Potential Remedies for Providers Excluded From Narrow Networks

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Background

In the wake of the Patient Protection and Affordable Care Act ("ACA"), insurers have faced growing pressure to increase the access and quality of health care while still reducing cost. In response to this pressure, many of the major insurance providers offering plans on the individual and small group marketplace ("Marketplace") have resorted to offering narrow network plans, a concept that first became popular with the rise of Health Maintenance Organizations ("HMOs") in the 1990s. Under a narrow network arrangement, an insurer enters into an agreement with a limited group of providers who are willing to accept a reduced payment in exchange for an anticipated increase in patient volume that results from insureds having a limited choice of providers.[1]

Under the ACA, these narrow network plans are thought to encourage consumer value-based purchasing; narrow plans are aimed at individuals who are willing to sacrifice their choice of a provider for premiums that are, on average, 5 to 10 percent lower than open access plans.[2] Currently, nearly two-thirds of the hospital networks on the Marketplace are considered to be narrow network plans.[3] Some states are beginning to require that major plans offer a narrow network alternative.[4] While approximately 7.1 million Americans have signed up for health insurance on the Marketplace, this number is expected to increase as the tax penalty for being uninsured increases and as employers choose to forego offering their employees job-based health coverage.

As individual enrollment through the marketplace increases, it is likely that the number of Americans who are insured under a narrow network plan will also increase. Additionally, some states have expressed an interest in implementing a narrow network model for their state Medicaid beneficiaries,[5] meaning that excluded hospitals could lose a large portion of their patient population. While these plans offer an affordable alternative for those beneficiaries who are willing to sacrifice choice for cost savings, narrow networks threaten to exclude teaching hospitals, specialized care hospitals and small rural hospitals in areas that are dominated by a single insurer.[6] In light of the popularity of narrow networks, many providers are beginning to

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[1] John Foley, Gerald Frye, Tracey Kline, Narrow Network Offerings- Market and Contracting Implications, American Health Lawyers Association Roundtable, 22 (May 20, 2013).

[2] *Id.*

[3] Julie Appleby, *Marketplace Plan's Networks are Very Small, Study Finds*, Kaiser Health News (Dec. 12, 2014, 2:41 PM).

[4] Rakel M. Meir, *Narrow Network Health Plan Products- Does the Adage "Less is More" Apply to Provider Networks?*, American Bar Association (Dec. 2013), (Massachusetts has required plans with 500+ enrollees to offer a narrow network option on the small group marketplace).

[5] *Id.*

[6] Caroline Chen, *Health Insurers Slash Specialty Hospitals to Keep Premiums Low*, Bloomberg (Feb. 6, 2014, 8:04 AM).

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question what remedies are available when they are excluded from a major health plan in their area.

Potential Remedies for Providers Excluded From Narrow Networks

Providers are increasingly turning to the court system to litigate network exclusions from Marketplace plans. As these suits proceed, the remedies available to excluded providers will become clearer. For institutional providers being excluded from Marketplace plans, some potential remedies may include ACA network adequacy standards, CMS and NAIC guidelines, state "any willing provider" laws and anti-trust violations.

I. ACA Qualified Health Plans and Federal Network Adequacy Standards

In order for a health insurer to offer a plan on the Marketplace, the plan must be certified as a Qualified Health Plan ("QHP"). To be certified as a QHP, the plan must meet the network adequacy standards of the exchange on which the plan is offered.[7] Federally-Facilitated Marketplaces ("FFM") must meet the ACA federal standard for network adequacy, as determined by HHS[8]. The only current federal regulation for network adequacy is that a QHP must ensure that the provider network of each its plans "is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to ensure that all services will be accessible without unreasonable delay."[9] The ACA does not define "sufficient" or "unreasonable delay," leaving interpretation up to the insurers or the states.[10] Health plan accreditation standards are beginning to address the issue of network access in an effort to fill the gap left by the lack of federal statutory definitions.[11]

For those institutional providers excluded from a narrow network plan in a FFM state, the remedies available under the ACA network adequacy standards may be limited because the federal statute is so broad. However, institutional providers who are excluded should offer comments on CMS's *Draft 2015 Letter to Issuers in the Federally-facilitated Marketplaces* to encourage CMS to develop time and distance requirements, standards for provider to patient ratios, and maximum wait limits for appointment times.[12] These additional standards may make it necessary for insurers to create broader networks on the Marketplace.

