MANAGED CARE: Hot Legal Topics

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Provider Directories and Network Adequacy

Where Do We Go From Here: Medicaid, Medicare, Marketplace

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Current State of Affairs

Provider Directory and Network Adequacy issues were high priorities in 2014 and 2015 – this trend will continue in 2016 and beyond.

The issues started in 2014 over the growing use of narrow provider networks in the Marketplace.

September 2014	• The Health and Human Services Office of Inspector General released a report which found that state standards for access to care (time, distance, number of providers, etc.) vary widely among the states for Medicaid managed care plan. http://www.gao.gov/products/GAO-15-710
December 2014	• The Health and Human Services Office of Inspector General released a report which found significant vulnerabilities in provider availability for Medicaid managed care plans, a key indicator in network adequacy. http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf
September 2015	• The Government Accountability Office released a report on Medicare Advantage (MA) plans, which found CMS is not doing a good job in ensuring that MA plans have adequate networks as CMS does little to assess the accuracy of network providers. http://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf

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Where Do We Go From Here

- Today's current standards for provider directories and network adequacy for Medicaid managed care plans, Medicare Advantage plans, and Marketplace plans are generally vague and provide little guidance.
- The CMS trend is to move away from these vague standards to more defined, specific standards that would help alleviate some of the provider directory and network adequacy issues.
- CMS has already proposed new rules for Medicaid managed care plans (currently under review at OMB); has proposed, but declined to adopt new Marketplace Rules as CMS wants to give states more time to adopt the NAIC Model Act; and CMS intends to propose new rules for Medicare Advantage plans in the near future.

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Medicaid Managed Care Plans: Current Rules

NETWORK ADEQUACY

- Current standards located at 42 C.F.R. § 438.206 & 42 C.F.R. § 438.207
- Standard is relatively vague
  - Must maintain network of providers sufficient to provide adequate access to all covered services
  - Must take into account: (1) anticipated enrollment, (2) expected utilization of services, (3) number and types of providers required to furnish services, (4) providers who are not accepting new patients, and (5) geographic location of providers, considering distance, travel time, and means of transportation of members
  - Must cover services out-of-network if they cannot be covered in-network or in a timely fashion
- Absent from the current standards are time, distance, and minimum number of provider standards

PROVIDER DIRECTORY

- Current standard located at 42 C.F.R. § 438.10
- Must provide a provider directory to potential and current members
  - Provider directory must include names, locations, telephone numbers of, and non-English languages spoken by current contracted providers
  - Must identify which providers are not accepting new patients
  - Provider directory must include, at minimum, information on primary care physicians, specialist, and hospitals
- Absent from the current standard, among other things, are any updating requirements and whether the provider directory must be in paper or electronic form

Medicaid Managed Care Plans: Proposed New Rules

FCMS is in the process of sweeping rule changes to modernize the regulation of Medicaid managed care plans - network adequacy and provider directory changes are apart of the proposed modernization

NETWORK ADEQUACY

- CMS is proposing to add a completely new regulation for network adequacy – 42 C.F.R. § 438.68
  - Under the proposed rule, the state would be responsible developing time and distance standards for specific provider types, such as, primary care (child and adult), OB/GYN, behavioral health, specialist (child and adult), hospital, pharmacy, pediatric dental, and any additional provider types that promote the objectives of the Medicaid program
  - This will be applicable to all geographic areas covered by the MCP
  - When developing the time and distance standards, the state will have to consider many different criteria, including anticipated Medicaid enrollment, expected utilization of services, health care needs of the member population and number and types of providers needed to furnish contracted Medicaid services
  - There will be an exception process for a MCP plan to apply for and if certain criteria is met, an exception may be granted
  - States will also be required to publish network adequacy standards online and send them to enrollees upon request

Medicaid Managed Care Plans: Proposed New Rules

PROVIDER DIRECTORIES

- CMS is proposing to add provider directory requirements by amending the current 42 C.F.R. § 438.10
  - Must be available in electronic or paper form and include: (1) provider's name and any group affiliation, (2) street address, (3) phone numbers, (4) website URL (as appropriate), (5) specialty (if appropriate), (6) whether a provider is accepting new patients, (7) the provider's cultural and linguistic capabilities, including languages spoken by the provider or skilled medical interpreter at the provider's office, and (8) whether the provider's office is accessible to people with disabilities
  - The above information must be included for each of the following provider types: (1) physicians, including specialists, (2) hospitals, (3) pharmacies, (4) behavioral health providers, and (5) LTSS providers.
  - Information located in a paper directory must be updated at least monthly and information located in an electronic directory must be updated no later than three (3) business days after the updated provider information is received
  - Provider directories must be made available on MCPs website in a machine readable format

The new proposed rules add quite a bit of specificity when compared to the current rules.

