California Eases Requirements for Workers' Compensation Insurers Under “Silent PPO” Legislation

After cracking down on the “silent PPO” industry in the state in 1999, the California Legislature recently revised the legislation to ease certain requirements for workers’ compensation insurers. Changes under the new legislation, effective January 1, include:

- eliminating the requirement that such insurers identify the network that actually holds the provider agreement permitting the insurer to pay a preferred rate, and
- requiring providers to explain why the insurer’s payment is not at the correct rate when questioning an insurer’s entitlement to the discounted rate.

Senate Bill 559 (SB 559), effective July 1, 2000, placed disclosure and other requirements on entities engaging in the “silent PPO” practice, essentially stopping “silent PPOs” from marketing and selling lists of provider panels that offer discounted rates. Senate Bill 1732 (SB 1732), effective January 1, revised the requirements of SB 559 applicable to workers’ compensation insurers, as discussed in more detail below.

Impact on Health Care Entities

Providers generally benefit from this legislation, which precludes third parties from selling a provider's discounted rates without the provider's knowledge, and requires payors (if claiming the discounted rates) to actively promote use of the provider's services to beneficiaries, unless the provider agrees otherwise. One additional burden placed on providers is the new requirement to state why a workers’ compensation insurer's payment is not at the correct rate when questioning an insurer's entitlement to the discounted rate. If such a statement is not included, the insurer is relieved of its obligation to demonstrate entitlement.

“Silent PPOs”

“Silent PPOs” refers to the practice of preferred provider organizations (PPOs) selling their reduced provider payment rates to payors (e.g., insurers) who are not party to the preferred rate agreements with provider panels and who do not provide incentives for their beneficiaries to see these providers. This practice has resulted in lost revenue for hospitals and physicians. Providers also objected to the practice because they never intended to extend their discounts to additional payors and were not being informed that their discounted services were being sold.
Legislative Intent
The California Legislature stated its intent to prevent the improper selling, leasing or transferring of a health care provider’s contract in enacting this new legislation. Specifically, the Legislature intended to stop the activities of “silent PPOs,” stating that “every arrangement that results in a payor paying a health care provider a reduced rate for health care services based on the health care provider’s participation in a network or panel shall be disclosed to the provider in advance and ... the payor shall actively encourage beneficiaries to use the network, unless the health care provider agrees to provide discounts without the active encouragement.” As set forth below, the Legislature amended pertinent provisions of the Business & Professions, Health & Safety, Insurance and Labor Codes to effectuate its purpose.

Restrictions on “Silent PPOs”
As amended, these Code Sections impose disclosure and other requirements on both contracting agents and payors.

Requirements for Contracting Agents
Every contracting agent that sells, leases, assigns, transfers, or conveys [hereinafter “transfers”] its lists of contracted health care providers and their contracted reimbursement rates to a payor or other contracting agent must do all of the following:

1. disclose to the provider whether the list may be transferred to other payors or contracting agents (specifying whether workers’ compensation or automobile insurers are included).
2. disclose specific practices, if any, payors use to actively encourage the payors’ beneficiaries to use the list of contracted providers when obtaining medical care that entitles the payor to the reduced rate.
3. disclose whether payors to which the list may be transferred may be permitted to pay the provider’s reduced rate without actively encouraging the payors’ beneficiaries to use the list of contracted providers when obtaining medical care.
4. disclose upon the initial signing of the contract, and within 30 calendar days (15 days under the Labor Code) of receipt of a written request from a provider or provider panel, a payor summary of all payors currently eligible to claim a provider’s contracted rate due to the provider’s and payor’s respective written agreements with any contracting agent.
5. allow providers on initial signing, renewal, or amendment of a provider contract to decline to be included in any list of contracted providers transferred to payors that do not actively encourage the payors’ beneficiaries to use the list when obtaining medical care. The provider’s selection is binding on the contracting agent the provider contracts with, and any contracting agent that obtains the list. A provider shall NOT be excluded from any list of contracted providers that is transferred to payors that actively encourage beneficiaries to use the list based upon the provider’s refusal to be included on any list of contracted providers that is transferred to payors that do not actively encourage beneficiaries to use the list.