Because the ACA has extremely broad network adequacy standards, HHS has given flexibility to State-Based and Partnership Marketplaces to establish more rigorous network adequacy standards to supplement the federal requirements.[13] In response, many states with State Based

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[7] 45 CFR § 155.20.

[8] In *CMS's 2015 Letter to Issuers in the Federally-facilitated Marketplace*, CMS stated that it will collect QHP provider lists and evaluate the provider networks using a "reasonable access" review standard in order to identify those networks that "do not provide access without unreasonable delay." CMS will focus on hospital systems, mental health providers, oncology providers, and primary care providers."

[9] 45 CFR §156.235.

[10] *Network Adequacy: What Advocates Need to Know*, Community Catalyst, 1 (Jan. 2013).

[11] Sara Rosenbaum, *Realizing Health Reform's Potential- How are State Insurance Marketplaces Shaping Health Plan Design?*, The Commonwealth Fund, 3 (December 2013).

[12] *Improving Network Adequacy: Ideas for Advocacy Strategies*, Community Catalyst, 2 (Jan. 2014).

[13] Rosenbaum, *supra* note 10, at 2.

and Partnership Exchanges have developed network adequacy standards more stringent than the federal requirements. These standards are monitored and enforced by the state's Department of Insurance ("DOI"), who retains the power to operate all exchange activities.[14] This leaves institutional providers in these states with additional remedies when excluded from a narrow network.

For example, providers can file an appeal with the DOI if a plan is in violation of the state network adequacy standards.[15] If additional state standards are not in place, institutional providers in these states can file a complaint with the state DOI, which can in turn conduct a hearing on the matter and suggest possible changes to the state legislature. Recently, Seattle Children's Hospital was excluded from five of the seven local plans offered on the Washington State Based Marketplace.[16] The hospital filed an administrative appeal requesting that the insurance commission exclude plans that did not include the hospital.[17] While this case is in the early stages, it could help set the stage for defining the scope of the federal network adequacy requirement.[18]

For state legislatures in those states that are operating a State Based or Partnership exchange, the adoption of the National Association of Insurance Commissioners ("NAIC") Managed Care Network Adequacy Act (Model #74) is a reasonable way to increase access to beneficiaries and limit the exclusion of specialty hospitals and major institutional providers from narrow networks. By adopting the Model Act and extending it to QHPs, the state can ensure compliance with federal network adequacy standards while adding additional requirements such as, "provider-covered person ratio; rural/urban geographic accessibility; appointment waiting times; hours of operation; provider acceptance of new patients; and hospital access."[19] The Model Act also allows the DOI Commissioner to institute a corrective action against an insurer in order to ensure compliance with network adequacy, opening up another potential remedy for providers excluded from a narrow network.

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[14] *Health insurance exchanges: Focus on state-based exchanges*, Practice Central (June 27, 2013), http://www.apapracticecentral.org/update/2013/06-27/exchanges.aspx.

[15] *See generally*, Sarah Palermo, *Insurance department to hold hearing on possible changes to network adequacy laws*, Concord Monitor (March 25, 2014) (discussing New Hampshire Insurance Commission hearing after several hospitals were excluded from narrow networks offered on the Marketplace).

[16] Meir, *supra* note 4.

[17] *Id.*

[18] Patrick Connole, *Providers Turn to Courts, Regulators for Relief as Insurers Favor Narrower Networks*, AISHealth (Oct. 21, 2013).

[19] *See Plan Management Function: Network Adequacy White Paper*, National Association of Insurance Commissioners (June 27, 2012), for a full discussion of how the NAIC Managed Care Network Adequacy Act can be adopted by states to regulate network adequacy under the ACA.