Medicare Advantage Plans: Current Rules

NETWORK ADEQUACY

- Current standard is located at 42 C.F.R. § 422.112
- Standard is relatively vague (but is given some substance by CMS in its HSD Guidance noted below)
  - Must maintain network of providers sufficient to provide adequate access to covered services to meet the needs of the population served
  - The providers typically used in order to meet the above standard include primary care physicians, specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics, and other providers.
  - MA plans must also establish written standards on timeliness of access to care that meet or exceed standards established by CMS
    - The standards established are located in the annual MA HSD Provider and Facility Specialties and Network Adequacy Guidance ("Guidance") and annual MA HSD Reference table
    - CMS will deem a network adequate if MA plans demonstrate: (1) their networks have a minimum number of providers/facilities to meet the utilization patterns and clinical needs of the Medicare population as determined by CMS, i.e., CMS has established ratios of providers required per 1,000 beneficiaries, and (2) their networks do not unduly burden beneficiaries in terms of travel time and distance to network providers, i.e., 90% of beneficiaries or more must have access to at least one provider/facility, for each specialty type, within time and distance standards established by CMS
    - MA plans may also need to include more than the minimum number of providers/facilities indicated by CMS, depending upon office locations of the provider/facilities – this goes towards time and distance requirements
      - For example, a practice of 20 physicians may be in the network but they are located in the Westside of the county and the majority of the MA plan members are located on the Eastside of the county
    - In addition, CMS standards vary based upon how the geographic area is categorized (metro, micro, rural, and large) and at the county level

Medicare Advantage Plans: Current Rules

NETWORK ADEQUACY (continued)

- It is very important to note, that for CMS to consider a provider for the purposes of network adequacy, the provider must: (1) have a contract signed by both the provider and MA plan and (2) be credentialed
  - If you have credentialed provider, but not a finalized contract, or only one party has signed the contract, then CMS will not allow the use of the provider in determining network adequacy requirements or vice versa
- CMS has not indicated as to whether or not they will be issuing new network adequacy for MA plans
  - This is likely due to the fact that CMS network adequacy requirements for MA plans via the HSD tables are fairly specific and do not require much change
  - However, CMS is considering a rule change to strengthen its oversight of network adequacy (this is in response to the GAO report mentioned earlier)

Medicare Advantage Plans: Current Rules

PROVIDER DIRECTORY

- Current standard is located at 42 C.F.R. § 422.111
  - Must provide a directory that identifies the number, mix, and addresses of providers from whom enrollees may reasonably be expected to obtain services
- In 2016 MA Final Call letter, CMS added some additional requirements for provider directories;
  - Online Provider directories must be updated in real time, i.e., as soon as the MA plan is notified of changes in a provider's status
  - MA plans are also expected to communicate with providers on a monthly basis regarding their network status which is meant to ensure the provider network directory maintains its accuracy
  - MA plans are also expected to establish and maintain a proactive, structured process that enable them to assess, on a timely basis, the true availability of contracted providers, which includes an analysis to verify the provider is sufficient to provide access to covered services. An effective process would include:
    - Regular and ongoing communications (at least monthly) with providers to ascertain their availability and whether they are accepting new patients and requiring contracted providers to inform the MA plan of availability changes; and
    - Developing a process to address member inquiries and complaints about being denied access to a contracted provider with a follow through to make changes to the provider directory
- Provider directories requirements has also been incorporated into the annual Medicare Marketing Guidelines

