market evolution firsthand, insurance regulators recognized the need to strengthen consumer safeguards in the managed care arena. The models under development apply in general to a wide array of managed care organizations. When appropriate, these models restrict the application of certain provisions to certain types of network plans.

The models include the following broad definition of "health carrier":

an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

In addition, the models define "managed care plan" as "a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier." Certain requirements within the models apply to managed care plans and certain subsets of such plans, as appropriate. Other requirements apply to all health carriers.

Many of the issues relating to provider contracting and consumer protections are addressed in the "Managed Care Plan Network Adequacy Model Act," but several other important issues are also addressed in the other models. I will briefly summarize these models and highlight provisions particularly relevant to the issues under discussion at this hearing.

Managed Care Plan Network Adequacy Model Act

The model establishes standards for the creation and maintenance of provider networks by health carriers and applies to all health carriers that offer managed care plans. It requires the arrangements between participating providers and health carriers offering managed care plans to address specific issues set forth in the act. The model also contains requirements for the contracts between health carriers and intermediaries.

Section 5 of the model, which addresses network adequacy, requires health carriers to maintain a provider network that is sufficient in the numbers and types of providers to assure that services to covered persons will be accessible without unreasonable delay. Section 5 also requires a health carrier to file with the insurance commissioner an "access plan" for each of its managed care plans. The access plan must describe the health carrier's network and other specified processes and procedures. The act requires a health carrier to make these access plans -- with protections for proprietary information -- available on its business premises and to provide them to any interested party on request.

Of particular relevance to today's discussion is Section 6 of the Model, which sets forth requirements that a health carrier must address in its contractual and other arrangements with participating providers. Importantly, it is worth noting that the model contains a provision prohibiting health carriers from preventing providers from discussing treatment options with covered persons, irrespective of the health carrier's position on the treatment options, or from advocating on behalf of a covered person within the plan's utilization review and grievance processes.

This provision is somewhat broader than the similar provision within H.R. 2976 as it also addresses a provider's ability to advocate on a covered person's behalf. H.R. 2976 prohibits plans from restricting "medical communications," defined as communications from a provider with a patient relating to the patient's physical or mental condition or treatment options. Because H.R. 2976 explicitly allows states to establish or enforce requirements that are "more protective of medical communications than the requirements established under this section," we assume that the provisions of this model act (and any state law based on the model act), that protect a broader range of provider actions would be clearly protected by the preemption language of H.R. 2976.

Other important requirements and provisions set forth within Section 6 of the model include: a provision requiring the health carrier to establish a mechanism for notifying participating providers of the specific covered services for which they are responsible; a provision prohibiting providers from attempting, under any circumstances, to collect from a covered person any money owed to the provider by the health carrier; and a provision prohibiting carriers from using standards to select providers that would allow the carrier to avoid providers serving potentially high-risk populations.

In addition, the model act contains a requirement that carriers make their provider selection standards available for review by the insurance commissioner and a provision prohibiting any inducement under the managed care plan for the provider to furnish "less than medically necessary services" to a covered person. The model also includes a requirement noting that when a provider's contract is terminated for whatever reason, the health carrier must make a good-faith effort to notify covered persons who are patients of that provider within 15 working days; a requirement that the health carrier ensure that providers treat all covered persons without regard to the person's status as a private purchaser or participant in a publicly-financed health care program; and a prohibition against the health carrier's penalizing a provider for reporting in good faith to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.

Section 7 of the model act addresses contracts between health carriers and intermediaries. It requires that intermediaries and participating providers must comply with all the model act's applicable requirements for the relationship between health carriers and providers. The model act specifies that the health carrier retains the statutory responsibility for monitoring the provision of covered benefits to covered persons and that the carrier cannot assign or delegate that legal responsibility to the intermediary.

Other provisions of this section establish recordkeeping and related requirements intended to ensure that the health carrier and the insurance commissioner have appropriate access to the books and records of intermediaries.

Sections 8 and 9 of the model act contain requirements for regulatory filing and oversight of the health carrier's provider contracts and material changes to those contracts.

The NAIC developed this model, along with all of the managed care models, through a public process in which the working group received and considered significant input from the health insurance and managed care industries, consumer representatives, and health care providers. The regulators attempted to strike the appropriate balance among the relevant concerns, while maintaining the protection of health care consumers as the paramount objective.

Utilization Review Model Act

The Utilization Review Model Act requires a health carrier to have a written description of its utilization review (UR) program addressing the issues set forth in the act. A health carrier must file with the insurance commissioner an annual summary describing its utilization review program activities, and its UR program must meet the operational requirements set forth in the model.

One managed care issue of prime interest to consumers and providers is the ability of a consumer to seek the closest and most convenient medical care in emergencies. Consumers and providers are understandably concerned when managed care plans retrospectively deny coverage for emergency care that seemed very justified at the time the services were received. The recommendation of the NAIC's Accident and Health Insurance (B) Committee for a regulatory approach to this problem reflected consideration and deliberation of several issues. These include the ability of consumers to determine the existence of a true emergency, health plan procedures to screen emergencies, and the need to control casual and inappropriate use of emergency rooms. The extensive testimony received by the working group on this issue from representatives of consumers, providers, and plans revealed the importance of this issue to all parties involved.

Section 12 of the utilization review model addresses emergency services and specifies a standard to be used by entities that conduct UR in making decisions about the coverage of emergency services. The standard requires a health carrier to cover emergency services necessary to screen and stabilize a covered person, without prior authorization of those services, if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. In addition, a covered person may obtain care from a non-contracting provider within the service area of a managed care plan for emergency services necessary to screen and stabilize the covered person, without prior authorization, if a prudent layperson would have reasonably believed that using a contracting provider would cause a delay worsening the emergency, or if a provision of federal, state, or local law requires the use of a specific provider. The NAIC working group adopted this standard after much public debate. The model defines the terms "emergency medical condition," "emergency services," and "stabilized."

Another provision of the Utilization Review Model Act prohibits the compensation to any individual or entity that provides UR services to a health carrier from containing incentives to make inappropriate review decisions. The provision specifies that the compensation of these individuals and entities may not be based on the quantity or type of adverse determinations that they render.

As with its other health plan standards, the NAIC developed its Utilization Review Model Act through a public process that included extensive participation from representatives of the insurance and managed care industries, health care provider groups, and consumers. These participants included the Utilization Review Accreditation Commission (URAC), the National Committee on Quality Assurance (NCQA), and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). The NAIC's working group made every effort to ensure that our model was consistent with the requirements of these other organizations.

In general, the NAIC's Utilization Review Model Act builds upon the authority already granted the insurance commissioner to regulate UR organizations, but provides a more detailed regulatory framework. As with all NAIC models, states are free to adapt this model to accommodate existing law and other circumstances. For example, some states may choose to alter the model for adoption as a regulation or may use the substantive provisions of the model, but enact a statute authorizing the health commissioner to regulate UR activities rather than the insurance commissioner.

Grievance Procedures Model Act

The NAIC committees drafting the Health Carrier Grievance Procedure Model Act recognized the importance of providing enrollees with a clear and accessible mechanism for addressing their complaints and appealing health plan decisions. This model contains standards for the procedures used by health carriers to resolve grievances submitted by covered persons. "Grievance" is broadly defined and includes complaints about the availability, delivery, or quality of health care services, including a complaint about an adverse determination made in the UR process. The term also includes complaints about claims payment, handling, or reimbursement issues, or about any matter pertaining to the contractual relationship between a covered person and a health carrier.

The model requires all health carriers to provide a "first level grievance review." These reviews enable a covered person to submit written material to a health carrier, but do not include the right to have a meeting with representatives of the health carrier. However, the model requires the carrier to provide a written decision within a specified timeframe, and the decision must contain certain information specified by the model.

In addition, the model requires a health carrier that offers managed care plans to establish a "second level grievance review" process. A second level review provides a covered person with the option of appearing in person before authorized representatives of the health carrier. If a face-to-face meeting is not practical for geographic reasons, the health carrier must provide and pay for the option of communication between the covered person and the reviewers by means of technology, such as a conference call or a videoconference. The health carrier must also provide a written decision containing specified information within a prescribed time period.

