VOLUME NO. 46 OPINION NO. 9

CONTRACTS - Application of competitive bid requirements to health maintenance organization contracts;
HEALTH - Application of competitive bid requirements to health maintenance organization contracts;
INSURANCE - Application of competitive bid requirements to health maintenance organization contracts;
STATUTORY CONSTRUCTION - Application of competitive bid requirements to health maintenance organization contracts;
MONTANA CODE ANNOTATED - Title 33, chapter 22, part 17; title 33, chapter 31; sections 33-22-1702 to -1704, 33-31-102, -111, -201, -221;
MONTANA LAWS OF 1987 - Chapter 638;
OPINIONS OF THE ATTORNEY GENERAL - 46 Op. Att'y Gen. No. 8 (July 21, 1995), 46 Op. Att'y Gen. No. 6 (July 6, 1995), 45 Op. Att'y Gen. No. 25 (June 21, 1994).

HELD: Health maintenance organizations operating under the provisions of Mont. Code Ann. title 33, chapter 31, are not bound by the competitive bidding requirements of Mont. Code Ann. § 33-22-1704(3) in contracting with health care providers, except when entering into a preferred provider agreement as authorized by that section.

November 6, 1995

The Honorable Bob Brown
President, Montana State Senate
333 Cougar Trail
Whitefish, MT 59937

Dear President Brown:

You have requested my opinion on an issue I have phrased as follows:

> Do the competitive bidding requirements of Mont. Code Ann. § 33-22-1704(3) apply to the contractual arrangements of health maintenance organizations governed by Mont. Code Ann. title 33, chapter 31?

The issue arises from an opinion of the state insurance commissioner, concluding that health maintenance organizations [HMOs] are subject to the Preferred Provider Agreements Act, Mont. Code Ann. tit. 33, ch. 22, pt. 17 [PPA Act], and accordingly "must seek bids for the provision of health care services." Letter from Ins. Comm'r Mark O'Keefe to Mark A. Burzynski (Apr. 24, 1995). The commissioner's conclusion was based primarily on the inclusion of HMOs in the PPA Act's definition of "health care insurer," Mont. Code Ann. § 33-22-1703(3), and the broad terms in which "preferred provider agreement" is defined, Mont. Code Ann. § 33-22-1703(7). Citing a contrary opinion from the Montana Legislative Council, the sponsor of the 1993 competitive bidding amendments to the PPA Act requested that you seek an opinion from this office.

Some understanding of HMOs and preferred provider agreements is helpful to resolution of your inquiry. Both the Montana HMO Act and the PPA Act were passed in 1987 in an effort to promote cost containment and efficiencies in the health care system. See 50th Mont. Leg., Sen. Pub. Health, Welfare & Safety Comm., Feb. 20, 1987, at 5 (statement of Sen. Regan, sponsor of S.B. 371); House Bus. & Labor Comm., Mar. 20, 1987, at 3 (statement of Sen. Meyer, sponsor of S.B. 353). HMOs and preferred provider arrangements are both examples of alternative health care delivery systems "because they offer an alternative to traditional fee-for-service healthcare." Dellinger, A., Healthcare Facilities Law § 16.3, at 1060 (1991). "An HMO is basically a method of pricing medical services. Instead of having the patient pay separately for each medical procedure, the patient pays a fixed annual fee for all the services he needs and the HMO undertakes to provide those services with the physicians with whom it has contracts." Blue Cross and Blue Shield United of Wisconsin v. Marshfield Clinic, 65 F.3d 1406, 1409 (7th Cir. 1995).

The Montana HMO Act, which is patterned after the Model HMO Act adopted by the National Association of Insurance Commissioners, defines HMO as "a person who provides or arranges for basic health care services to enrollees on a prepaid or other financial basis, either directly through provider employees or through contractual or other arrangements with a provider or a group of providers." Mont. Code Ann. § 33-31-103(7). This definition reflects the integrated nature of an HMO, "combining the functions of healthcare insurer and provider of healthcare services." Dellinger, § 16.4 at 1062. The typical components of an HMO include:

- an organized health care delivery system capable of providing or arranging for ambulatory, inpatient, emergency and preventive medical services;

- voluntarily enrolled families and individuals who have chosen to contract individually or as members of a group with the HMO for health services;

- a financial plan that guarantees delivery of services on a prenegotiated and prepaid basis;

- an identifiable administrative organization that ensures legal, fiscal, public and professional accountability; [and]

- arrangements by which the organization significantly bears the risk of providing health services and in some instances requires providers to share the risk.