Medicare Advantage Plans: Current Rules

PROVIDER DIRECTORY – NEW DEVELOPMENTS

- In the 2017 Draft MA Call Letter, CMS stated it "has purposefully not prescribed the means by which MA plans must update their provider directories in order to allow for innovation in this area."
- CMS also noted that regulatory updates would generally be needed to 42 C.F.R. § 422.111 to require MA plans to issue provider directories that include additional elements
- CMS will be proposing updates to 42 C.F.R. § 422.111 in the near future, but has encouraged the inclusion of the following provider directory data elements before the updates to 42 C.F.R. § 422.111 are completed:
  - The provider directory must be available in machine readable format, include provider medical group and institutional affiliations, include non-English language spoken by the provider, include provider website address, and indicate accessibility for people with disabilities
  - CMS has also asked MA plans to institute a "warm transfer" policy in which enrollees calling the MA plan requesting help finding a provider would be transferred to the provider's office to allow the enrollee to set up an appointment

Marketplace Plans: Current Rules

NETWORK ADEQUACY

- Current standards are located at 45 C.F.R. § 156.230 & 45 C.F.R. § 156.235
- Standard is relatively vague
  - Marketplace plans must ensure its provider network includes: (1) essential community providers ("ECP") in accordance with 45 C.F.R. § 156.235; (2) sufficient providers in numbers and types, including providers that specialize in mental health and substance abuse disorders, to assure all services will be accessible without unreasonable delay; and (3) is consistent with 42 U.S.C. § 300gg-1(c)
  - CMS uses a "reasonable access" standard in order to identify networks that fail to provide access to care without reasonable delay
- Absent from the current standards, among other things, are time, distance, and minimum number of provider standards
- However, in the Final 2017 Letter to Issuers CMS stated that for 2017 CMS will focus on the following specialties, which have historically raised network adequacy concerns: (1) hospital systems, (2) dental providers, (3) endocrinology, (4) infectious disease, (5) mental health, (6) oncology, (7) outpatient dialysis, (8) primary care, and (9) rheumatology and will determine if Marketplace plans provide reasonable access to these providers by using maximum time and distance standards stated in the Final 2017 Letter to Issuers
  - This is new for 2017, but CMS stated that when using the time and distance standards on network data submitted for the 2016 plan, over 90% of Marketplace plans would have be in compliance – BUT this still means around 10% of Marketplace plans would not have been in compliance
  - This is something to watch for during the 2017 Marketplace plan certification process
- CMS has also, through its Draft 2017 Letter to Issuers, indicated that Marketplace plans need to contract with 30% of available ECPs in the Marketplace plan's service area to satisfy 45 C.F.R. § 156.235

Marketplace Plans: Current Rules

PROVIDER DIRECTORY

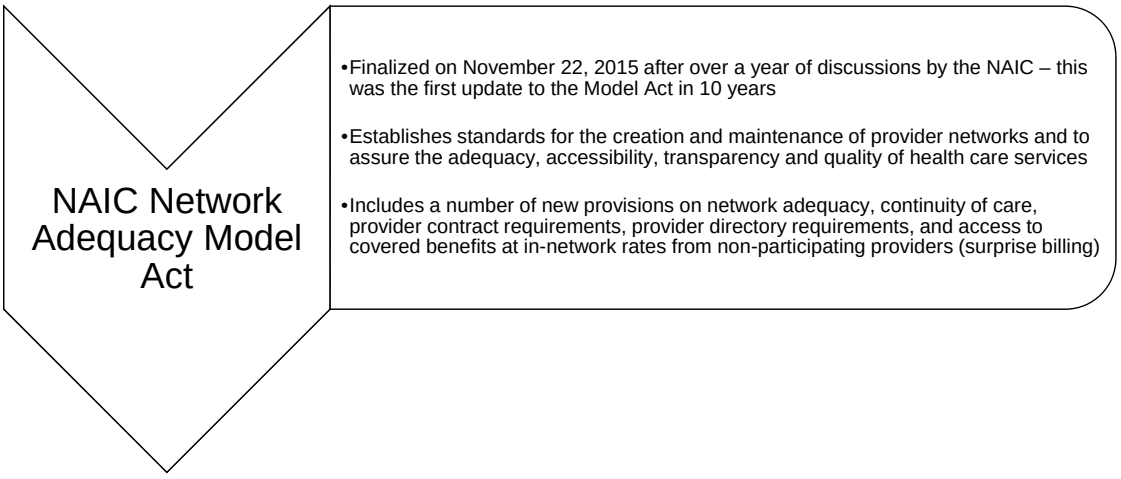
- Current standard is located at 45 C.F.R. § 156.230
  - Provider directory must be made available online without requiring a potential or current member to log into any system or enter a policy number
  - Provider directory must be made available to potential and current members in hard copy upon request
  - The provider directory must identify which providers are not accepting new patients, provider's location, contact information, specialty, medical group, and any institutional affiliations
  - Provider directory must indicate which providers participate in what plans and networks, if the Marketplace plan has multiple plans and/or networks
  - The provider directory must also be kept up-to-date and accurate
    - CMS in its Final 2017 Letter to Issuers noted that it will consider a provider directory up-to-date if it is updated at least monthly
    - However, CMS has not prescribed time standards or the amount of days a Marketplace plan needs to update the directory once the Marketplace plan is aware of a provider status change, which could raise potential compliance issues