The grievance model also specifies the appropriate grievance procedures for a complaint involving a UR decision. These sections are intended to be completely consistent with similar provisions in the Utilization Review Model Act.

Quality Assessment and Improvement Model Act

The Quality Assessment and Improvement Model Act establishes criteria for the quality assessment activities of all health carriers that offer managed care plans. It also establishes additional criteria for the quality improvement activities of carriers issuing "closed plans," which are essentially HMO-type managed care plans. The model requires health carriers to develop quality assessment and quality improvement programs and to file a written description of these programs with the insurance commissioner or other appropriate regulatory authority.

"Quality assessment" is defined as "the measurement and evaluation of the quality and outcomes of medical care provided to individuals, groups or populations." "Quality improvement" means "the effort to improve the processes and outcomes related to the provision of care within the health plan."

The model requires a health carrier to include a summary of its quality assessment and quality improvement programs in its marketing materials and to describe them in its certificates of coverage. The health carrier must also make available each year to providers and covered persons the findings from its quality assessment and improvement programs and information about the carrier's progress in meeting internal goals and external standards. In addition, a health carrier must give covered persons the opportunity to comment on the quality improvement process.

Health Care Professional Credentialing Verification Model Act

The Health Care Professional Credentialing Verification Model Act requires all health carriers that offer managed care plans to establish a "credentialing" verification program to ensure that the professionals participating in the carrier's managed care plans meet specific minimum standards of professional qualification. "Credentialing verification" refers to the process of obtaining and verifying information about the professional's education, current licensure status, board certification, hospital privileges, and other qualifications. The act requires a health carrier to verify specified credentials when a professional first applies to participate in the carrier's managed care plan and to reverify the professional's credentials at least every three years. The act specifies that the credentialing process is separate from the selection process that a health carrier may use to choose its participating providers. Carriers may use separate or additional criteria to choose their providers. The act also establishes the right of the health care professional who is the subject of the credentialing verification process to review information obtained to satisfy the requirements of this act and to submit corrected or supplemental information.

Health Information Confidentiality Model Act

The NAIC has essentially completed its work on the five models just described. Over the next six months, the NAIC will devote considerable attention to our draft Health Information Confidentiality Model Act. This draft model is in a preliminary stage. The model requires a health carrier to provide written notice of its information practices to all applicants and covered persons. The draft also requires health carriers to provide an individual with access to his or her own recorded personal information. Also, the draft specifies a procedure for an individual to request a health carrier to amend the individual's recorded information. The act also limits the circumstances under which a health carrier may disclose personal or privileged information.

The NAIC is aware of congressional interest in legislation addressing the confidentiality of health information. The (EX) Special Committee on health insurance has commented on S. 1360, "The Medical Records Confidentiality Act", sponsored by Senator Bennett and others and has highlighted issues raised by the bill in the areas of state flexibility and regulator access to information. The NAIC Committee also appreciated that the provisions within H.R. 3103, as passed by the House, relating to Administrative Simplification, specifically allow states to enact different confidentiality standards for health information from the federal standards, as long as the state standards are more stringent.

We hope to obtain the advice and participation of experts from the federal government and representatives of consumer groups as we work on our Health Information Confidentiality Model Act. We

have an open drafting process in which we invite public participation, both at our quarterly meetings and through written comments solicited by circulating our draft models. We hope that the expertise of state insurance regulators in dealing with highly sensitive financial information, combined with extensive public input on the subject of health care information, will enable us to contribute to the current effort to define a regulatory framework for health information.

Existing NAIC Models and State Laws Governing Managed Care Plans

NAIC Health Maintenance Organization Model Act, Preferred Provider Arrangements Model Act, and the Prepaid Limited Health Service Organization Model Act

The proposed NAIC health plan standards expand upon many of the protections within the NAIC's existing model laws and those in place in many of the states. Forty-nine states have laws regulating HMOs and 29 of these laws are based upon or similar to the NAIC's Health Maintenance Organization Model Act. This act includes several consumer protections, including specifications for group contracts, requirements that HMOs maintain a quality assurance program and a grievance procedure approved by the relevant state agency, and confidentiality and insolvency protections. The proposed health plan models therefore build upon existing requirements in place in many of the states.

The NAIC's Preferred Provider Arrangements Model Act contains requirements relating to disclosure, access, and provider contracts to ensure that consumers of preferred provider arrangements are informed of differences in benefit levels and that providers are not unfairly discriminated against, among other protections. The NAIC's Prepaid Limited Health Service Organization Model Act contains protections for enrollees of managed care plans providing a limited number of health services, such as dental care services or vision care services. These models have served as the basis for several state laws in these areas.

Health Plans Governed by ERISA

In the NAIC's ERISA white paper (ERISA: a Call for Reform) and in our testimony before Congress over the past year, we emphasized that all consumers of health care coverage should have the benefits of certain critical consumer protections. We would like to highlight that a significant portion of the health care market, including the managed care health care market, is outside the jurisdiction of state law. ERISA-governed plans differ from state-licensed managed care plans in terms of the applicable financial and other licensure requirements. However, the plans are similar in their ability to restrict enrollees' choice of providers and to specify requirements in provider contracts. Hence, many of the same provider contracting issues that arise in the regulation of state-licensed plans and HMOs also arise in the ERISA context. The NAIC Committee appreciates that H.R. 2976 extends its scope to ERISA plans, over which the states do not have jurisdiction, and thereby recognizes this market reality. The NAIC Committee also recommends consideration of additional protections for such plans so that consumers of both ERISA-governed and state-licensed health plans have similar levels of security and ability to challenge any possible unfair treatment by health plans.

Conclusion

As insurance regulators, we are concerned about consumer protections, which include the fair and equitable treatment of enrollees and providers in their dealings with health plans. We believe that the application of health plan standards to all health plans will help ensure that the health care received by consumers is of the highest quality and will ensure that consumers receive medically-necessary care based on medical decisions. We believe that the augmentation of consumer protections represented in the proposed NAIC's models, together with the upcoming development of a consolidated licensing scheme, will ensure that all state-licensed health plans that finance and deliver health care will be solvent and able to deliver the services promised.

We urge you to maintain the states' ability to implement innovative and effective protections for reform of the health insurance market. By doing so in H.R. 2976, as in H.R. 3103, you have recognized the expertise of the states in regulating the health insurance market and in dealing with health insurance reform.

We appreciate the opportunity to testify before this subcommittee concerning the NAIC's and state activities in this area. The NAIC looks forward to continuing to work with the 104th Congress as it attempts to enact meaningful market-based reforms of the health care insurance market.

Mr. CHRISTENSEN. Thank you for your testimony.

Thank you all for your testimony.

Ms. Musser, first, I would like to ask you, Does your department review contracts of health plans seeking licensure of each plan?

Ms. MUSSER. Yes. They have to file a business plan, any material changes to their business plan, all provider contracting arrangements, and all financial data, including the IPA or the network financial data.

Mr. CHRISTENSEN. Do you specifically look for gag clauses or those types of paragraphs that might be interpreted by physicians as gag clauses?

Ms. MUSSER. We specifically look for all violations or, stated more positively, all areas of compliance with our State statutes, including compliance with the provision prevents the interference by an insurance company with the professional relationship of a physician with his patient.

Mr. CHRISTENSEN. How many various presentations have you reviewed in your tenure in Wisconsin?

Ms. MUSSER. I believe that we have reviewed and licensed six or seven new HMOs. We have a total of 27 now in the State. And we have renewed and reviewed material changes which, of course, mean mergers and acquisitions and other changes of ownership, I would say in another half dozen.

Mr. CHRISTENSEN. Have you turned down any HMO or managed care contracts that have applied for doing business in Wisconsin yet?

Ms. MUSSER. We do not exactly turn them down. We send them back.

Mr. CHRISTENSEN. Have you sent any back?

Ms. MUSSER. Yes.

Mr. CHRISTENSEN. Sending back for the provision that would be called a gag clause?

Ms. MUSSER. Not to my knowledge. All of my examiners, market conduct and financial, in reviewing the HMO contracts have not seen the contractual provisions. That is why we have looked for the operational effects and found none there, as well. The examiners also look for operational effects in the market conduct exams.

Mr. CHRISTENSEN. Do other States, as you know, review these types of contracts as closely as Wisconsin?

