Dynamic Chiropractic

Counsel in Dissent #10

PREPAY -- KNOX-KEENE ACT -- A FEW LAST WORDS

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In a prior article (Counsel in Dissent #8, February 23, 1998), I addressed a ruling from the California Department of Insurance (DOI) relative to the specific prepay contract I had submitted to that agency as the attorney for the Prescott Group. (This group is headed by my daughter. I am only the attorney for the group and not a member of it.) In that article, I included a copy of the ruling letter from the Department of Insurance so that anybody wishing to prepare a similar contract would know the precise basis for the DOI's ruling that the referenced contract does not constitute the business of insurance.

I left open the question as to whether the contract might be a health care service plan (managed care plan) as defined under the Knox-Keene Act. This act is administered by the California Department of Corporations (DOC). Actually, I had, before writing the prior article, received unofficial notice from the DOC that the Prescott Group contract does not violate (fall within the provisions of) the Knox-Keene Act. I was awaiting written confirmation before going into the matter further in this publication. I will do that here.

Let me briefly explain some of the reasoning behind the DOC's opinion that the Prescott Group contract is not a "health care service plan." Some people have previously expressed the opinion that you do not have to utilize the Prescott Group contract to obtain the benefit of the prior ruling by the Department of Insurance. Of course, that is absolutely true. You only need to make sure your contract meets the criteria spelled out in the letter included in my prior article. In principle, the same premise applies to the position taken by the Department of Corporations. However, the whole matter is becoming somewhat complex, and I have therefore suggested to my client that she make the actual contract submitted to the DOC available to anybody desiring to use it. She has agreed, and you may obtain a copy for duplication and use by calling (714) 730-0855. There is a $10 handling and mailing charge for the contract.

It is obvious to all concerned that there are distinct similarities between health insurance and managed care contracts (HMOs, etc.). Why then are not both types of contracts administered by the Department of Insurance? They are in many states, but in California they are not for purely historical reasons. At the outset of managed care in California, there were many accusations floating around that some of the personnel with the Department of Insurance were taking kick-backs, etc., from providers. Thus, when the Knox-Keene Act was passed, the legislature placed the administration of the act in the Department of Corporations to resolve any questions about the fraud accusations.

The Knox-Keene Act applies to contracts (plans) which involve a so-called prepayment. What does this term prepayment mean in this context? The term arose in the 1960s when the state of California was seeking to solve its financial burdens as to indigent care under the Medi-Cal program. Prior to the 1960s, all indigent medical care was dealt with under a typical health insurance-type program where the doctor was paid only after services were actually rendered (called a "fee-for-service" arrangement).

The state decided to shift part of the burden to providers and came up with a scheme where doctors would be paid a certain amount for each person they agreed to treat. The doctors were to be paid before the need for care arose on the basis of a set fee for the number of persons (per capita) for whom they agreed to provide future care. Thus the concept of a "prepaid" plan.

Actually, the contract submitted by the Prescott Group to the Department of Corporations is different from the one submitted to the Department of Insurance. Of course, the criteria established by the DOI as stated in the previously published letter were still met. The contract submitted to the Department of Corporations is designated as a fee-for-service agreement and contains two plans. In plan I, the patient pays for the services rendered each visit. In plan II, they receive a discount for paying cash in advance of the needed care being given. However, the need for care has been diagnosed before the payment is made. Although the patient is in a sense making a prepayment, the payment is not being made before the need for care has arisen as envisioned under a managed care (Medi-Cal, HMO, etc.) concept. Plan II is more appropriately called a discounted fee-for-service agreement rather than a prepayment plan.

One additional issues requires comment. I have heard a rumor that some lawyer has suggested that a patient discount plan such as addressed in this article may constitute an illegal referral fee. Suffice it to say, a referral fee is something a doctor (or lawyer, etc.) pays to a third person for them having sent a patient, etc., to you -- not a discount granted the patient themselves. I will close with a question: Why do so many people work so hard to limit the economic opportunities of chiropractors? It makes one wonder.

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JUNE 1998