NANCY VANDERMEER

STATE REPRESENTATIVE • 70TH ASSEMBLY DISTRICT

TO: Honorable Members of the Senate Committee on Insurance, Housing and Trade

FROM: State Representative Nancy VanderMeer

DATE: October 11, 2017

SUBJECT: Testimony in Support of 367

Thank you Chairman Lasee and members of the Senate Committee on Insurance, Housing and Trade for holding a hearing on Senate Bill 367 today. As the author of this legislation, along with Senator LeMahieu, I am pleased to offer testimony in support of the bill.

Senate Bill 367 sets requirements on certain health insurance plans that rent networks of dental service providers to other entities. Like many other medical providers, dentists sign agreements with insurance or dental benefit companies to provide services at set rates. Dentists then agree to see patients in that particular company's network. Unfortunately, across the country and in Wisconsin in particular, dentist's contracts with dental benefit companies are being rented to other networks with whom the dentist never signed a contract. The process is known as "network rental" or "silent PPO". These rentals can take place without the dentist's knowledge or consent. Additionally, some dentists have found that their fee schedules in the new networks differ from their original agreed upon contract.

The issue this poses for dentists is that as a result, they can end up being contracted to provide services with a network they never joined, while at the same time being paid less than their agreed-upon rate. On top of that, as it exists right now, these contract changes can happen without their knowledge or consent. The first time a dentist usually finds out that their contract has been rented is when patients from the new network start calling to book appointments, because the dentist now appears as an in-network provider.

Current law is silent on this issue. In order to provide fairness and transparency for dentists, this bill does the following:

- A dental benefit/insurance company must notify a dentist within 45 days of rental that their services have been rented, and to whom;
- The benefit/insurance company must maintain a listing of networks to which they rent;
- Requires that the terms of the original contract, including agreed-upon fees, apply to any rental; and
- The dentist must be able to opt out of a rental after they have been notified.

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STATE REPRESENTATIVE • 70TH ASSEMBLY DISTRICT

In closing, I'd like to share that this issue especially resonates with me as a small business owner. I think that many people forget that dentists are not only healthcare providers, but they're business people too, and many times small business people. As a small business owner, you're not only responsible for delivering on the service you provide, but you're also responsible for turning a profit on your services. The latter (turning a profit) doesn't come without the former (delivering on the service you provide).

Most business owners have a desire to provide fairness and transparency for their clients, and they expect the same fairness and transparency from the people they work with (their vendors, suppliers, etc.), and this bill provides that. I ask that you join Senator LeMahieu and myself in support of this legislation.

Again, thank you for the opportunity to submit testimony on this important legislation. I unfortunately could not attend the hearing today because of a need to be in my district, attending to my small business. If questions, comments, or concerns come up with the legislation that I can address, I'd be happy to respond to them at a later date and make the information available to all committee members.

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October 11, 2017

Testimony On SB 367
Senate Committee on Insurance, Housing, and Trade
Director of Government Services, Matt Rossetto

Dear Chairman Lasee and committee members,

Thank you for holding this hearing and providing us with the opportunity to testify in favor of SB 367. This legislation is before you today because we believe that, as medical practitioners and small business owners, it is imperative that dentists are aware at all times of the networks in which they are contracted to participate.

The practice we are referring to is generally called "network rental", or "silent PPO". In essence, dental benefit companies are renting out their networks to other benefit companies without the knowledge or consent of the dentists involved. This means that dentists find themselves as members of provider networks that they never agreed to join. In many cases, even if dentists do decide to see patients from these new networks, the dentist finds that their original fee schedule is not adhered to. This means that they get paid less than the amount they originally contracted for.

Further complicating matters is that, if the dentist does not want to see patients from this new network, they are not always given the option of leaving that network. Some entities allow the dentist to opt out, while others do not. The only ultimate solution is to cancel the contract with the original insurance company, which most dentists do not wish to do.

For this reason, we are supportive of SB 367, which would allow for basic fairness and transparency by doing the following:

- Requiring a dental benefit company to notify a dentist within 45 days that their contract has been rented, and to whom;
- The benefit company must maintain a regularly-updated listing of networks to which their services are rented;
- The terms of the original contract, including the agreed-upon fee schedule, must apply with any rental;
- The dentist must be able to opt out of the rental after they have been notified.