Marketplace Plans: New Developments

NETWORK ADEQUACY & PROVIDER DIRECTORY

- In the Final 2017 Letter to Issuers CMS noted that it did not finalize proposals concerning network adequacy time and distance standards as CMS wanted to give states more time to adopt the NAIC Network Adequacy Model Act in order to avoid duplicate duplicative federal and state review processes
  - The NAIC Network Adequacy Model Act includes both network adequacy and provider directory requirements since those two items often effect each other
  - CMS has indicated that it fully expects states to implement the NAIC Network Adequacy Model Act and will be monitoring states' progress
    - The NAIC expects a majority of the states will have the NAIC Network Adequacy Model Act adopted within 3 years
- In the 2017 Payment Notice Final Rule, CMS amended 45 C.F.R. § 156.230 to include a new network adequacy requirement for Marketplace plans to meet starting in 2018
  - In order for CMS to deem a network adequate, the Marketplace plan must count cost sharing paid by an a member for an EHB provided by an out-of-network ancillary provider in an in-network setting towards the members annual limitation on cost sharing; or
  - The Marketplace plan must Provide a written notice to the enrollee by the longer of when the issuer would typically respond to a prior authorization request timely submitted, or 48 hours before the provision of the benefit, that additional costs may be incurred for an EHB provided by an out-of-network ancillary provider in an in-network setting, including balance billing charges, and that any additional charges may not count toward the in-network annual limitation on cost sharing.

NAIC Network Adequacy Model Act



NAIC Network Adequacy Model Act

- High level requirements of the NAIC Network Adequacy Model for network adequacy and provider directories include:
  - NAIC Network Adequacy Model Act puts the burden on state insurance commissioners to determine the adequacy of an network, using criteria laid out in the Model Act, such as: (1) provider-covered person ratios, (2) geographic accessibility of providers, (3) waiting times, (4) hours of operation, (5) the ability of the network to meet the needs of covered persons with chronic conditions, and (6) other health care service delivery system options, such as telemedicine or mobile clinics
    - Insurers must also submit access plans to their state insurance commissioners, which must detail and describe a number of different items such as: (1) insurer's procedures for making and authorizing referrals in and out of the network, (2) the factors used by the insurer in building its network, including a description of the criteria used to select providers, and (3) insurer's methods for assessing the health care needs of covered persons

NAIC Network Adequacy Model Act

- NAIC Network Adequacy Model Act requires insurers to post the provider directory electronically and make it accessible without requiring members to log-in
  - Provider directory must be updated at least monthly and must be periodically audited for accuracy
  - Provider directory must be made available in hardcopy upon request
  - Provider directory must include in plain language, among other things, a description of the criteria the insurer used in building its network, note that authorization or referral may be required to access some providers, if applicable, and include a customer service email address and phone or electronic link that covered persons or general public may use to notify the plan of any inaccuracies
  - Provider directory must include information on providers, facilities, and hospitals and the information that must be included on providers, facilities, and hospitals is different for each
- The adoption of the NAIC Network Adequacy Model Act by the states will require Marketplace plans to significantly change their current practices on network adequacy and provider directory and will likely cause a host of new compliance concerns