The chart below outlines the type of Marketplace established in each of Taft's office locations. Additionally, the chart demonstrates what other network adequacy laws have been enacted by the state legislature.

Marketplace Structure and Additional State Network Adequacy Standards

	Type of Marketplace	No Additional State Adequacy Standards	Maximum Travel Time	Patient to Provider Ratio	Hours of Operation and Waiting Times	Specialist Requirements	Other geographic requirements
Indiana[20]	Federal	X					
Illinois[21]	Partnership		X	X	X	X	X
Kentucky[22]	State		X	X	X	X	X
Ohio	Federal	X					

IV. State Any Willing Provider Laws

One of the best remedies for institutional providers who are excluded from a narrow network insurance plan may be state Any Willing Provider ("AWP") laws. AWP laws were first developed as a way to prevent managed care organizations from limiting the health care providers who participated in a plan, thus reducing insured choice and access. While many states have repealed their AWP laws or have limited the laws to non-institutional providers and pharmacies, some states still have comprehensive AWP laws in place that could offer institutional providers who are excluded from narrow networks under the ACA a potential remedy in the form of a court order requiring the provider to be included in the plan. As key provisions of the ACA go into effect, many argue that AWP laws will need to be repealed because they stifle competition among providers and the ACA relies on competition in order to drive price down and meet its objectives of lowering price and increasing accessibility.[23]

[20] Ind. Code § 27-8-11-4.

[21] 215 ICLS § 370i.

[22] KRS § 304.17A-515.

[23] Appleby, *supra* note 3.

The chart below outlines what type of AWP laws are in place in Taft's various practice locations.

Any Willing Provider Laws By State

	AWP State?	Institutional Providers?	Non-Institutional Providers?	Statute	Key Provisions
Indiana	Yes	Yes	Yes	Ind. Code 27-8-11-3	-Before entering into an agreement with providers, insurers must establish terms and conditions that must be met by providers wishing to entering into an agreement -Terms and conditions may not discriminate unreasonably against providers -Price differences among hospitals and institutional providers produced by a process of individual negotiation are not discriminatory -No hospital, physician, pharmacist , or other provider willing to meet the terms and conditions may be denied the right to enter into an agreement
Illinois	Yes	No	Yes	215 ILCS 5/370h	-Insurers must establish terms and conditions that must be met by non-institutional providers wishing to enter into an agreement -Terms and conditions cannot unreasonable discriminate against non-institutional providers -Price differences among non-institutional providers produced by negotiation is not discriminatory -An insurer may not refuse to contract with a provider who meets the terms and conditions
Kentucky	Yes	Yes	Yes	KRS 304.17A-270	-A health insurer cannot discriminate against any provider in its geographic coverage area who is willing to meet the terms and conditions established by the insurer
Ohio	No				

The ACA itself does not contain an AWP law. The ACA contains a provision that insurance issuers should not discriminate with respect to participation against any provider who is acting within the scope of that provider's state licensure.[24] However, the ACA makes clear that "this section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer."[25] The ACA also allows insures to vary reimbursement rates for providers based on quality or performance measurers.[26]

[24] Public Health Services Act § 2706.

[25] *Id.*

[26] *Id.*

While some states have repealed their AWP laws since the enactment of the ACA, the ACA does not contain any provisions that pre-empt state AWP laws. Nothing contained in the ACA is to be construed to preempt any state law that does not prevent the application of the ACA.[27] The ACA is primarily concerned with increasing access and the ACA's network adequacy standards are designed to ensure that all beneficiaries can reasonably access healthcare providers. State AWP laws do not prevent the application of network adequacy standards, but rather complement them. If state AWP laws are interpreted as forcing an insurer to accept any institutional provider that is willing to comply with the insurer's terms and conditions, then AWP laws increase network adequacy and are therefore not preempted by the ACA.