Id. at 1061-62.

A preferred provider arrangement is a "hybrid of an HMO and traditional insurance," under which participating providers are paid on a predetermined fee-for-service basis at or below their usual rates. Dellinger, § 16.5 at 1067-68. Unlike HMO enrollees, "[t]he consumers are free to use non-PPO [Preferred Provider Organization] providers, but there are strong financial incentives (in the form of reduced or eliminated copayments and deductibles) to use preferred physicians and hospitals." Id. at 1068. See also Marshfield, 65 F.3d at 1410 (describing preferred provider organization as a health care pricing system "under which the insurer offers more generous reimbursement if the insured patronizes physicians who have contracts with the insurer to provide service at low cost to its insureds").

Montana law recognizes both the HMO and the preferred provider arrangement as valid alternative health care delivery systems, and sets forth a distinct statutory framework for each. The purpose of the PPA Act is contained in Mont. Code Ann. § 33-22-1702:

> The purpose of this part is to ***allow*** a health care insurer providing disability insurance benefits to negotiate and contract with health care providers to:
>
> (1) provide health care services to its insureds or subscribers at a reduction in the fees customarily charged by the provider; or
>
> (2) enter into agreements in which the participating providers accept negotiated fees as payment in full for health care services the health care insurer is obligated to provide or pay for under the health benefit plan.

(Emphasis added.) The PPA Act is voluntary; no insurer is required to enter into preferred provider agreements. Mont. Code Ann. § 33-22-1704(1). However, under 1993 amendments to the Act, if an insurer intends to offer a preferred provider arrangement, it "must provide each health care provider [in the geographic area covered by the proposal] with the opportunity to participate on the basis of a competitive bid or offer." Mont. Code Ann. § 33-22-1704(3).

The insurer must issue a request for proposals and is required select the lowest cost bid or offer unless it reserves the right in its request for proposals to reject a low bid. Mont. Code Ann. § 33-22-1704(5).

HMOs are governed by chapter 31 of the Montana insurance code and may be established upon approval of the state insurance commissioner. Mont. Code Ann. § 33-31-201. Among the statutory powers of HMOs is "the furnishing of health care services through a provider who is under contract with or employed by the health maintenance organization[.]" Mont. Code Ann. § 33-31-221(c). Except to the extent provided in Title 33, chapter 31, HMOs are exempt from state "insurance or health service corporation laws[.]" Mont. Code Ann. § 33-31-111(1).

The PPA Act and the HMO Act each contain a set of definitions applicable to the provisions of the respective Acts. Mont. Code Ann. §§ 33-22-1703 (PPA Act definitions); 33-31-102 (HMO Act definitions). Each Act provides its own definition of "health care services" (§§ 33-22-1703(4) and 33-31-102(5)) and of "provider" (§§ 33-22-1703(8) and 33-31-102(11)). The definitions are not identical. In addition, the HMO Act includes a definition of "basic health care services" (§ 33-31-102(1)). The HMO Act also defines "plan" (§ 33-31-102(10)) and "health care services agreement" (§ 33-31-102(6)), while the PPA Act defines "health benefit plan" (§ 33-22-1703(2)). The HMO Act uses the term "enrollee" for the person receiving health care services under the "plan" (§ 33-31-102(3)), while the PPA Act uses the term "insured" to define the person entitled to reimbursement for expenses of health care services (§ 33-22-1703(5)). Finally, the HMO Act authorizes and sets forth provisions regarding "contracts" between the HMO and health care providers. Mont. Code Ann. §§ 33-31-201(3)(d)(iv), (x), 33-31-221(1)(c). The PPA Act, on the other hand, speaks in terms of "agreements" with providers. Mont. Code Ann. §§ 33-22-1702(2), -1704, -1705.