Litigation – Provider Directories and Network Adequacy

- California is the current battleground for provider directory and network adequacy lawsuits
- At least six (6) separate lawsuits have been filed in California against insurers and several are class action lawsuits (five lawsuits arise from Marketplace plans and one arises from an MA plan)
  - The main claims are: (1) the insurers misrepresented to plaintiffs that their physicians and hospitals were in-network; (2) subjected plaintiffs to inadequate networks; and (3) denial of medical services as out-of-network after representations that the services were in-network
  - Plaintiffs are bringing: (1) fraud claims; (2) negligent misrepresentation claims; (3) breach of contract claims; and (4) violations of state consumer protection law claims
  - Plaintiffs are seeking injunctive relief, damages, and restitution
- A lawsuit has also been filed in Missouri as a class action which raises similar issues as the California lawsuits
- As of March 14, 2016, all of the cases are still pending with no resolution
- However, the California Department of Managed Health Care (CDMHC) has taken action against two insurers as a result of inaccurate provider directories which resulted in network adequacy issues
  - CDMHC fined one insurer $250,000 and the other insurer $350,000 and both insurers are required to improve the accuracy of their provider directories and reimburse members for costs incurred from care received outside of the network due to inaccurate provider directory information
    - One insurer has already reimbursed its members over $38 million, while the other insurer is waiting to reimburse members due to litigation issues

Cases

1. *Roberts v. United Healthcare Servs., Inc.,* No. BC540910 (Cal. Super. Ct. L.A. County, filed March 28, 2014)
2. *Felser v. Blue Cross of Cal.*, No. BC550739, (Cal. Super. Ct. L.A. County, filed July 9, 2014)
3. *Davidson v. Cigna Health and Life*, No. BC558566 (Cal. Super. Ct. L.A. County, filed Sept. 24, 2014)
4. *Lehman v. Health Net of Cal.,* No. BC567361 (Cal. Super. Ct. L.A. County, filed Dec. 21, 2014)
5. *Harrington v. Blue Shield of Cal.,* No. CGC-14-539283 (Cal. Super. Ct. S.F. County, filed May 14, 2014)
6. *Brown, et al. v. Blue Cross of Cal.,* No. BC554949 (Cal. Super. Ct. L.A. County, filed August 19, 2014)
7. *Simon, et al. v. Blue Cross of K.C.*, No. 1416-CV12765 (Cir. Ct. Jackson County Missouri, filed May 29, 2014)

Best Practices – All Plans

- Update the provider directory immediately (nightly) upon notice of the provider on any change in availability (termination, not accepting new patients, location change, etc.)
- Include a disclaimer on provider directories detailing that the accuracy of the provider directory cannot be guaranteed due to networks changing on a daily basis and recommend the member call the provider directly or calling member services
- Institute a "warm transfer" policy of transferring members to the provider directly to allow them to set up an appointment
- Include in provider contracts provisions requiring the provider to update the plan on a monthly basis on any availability changes (termination, not accepting new patients, location change, etc.)
- Audit your provider directory on a consistent (monthly) basis to ensure accuracy
- When a provider is incorrectly listed on a provider directory and a member receives services from such provider, the plan should cover the services at in-network rates and ensure the member will not be balanced billed and then help the member find an in-network provider

Best Practices – All Plans

- Include a safety net of providers in the network to ensure adequacy is maintained at all times.
  - For example, if you need to have 100 primary care providers in the network, include 105 or 110 providers as a safety net, to account for the churn
- Notify your plan members right away when their provider leaves the network
  - Medicaid Plans must make a good faith effort to give written notice of termination within 15 days – 42 C.F.R. § 438.10(f)(5)
  - Medicare Advantage plans must make a good faith effort to give written notice of termination within 30 days – 42 C.F.R. § 422.111(e)
  - Marketplace plans, starting in 2017, must make a good faith effort to provide written notice of termination within 30 days - 42 C.F.R. § 156.230(d)(1)
  - All notices must be given prior to the effective date of the termination. For example, if a Medicaid provider is set to be terminated on January 16, then the plan must give notice on January 1.