The thing to remember is that this bill places zero restrictions on the practice of network rental. It does not tell insurance companies when or how they may rent the contract. This bill is about notification. Most importantly, it does not impact currently existing contracts.

As you are likely aware, OCI must prepare a social and financial impact report on bills that could affect issues in this area. On August 24th, Commissioner Nickel issued an explanatory letter regarding why OCI would not be submitting a full report. It reads, in part, "As currently written, the proposed legislation will not impact an insurance policy, plan, or contract. More specifically, while this bill may impact consumers, it will not impact their contract with an insurance provider."

This legislation specifically provides that it does not apply to currently existing contracts, so as to avoid causing undue burden to dentists and insurance companies alike.

Our thanks go particularly to Representative VanderMeer and Senator LeMahieu for their authorship of this legislation. We appreciate your attention and I am happy to answer any questions you may have.

Matt Rossetto
Director of Government Services
mrossetto@wda.org
608-250-3442

SB 367 Testimony

Submitted by Ed Chiera

My name is Ed Chiera. I'm a general dentist in Beloit, WI testifying in favor of Senate Bill 367. The practice of insurance companies leasing contacts out to other entities has a direct impact on our office. We are a preferred provider for a number of PPO programs since that's what most employers in our community offer. In the past our office would have the opportunity to negotiate fee schedules with insurance companies. If we could not reach an agreement, we would drop the plan. Now we are experiencing parent companies leasing us back into plans we've dropped. It's like an arranged marriage with someone you just divorced.

So, why as a Legislator should you care? It is difficult to participate in every single PPO and run a thriving practice. As it stands now, the only way out is to drop all PPO's by way of dropping the parent company. I would prefer not to do this. I personally would be OK downsizing my practice. However, half of my staff would be out of a job and too many patients would be displaced.

Providers need to be at the table to determine what insurance programs fit their office. Silent PPO contract leasing, in my opinion, is an abuse of anti-trust immunity. There ought to be a law.

Those opposing this bill will state that it is government intrusion on a private matter. However, that intrusion has already occurred with insurance companies being granted anti-trust immunity. Opposition will also state that this could be settled within the insurer/provider contract. The problem is that contract leasing is occurring after contract agreements with no language to support it. Creating this legislation will provide a fair way to negotiate this matter.

Thank you for your attention to this matter.

Sincerely,

Ed Chiera,DDS
2149 Pioneer Dr.
Beloit, WI 53511

LRB-3819/1

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott Walker, Governor
Theodore K. Nickel, Commissioner

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August 24, 2017

Senator Scott Fitzgerald
Senate Majority Leader
Room 211 South
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P.O. Box 7882
Madison, WI 53707

Representative Robin Vos
Speaker of the Assembly
Room 211 West
State Capitol
P.O. Box 8953
Madison, WI 53708

Re: Social and Financial Impact Report—2017 Senate Bill 367 and 2017 Assembly Bill 457 relating to dental provider network rental by insurance plans

Dear Majority Leader Fitzgerald and Speaker Vos:

Pursuant to s. 601.423, Wis. Stat., I am submitting this letter regarding a social and financial impact report on 2017 Senate Bill 367 and 2017 Assembly Bill 457 relating to dental provider network rental by insurance plans.

The proposed legislation creates various changes in the contractual relationship between dental providers and a provider network. As currently written, the proposed legislation will not impact an insurance policy, plan or contract. More specifically, while this bill may impact consumers, it will not impact their contract with an insurance provider. For this reason, my office is not intending to prepare a social and financial impact report as allowed under s. 13.0966 (2) (b), Wis. Stat.

If you disagree with our interpretation, have questions or concerns, we welcome the opportunity to discuss. You may contact Elizabeth Hizmi at (608) 267-9460 or elizabeth.hizmi@wisconsin.gov.

Respectfully submitted,

Theodore K. Nickel
Commissioner

cc: The Honorable Scott K. Walker, Governor of Wisconsin

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AMERICAN MEDICAL NEWS

Silence of the PPOs: A stealthy way to pay you less

■ A "silent PPO" is actually a process in which physicians suddenly find themselves on a health plan they didn't sign up for. And it's bigger than ever. Here's why, and what physicians can do about it.

By — Posted Sept. 19, 2005

Silent PPOs are the leaky faucet of the health plan world. They drip, drip, drip money away from physicians' practices, slowly enough that it seems as if fixing the leak is not worth the expense.

