

The Rise of Narrow Networks: Opportunities, Risks and Legal Uncertainties

Prepared for: Nashville Council of Healthcare Attorneys

**Prepared by: Thomas Bartrum, Esq.
Baker Donelson**

**Deborah Farringer, Esq.
Belmont University College of Law**

The Return of Narrow Networks

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[Back to previous page](#)

Insurers restricting choice of doctors and hospitals to keep costs down

By [Sandhya Somashekhar](#) and [Ariana Eunjung Cha](#),

As Americans have begun shopping for health plans on the insurance exchanges, they are discovering that insurers are restricting their choice of doctors and hospitals in order to keep costs low, and that many of the plans exclude top-rated hospitals.

The Obama administration made it a priority to keep down the cost of insurance on the exchanges, the online marketplaces that are central to the Affordable Care Act. But one way that insurers have been able to offer lower rates is by creating networks that are far smaller than what most Americans are accustomed to.

The decisions have provoked a backlash. In one closely watched case, [Seattle Children's Hospital](#) has filed suit against Washington's insurance commissioner after a number of insurers kept it out of their provider networks. "It is unprecedented in our market to have major insurance plans exclude Seattle Children's," said Sandy Melzer, senior vice president.

The result, some argue, is a two-tiered system of health care: Many of the people who buy health plans on the exchanges have fewer hospitals and doctors to choose from than those with coverage through their employers.

A number of the nation's top hospitals — including the [Mayo Clinic](#) in Minnesota, [Cedars-Sinai](#) in Los Angeles, and children's hospitals in Seattle, Houston and St. Louis — are cut out of most plans sold on the exchange.

In most cases, the decision was about the cost of care.

In Seattle, the region's predominant insurer, [Premera Blue Cross](#), decided not to include the children's hospital as an in-network provider except in cases where the service sought cannot be obtained anywhere else. "Children's non-unique services were too expensive given the goal of providing affordable coverage

McKinsey 12-2013 Report on Hospital Networks in Exchanges

- Narrow and ultra-narrow networks are prevalent in the exchanges (70%)
- A median premium savings of 26% between broad and narrow network within the same carrier, product type, metal tier and rating area
- Narrow networks correlate with HMO-like designs instead of PPO-like designs
- Frequency of narrow networks differ notably by carrier type
- Academic medical centers are participating predominantly in broader, higher-priced exchange offerings (usually 10% higher premium on average)
- Available at:
http://www.mckinsey.com/~media/mckinsey/dotcom/client_service/healthcare%20systems%20and%20services/pdfs/hospital_networks_configurations_on_the_exchanges_and_their_impact_on_premiums.ashx

What is a Narrow Network?

- Limited provider network
 - Looks a lot like 1990s model HMOs
 - Typically restricted to low-cost providers—less about quality
 - Can be part of a tiered network offering
- Insurance exchange products definitely driving narrower networks
- But narrow networks have been growing over the last couple of years for employer-sponsored plans as well
- Only one driver—Cost
 - Aetna: Large employer models: 15-35% cheaper than PPO
 - BCBSI: 20-30% less than broad network exchange products
 - Health Net offering in California (25-year-old male):
 - Bronze Plan (higher cost sharing) preferred provider network: \$195/month
 - Silver Plan with narrow network \$174/month