Indiana's AWP was litigated in 1986, long before the ACA was enacted. In *Ball Memorial Hospital, Inc. v. Mutual Hospital Insurance Inc.*, Blue Cross and Blue Shield of Indiana (the Blues) decided to offer a PPO.[28] The Blues asked for bids from all acute care hospitals in the state of Indiana. Ninety-one hospitals submitted bids.[29] The Blue's negotiated with all ninety-one hospitals and did not give any of the hospitals information about the bids submitted by other hospitals in the area.[30] The Blues then selected those hospitals with the lowest bid that were conveniently located for the insured.[31] Of the ninety-one hospitals that submitted bids, only sixty-one were enrolled.[32] The hospitals left out of the PPO filed suit on the grounds that the Blues were in violation of the Indiana AWP law and the Sherman Antitrust Act.[33]

The court found that in order to lower healthcare costs, it was reasonable for an insurer to direct patients to a particular hospital.[34] In order for this to be successful, insurers needed to reduce the number of hospitals in a PPO plan in any given city.[35] It would not make sense for a PPO to offer the same price to all hospitals and enroll any provider willing to accept that level of reimbursement.[36] The court interpreted the Indiana AWP law to mean that for hospitals and institutional providers, differences in prices based on individual negotiation were not unreasonably discriminatory.[37] To hold otherwise would nullify the benefit of price negotiations allowed by the Indiana AWP law and would remove the "preferred provider" status common for PPOs.[38] Additionally, allowing hospitals to view a rival's bid would stabilize or increase prices.[39]

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[27] Patient Protection and Affordable Care Act § 131(d).

[28] *Ball Mem'l Hosp., Inc. v. Mut. Hosp. Ins., Inc.*, 784 F.2d 1325 (7th Cir. 1986).

[29] *Id.*

[30] *Id.*

[31] *Id.*

[32] *Id.*

[33] *Id.* at 1342.

[34] *Id.* at 1343.

[35] *Id.*

[36] *Id.*

[37] *Id.*

[38] *Id.*

[39] *Id.* at 1344.

While this interpretation of the Indiana AWP law does not offer a favorable outcome for institutional providers excluded from narrow network plans offered under the ACA, the Seventh Circuit made clear that *Ball Memorial* was not a "final construction of the statute."[40] In light of the changes that the ACA has had on the insurance industry, it is possible that a court would interpret the Indiana AWP law differently given the recent healthcare reform.

V. Antitrust Violations

The antitrust laws may also offer a potential remedy for providers that have been excluded from narrow networks. The ACA specifically provides that it should not "be construed to modify, impair, or supersede the operation of any of the antitrust laws."[41] The Federal Trade Commission ("FTC") has also confirmed that "enforcing the United States antitrust laws will not conflict with the goals of the [ACA]" and that the FTC will safeguard the health care market to lower cost and increase quality.[42] While most of the antitrust issues surrounding the ACA have centered on the formation of Accountable Care Organizations ("ACOs") and mergers of providers, antitrust principles applied in other contexts should be applicable to narrow networks.

Any antitrust challenge to a narrow network will face two initial hurdles. First, the antitrust laws protect competition, not competitors.[43] If a narrow network has the effect of lowering prices to consumers, excluded providers as well as providers that contract at lower reimbursement rates may have difficulty demonstrating an unreasonable restraint upon competition. This principle also limits the legal standing of some providers to challenge their exclusion from a network. In addition, a business, even a monopolist, has a right to unilaterally refuse to deal with another business, or to only deal with that business on terms acceptable to it.[44] However, when a party refuses to deal in an attempt to exclude competition or extend its market power, or combines with others to boycott a provider, that may give rise to an antitrust claim. Those exceptions also should be applicable to certain narrow network arrangements.

A provider that seeks to challenge its exclusion from a narrow network under the antitrust laws will have to establish that the MCO that established the network (or perhaps the network itself) has market power in a relevant product and geographic market.[45] Neither the courts nor the antitrust enforcement agencies have reached a consensus about how these markets should be defined when the "product" involved is "health care financing." In the Seventh Circuit, Judge Posner has rejected the proposition that HMOs are in a product market separate from other forms of medical services contracting,[46] while Judge Easterbrook has found that geographic markets for various forms of health insurance are "regional if not national."[47]

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[41] Patient Protection and Affordable Care Act § 1560(a).