But a leaky faucet eventually turns into a running faucet, which turns into a gusher. And that's what's starting to happen with silent PPOs. Organized medicine, including the American Medical Association, is reporting a skyrocketing number of complaints about silent PPOs, a term used to describe when physicians think they're treating a patient under one contract, only to get a statement later that puts the patient on some other, lower-reimbursing plan. The AMA estimates anywhere from a $750 million to $3 billion annual loss to physicians caused by silent PPOs.

Fixing the leak is now very much worth it. Organized medicine has launched campaigns for increased state regulation or legislation aimed at unsilencing the silent PPOs.

"It's an issue of fairness," said J. James Rohack, MD, the AMA's immediate past board chair, who in the past few months has spoken before the National Assn. of Insurance Commissioners and the National Council of Insurance Legislators on silent PPOs, among other contract issues.

Silent PPOs are not making health care more affordable, but instead are "taking money out of what could be paid for health care. ... It's affecting the doctors, and it will affect more and more the citizens of every state. It's a system that's evolved to be difficult to understand and shrouded in secrecy," he said.

Silent PPOs have been a source of physician chagrin for about 10 years, but depending on which physicians, organized medicine representatives, consultants or other industry-watchers you talk to, their re-emergence can be blamed on some combination of insurer consolidation, growing patient PPO membership, a lack of PPO regulation and corporate pressure to reduce rising health care costs.

That last point -- corporate pressure to reduce rising health care costs -- is what makes a market in the first place for companies who call themselves "repricers," said Joseph

Paduda, a Madison, Conn.-based health care consultant who formerly was a health plan executive handling workers' compensation -- a popular target for silent PPOs.

"What's happening is employers are looking for any way they can to save money," Paduda said. "And silent PPOs are going to get bigger, because it's a very high-margin business."

Stacking contracts

A silent PPO works kind of like that 1970s ad for shampoo, the one in which a sudsy-haired woman said the world would be beautiful if "you tell two friends, they tell two friends, and so on, and so on." In a silent PPO, you sign a contract with one plan, which can rent your name to another network, which can rent your name to another network, and so on, and so on.

That's a gross oversimplification, but detailing the exact particulars of how your name gets shopped around can be eye-glazingly difficult. Here's a couple of examples of how it works in practice.

Say you're treating a patient under a worker's compensation or auto insurance claim. In most states, there's a price, dictated by law, as to what you must be paid for your work by the insurance carrier. But if the insurance carrier can glom onto a PPO network you've enrolled in, then it can pay you a lot less. So the carrier goes to a contracted repricer, whose job it is to reduce a company's health costs by affiliating with many networks and selecting the least expensive one in which a physician's name pops up. So you've just unwittingly given a discount to someone you never intended.

Also, say you're treating a patient who is part of a corporation's self-insured PPO. It's similar to the workers' compensation scenario -- the third-party administrator handling the PPO's administration goes to a contracted repricer to see if you're part of another, cheaper PPO network. If so, then you've just unwittingly given a discount to someone you never intended.

In any case, you don't realize that you've been put in a silent PPO until you get an explanation-of-benefits form carrying the name of an insurer you've never heard of. Those insurers, Dr. Rohack says, are counting on the fact that you won't do the legwork to figure out where they came from. That's because physicians generally judge, correctly, that the time and money they would spend to track down such individual claims isn't worth the nickels and dimes lost on them.

"With so many transactions, it's easy to screw 4.5% out of billing," said Mark Piasio, MD, an orthopedic surgeon in DuBois, Pa., who has noticed some silent PPO activity in his practice.

Dr. Rohack blames insurer consolidation for the rise in silent PPO activity. Paduda explains it like this: As WellPoint and United Health Group grow into massive national companies, independent PPOs don't have the resources to build their own insurance plans. So independent PPOs instead "rent" names from other PPOs to build their own networks, then sell the use of those networks.

Also, those in the business of building networks and repricing health care are themselves getting larger, as witnessed by Texas-based Concentra Operating Corp.'s August announcement that it would buy Beech Street, an independent, California-based PPO company, for $165 million. Concentra, which among other things collects a percentage from corporate clients for every dollar it can reprice and save them on health care costs, did not return calls seeking comment.

Finding doctors on PPO lists, too, has become much easier as, in the last few years, a majority of private-pay patients have enrolled in those plans over HMOs.