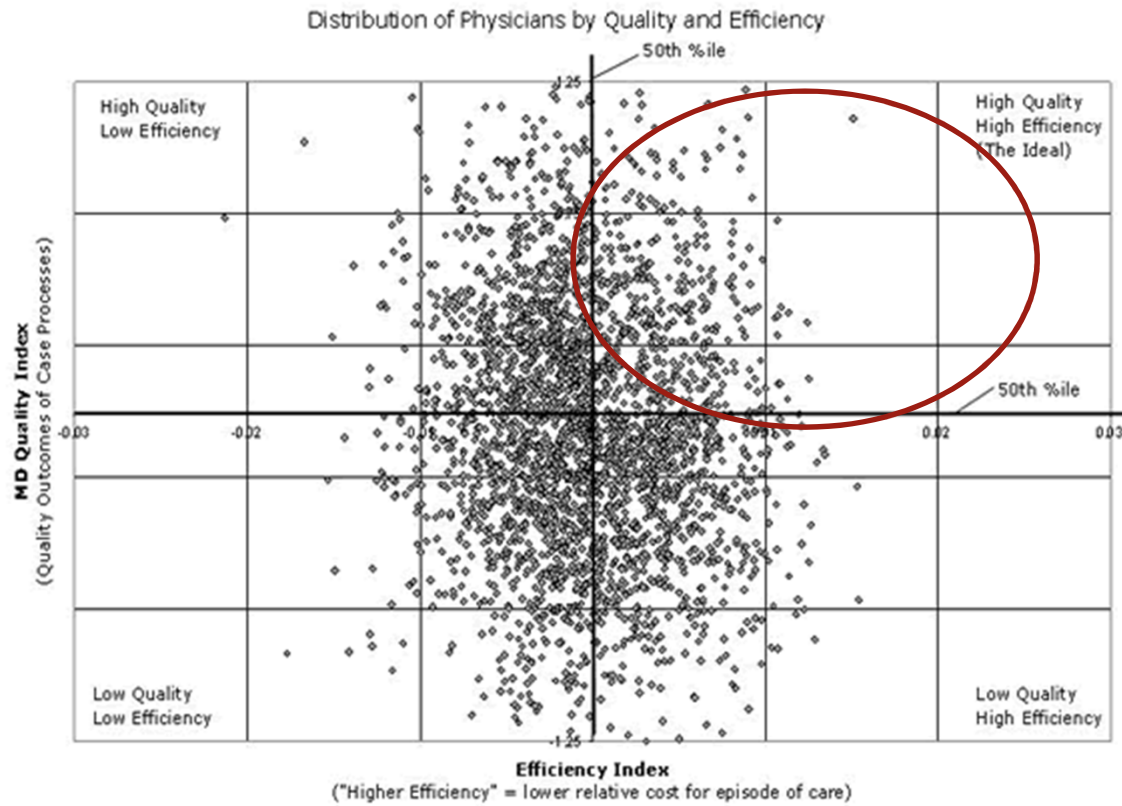
Narrow Networks v. Tiered Networks

- Tiered Networks:
 - Providers are placed into tiers based upon total cost of care, pricing or some quality and cost index
 - Enrollees have different cost sharing rates for different tiered providers—may need to incentivize enrollee selection
 - BCBSMA Blue New England Option
 - Normal Delivery Copay:
 - Enhanced Tier: \$250
 - Standard Tier: \$500
 - Basic Tier: \$1000
- Narrow Network: Insurer usually pays nothing for out-of-network care unless the service is not available within the network or emergent
- CINs and ACOs can serve as basis for either a narrow network or a tiered network product

Who Gets In the Network?

- Providers indexed on some cost basis
 - How good is the data?
 - RAND Corp. (2010): “reliability of physician cost profiles varied widely across specialties”
 - Ability to challenge exclusion/tier assignment
- Providers commit to providing better care management
 - Increased UR
 - Commitment to adhere to specialty specific practice protocols
 - In-network referrals
 - Submission of specific quality metrics
- In tiered networks, providers can typically transition tiers during the contract term

Its All About the Data



Narrow
Network
Invites

Narrow Networks and the Affordable Care Act

- Definitely driving development
 - Insurance exchanges
 - Medicare Shared Savings Program
 - Center for Medicare & Medicaid Innovation
 - Value-Based Purchasing Programs
- QHPs:
 - Must ensure sufficient choice of providers
 - Health plan certifies adequacy and approved by both state and federal regulators
- Interim final rules of the Affordable Care Act requires group health plans to reimburse out-of-network providers who provide emergency services the greater of:
 - the median in-network rate;
 - the usual and customary rate using payor's formula for calculating; or
 - the Medicare rate

Payors' Perspective on Narrow Networks

- Offering different value propositions at different price points
 - In exchanges, limited choice better than no choice
- Opportunity to educate employers on the real cost of health care
- Opportunity to get enrollees involved in value-based purchasing
 - How quickly will market embrace limited network products?
- Opportunity to migrate care away from high-cost settings
 - Underlying policy concerns: who pays for medical education, charity care, etc.
- Just part of moving away from traditional fee-for-service reimbursement and offering incentives to maximize efficiencies
- One tool in slowing the health care cost curve

Providers' Perspective on Narrow Networks

- Provider perspectives vary:
 - Some are voluntarily removing themselves from such networks
 - Some see this as a market play to pick up higher patient volume at reduced margins
 - Some see this as an opportunity to differentiate themselves within the market as an efficient health care provider
 - Some see this as an opportunity to private label or joint venture a product with a payor
 - Some are fighting exclusion
 - Some simply fear exclusion but have not done their internal analysis to understand if the volume growth will set off discounts