Marketplace Compliance

- 45 C.F.R. § 156.715 gives CMS the authority to conduct compliance reviews of Marketplace plans
- During a compliance review by CMS the Marketplace plan must:
  - Make available to CMS records that pertain to its activities under the Marketplace
    - Books, contracts, policy manuals, plan benefit information, policy and procedures, and all other reasonably necessary items for CMS to evaluate compliance
  - The Marketplace plan's premises and equipment must be made available to CMS during the compliance review
    - The compliance review may be onsite or a desk review
- A Marketplace plan is subject to a compliance review by CMS up to 10 years from the last day of the plan benefit year or 10 years from the last day that the Marketplace plan is effective if the Marketplace plan is not longer available through the Marketplace
  - However, if the 10 year review period falls during an on-going compliance review, the 10 year period will be extended until the compliance review is completed

Marketplace Compliance

- The good faith safe harbor, located at 45 C.F.R. § 156.800, end at the end of the 2015 plan year
  - 2016 will be the first year a Marketplace plan could face sanctions from CMS
- Marketplace plans may face civil monetary penalties as stated in 45 C.F.R. § 156.805, if CMS finds credible evidence of:
  - Substantial non-compliance with the Marketplace standards;
  - Limiting of access to medically necessary services;
  - Imposing premiums in excess of what is permitted by CMS;
  - Engaging is discriminatory practices;
  - Intentionally or recklessly misrepresenting or falsifying information; and
  - Failure to remit user fees and failure to comply with cost sharing reductions and APTC standards
- The maximum amount of penalty imposed for each violation is $ 100 for each day for each individual adversely affected by the non-compliance
  - Where the number of individuals cannot be determined, CMS may estimate the number of individuals adversely affected by the non-compliance

Marketplace Compliance

- Marketplace plans may also face decertification of a Marketplace plan as stated in in 45 C.F.R. § 156.810
- A Marketplace plan may be decertified if the Marketplace plan:
  - Substantially fails to comply with federal laws and regulations applicable to Marketplace place participation;
  - Substantially fails to comply with transparency and marketing standards;
  - Substantially fails to comply with APTC and cost sharing standards;
  - Operates in the Marketplace in a manner that hinders efficient and effective administration of the Marketplace;
  - Committed or participated in fraudulent or abusive activities;
  - Failed to meet network adequacy standards;
  - Substantially fails to comply with internal appeals and external review process; and
  - Many, many more!
- CMS may use a standard or an expedited decertification process depending on what the issue of non-compliance (fraud, network adequacy, internal appeals and external review)

Marketplace Compliance: Hot Topics

- If selected for a compliance review, CMS will send a notification of selection, which may occur any time during the year
- For the 2016 benefit year CMS has indicated it will focus its compliance reviews on Marketplace plan certification standards under 45 C.F.R. Part 156 and other key operational standards
- 45 C.F.R. Part 156 houses at least 20 different regulations that may be used by CMS when conducting its compliance reviews
- CMS is likely focus on the following:
  - Network adequacy
  - Provider directories
  - Discriminatory benefits (age limits on benefits, transgender, prescription drugs)

Managed Care Provider Contracts

Potential Exclusionary Provisions

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Potential Exclusionary Provisions

- The ACA has caused health care providers and health plans to contract differently.
- In working to achieve cost savings and create narrow networks, providers and health plans include provisions in managed care contracts that could be construed as exclusionary.
- Examples of provisions that may be exclusionary are most favored nation clauses, exclusivity language, anti-steering and anti-tiering.
- These provisions can cut both ways. They can be procompetitive in some circumstances and anti-competitive in other settings.
- From a compliance standpoint, it is important to recognize whether such provisions are exclusionary, meaning that they have an anti-competitive impact.

KEY QUESTION: Whether either party has taken deliberate steps to eliminate or substantially weaken existing rivals or prevent new competition in unnecessarily restrictive ways?

Most Favored Nation (MFN) Clauses

In the health care context, MFN clauses are contractual provisions between health insurance plans and healthcare providers that essentially guarantee that no other plan can obtain a better rate than the contracting health insurance plan.

Fairly consistent definitions of MFNs can be found within statutes, regulations and case law.