The idea of a PPO, for a physician, was to give a discount in exchange for patient volume, but with so much horse-trading of contracts going on, Paduda says, "if everybody's in a network, you're not getting volume."

Regulating the silent PPOs

Companies in the business of renting networks and repricing services don't call themselves "silent PPOs" -- that's a pejorative term that comes from physicians. Generally, the companies claim they wring savings out of the health care system, though physicians argue that the savings goes nowhere but those companies' own pockets.

Physicians ask themselves: Why do insurers do this, and how do they get away with it? The answer to both questions is because they can. "It's a situation where an industry like the insurance industry, if they get away with a manner of reducing medical expenses, they'll do it," said Carlin Phillips, a North Dartmouth, Mass., attorney who has represented numerous parties filing lawsuits regarding silent PPO activity.

North Carolina is considered to be the only state defining silent PPOs as an "unfair trade practice," and the AMA was successful a few years ago in getting silent PPOs banned from all Federal Employee Health Benefits Plan contracts. In other states that regulate silent PPO activity, such as Texas and Florida, the laws don't ban silent PPOs outright, but they do try to make them less silent.

For example, a few years ago, Texas passed a Texas Medical Assn.-backed bill that requires any insurer to put on the back of a patient's card any secondary insurer it has for repricing. "I can look and say, 'I didn't sign up for that group,' and I know the discount is not properly applied," says Dr. Rohack, a cardiologist in Temple, Texas.

Florida requires that any personal-injury claim can pay physicians based on a PPO discount only if the worker's compensation or auto insurer or other such company has a direct PPO contract with the physician. But "direct" means different things to different courts in Florida, with rulings stating that an insurer must have a signed deal with a physician, and others ruling that a physician getting lumped in with a company-affiliated repricer can be deemed to have a "direct" contract.

Still, other states are considering legislation to put some sort of reins on silent PPOs. Dr. Piasio, in his role as vice president of the Pennsylvania Medical Society, testified to the Pennsylvania House of Representatives Insurance Committee about silent PPOs and other contracting practices in support of a bill promoting contract reform in health care. The California Medical Assn. is pushing legislation in its home state that would require more

insurer disclosure on repricing contracts, limit how many times a network may be sold, and create other means to cut down the reach of silent PPOs. Both bills are pending.

For now, Phillips says, the best protection physicians have against silent PPOs is their own vigilance. First, in making sure the PPO contracts they want are defined as specifically as possible to ensure that the plan is not given carte blanche to sell a physician's name -- and discounts -- to as many networks as possible. For example, Phillips says on his Web site that the word "payer" should not be left to include "every possible payer under the sun. If you do that, you may as well open up your wallet and start handing out money to every insurer in the country."

Phillips also advises physicians to watch their EOBs, and to send them out for audits to see if there are patterns emerging as to where the silent PPOs are coming from. After all, one of the best ways to take care of a leaky faucet is to know what's causing it to drip.

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ADDITIONAL INFORMATION

Penny-wise

For every dollar that a physician bills for a medical service, about two-thirds is eaten up by health plan "pricing edits."

Unauthorized discounts and other fee schedule adjustments	54 cents
Payer's adjustments and denials	3 cents
Adjustments based on CPT, CCI and Medicare	3 cents
Patient's co-pay	6 cents
Payer's check to you	34 cents
Total	**$1**

Source: AMA report using National Healthcare Exchange Services data

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EXTERNAL LINKS

Phillips & Garcia law firm's guide to silent PPOs (**link**)
June 13 testimony of past AMA Chair J. James Rohack, MD, to the National Assn. of Insurance Commissioners regarding contract transparency, in pdf (**link**)
May 12 testimony of Mark Piasio, MD, to Pennsylvania legislators regarding silent PPOs and other contracting issues (**link**)

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Wisconsin Association of Health Plans

The Voice of Wisconsin's Community-Based Health Plans

Testimony Presented to the
Senate Committee on Insurance, Housing and Trade
In Opposition to Senate Bill 367
October 11, 2017

Chairman Lasee, Ranking Member Bewley—thank you for the opportunity to testify in opposition to Senate Bill 367.

My name is Tim Lundquist and I am the Director of Government and Public Affairs at the Wisconsin Association of Health Plans. The Association is the voice of 12 Community-Based Health Plans that collectively do business in every county in Wisconsin. Association health plans provide health insurance coverage to individuals, employers, and government programs.