Requirements for Payors
Every payor with exceptions for workers’ compensation insurers as set forth below, must do all of the following:

1. provide an explanation of benefits or explanation of review that identifies the name of the plan or network that has a written agreement signed by the provider whereby the payor is entitled, directly or indirectly, to pay a preferred rate for the services rendered.
Changes for Workers’ Compensation: Under the Labor Code, as amended by SB 1732, however, the payor must only identify the name of the network with which the payor has an agreement entitling them to pay the preferred rate for services rendered.10

2. demonstrate that it is entitled to pay a contracted rate within 30 business days of receipt of a written request from a provider who has received a claim payment from the payor. If the payor fails to demonstrate its entitlement in a timely manner it must then pay the provider the proper amount for services within 10 business days of written notice from the provider, and is prohibited from taking any discounts in the future without the provider’s express written consent until it can demonstrate its entitlement to do so. A payor is deemed to have demonstrated its entitlement if it:
• discloses the name of the network that has a written agreement with the provider for discounted rates and describes its specific practices to actively encourage beneficiaries to use the list when obtaining medical care, or
• identifies the provider’s written agreement with a contracting agent whereby the provider agrees to be included on lists of contracted providers transferred to payors that do not actively encourage beneficiaries to use the list.

Changes for Workers’ Compensation: Under the Labor Code, as amended by SB 1732, the provider must also include in its request a statement explaining why the payment is not at the correct contracted rate for the services provided or the payor is relieved of its duty to demonstrate its entitlement. In addition, a payor is deemed to have demonstrated its entitlement if it:
• describes the specific practices it uses to actively encourage beneficiaries to use the provider list when obtaining medical care and demonstrates compliance with the disclosure requirements regarding transfer of the list, or
• identifies the contracting agent with whom the payor has a written agreement whereby the payor is not required to actively encourage employees to use the list of contacted providers.

Senate Bills 559 and 1732

SB 559
SB 559 made the initial changes to the law to stop the “silent PPO” phenomenon beginning July 1, 2000, by imposing the disclosure and other requirements discussed above on contracting agents and payors.

SB 1732
SB 1732, chaptered into law on September 30, 2000 and effective January 1, made the following changes applicable to workers’ compensation insurers and made other non-controversial technical changes to the law:
• Workers’ compensation insurers are not required to (i) identify the name of the network that has a written agreement signed by a provider entitling the insurer to pay discounted rates (rather, the insurer must only identify the name of the network with which the insurer has an agreement), and (ii) identify a provider’s written agreement with contracting agents whereby the provider agrees to be included on lists of providers transferred to insurers that do not actively encourage employees to use the list (rather, insurers must only identify the contracting agent with whom the insurer has an agreement).
• Contracting agents that transfer lists of providers and their contracted reimbursement rates to payors must: (i) maintain a toll-free telephone number and a Web site to provide each provider with access to a summary of all payors currently eligible to claim the provider’s contracted rate, and (ii) disclose to contracted providers any transfer of the rates to another contracting agent or payor.
Health care providers that request that an insurer demonstrate its entitlement to pay a discounted rate must include a statement in the request explaining why the insurer’s payment is not at the correct contracted rate. Failure to include the statement relieves the insurer from its responsibility to demonstrate entitlement to the discounted rate.

Catalyst for the SB 1732 Changes
According to a bill analysis available on the California Legislature’s Web site,11 these changes with respect to workers’ compensation insurers were initiated by an insurance company that felt it was inappropriate to place the burden of policing the contractual arrangements between PPOs and providers on workers’ compensation insurers, particularly given that workers’ compensation law has a statutory process to dispute billings (the workers’ compensation lien procedure under the Workers’ Compensation Appeals Board) already in place. In addition to being unnecessary and redundant given these existing procedures in workers’ compensation law and the disclosure already required of contracting agents under the new law, workers’ compensation insurers do not have the ability to provide information on agreements between providers and contracting agents because they are not parties to such agreements and otherwise have no access to them. As such, SB 1732 revised provisions of the Labor Code applicable to workers’ compensation insurance to reflect these concerns.