Ms. MUSSER. I believe that several other States do. The problem is that the insurance commissioners regulate HMO plans in most States. The health commissioners regulate them in a number of other States. And in a few States it is the department of corporations that regulates HMOs.

In fact, no other State licenses them as insurers, like we do. So, we have, I think, a different evolution of the regulation.

Mr. CHRISTENSEN. What would be the general consensus across the country? You said that some have the department of corporations, some have the insurance commissioners, some have the health regulators. What is the predominant way that the States handle this area?

Ms. MUSSER. The insurance commissioners.

Mr. CHRISTENSEN. And do the insurance commissioners generally have the authority to ask health maintenance organizations to

remove clauses from the contract, or does that have to come from the Governor or the State elected body?

Ms. MUSSER. I am sorry. I do not know the answer to that. I can find out and provide you with the information. A State's authority varies depending on requirements for filing.

Mr. CHRISTENSEN. Do most States require HMOs to establish a process for consumers complaints, and how does Wisconsin handle that area?

Ms. MUSSER. Most of the States have adopted the NAIC Model HMO Act which establishes a grievance process. Wisconsin handles it by providing, within the department of insurance, a grievance process for all consumers, all plans are required to notify each plan participant of our 800 number and plan participants right to file a complaint on all their billing and other materials.

Mr. CHRISTENSEN. How is the term provider defined in that act?

Ms. MUSSER. In the grievance?

Mr. CHRISTENSEN. No. In the——

Ms. MUSSER. In the HMO?

Mr. CHRISTENSEN. Yes. I am not certain, but I know that in the health plan accountability standards, the provider terminology is broad, similar to the definition in H.R. 2976.

Mr. CHRISTENSEN. OK.

Ms. Archer, I wanted to ask you, you stated that as originally introduced H.R. 2976 would accomplish the goals that you had set out for the needed change in this area. What changes in H.R. 2976 have occurred that you do not agree with and what would you like to see changed to move back to the original H.R. 2976?

Ms. ARCHER. I believe that the physician disclosure of financial incentives should be permitted. HMOs should not be permitted to forbid disclosure of financial incentives. And also, that nondisparagement clauses should not be included in HMO contracts. I understand the HMO's business interest in keeping providers from speaking against them. On the other hand, one doctor's comment either about the way the HMO deals with his or her particular specialty or the way the HMO deals with mental health from a gynecologist is not going to affect the HMO business. More likely a reporter's, who knows very little about care, story in the New York Times will do that. And I think that open communication is always a good idea.

Mr. CHRISTENSEN. In your testimony you stated that the ability to terminate physician contracts without cause may have the greatest chilling effect on patient-physician communications. Could you explain more fully what you meant by that?

Ms. ARCHER. Well, it goes back to the point that's been made throughout the afternoon by some of the witnesses which is that there may not be any gag rule in the contract with a provider but the fact that the HMO can terminate a physician for any reason will silence or can silence the physician.

Again, it is not going to be every physician who is silenced, but the point is we want to encourage open communications between physicians and patients. The HMO certainly will always have and should have the ability, both to screen physicians before admitting them to the network and to terminate physicians who do not prac-

tice good medicine and we want that. But open communications is something that we should also want.

Mr. CHRISTENSEN. Ms. Craft, have any of your employers mentioned concerns about whether physicians are telling their employees about all treatment options or that they might be holding back information because of the way they have been paid?

Ms. CRAFT. That has been a concern within some employers. Primarily within our business coalition, that has been a concern of large employers with multiple locations. Managed care has moved very slowly into Southwest Virginia. At this point, we only have HMO offerings that are still discount fee-for-service. We are not into a capitation arena. So, we are hearing that, but from some of our larger employers with multiple locations.

Mr. CHRISTENSEN. Dr. Jagmin's testimony earlier reflected his concern and the association's concern about a sliding scale, a slippery slope approach to the Federal Government getting into this area of the law. What is your coalition's view on the Federal Government moving into this area to try to, what I think maybe needs to be corrected, what is your coalition's view on that?

Ms. CROFT. Our view, as a business coalition and representing many business coalitions, is that this kind of legislation to prevent gag rules and that kind of thing is not a bad thing. However, especially with this piece of legislation, there are so many ambiguities, so many things that do not seem to be very clearly defined that I think employers fear what could come out of this. There could be multiple layers of regulation from the Federal Government, the State government, from different areas, and from Health and Human Services, that they have never been regulated by before.

And I think that they just would like to see some of these ambiguous areas clearly defined. I think they would like to see some of the terms, such as oral communication, very clearly defined so that it could not be a passing comment that a doctor made one time or it could not be simply what a patient perceived that the doctor said to them. I think with some definition some of this could become more acceptable.

Mr. CHRISTENSEN. OK. Would any one of you want to have any kind of closing statement? I apologize for the interruption we had earlier, and I want to give you each a fair opportunity just to have a closing comment.

Yes, Ms. Musser.

Ms. MUSSER. I think there is an advantage to going last because there are many things that I would like to comment on this afternoon, but I will mention just a couple of issues. I would like to caution all of us not to confuse issues related to informed consent or issues of responsibility for knowledge of what is covered in an insurance policy. Whose responsibility is it to understand what is covered and what is not covered? I would maintain it is not the physician's responsibility to find out or to be prepared for a coverage issue. Those issues are the patient's responsibility, except in emergency situations when patients do not have the time to call the human resource managers or to find out what is covered or not.

To address the anecdote that Dr. Nelson shared with us earlier, I do not believe it is the physician's responsibility to stop a procedure to find out what is covered. And if it is an indemnity plan,

you would find out in retrospect what was covered. I think that this is where we may confuse informed consent and knowledge of coverage issues.

I think the issue of informed consent and the ethics and the code that is related to informed consent is a very important one. Physicians are required to discuss treatment options, and I would say it is the physician's responsibility not to sign a contract that violates his or her code of ethics.

Now, I realize there are market pressures, and maybe we need to address some of those, including termination without cause. I think the Code of Ethics ought to separate sort of the wheat from the chaff in this issue. Physicians are required to behave according to their code of ethics.

The third point that I would caution us against confusing are issues related to employment law. In the high-tech industry, employees are restricted by noncompletion clauses. Employees are frequently, or can be, fired for issues of disparagement or disloyalty. We have to avoid confusing informed consent issues with issues related to proprietary information. We have to be careful not to hogtie the HMO and the managed care industry from achieving what we want them to achieve. As you pointed out earlier, there is a balancing act between cost containment and what we want in terms of quality care. There exists employment law. I think we need to focus and not to overstep in that arena.

The area of a patient's right to know his or her treatment options is a critical one. Some of the other areas related to proprietary information in terms of capitation rates and others, are business issues, and I would caution us to be careful to separate them. That is why I like this version of H.R. 2976 more than the prior one.

I also found out the definition of "provider" in our managed care act, our HMO model act. "Provider" means a physician, hospital, or other person licensed or otherwise authorized to furnish health care services.

Mr. CHRISTENSEN. Thank you.

Ms. Archer.

Ms. ARCHER. Yes. I would just like to urge you, the Subommittee, to remember that there really is not a level playingfield here. That it is the HMOs with all the power and as powerful as we may believe the doctors to be or the consumers to be, we just do not have the leverage that the HMOs have right now. And the HMOs are out there rightly promoting what they have to offer. And as I said before, I think a lot of it is very good. They are giving the positive spin on everything and they should because they want to sell their product.

But just as we require cookie companies to discuss their fat content, I think that because we want the public to understand that the cookie isn't only as delicious as the company says it is, but is made up of certain ingredients and has certain nutritional values, we should want the HMOs to make public and disclose what they are really doing, what product they are selling. And a piece of that is to have the physicians able to tell the patients what is being sold.

And if we do not make the patients aware of that, then we do not have the HMOs truly competing in the marketplace and consumers are not making the choices.

Mr. CHRISTENSEN. Thank you.

Ms. Craft.

Ms. CRAFT. Yes. I would like to repeat that I think there are a lot of unclear and ambiguous points within this bill and to over simplify, if I could liken employers sponsoring ERISA plans to children getting on a schoolbus, right now those employers get on the bus and they know that DOL is driving the bus and they know what the rules are. According to this bill, with all the different layers of people that could be involved in regulation, how many drivers is the bus going to have?