Legal Concerns Over Narrow Networks

- State Any Willing Provider Laws
- Antitrust
 - Exclusionary practice
 - Network price fixing
- State Insurance Regulations
 - Network adequacy
 - Provider network subject to state insurance law
- Consumer Protection Laws
 - If payor states that selection is based on quality and not just cost, then must actually select based upon quality metrics as well

State Any Willing Provider Laws

- These laws vary by state
 - As to scope (what providers are protected and what types of payor products are subject to the law)
 - As to whether the provider must comply with all of the contractual prerequisites of the network
 - As to whether the law can be used to force coverage of a provider's services
- Passed in backlash against HMOs in the 90s
- Criticized as largely anticompetitive
- Not a lot of prosecutions or administrative action
- Some states have overturned in response to health care reform
- Likely future battleground—both legally and politically
- Similarly, choice of provider laws

Network Adequacy Issues

- Federal Health Care Program Requirements
 - Medicare Advantage
 - State Medicaid
- QHP Requirements
 - Must include essential community providers
 - Be sufficient in numbers and types of providers
 - Consistent with the network adequacy provisions of the PHS Act
- NAIC Model Act/State Insurance Laws
 - Access to covered benefits in a way that doesn't negatively impact the enrollee's health
 - Number of providers
 - Range of services
 - Location of providers relative to service area
- NCQA Standards if accredited

Developing Law in Key States

- Washington State
 - Seattle Children’s Hospital excluded from state exchange networks
 - Filed suit against Washington Insurance Commissioner
 - Violated federal law that mandates essential community providers
 - Abused its discretion in approving plans without a children’s hospital
 - Legislative proposal to include in networks
 - Governor issued Executive Order 13-05
 - Still not on any network on the exchange

Developing Law in Key States

- New Hampshire
 - Anthem BCBS Exchange Plans exclude 1/3 of the state's hospitals
 - Frisbie Memorial Hospital has sought a hearing at the state Insurance Department
 - Hearing denied December 12, 2013
 - Indicated that it will hold a public hearing on adequacy in January
 - Legislation proposed any willing provider law to force expansion of network
 - South Dakota, Mississippi and Pennsylvania are considering similar laws

Out-of-Network Payment Theories

- In the absence of federal law, state law controls who is responsible for paying the provider and how much providers are paid for out-of-network services
- Some states have specific statutes or rules addressing these issues
- Most states, however, rely upon judicial precedents recognizing a payment obligation under various theories including:
 - Quantum Meruit/Unjust Enrichment
 - Detrimental Reliance
 - Third Party Beneficiary to Underlying Patient Contract with Payor
 - Unfair or Deceptive Trade Practices
 - State Prompt Pay Laws
 - Implied by Law Contract (usually emergency services) or Implied in Fact Contract (usually arises when coverage is verified prior to provider furnishing services)
- Some states do not recognize a right to payment

Reasonable Payment Under a Quantum Meruit Theory

- Quantum Meruit: An equitable theory that requires reasonable payment for services rendered under the theory that it would be inequitable to allow the recipient to enjoy the benefit without payment
 - Courts have rejected payors unilaterally paying non-network providers the same as network providers (e.g., TN and PA)
 - Courts have criticized plans that attempt to reimburse based upon Medicare and Medicaid fee schedules
 - Likewise, courts usually do not allow a recovery of full charges in a quantum meruit
 - Many states require payment at usual, customary and reasonable (“UCR”) rate for the provider’s community

Common Payor Defenses to Out-of-Network Claims

- ERISA preemption:
 - State law preempted by ERISA
 - The regulation of insurance is carved out from such preemption
 - The issue becomes whether self-insured or not
- Failure to exhaust administrative remedies (ERISA)
- Lack of standing because not contractual arrangement
- Many payors continue to pay out-of-network providers as a matter of course
 - We expect the trend of greater push back on these issues to intensify

Contractual Considerations

- Structure—contractual relationship, joint venture between provider and payor
- Who do you represent and what side of the issue are you on?
- Branding
- Exclusivity—heightened antitrust concerns
- Geographic scope of project
- Ability to drive
- Responsibility for enrollee information obligations
- Enrollee incentives/steerage
- Dispute resolution process
- Tiers/pricing
- Out-of-network pricing
- Pay-for-performance/shared savings
- Care coordination v. preauthorization

Contact Information

- Thomas Bartrum
 - (615) 726-5641
 - tbartrum@bakerdonelson.com
- Debbie Farringer
 - (615) 460-8281
 - deborah.farringer@belmont.edu