Conclusion
The changes enacted by these two bills help ensure that providers are aware of all payors subject to the given provider’s discounted rates. The practice of third parties selling the rates without the provider’s knowledge is precluded. In addition, the legislation helps ensure that payors using the discounted rates will actively promote to their beneficiaries’ use of medical services from provider’s offering the reduced rates, unless the provider waives this requirement. Providers must explain why they believe an insurer’s rate is not correct when requesting demonstration of entitlement from a workers’ compensation insurer, or the insurer is relieved of its obligation to demonstrate entitlement.

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3 In addition, Cal. Labor Code Sec. 4603.2, covering payment to physicians for patients under workers’ compensation, is amended.
4 “Contracting agent” is defined in the Cal. Bus. & Prof. Code as a third party administrator or trust not licensed under the Health & Safety Code, the Insurance Code, or the Labor Code, a self-insured employer, a preferred provider organization, or an independent practice association, while engaged, for monetary or other consideration, in the act of selling, leasing, transferring, assigning, or conveying, a provider or provider panel to provide health care services to beneficiaries. It does not include a health care service plan, specialized health care service plan, an insurer licensed under the Insurance Code to provide disability insurance that covers hospital, medical or surgical benefits, automobile insurance, or workers’ compensation insurance or a self-insured employer. See Cal. Bus. & Prof. Code Sec. 511.1(d)(2). “Contracting agent” has more limited definitions in the Cal. Health & Safety, Insurance and Labor Codes.
5 A “payor” is defined in this subsection as a health care service plan, a specialized health care service plan, an insurer licensed under the Insurance Code to provide disability insurance that covers hospital, medical, or surgical benefits, automobile insurance, workers’ compensation insurance or a self-insured employer that is responsible to pay for health care services provided to beneficiaries. See Cal. Bus. & Prof. Code Sec. 511.1(d)(3)(A).
6 Active encouragement is deemed to have occurred if the payor offers its subscribers or insureds direct financial incentives (e.g., reduced copays or deductibles, discounts for use of the provider panel, penalties for nonuse of the provider panel) to use the list of contracted providers or if the payor provides information directly to beneficiaries (or the employer in the case of workers’ compensation), prior to selection of a health plan.
care provider, of the existence of the list of contracted providers
through advertising or marketing approaches such as provider directories,
toll-free telephone numbers or internet web site addresses that include
the name, address and telephone number of contracted providers.
Internet Web site addresses alone do not satisfy the requirement, but
contracting agents or payors may provide only listings of providers in
a reasonable geographic area to the beneficiaries. See Cal. Bus. & Prof.
Code Sec. 511.1 (b)(2). The requirements under Cal. Labor Code
Sec. 4609 vary slightly.

7 Payors need not actively encourage use of providers on the list for

8 “Payor summary” is defined as a written summary that includes the
payor’s name and type of plan (e.g., group health plan, automobile
Code Sec. 511.1(d)(4).

9 “Payor” is defined in this subsection to include only those entities
that provide coverage for hospital, medical or surgical benefits that are
definition is limited to health care service plans in the Cal. Health &
Safety Code, insurers in the Cal. Insurance Code and entities responsible
for paying for work-related injuries under the Cal. Labor Code.
See Cal. Health & Safety Code Sec. 1395.6(d)(3)(B); Cal. Insurance

10 See Cal. Labor Code Sec. 4609(c)(1).

11 See Bill Analysis of SB 1732, Senate Rules Committee, Office of
Senate Floor Analysis (available on California Legislature website:
www.leginfo.ca.gov).
If you have any questions about this Client Alert, please contact any of the attorneys listed at the right.

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