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Lori Bielinski, Executive Director
Washington State Chiropractic Association
21400 International Blvd. Suite 207
SeaTac, Washington 98198

Dear Lori,

Below is my review of the latest ACN group provider agreement [UHIC/PROVDR-2005]. The provider agreement is filed under United HealthCare Insurance Group. This revised contract follows the WSCA complaint and objection to the prior contract which was approved and then approval withdrawn by the Washington State Insurance Commissioner (OIC).

The new contract violates a long standing filing requirement of the OIC that provider agreements incorporate additions and deletions rather than amend through an addendum to an existing contract. Rather, the contract must incorporate the Washington requirements.

(2) ... All changes to contracts must be indicated through strike outs for deletions and underlines for new material. *Alternatively*, carriers may refile a sample contract that incorporates changes along with a copy of the contract addendum or amendment and any correspondence that will be sent to providers and facilities sufficient for a clear determination of contract changes... [WAC 284-43-330]

To understand the contract, the provider must read the base agreement and integrate Schedule A "Washington Regulatory Requirements" – a daunting task even for a lawyer since the two documents are incompatible. For example, the Washington requirements only apply to "Covered Services rendered to Members in the state of Washington." Thus, the Washington regulations do not apply to services to Members who live outside of Washington e.g. Portland even if they obtain services in Washington. Moreover, a provider must determine which of the ACN plans are subject to the Washington rules.

In another example comparing the base agreement §3.1 to "Schedule A" §14 governing, in part, retrospective claim denial, you will find these conflicting statements:

§3.1 Plan retains the right of final verification of eligibility and this verification supersedes any previous approval of care, verification of eligibility, and/or claims payment review.

§14 In the event Carrier offers a Benefit Plan that is governed by RCW 48.43.525 or WAC 284-43-410(3), ACN will comply with the applicable retrospective claim denial requirements as set forth in RCW 48.43.525 and WAC 284-43-410(3) which prohibit retrospective denial of coverage for emergency and nonemergency care that had prior authorization under such plan's written policies at the time the care was rendered.

How will a provider know which of these two conflicting provisions apply to coverage authorized by the Carrier? An eligibility decision may or may not be retrospectively denied depending upon state jurisdiction of the particular plan and an analysis of the state law in the particular circumstances of the claim. Moreover, the Washington state law only applies to plans offered by United Health Care and not to the plans of any other carrier “renting” the ACN network. This is critical since a health care practitioner is bound to provide care to Members defined to mean a person covered under any plan that United Health Care authorized to access the network [the definition of “Plan” is defective in any case.]

Provisions of the Base Agreement

§1 “Plan” is defined as an individual or entity authorized by the Carrier to access one or more networks of Participating Providers developed by ACN. “Benefit contract” is defined as a “benefit plan”. Traditionally and under state law, “plan” is defined as “any individual or group policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care service” [WAC 284-43-130(15)]. Under the contract, “Plan” literally includes a plan member or beneficiary. By its novel definition of “Plan”, the contract creates bizarre interpretations and consequences.

§3.1 The provisions of §3.1 demonstrate the strange application of the definition of “Plan” in the following sentence. “Plan retains the right of final verification of eligibility and this verification supersedes any previous approval of care...” Inserting the definition terms in place of the word “Plan”, you get this statement – “The person authorized by Carrier to access [the network] retains the right of final verification of eligibility...” Of course, this is not true since the Schedule A amendments establish different standards for certain Members covered under plans offered by United Health.

§3.3 Provider is required to comply with the provisions of the ACN Operations Manual. The OIC analyst worksheet states unequivocally that “the provider agreement should be a complete document and not reference additional documents, administrative manuals, or procedures not contained in the provider agreement submitted for approval.” [OIC Analyst Checklist found at: http://www.insurance.wa.gov/publications/health/worksheets/Analyst_Worksheet_ProviderAgrmnt_03-15-06.pdf]

The purpose of the rule is not only to give notice to providers contracting with the Carrier but also, to allow the regulatory analyst to determine whether under the particular provisions of a “manual”, a provider is required to adhere to a standard violating state law. These provisions are extended to a great extent in §3.4 which requires a provider to comply with a wide range of standards outside the contract including “the Operations Manual, or other documents of ACN, Carrier, or Plan, as amended from time to time.” Why should a Carrier file a contract amendment when the Carrier can simply amend procedures? Of course, all of these provisions are subsequently amended by §3 of Schedule A which establishes a different standard for provider notice of and agreement with “administrative” changes depending upon state jurisdiction of the plan.

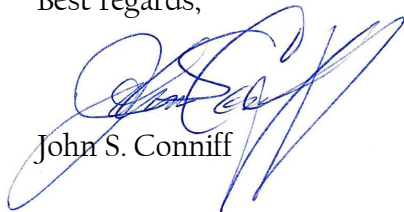
§4 Provisions governing payment to provider are substantially swallowed up by the provisions of Schedule A §§ 5, 6, and 8. For example, §4.3 limits the Carrier’s obligation to pay additional

amounts under claims to a 12 months following the initial claim payment while Schedule A extends this to 24 months under certain circumstances and for certain plans.

§10.9 The most unusual and potentially problematic provision of the base contract stipulates that “Additional and/or alternative provisions, if any, related to certain Covered Services rendered by Provider to Members covered by certain Benefit Contracts that are not contained in the Plan Summaries are set forth in the Appendices.” This clause is subject to many different interpretations some of which may even violate ERISA on its face, e.g. an employee’s Plan Summary cannot be amended without notice to the employee by a requirement in a provider agreement. Moreover, the entire clause is supplanted by §2c of Schedule A; but, Schedule A applies to only certain contracts subject to OIC jurisdiction. Will the Carrier be supplying a list of plans that are or are not subject to Schedule A?

For the foregoing reasons, I recommend that the WSCA object to this contract as failing to satisfy Washington regulatory requirements.

Best regards,



John S. Conniff