Most Favored Nation (MFN) Clauses

An MFN is often defined by law as a clause within a provider contract that:

- Prohibits or grants a contracting insurer an option to prohibit a provider from contracting with another party to provide health care services at a lower rate than the payment or reimbursement rate specified in the contract with the contracting insurer;
- Requires, or grants a contracting insurer an option to require a provider to accept a lower payment or reimbursement rate if the provider agrees to provide health care services to any other party at a lower rate than the payment or reimbursement rate specified in the contract with the insurer;
- Requires or grants a contracting insurer an option to require termination or renegotiation of an existing provider contract if a provider agrees to provide health care services to any other party at a lower rate than the payment or reimbursement rate specified in the contract with the insurer; or
- Requires a provider to disclose, to the insurer the provider's contractual payment or reimbursement rates with other parties.

Most Favored Nation (MFN) Clauses

MFNs were heavily scrutinized in the 1990s. However, MFN clauses have been more recently the subject of high-profile enforcement cases in the past 5 years.

MICHIGAN

- A case study of when entering MFNs went horribly wrong for both a plan and its contracted providers:
  - BCBSM is the dominant insurer in Michigan
  - The Department of Justice ("DOJ") challenges Blue Cross Blue Shield of Michigan ("BCBSM") Acquisition of Physicians Health Plan of Mid-Michigan (March, 2010)
  - The DOJ conducts discovery during its review of potential acquisition and learns that BCBSM hospital provider agreements contain MFN clauses
  - The DOJ then filed a civil antitrust lawsuit against BCBSM alleging that provisions in BCBSM's provider contracts raise hospital prices, prevent other insurers from entering the market, and discourage discounts (October 2010)
  - The DOJ alleged that BCBSM used MFNs in at least 70 of Michigan's general acute care hospitals
  - The DOJ dismissed its lawsuit when Michigan law changed in 2013. See MCL 500.3405 and Mich. Insurance Commissioner Order No. 12-035-M

Most Favored Nation (MFN) Clauses

MICHIGAN (continued)

The Michigan MFN controversy does not end there:

- Aetna, Inc. files $2 Billion antitrust lawsuit against BCBSM in 2010.
- *Aetna, Inc. v. Blue Cross Blue Shield of Mich.*, Case No. 11-15346
- BCBSM settles with Aetna in March of 2015 for undisclosed amount
- In March of 2016, *Crains Detroit* reported that BCBSM had a net loss of $68 million for 2015.
- Vice President of Finance attributes that the settling of long-standing lawsuits contributed to losses--approximately $330 million in total litigation costs.
- Legal experts have speculated that the bulk of the $300 million in settlements were due to the Aetna antitrust/MFN lawsuit
- Additional lawsuits related to BCBSM's use of MFN clauses
  - *Shane Group v. BCBSM, Case No. 2:10-cv-14360*
  - *City of Pontiac v. BCBSM, Case No. 11-10276* (lawsuit filed against BCBSM and 22 hospitals)

States Banning MFN Clauses

Various states, in addition to Michigan, have banned MFN clauses.

- Ohio: ORC §3963.11
- Connecticut: Conn. Gen. Stat. Ann. § 38a-479b(d)
- Georgia: O.C.G.A. § 33-6-13; Georgia Office of Insurance and Safety Fire Commissioner Directive 10-EX-2 (July 23, 2010)
- Idaho: Idaho Code Ann. § 41-3927(4)
- Indiana: Ind. Code Ann. § 27-8-11-9
- Maryland: Md. Ins. Code Ann. § 15-112(l)
- Massachusetts: Mass. Gen. Laws 176D, § 3
- Maine: Maine Rev. Stat. Ann. 24-A, § 4303
- Minnesota: Minn. Stat. § 62A.64
- North Carolina: N.C. Gen Stat. § 58-50-295
- New Hampshire: N.H. Rev. Stat. Ann. §417:4
- New Jersey: N.J. Admin. Code § 11:24B-5.2, 4.2
- North Dakota: N.D. Cent. Code § 26.1-04-03
- Rhode Island: R.I. Gen. Laws § 23-17.13-2, 3
- Vermont: Vt. Stat. Ann. tit. 18, § 9418e
- Washington: Wash. Admin. Code 246-25-045

Most Favored Nation (MFN) Clauses

MFNs can carry a potential for serious consumer harm.

When used by dominant players, MFNs can increase prices by removing seller incentives to discount to other buyers.