Mr. CHRISTENSEN. Well, we are going to try to hopefully make this bill a better bill when it comes out of our Subcommittee.

I want to thank you all for your testimony and I appreciate the time that you have taken out of your schedule this late afternoon.

The Subcommittee stands adjourned.

[Whereupon, at 4:31 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

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July 29, 1996

The Honorable
Bill Thomas
Chairman, Ways and Means Committee Member
United States House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Please include this letter in the record for the July 30 hearing to be held by the House Committee on Ways and Means on H.R. 2976, the Patient Right to Know Act. The American College of Cardiology (ACC) strongly supports H.R. 2976 and urges the members of the Committee to act favorably on this legislation on behalf of our patients.

As a member of the Patient Access to Specialty Care Coalition, the ACC believes strongly in empowering patients to make the best possible health care decisions. Such decisions can only be made in an atmosphere that allows maximum communication between physicians and patients. We believe that H.R. 2976 would guarantee - unequivocally - that such an environment exists in *all* practice settings and would enhance the quality of health care in this country.

The American College of Cardiology is a 23,000 member non-profit professional medical society and teaching institution whose purpose is to foster optimal cardiovascular care and disease prevention through professional education, promotion of research, and leadership in the development of standards and formulation of health care policy.

Please do not hesitate to contact Marie E. Michnich, Dr.P.H., Senior Associate Executive Vice President, at the ACC if we can be of any additional assistance.

Sincerely,

Richard P. Lewis, M.D., F.A.C.C.
President

STATEMENT OF

AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS

to the

Committee on Ways and Means
United States House of Representatives

July 30, 1996

RE: Patient Right to Know Act (HR 2976)

The American Society of Plastic and Reconstructive Surgeons (ASPRS) represents 97% of the nearly 5,000 board certified plastic surgeons in the United States. Plastic surgeons provide highly skilled surgical services which improve both the functional capacity and quality of life of our patients. These services include the treatment of congenital deformities, burn injuries, traumatic injuries, and cancer.

We commend Committee Chairman Bill Archer for holding this important hearing, and wish to thank the Ways and Means Committee for the opportunity to submit this written statement about "gag clause" provisions commonly found in many of today's managed care contracts.

Gag clauses undermine a physician's ability to provide his or her patients with the best possible care. The inclusion of these provisions in contracts between physicians and managed care entities also raises significant ethical concerns for physicians. We maintain that patients should receive the most complete information available about their health care options from their physician without interference from third parties. In many situations, gag clauses have been written so broadly that any communication between physician and patient could be interpreted to fall within the provisions of this clause, including medical treatment options and whether a given health plan meets the needs of a given patient. These onerous medical "gag clauses" violate sound public policy and should be made unenforceable by Congress.

Types of "Gag Clauses"

Generally, gag clauses are written explicitly in health care contracts. The language is designed to limit the communications between physicians and their patients by prohibiting some or all of the following types of communications:

1) discussion of treatment options which have not been authorized for payment by the plan;

2) making critical comments about the plan, its policies, or quality standards to enrollees or other physicians;

3) communicating with plan patients in the event the physician is deselected (raising concerns of continuity of patient care);

4) discussing financial incentives to reduce care, including capitation and utilization review procedures; and,

5) referring patients to specialists or facilities that are not included in the plan's network.

In addition, more subtle, often unwritten, plan policies and procedures are used to impede physicians from discussing treatment options if the plan does not cover those treatments. Recent media reports have documented the use of a number of these "implied" gag clauses by health plans that value cost containment and financial gain for shareholders over the well being of patients.

Both explicit and implicit gag clauses are designed and implemented with the purpose to control physician behavior and to limit patients' access to the full range of information that is needed to make informed decisions about the proper course of their medical treatment. While we understand the legitimate business interest to control costs and avoid unjustified disparagement of a plan's operations, such efforts should never undermine the quality of care received by patients.

We note that many health plan contracts do not contain "gag clauses." In addition, several plans have voluntarily removed these contract provisions in response to negative media publicity and the enactment of state legislative restrictions.

Gag Clauses Violate Medical Ethics

The fundamental issue that "gag clauses" present is an inherent ethical conflict of interest for physicians, which strikes at the heart of the patient-physician relationship. The ASPRS Code of Ethics states the general rule that "physicians should provide services under terms and conditions which permit the free and complete exercise of sound medical judgment and skill. (*Code of Ethics for the American Society of Plastic and Reconstructive Surgeons, Section 1, Paragraph VI*).

Patients must be able to trust and rely on the information their physicians provide to them regarding appropriate medical treatment and care. Indeed, even setting aside ethical concerns, physicians have a legal duty to make patients fully informed of their options regardless of cost or potential payment limitations. Gag clauses, however, effectively place a wedge between a physician and his or her patients. While a physician maintains an ethical and legal duty to the patient, the plan's contractual language seeks to place an opposing contractual duty on the physician.

Gag clauses erode a fundamental element of the healing process. Trust is the most basic component in the patient-physician relationship, yet these clauses cause doubt in the minds of patients, often at a time when they are most vulnerable.

Physicians find it increasingly difficult to act as patient advocates, our most basic mission. If we advocate zealously on our patients' behalf, we place ourselves in danger of being dropped by the health plan. If we don't press hard enough, we don't live up to our ethical obligations. Physicians need support to act as professionals, not as vendors of a third party to control costs.

The Need for Federal Legislation: The Patient Right to Know Act

Negative reaction to gag clauses on the part of the public and media have resulted in a number of states enacting legislation prohibiting gag clauses in recent months. Legislatures in Massachusetts, Colorado, Georgia, Indiana, Virginia and Vermont have recently passed such laws. Similar bills are pending in several states including California, Illinois, New York and New Jersey. Oklahoma, Tennessee and New Jersey have moved against these provisions through regulatory action.

However, action at the state level is not sufficient to remedy this problem. Many health plans, such as self-funded ERISA-preempted plans, are not be reached by state law. In addition, an increasing number of Medicare beneficiaries have begun to join managed care plans. Because this population often uses a greater number of specialists, managed care gag clauses pose especially acute problems for unsuspecting Medicare beneficiaries.

Federal legislation covering all private and public sector health plans is, therefore, needed in order to ensure that every patient is adequately protected from these contractual provisions.

ASPRS strongly supports the legislation sponsored by Representatives Greg Ganske (R-IA) and Edward Markey (D-MA), the Patient Right To Know Act of 1996 (HR 2976). This bill would render managed care contract "gag clauses" unenforceable and prohibit plans from contractually interfering with "medical communications" between physicians and their patients, as well as taking "adverse actions" against physicians.

The bill would set the above described provisions as a federal floor and thus preempt state law in cases where a state sets a lesser standard. Finally, the bill would cover all health plans, including self-insured ERISA plans and would provide for fines and penalties for violation of the statute. HR 2976 is necessary to rid the health care system of these egregious contract provisions without unduly interfering with the legitimate business practices of managed care companies.

Conclusion

ASPRS submits that gag clauses interfering with communications between physicians and patients should be made legally unenforceable. We strongly support the Patient Right to Know Act of 1996 (HR 2976), legislation designed to prohibit such clauses as an unreasonable burden on the health care system. We appreciate the opportunity to comment and are prepared to work with the committee on this important issue.

Samuel Brola
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August 12, 1996

Philip D. Mosely, Chief of Staff
Committee on Ways and Means
U. S. House of Representatives
1102 Longworth House Office Building
Washington, D. C. 20515

RE: Committee on Ways and Means, Subcommittee on Health, Hearing on H.R. 2976, the "Patient Right to Know Act of 1996" held on Tuesday, July 30, 1996.

Dear Mr. Mosely,

I am submitting this evidence as an individual who has been through all stages of disgust with the way managed care is being operated.

I do not officially represent any organization but am merely the person who has fought their case the longest and hardest while seeking justice and the truth. However, I believe my case is only one of thousands in the Miami area.

The hearings are all about gag clauses and secret contracts. SECRETS are at the root of the managed care problem and secrets kept from the public are not in the best interests of the people.

I believe that health care cannot be left to profit oriented/cost cutting managers. There must be Federal laws that protect the patient by:

1) Eliminating all gag clauses and secret contracts. The people have a right to know!