These definitional differences have more than semantic significance. They reflect the distinct methods by which health services are contracted for in a preferred provider context and the method used in a traditional HMO context. In the former, the patient, or "insured," has two contractual relationships--one with the health care provider and a second with the health care insurer. There is, as well, a third contractual relationship between the insurer and the provider which limits the former's liability to a prescribed set of rates. The definition of "insured," as stated above, thus means a person who is "entitled to ***reimbursement***" for expenses attendant to a provider's services. Mont. Code Ann. § 33-22-1703(5). In the ordinary HMO environment, however, the enrollee has only one contractual relationship--that with the HMO to provide appropriate health care services. No independent contractual relationship is established between the enrollee and the provider for which "reimbursement" occurs. While the

definition of "health benefit insurer" in the PPA Act includes HMOs and thereby recognizes the theoretical possibility that an HMO may elect to enter into a preferred provider agreement, that statute is concerned with fee-for-service relationships between patients and medical personnel, not with relationships established by HMOs to provide health care services to enrollees where no reimbursement for fees paid to providers is contemplated.

I accordingly disagree with the insurance commissioner's conclusion that the PPA Act applies to a contract entered into by an HMO with a provider for the purpose of discharging its obligation to provide medical services to enrollees. Although the commissioner has administrative responsibility for adopting rules to implement the PPA and HMO Acts, the issue here is one of law, and the commissioner's view would not be entitled to deference. Rather, the standard of review of an administrative agency's conclusions of law is "whether the agency's interpretation of the law was correct." E.g., Baldridge v. Board of Trustees, 264 Mont. 199, 205, 870 P.2d 711, 714 (1994).

The statutes in question are not subject to a single obvious construction. Unlike the commissioner, however, I find no irreconcilable conflict between the PPA Act's definition of "health care insurer" and the exception for HMOs from application of insurance laws in § 33-21-111. Such conflicts may not be found unless no other reasonable construction is possible (Continental Oil Co. v. Board of Labor Appeals, 178 Mont. 143, 151, 582 P.2d 1236, 1241 (1978); 46 Op. Att'y Gen. No. 6 (July 6, 1995)), and here the statutes readily are harmonized. The PPA Act constitutes a grant of authority to "health care insurers," including HMOs, to enter into preferred provider agreements, but those agreements do not include contracts between HMOs and providers that entitle HMO enrollees to receipt of medical services rather than reimbursement of medical expenses.

Finally, the legislature is presumed to act with full knowledge of existing laws. Thiel v. Taurus Drilling Ltd., 1980-II, 218 Mont. 201, 207, 710 P.2d 33, 36 (1985); 46 Op. Att'y Gen. No. 6, at 6; 45 Op. Att'y Gen. No. 25, at 3 (July 21, 1994). The competitive bid requirements in the PPA Act were enacted as an amendment six years after the original adoption of that law and the HMO Act. The HMO Act provisions existing at the time of the Act's original adoption and passage of the 1993 amendment contained no restriction on the procedures used by HMOs to enter into provider contracts for the rendition of medical services to plan enrollees. I am unable to conclude that the legislature sub silentio intended the 1993 amendment to constrict the ability of HMOs to contract with providers as they had in the past. Rather, I find that the PPA Act applies to a limited class of provider agreements not including those typically entered into by HMOs.

By its passage of the HMO Act and the PPA Act, the legislature intended to provide for two alternative health care delivery systems that would maximize options for health care cost savings. The independence of those two Acts is clear from their separate requirements, uses of distinct terminology, and autonomous definitions. I find nothing in the statutes to support mandatory application to HMO provider contracts of an otherwise voluntary competitive bidding process under the PPA Act.

THEREFORE, IT IS MY OPINION:

> Health maintenance organizations operating under the provisions of Mont. Code Ann. Title 33, chapter 31, are not bound by the competitive bidding requirements of Mont. Code Ann. § 33-22-1704(3) in contracting with health care providers, except when entering into a preferred provider agreement as authorized by that section.

Sincerely,

JOSEPH P. MAZUREK
Attorney General

jpm/esb/dm