MFNs can foreclose competitors from entering the market by preventing entrants from gaining access to the more favorable terms they may need to compete.

Exclusive Contract Provisions

Various forms in health plan/provider relationships.

Some examples:

- Health plan contracts with provider to provide services to all of health plan's members;
- Health plan contracts with provider to be the exclusive provider for one of health plan's product networks (i.e., Marketplace).
- Health plan and provider enter into an arrangement that creates a substantial disincentive from the health plan to include other such providers in its network.
- Exclusive contracts are not *per se* illegal and, in fact, are often procompetitive.
- Need to focus on whether the exclusive dealing forecloses competition from entering market.
- What is the term of this agreement? The longer the term, the more likely the arrangement will be scrutinized.
- Does the arrangement delay or prevent the expansion and entry of competitors, likely leading to higher health-care costs and higher health insurance premiums?
- Does it lead to limited price competition for price-sensitive patients, likely leading to higher health-care costs for those patients?
- Does contract reduce quality competition between provider and its competitors?

Anti-tiering and Anti-steering Provisions

EXAMPLE: *"Plan shall not carve out, steer, or tier, by contract or otherwise, any services which are provided in the ordinary course by Facility, and allow another provider to render such services in lieu of allowing Members to receive such services at Facility."*

A provider, through this type of clause may:

- demand to be placed in preferred tier;
- and attempt to prohibit or inhibit insurers from creating limited network products or tiered products that might steer patients away from the contracted provider.

Peter Muchetti of the DOJ has stated that "[a]nti-steering and anti-tiering provisions have the potential to lessen competition in health care provider markets. These provisions can reduce the incentive for providers to improve quality and lower prices because the provisions inhibit a payer's ability to direct more business to higher-quality/lower-cost providers."

See *American Health Lawyers Association Practice Group Spotlight, "Questions for the Antitrust Division of the U.S. Department of Justice"* (May 2015)

Practice Tips

If a health plan or provider insists upon including MFN, exclusivity or anti-steering/tiering provisions in provider contracts, take the following steps before agreeing to such terms:

- Proactively educate business owners, contractors, and in-house counsel about potential risks involved in using MFNs, exclusivity and anti-steering/anti-tiering clauses in provider contracts;
- Determine whether either party is a dominant player in the market;
- Avoid the inappropriate sharing of competitive information with the other party;
- Engage counsel (preferably antitrust counsel) to assist in negotiating such provisions and/or in defending against including such provisions in a contract;
- Review all state and federal laws to determine whether such provisions are legal in each applicable state;
- Analyze the motivation/intent/business justification underlying the proposed provision(s);
- Conduct an analysis of the relevant market; and
- Evaluate whether competition can be harmed.

The more dominant the health plan or health care provider is in the market, the more likely the arrangement will be scrutinized and could be problematic.

Managed Care: Hot Legal Topics

Member Rewards and Incentives: What's an MCO to do?

Jeffrey E. McFadden, Partner – Stradley Ronon Stevens & Young, LLP

Background

- Historical concerns: kickbacks, inducements
- 2014 CMS Regulations (MA Plans)
  - Allow member rewards and incentives
  - Activities focused on:
    - Promoting improved health
    - Preventing injuries and illnesses
    - Promoting efficient use of health care resources
  - Must include certain protections (e.g. no cash/monetary rebates or reduced cost-sharing premiums)

Recent Advisory Opinions

- **Common arrangement**
  - Hospital would provide up to 100% discounts on Part A inpatient deductibles for policyholders
  - Medigap insurers would not be required to pay the amount of the discount to the hospital, only an administrative services fee for each discount received
  - Policyholders would then receive a portion of the savings via premium reduction
- **OIG Analysis**
  - Violated the prohibition against inducements
  - No sanctions because unlikely to:
    - Increase Medicare costs
    - Affect competition
    - Affect medical judgment
    - Affect patient choice
- **Trend:** Increasing frequency of similar opinions

Trends

Provider Incentives	• Quality incentives • Value-based payment
Consumer Incentives	• Population health / healthy behaviors • Cost-reduction efforts for necessary services
State Medicaid Programs	• Capitation / shared savings • Quality incentives

Questions?

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