2) Eliminating any blocks to a patient suing his HMO and his employer in State Court. The current system too often allows HMO's escape by citing ERISA. Filing a suit in Federal Court is expensive and since attorney's fees are not guaranteed; most Americans cannot afford due process.

3) Requiring that all HMO personnel who make decisions of medical necessity must be licensed as medical doctors in the state where the patient is located. We are trying to clarify this issue through a criminal court case.

4) Holding individuals, not corporations, liable for malpractice, bad faith, and contract compliance. Anything less will not change the corporate behavior.

I am enclosing 25 copies of the evidence I wish to have printed as part of the printed record of this hearing. Please use them in the following prioritized order.

1) Copies required to ensure printing for the record.

2) 13 Copies - One to each member of the subcommittee.

3) Please distribute any remaining copies to media representatives who expressed an interest in this hearing.

PLEASE CONFIRM BY PHONE, FAX, OR E-MAIL THAT THIS EVIDENCE WILL BE PRINTED AS PART OF THE HEARING.

Samuel Brola

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August 11, 1996

Committee on Ways and Means
Subcommittee on Health
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D. C. 20515

RE: H. R. 2976, "Patient Right to Know Act of 1996"

Dear Members of Congress:

I am writing to you in an effort to clarify some issues before you. There are many things a patient has the right to know.

1) Patients have both a right and a need to know whether there are treatment plans available other than the one preferred by their HMO.

2) Patients have both a right and a need to know whether their physician has monetary incentives to deny medical care and what they are. The attached "AvMed Bonus Letter" and the summary of experiences with AvMed HMO will show what GREED causes.

3) Patients have both a right and a need to know if their physician is forbidden from telling the TRUTH by their contract with an HMO.

4) Medicare & Medicaid HMO patients also have a right and a need to know what medical care and services the government's contract requires the HMO to provide. HCFA has informed me that the Medicare HMO contract particulars referring to what medical care and services the HMO MUST provide, are confidential. How absurd!! How is a patient/taxpayer supposed to know what they are getting for the billions in tax dollars.

During the Florida Department of Business & Professional investigation of Roger H. Strube, M. D., (former Medical Director of AvMed HMO's Miami Plan) a form letter was obtained by the investigator to show that Roger H. Strube used the M.D. after his name in the conduct of business, without being licensed in Florida. Nobody apparently read the letter until I requested a copy of the investigative file. This letter clearly explains how AvMed uses financial incentives to control their physicians. The fourth paragraph states: **"Patient complaints, member PCP changes, your office's cooperation with AvMed, and your office's compatibility with and support of the AvMed philosophy were used as modifiers which either increased, decreased or did not change the above scores."** To me, that clearly states: **DO WHAT WE SAY OR YOU GET NO BONUS!!**

The results of all this secrecy are a direct threat to the life and health of my son. Even the Dade State Attorney is trying to gag me about what I discovered about AvMed Health Plan. Nobody wants me on the record because I can prove that HMO personnel who are NOT licensed physicians, routinely practice medicine within the statutory definition. If this case were to go to trial, it would set precedent across the country. Those persons making decisions at HMO's are practicing medicine, must be licensed physicians, and are therefore subject to personal malpractice lawsuits. Of course, if an HMO employee can be held responsible for his actions, he will be less cruel and vicious in denying care. That would hurt the bonuses of the HMO executives as well as the CEO's of the major corporate employers who are driving managed care down the people's throats.

Please restore our citizens' rights by passing legislation that will eliminate all the SECRECY that the HMO's use to avoid responsibility for their actions. The current situation is not the type of government I <u>thought</u> I was defending during my 20 years of military service.

Samuel Brola Monika D. Brola

AV-MED

June 28, 1994

Dear Doctor (s),

Congratulations and thanks from AvMed Health Plan! You have been selected to receive a cash bonus as one of AvMed's outstanding Primary Care Physicians (or Practices).

AvMed is continually striving to improve the quality of health services to its members. One way by which this is accomplished is by the recognition of those physicians who consistently provide high quality services in an efficient manner.

In 1993, AvMed improved the mechanism by which physicians were chosen to receive financial incentives. Objective parameters were used for the selection process. Rather than describing in detail the complex formula, I will simply describe the basic criteria which were utilized. They included acceptance of capitation for the year 1993 as part of at least 100 AvMed members, current participation with AvMed, a patient satisfaction survey which looked at such issues as accessibility, availability, waiting time, ease of referrals, and general patient satisfaction with your services. A separate bonus was predicated solely on the basis of patient satisfaction. A second level of measurement was made on the basis of the scores you received on your medical records review. A separate bonus was then predicated on the basis of quality of services as reflected in the scored medical record review.

Patient complaints, member PCP changes, your office's cooperation with AvMed, and your office's compatibility with and support of the AvMed philosophy were used as modifiers which either increased, decreased or did not change the above scores. PCP's may qualify for one or both of these bonuses. PCP's in the upper 50 percentile were included in the distribution of bonuses.

I am pleased to award the enclosed check (s) in recognition of the quality service provided to your AvMed patients. Our thanks and best wishes for continued excellence in the future.

Sincerely,

Roger H. Strube M.D.

Roger H. Strube, M.D.
Medical Director, Miami Plan

RHS/tm

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August 9, 1996

RE: Our history with AvMed HMO, Miami Plan

Patient: David Lee Bissonette, born March 5, 1976

David is unable to walk, stand, or sit alone. He has little or no functional use of his extremities. He is totally dependent on others in all areas. He cannot feed, clothe or bathe himself and cannot speak to ask for assistance or to describe his pain.

Diagnoses: Cerebral palsy, spastic quadriplegia, anoxic encephalopathy, microcephaly, scoliosis (partially corrected by CD rods on spine), esophageal reflux (partially corrected by fundoplication surgery), seizure disorder, chronic pulmonary disease (right lung tested 5% function - no blood circulation).

None of these is curable, nor will they improve substantially. While David is severely physically handicapped, he is not a vegetable. He is very aware of his surroundings and communicates by eye-pointing and answering questions by yes and no head movements. His facial expressions communicate more than most people's words.

HISTORY WITH AVMED:

We are covered by AvMed through my employer, Florida Power & Light, which is self-insured. Our enrollment in AvMed was effective on January 1, 1991. The contract covers all pre-existing conditions immediately and has no financial cap limiting costs. We thought we had found a tremendous blessing. We did not know that a seemingly unending nightmare was just beginning.

1. July 5; Aug 30; Sept 27, 1991 and Jan. 18, 1992 - Letters delivered to us at Miami Children's Hospital on Friday evening stating that David's hospital benefits would terminate either at midnight or the next day. The intent was to coerce families to discharge their children without being able to contact anyone at AvMed, or in some cases, their physician.

ALL OF THE ABOVE LETTERS WERE SENT BY AVMED WITHOUT CONTACTING DAVID'S PHYSICIAN, HIS FLOOR NURSES, OR THE HOSPITAL'S RESIDENT PHYSICIANS TO INQUIRE ABOUT HIS CONDITION!!

2. After one of his many hospital admissions, David was discharged to Greenbriar Nursing Home in Kendall. We were forced to accept this arrangement. After only 12 days at Greenbriar, the situation was:

   a. There was no air conditioning in David's room (approx. 86 degrees), David had a 104.2 degree fever, and he was on oxygen. He was on a heated air bed dressed only in a diaper. He had a huge fan blowing on him. The nursing home's personnel had not called to inform us that he was sick.

   b. Even after four phone calls, Dr. Grijalva, the Nursing Home physician, refused to come. He told my wife that David's blood test (CBC) showed a white cell count in the normal range (approx. 7,000 to 9,000) and that it was

"normal" for "these kids" to "sometimes spike a temperature". My wife informed him that, having raised David at home for 15 years, she knew it was not normal for David. The doctor still did not come. He said he would stop by "later this evening".

c. When I arrived, I called David's pulmonologist, Morton Schwartzman, M.D. He told me to get David to Miami Children's Hospital emergency room right away. I instructed the nursing home's nurse supervisor to call an ambulance to transport David. She REFUSED. I called 911 for an ambulance for transport. When David arrived at Miami Childrens' Hospital, he was evaluated and then admitted to the Intensive Care Unit. His white cell count was now over 20,000, quite contrary to Dr. Grijalva's "diagnosis".