Community-Based Health Plans oppose Senate Bill 367 because government should not dictate the terms of contracts between private parties.

Senate Bill 367 impairs contractual rights by requiring contracts between two private parties contain provisions to the benefit of one. Market economies work best when private parties freely agree to the terms of their business arrangments.

Dental practices, like any business, negotiate the terms of their contracts. If dentists value the provisions of Senate Bill 367, they should negotiate for them. If dentists seek to preserve additional control over future participation in rental networks, they should negotiate for that control.

It is unfair to instead seek legislation to enact more regulations and more government mandates.

Senate Bill 367, if approved, creates a troubling precedent where government begins to negotiate and determine the terms of contract between private businesses.

Community-Based Health Plans are opposed to Senate Bill 367.

Thank you again for the opportunity to testify.

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October 11, 2017

Senator Frank Lasee
Chair, Senate Committee on Insurance, Housing and Trade
Room 316 South
Wisconsin State Capitol
Madison, WI 53702

Re: OPPOSE – S.B. 367 – Dental Provider Network Rental by Insurance Plans

Dear Chairman Lasee:

I am writing on behalf of America's Health Insurance Plans (AHIP) to express our concerns with proposed legislation before your committee that threatens to diminish access to high-quality dental provider networks for Wisconsinites. AHIP is the national association whose members provide insurance coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

Prior to formal introduction of S.B 367, we opposed this bill along with a robust coalition of associations that represent not only health insurance companies, but the employers that provide coverage to Wisconsin workers. The purpose of our collective effort was to inform members of the legislature about the drawbacks of this bill, which could endanger the health and stability of the private market for dental benefits in your state. This legislation provides no benefits to justify the risks and we therefore continue our opposition to this bill.

Health plans – both dental and major medical – have taken important steps over the last several years to address the critical issues of increasing access to innovative, affordable quality care and cost control mechanisms that would better allow individuals and businesses to obtain insurance coverage in the private market. It is important to note that the dental insurance segment of the market differs greatly from the comprehensive major medical market. Legislative proposals must take these differences into account to avoid unintended harms to the market. One primary factor to consider is that premiums for dental plans are much lower than major medical premiums, despite the similarities in fixed costs. Accordingly, there is little room for dental carriers to absorb the impact of onerous new legislative or regulatory burdens and therefore the cost benefit of the change should be rigorously reviewed when assessing whether new laws will provide sufficient consumer benefit to justify this risk.

The legislation before your committee does not clear that hurdle. The purpose of S.B. 367 is not to benefit consumers, but to permit providers to circumvent the contractual process already

governed by statutory and common law. As part of this process, many dentists agree to permit dental plans to provide other parties with access to their networks in order to enhance the options available to employers and consumers. The benefits of this are not one-sided – dentists also gain access to new market segments and the revenue that comes with it, and consumers are able to access broader networks. This mutual benefit is the reason that both dental plans and dentists voluntarily agree to enter into these contractual arrangements.

The legislation in question seeks to disrupt the balance of free-market negotiations by permitting dentists to pick and choose provider networks, regardless of their contractual obligations. In the absence of agreement between both parties, in-force contracts should remain undisturbed and the right of private parties to negotiate contractual language should be paramount. The best way for contracting parties to compromise in a manner that benefits all involved is to address these contract issues through direct negotiations and not through legislative directive.

We are further concerned by language in the bill that would create new administrative requirements that could endanger the health of the private dental insurance market. Given the low margins with which dental plans operate, the magnitude of new administrative costs is much greater than with comprehensive major medical coverage. New government rules that are perceived as insignificant can have dramatic effects on the market. Provisions of the bill mandating the creation of new Internet websites and dictating the communications between dental plans and dentists provide no benefit to the people of Wisconsin and will only drive up administrative costs for dental coverage in the state.

While we appreciate the desire of Wisconsin legislators to ensure the integrity of contractual arrangements, this particular intervention will benefit a small group of dental providers at the expense of dental plans, patients, and the broader market. For this reason, we respectfully oppose S.B. 367.

Thank you for the opportunity to communicate with you concerning AHIP's concerns with the proposed legislation.

If you have any questions, please do not hesitate to contact me at jkeepes@ahip.org or (202) 778-8477.

Sincerely,

Joshua Keepes, J.D.
Regional Director