[42] Martin Gaynor, *To the Editor: Re "Health Law Goals Face Antitrust Hurdles," by Eduardo Porter*, New York Times (Feb. 17, 2014).

[43] *Atlantic Richfield Co. v. USA Petroleum Co.*, 495 U.S. 328, 339 (1990).

[44] *Monsanto Co. v. Spray-Rite Serv. Corp.*, 465 U.S. 752, 764 (1984).

[45] *Ball Memorial Hosp.*, 784 F.2d at 1334.

[46] *Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic*, 65 F.3d 1406, 1409-10 (7th Cir. 1995).

[47] *Ball Memorial Hosp.*, 784 F.2d at 1336.

The impact of the ACA on health insurance markets (and the extreme variability between different states' exchanges) has yet to be determined in establishing market definitions and market power. However, recent consolidation and regulatory restrictions in the health insurance market appear to have reduced competition. For example, when Ball Memorial Hospital challenged its exclusion from the Blues' network, the Blues held 27% of the health insurance market in Indiana.[48] Today, the Blues insure over 50% of the State of Indiana. The Blues also are the major carrier of plans on the Marketplace in Indiana. Indiana has only four Marketplace carriers, many of whom do not offer state-wide coverage.[49] The insurance market post ACA is not as fluid in that consumers must use the Marketplace in order to take advantage of subsidies and tax credits, limiting their choice of insurers. While these beneficiaries do have the option of paying more for a non-narrow network, those looking to save cost are likely limited to a narrow network plan that excludes a large number of specialty or rural providers.

In a recent case brought by a health care system against Blue Cross and Blue Shield of Rhode Island, the federal district court recognized one of the exceptions to the general rule that a monopolist can choose to deal with whomever it wishes.[50] Steward Health Care System operated a number of hospitals in Massachusetts, and also sold health insurance that utilized Steward's network of community hospitals. After Steward contracted to acquire Landmark Hospital, a financially distressed community hospital in Rhode Island, which Steward intended to use to extend its business model into that state, Blue Cross began steps to remove Landmark from its provider network. Even though Steward offered to accept rates 5% below what Blue Cross was paying to other Rhode Island providers, Blue Cross terminated its contract with Landmark and also discouraged other Rhode Island providers from dealing with Steward. Steward abandoned its efforts to acquire Landmark and sued Blue Cross under Section 2 of the Sherman Act. In denying Blue Cross's motion to dismiss, the Court recognized that the termination of a voluntary course of dealing by a monopolist that elects to forego short-term profits in order to eliminate competition and refuses to deal even at rates that the defendant already provides to others might violate Section 2 of the Sherman Act.[51]

In addition, collective agreements among competitors to refuse to deal with a provider excluded from a narrow network could be unlawful under Section One of the Sherman Act. For example, in *Heartland Surgical Specialty Hospital, LLC v. Midwest Division, Inc.*,[52] a federal district court denied a motion for summary judgment in an antitrust case and found sufficient evidence of an agreement among the largest MCOs and the largest hospital systems in the Kansas City metropolitan area to exclude a specialty hospital from participation in the MCOs' provider networks. The plaintiff produced evidence that the hospital systems collectively agreed that the specialty hospital was a competitive threat and agreed to accept lower reimbursement from the MCOs in exchange for the MCOs' agreements to exclude the plaintiff from their networks by granting the hospitals the right to approve the addition of new hospitals into the network.

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[48] *Id.*, at 1337.

[49] J.K. Wall, *Most individuals will pay less, not more, in Obamacare exchanges*, The Indiana Business Journal (July 22, 2013).

[50] *Steward Health Care System, LLC v. Blue Cross and Blue Shield of Rhode Island*, 2014 WL 630678 (D.R.I. Feb. 19, 2014.)

[51] *Id.*, at * 5-6.

[52] 527 F.Supp.2d 1257 (D. Kan. 2007).