6. In October 1991, after David's hospital admission caused by the nursing home's neglect, AvMed tried to have David discharged to the same nursing home. We refused and David was finally discharged with 12 hours per day of nursing care in our home. We were able to keep him out of the hospital for all of two months.

7. On December 4, 1991, David was again admitted to Miami Children's Hospital with serious pulmonary infection and pleural effusion, including abscesses and fluid in and around the right lung. David failed to respond to many different treatments and, by mid-January, 1992, we thought he would die any day.

8. January 18, 1992 - Letter delivered to us at the hospital stating that David no longer required treatment in an acute care facility and could be discharged to Greenbriar Nursing Center. His doctor said that he was nowhere near ready for discharge AND we would not return him to Greenbriar, since they had nearly killed him.

9. Jan. 30, 1992 - Letter delivered to us at Miami Children's Hospital threatening not to pay for David's care unless we agreed to transfer him back to Greenbriar. They had obtained a "second opinion" about David's suitability for Greenbriar. The so-called "second opinion" was from Dr. Grijalva, the physician from Greenbriar who had refused to come when David was there. We again refused to transfer David to Greenbriar AND refused to discharge him from the hospital.

   After several weeks, AND after obtaining the services of an attorney, AvMed provided David with nursing, respiratory therapy, etc., at home as a substitute for hospital care. David has a RIGHT to high quality care provided by licensed medical professionals. AvMed has continually attempted to curtail care without changes in medical orders and to do so without our prior knowledge. To date, we have kept them from reducing his care to dangerous levels.

10. June 1992 - AvMed attempted to cease providing licensed respiratory therapists by calling the home care agency telling them to stop sending therapists, but not to tell us in advance. We notified the company that there had been no change in the medical orders and that they and AvMed would be liable if care was stopped.

11. Aug. 23, 1992 - David admitted to hospital with pulmonary infection.

12. AUGUST 24, 1992 - HURRICANE ANDREW - My wife, Monika, stayed at the hospital with David while I endured the northern eye wall of the storm in our master bathroom with my daughter, father-in-law, sister-in-law, and my nephew. We all huddled there while most of the rest of our house came apart. We experienced the eye wall of Andrew for hours without injury, but our home, was destroyed.

13. Aug. 31 - Sept. 10, 1992 - When we were finally able to retrieve telephone messages from the Southern Bell message service, we heard AvMed threatening to disenroll us if we did not immediately have David discharged from the hospital. I called to inform them that there had been a hurricane and we no longer had a

home to take him to. They said the hurricane was not their problem, that we should seek public assistance if we had no home, and that they would immediately stop payment for David's care if we did not discharge him. They also stated that Greenbriar was no longer an option. I told them Greenbriar would NEVER be an option and that we would discharge David WHEN we had a home to take him to AND when AvMed had arranged for resumption of his nursing and respiratory care.

14. Sept. 10, 1992 - After days of phoning, found a rental house in North Miami Beach and discharged David with home nursing care and respiratory therapists.

15. Jan./Feb. 1993 - AvMed attempted to curtail respiratory treatments and drug deliveries by phone calls. We demanded a Member Appeals Committee.

16. March 1993 - Result of Member Appeals Committee was that AvMed would NOT attempt to cease providing care without prior written notification to us with sufficient time for us to appeal. We were accompanied by Attorney Arthur Garcia.,

It was around this time that Roger H. Strube, M.D., became the Medical Director of AvMed HMO in Miami. He is licensed in Wisconsin and Indiana but has never been licensed in Florida. His license record in Wisconsin reflects that he accepted a disciplinary entry on his license record that he had improperly prescribed amphetamines over a seven year period. This is on his record with his acquiescence and that of his attorney. It was also placed in his record without the cooperation of the patients involved. The average person would have to question his **ethics** and **judgement**. AvMed may or may not have known about his lack of license or the discipline in Wisconsin.

If AvMed did not know about his past, it means that a huge medical corporation hired a top executive at a large salary and gave him responsibility for the medical care of 110,000 AvMed members in Dade County WITHOUT the most cursory background check. I believe that constitutes: reckless endangerment of the members by IMPROPERLY HIRING an executive with questionable (at best) background. I believe that AvMed did do a background check and decided that Roger H. Strube had EXACTLY the ethical behavior pattern they desired. I stated this belief clearly at our hearing before the Statewide Providers & Subscribers Assistance Panel in early 1995. The Panel was made up of representatives from the Florida Department of Insurance and the Florida Agency for Health Care Administration.

17. July 1993 - AvMed tried to terminate respiratory services without a change in medical orders or prior notice. Mr. Garcia prevented AvMed's action.

18. Oct. 1993 - Unknown to us at the time, a patient filed a complaint against Roger H. Strube with the Department of Business and Professional Regulation, Case No. 93-18811. Roger Strube was notified of the complaint and was requested to sign a Cease and Desist Agreement. The Investigative Report shows Stephen J. deMontmollin to be Strube's attorney. Stephen J. deMontmollin is Vice President and General Counsel of AvMed.

19. Jan. 9, 1994.- The medical home care provider, Infusion Therapies, fired their subcontracted respiratory therapists, Greg Lane and Associates. Mr. Lane received the letter on Saturday which told him to cease providing care to all of his patients on Monday. This incident coincided with the visit to Miami AvMed of Infusion Therapies' Chief Operating Officer from Atlanta.

20. Jan. 12, 1994 - A Mr. Thomas P. Jarrett from Infusion Therapies came to bring a new pulse oximeter. He informed our nurse that he would be taking over David's respiratory treatments the next day.

21. Jan. 13, 1994 - Mr. Jarrett did not show up for David's 8:00 a.m. and 12:00 noon treatments. When he finally arrived for David's 4:00 p.m. treatment, I asked to see

his respiratory license. He showed me a folded up copy of a copy of a copy of a respiratory license. His drivers license picture did not look like him and the license had been peeled open. We wrote down his drivers license number and his respiratory license number. The year of birth in his drivers license number did not match his respiratory license information. We later filed a complaint with the Dept of Business and Professional Regulation in Tallahassee. They refused to investigate even though the local Miami office had expressed an interest, since multiple users of a single license are apparently a large problem.

22. Jan. 1994 - Mr. Jarrett came from Davie to our home in South Dade 3 times a day for the next week, accompanied by a Mr. Hopper of Infusion Therapies, to insist that Mr. Jarrett did not have to show me an original of his license. I agreed but had to remind these people that this is MY home and my son. I will NOT be forced to let just anyone into my house, especially someone whom I consider to be unqualified.

23. Jan. 1994 - We received a visit from an HRS Child Protective Services investigator because of an anonymous report that we were purposely denying David needed respiratory treatments. I am sure that it was Roger H. Strube of AvMed who filed the false and malicious complaint because he threatened in writing to do the same thing to Mr. Dennis Peterson, another AvMed member whose son is chronically ill.

24. March 1994 - At another AvMed Member Appeals Committee, I presented eight pages of facts to the attending AvMed managers and executives. I have their names in their own writing. The result of this meeting was an agreement that NO CHANGES to David's care would be attempted until after a meeting was held among us, David's primary care physician and AvMed's Complex Case Manager.

25. April 1994 - AvMed attempted to cease providing David's feeding formula, feeding bags, and other medically necessary "disposable and consumable" medical supplies. They attempted this in spite of a Member Appeals Committee agreement to make no changes prior to the meeting with David's Primary Care Physician.

26. June 1994- The meeting took place between us, Dr. Jarrett, and Sue Shepper, RN, of AvMed in the doctor's office. The doctor did not examine David. He merely stated that since the current care plan was keeping David as healthy as possible, he did not intend to change it. He also agreed that it was not up to him to decide WHO provided the care, since Florida law specifies the qualifications required to perform various levels of medical care.

27. Sept. 12, 1994 - Roger H. Strube of AvMed sent us a letter claiming to have "recently received updated orders from both Dr. Jarrett and Dr. Gustman," and that the case would be transferred to Roche Professional Service Centers, a home care agency whom we had previously fired for incompetence. What happened is clearly described in a response I received from Karen Nagle, an attorney for Roche Professional Service Centers, Inc. in New Jersey. "RPSC was following the directions of Dr. Strube to create a plan of care for your son and get physician orders in order to be able to follow through on this plan. It is necessary to obtain physician orders before rendering service, so that only care ordered by a physician is rendered."

    Roger H. Strube illegally dictated the orders, (practicing medicine without a license), Karen Martel, R.N., of Roche wrote the orders and illegally obtained signatures. (It is illegal in Florida to obtain medical information/orders without prior written permission of the patient/parent.) Paul M. Gustman, MD, illegally signed a set of the orders (per Karen Martel's statement and Strube's). He had removed himself from David's case in February and had on one occasion refused to order an antibiotic for David when called by the nurse on duty. Is it malpractice for a physician to sign medical orders for a patient he has not seen in eight months and whose case he has given up? We filed a complaint against Karen Martel, RN of

Roche with BPR. They declined to investigate. We filed a complaint against Paul M. Gustman, MD, in May 1995. It has FINALLY been investigated and the report was sent to Tallahassee in February 1996. I wrote dozens of letters to legislators and to the Board of Medicine and BPR. Finally, a legislator told me to call Randolph Collete, an attorney at BPR who had closed all three Strube cases. When his secretary gave me the run-around, I informed her that I had already called the FBI once to accuse AvMed of having undue influence on regulators. I stated I was going to call the FBI again with my belief that Randolph Collette was the contact point for the improper influence. Within three hours, we received a call from a BPR investigator in Miami that had been assigned the case. Case #95-15826 has been assigned to Dahna Schaublin in Miami since Nov. 1995. I have begged the Dade State Attorney to file charges of Criminal Conspiracy against Roger H. Strube, Karen Martel, RN, and Paul M. Gustman, MD. So far, those charges have not been filed although the evidence is clear, documented, and compelling. We have reason to fear retribution from Karen Martel since she is now a Supervisor at Nations Health Care, the medical provider that has David's case.

28. Sept. 22, 1994 - After being told that it was a Federal requirement that employers have an effective appeals process for complaints, I called and then wrote Scott Robinson at Florida Power & Light's Human Resources Department in Juno Beach. I sent him some 60 pages of documentation of the abuse we were taking from AvMed. I also informed him that I believed that Roger H. Strube was practicing medicine without a license. I did not even receive a phone call in response. FPL is self-insured, so this is not a big surprise.

29. Oct. 25, 1994 - When I tried to call Scott Robinson, FPL HRC/JB, I was told that he had been replaced by a Julie Barone. She confirmed that Mr. Robinson had received my complaint. I sent her a copy of BPR's certified statement that Roger H. Strube had never been licensed in Florida. I did not hear from her again.

30. Nov. 2, 1994 - We attended a Member Appeals Committee Meeting at AvMed. We do not believe it met contract requirements. The contract describes a Member Appeals Committee as a FORMAL PROCEDURE. The bold print and capital letters are direct from the contract. We requested that the Case Managers and Karen Martel, R.N. be present. We also requested that we be allowed to bring a Court Reporter to record the minutes and prevent confusion in the future. AvMed refused on both requests, in writing. At this meeting, we obtained a copy of a "Case Summary" dated 10/28/94 which we believe shows that AvMed had already decided to ignore our appeal. I requested that each of the attending executives sign an attendance log and then gave each of them a copy of my eight page presentation. In this presentation we accused Roger H. Strube of Practicing Medicine Without a License and misrepresenting himself as a licensed medical doctor. (We were not yet aware of the 1993 BPR case.) Roger Strube's response was: "You can take it to the top if you want, Mr. Brola, and one of two things will happen, ha ha, either I'll be VERY secure in my position, or I'll get a great severance package." I informed the AvMed executives that he (Roger H. Strube) was "going down" and that it was up to them if they wanted to be accessories to his criminal activities.

31. Nov. 3, 1994 - AvMed sent us the MEMBER APPEALS COMMITTEE DETERMINATION stating: "The Committee determined that the new plan of treatment ... as outlined in the September 12, 1994 letter from Roger H. Strube, M.D., AvMed Medical Director, is appropriate for David's medical condition and AvMed will only authorize payment for that plan of treatment effective January 1, 1995." In other words, we are reducing your son's care in spite of the law.

32. Dec 8, 1994 - AvMed's Vice President & General Counsel, Stephen J. deMontmollin sent us a letter threatening to "seek a legal remedy" if I did not cease informing AvMed's physicians about unlicensed medical professionals in AvMed's Miami Office. It turned out that Marian Carolan, RN (Complex Case Manager) of AvMed,

is really Marie G. Carolan, RN. She was not using her legal name as it appears on her license. I informed Mr. deMontmollin that I would continue educating Floridians to the FACTS about AvMed's unlicensed Medical Directors (E. Leon Cooper, Strube's predecessor, was not licensed, either) and if that proved to be a slight inconvenience for Strube or AvMed, then I would be happy to respond to their threatened lawsuit. I have heard no more on the matter.

33. Dec 16, 1994 - Alise Moss Vetica, Manager, Corporate Member Relations, sent a letter threatening to terminate our AvMed membership on January 1, 1995 if we did not select a new Primary Care Physician for David. (David's PCP, Wentworth Jarrett, MD, had continued David's old medical orders for an additional 62 days, but was forced to remove himself from the case. He told us privately that he could not practice medicine for anyone while AvMed was calling him dozens of times every day, determined to cut David's care, no matter what.) The above-mentioned letter also stated: **"In the event you do select an AVMED PCP by the above time frame, please understand that the new plan of treatment will go into effect on January 1, 1995. This transition of that new treatment plan will not be placed on pending status while you appeal to the State of Florida."** Their intention was to coerce the new physician into signing the orders AvMed and Strube wanted.

34. Dec 27-29 1994 - I called FPL Human Resources to beg for help. It seemed everyone was powerless to prevent the crimes being committed. Scott Robinson called me at home and started spouting quotes from Steven Ziegler, Esq., AvMed's Miami attorney. When he repeated AvMed's LIES about having paid for David's hospital bed and expensive custom wheelchair, I exploded. I then told him I was wasting time with him and hung up. He called back, telling me angrily that he didn't like to be hung up on. I told him I didn't like to ignored when my son's life was threatened, and that if he kept defending AvMed's crimes, I would hang up again.

35. Dec. 30, 1994 - We selected Leonard Askowitz, M.D. as David's new PCP. He renewed the old orders. He has since also removed himself from David's case. Dennis Peterson and I had at that time both filed complaints with the Department of Business and Professional Regulation. Case numbers:9420668 & 9500489. After the BPR inspector observed Roger Strube making medical decisions, all three cases against him were completed. The Chief Medical Attorney of the Florida Agency for Health Care Administration found that in all three cases, probable cause exists to believe that Roger H. Strube was practicing medicine without a license and misrepresenting himself as a licensed doctor. He also finally issued Cease and Desist Orders for all three cases in February 1995.

At approximately this time, AvMed either fired Roger H. Strube or allowed him to resign. This despicable individual was then selected by CareFlorida as their Vice President and Chief Medical Officer for their operations throughout the entire State of Florida. I then convinced the Fort Lauderdale Sun Sentinel to publish an article regarding the Probable Cause findings on Strube. CareFlorida terminated him.

Finally, after dozens of letters to the State Attorney's Office and dozens of phone calls to Katherine Rundle, a single count of practicing medicine without a license has been filed against Roger Strube. It is Police Case # 951592, Court Case # F95032394 and is currently assigned to Herb Andrews at the SAO. His trial has been delayed several times.

Since this case began, our provider, Nations Health Care, and Roche Professional Services have merged. The pharmacist from Roche who always gave our nurses a hard time about everything the doctor ordered, is now the pharmacist at our provider. Karen Martel, R.N., the nurse from Roche who illegally obtained medical orders, is now a supervisor at this company. FPL, my employer, is undergoing "Strategic Review" (layoffs). Being self-insured, FPL could save lots of money by laying me off.

In the Spring of 1995 we had a hearing before the Statewide Providers & Subscribers Assistance Panel. AvMed's attorney, Mr. Cholodofsky, stated that the care being provided for David was not medically necessary. The doctor on the Panel asked Mr. Cholodofsky, WHO at AvMed was qualified to make that decision. The doctor asked FOUR times. He did not get an answer. The nurse on the panel asked Dr. Edelstein of AvMed., WHY anyone would ever consider reducing care to a patient whose conditions will not improve and can only get worse and who has a DO NOT RESUSCITATE order in place. She asked FIVE times and the main response was to complain about how complicated David's case was and that my letter writing made the case even more complicated.

Part of the BPR Case File on Strube is a letter obtained by the investigator simply to show how he signed his letters. Apparently, no one there had read it until I pointed out its contents. In it, Roger Strube clearly described how AvMed controls physicians financially. He states: "Patient complaints, member PCP changes, your office's cooperation with AvMed, and your office's compatibility with and support of the AvMed philosophy were used as modifiers which either increased, decreased, or did not change..." the physician's bonus. To me, that states very clearly, "Do what we tell you or you will not receive a bonus.

AvMed has used financial leverage in other ways. With the cooperation of Nations Health Care, Nursefinders' (nursing agency subcontracted by Nations) payments were delayed by up to six months. At one time the past due amount exceeded $200,000.00. This was a successful attempt to force the nurses to accept several dollars an hour less pay.

The January 22, 1996 TIME Magazine reports on a case in California where an arbitration panel found that telephone calls made to "influence or intimidate" the doctors was interference in the doctor-patient relationship. They decided this constituted "intentional infliction of emotional distress". They also determined that the California HMO's actions fit the legal definition of "extreme and outrageous behavior exceeding all bounds usually tolerated in a civilized society." I believe the actions of all the individuals/entities in our case exceed those described in the magazine and these people should be held legally and financially accountable.

As of April 25, 1996, we learned that AvMed, their Miami Attorney Steven Ziegler and Venturi Investigations have improperly, unethically and probably illegally, been attempting to gather information about me and my family. They have contacted our son's health care providers and used false statements in their efforts to induce cooperation. They have threatened to use subpoenas. AvMed is not charged with anything and therefore cannot subpoena anyone. We believe this is one more attempt to frighten or intimidate us into dropping every available avenue to pursue our rights under the law, and to see that justice is done, finally.

August 1, 1996
We have been told by Assistant State Attorney Paul Silverman that the charge against Roger H. Strube will be dismissed because he is only consulting and because the Florida Agency for Health Care Administration now claims there is no one at that agency to testify that Roger H. Strube's actions constituted practicing medicine. Trial date is still set for August 19, 1996.

August 2, 1996
Sent fax letter to Paul Silverman and a copy to Dade State Attorney Katherine Rundle, citing the Florida Supreme Court decision in Reams v. State, which states: "In prosecuting for practicing medicine without a license, State is required to prove only that defendant is not a licensed physician and that he practices within the statutory definition and exceptions to the act must be raised and proved by the Defense."

August 4,1996
Sent fax letter to State Attorney Katherine Rundle with a copy to Paul Silverman, citing the Florida Supreme Court decision, Florida Statutes, Black's Law Dictionary, and the Notice

of Dismissal/Closing Order for BPR Case 95. I stated clear concise methods to convict Roger H. Strube without expert witnesses. It is IMPOSSIBLE for Roger H. Strube to prove that he meets the exception requirements for consultants.

August 6, 1996
Sent fax letter to Katherine Rundle with copy to Paul Silverman, citing the Florida Constitutional Amendment, Article 1, Sec. 16(b) about crime victims having the right to be informed, to be present, and to be heard when relevant, at all crucial stages of criminal proceedings. I demanded to be heard at the motion hearing scheduled for August 19.

August 7, 1996
I called Paul Silverman to ensure the faxes had been received. He confirmed that he had received them and informed me that I would be heard at the hearing. He also informed me that it would probably be rescheduled for August 16 due to a conflict.

August 8, 1996
I called Paul Silverman to request more information about the Motion Hearing. He informed me that now there would be NO hearing at all. He plans to present a Nolle Prosequi to the judge and that will end the case. I asked if I would still be heard. He said probably not, since once he submits the Nolle Prosequi, the case ceases to exist. I informed him that there sure must be a lot of people who don't want me to be heard. Nobody in the State Government wants me "On the Record".

The Statewide Providers & Subscribers Assistance Panel did NOT get a transcript of our hearing. I had to order and pay for it myself. I have offered to meet with AvMed's attorneys. They refused. Roger H. Strube's attorneys have chosen to not depose me because I would then be "On the Record." Now the Dade State Attorney plans to further deprive me of my rights. Not only has Katherine Rundle REFUSED to file all charges against all persons/entities I have accused (and provided documentation for), she now plans to completely drop the only charge filed without my having a chance to be heard. Paul Silverman informed me that not only didn't he have to tell **me** why they were dropping the case, he didn't have to tell the Court and did not plan to.

Nobody wants my case to go to court because that will require a court ruling that the HMO medical director IS practicing medicine when he tells physicians what care to order or not to order. Most state laws are similar in defining "practice of medicine" and this decision would have national consequences. If the HMO medical directors, case managers, etc. are practicing medicine, then they must be properly licensed under the laws of the state where they are located. But the big thing the HMO's are afraid of is this. Those persons who would now have to be licensed physicians would also now be personally liable for malpractice civil suits. When a person is personally responsible for his actions, they are less likely to be as vicious in denying care as the HMO's want.

It sure seems like the criminals have all the rights while the victims have none. This is especially true if the criminals are huge corporations, managed care lobbyists, and high government officials.

That is why the "powers that be" are determined to shut me up.

Is this still the United States of America?

STATEMENT OF RENEE MCLEOD, MSN, RN, CS, CPNP
PRESIDENT
NATIONAL ASSOCIATION OF PEDIATRIC NURSE ASSOCIATES AND PRACTITIONERS

As president of the National Association of Pediatric Nurse Associates and Practitioners (NAPNAP), I am submitting testimony on behalf of over 5,000 Pediatric Nurse Practitioners (PNPs). We are health care providers dedicated to the care of children. We urge your swift action in support of legislation to prohibit "gag rules," restrictions on communication between health care providers and patients.

It is imperative that providers be allowed, if not encouraged, to share all treatment information with patients, even treatment options which may not be "covered" by a certain health plan. This is particularly important when children are concerned because children represent so much potential for life.

The Patient Right to Know Act, H.R. 2976, would prohibit health plans from having a policy which restricts medical communications between providers and patients. The bill would protect the right of the health care providers to speak freely and openly about the patient's physical and mental condition and/or treatment options. While we also believe that the patient has a right to know information relating to the financial arrangements between health plan and provider, we strongly support H.R. 2976 as passed by the House Commerce Committee.

Managed care health plans are doing a great deal to address one of the biggest problems in our health care system: rising costs. We recognize this, and agree that managed care can be a very positive option for millions of Americans. However, health care providers have a responsibility to look critically at health care systems, and work to make improvements wherever possible. We must make sure that above all else, the health and well-being of patients are given the highest priority and quality of care. The Patient Right to Know Act is a necessary step toward putting patients first. Communication between provider and patient is the first part of high quality care.

PNPs specialize in providing prevention education, routine physical exams and sick care for children. When a child has an illness that may require a specialist, communication with parents is critical. We have the benefit of experience and knowledge, and what we share with these parents about the kind of treatment options available can be the difference between life and death. Our efforts to share all the information available should not be affected by the health plan which employs us. If we cannot share information because a treatment option is not covered by the patient's plan, but may be covered by another, we are not fulfilling our commitment to that child, to those parents who put their trust in us. Communicating openly and freely with patients and parents is perhaps the greatest power we have as PNPs.

Communication is so important, not just for PNPs, but for all providers, patients, consumers, and for the future of the greatest health care system in the world. Yes, it is important to cut the rising costs of health care, but we must never forget the mission of health care providers, to provide the best care possible for patients.

The Patient Right to Know Act will ensure that the needs of patients come first, and that health care providers can fully address those needs regardless of health plan. We strongly support this legislation, and thank the Committee for holding this hearing. We urge you to move quickly in support of this important legislation. Patients, providers, and health plans all agree that open communication between providers and patients on medical treatment is in everyone's best interest. Please act on this opportunity to bring the Patient Right to Know Act one step closer to law.