2016

Everything Old is New Again: Will Narrow Networks Succeed Where HMOs Failed?

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EVERYTHING OLD IS NEW AGAIN: WILL NARROW NETWORKS SUCCEED WHERE HMOS FAILED?

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If history repeats itself, and the unexpected always happens, how incapable must Man be of learning from experience.
– George Bernard Shaw

I. INTRODUCTION

In much the same way that the phrase "Read my lips: no new taxes"[1] will forever be associated with President George H.W. Bush and his notorious campaign promise,[2] few phrases from President Barack Obama's national tour promoting health care reform will be remembered like ". . . if you like your health care plan, you keep your health care plan. Nobody is going to force you to leave your health care plan. If you like your doctor, you keep seeing your doctor."[3] Just as critics harangued Bush when he raised taxes two years after his then-famous speech,[4] critics vilified Obama for his 2009 statement when,[5] three years following

[1] George H.W. Bush, Acceptance Speech for the Nomination as the Republican Presidential Candidate at the Republican National Convention (Aug. 18, 1988) (transcript available at http://millercenter.org/president/bush/speeches/speech-5526).

[2] Bush was elected following the speech he made at the Republican National Convention. Two years after his election, with a struggling economy, a large military presence in Saudi Arabia, and a Democratic Congress, he reneged on his earlier promise and signed a budget that included raising taxes. *See* Ken Blackwell & Bob Morrison, *Broken Promises/Broken Presidencies*, HUFFINGTON POST (Nov. 4, 2013), http://www.huffingtonpost.com/ken-blackwell/broken-promisesbroken-pre_b_4181566.html.

[3] Barack Obama, President, Remarks by the President in Town Hall on Health Care in Grand Junction, Colorado (Aug. 15, 2009) (transcript available at https://www.whitehouse.gov/the_press_office/Remarks-By-The-President-In-Town-Hall-On-Health-Care-Grand-Junction-Colorado/).

[4] *See* James D. Desmond, Note, *The Earth Summit and Limits on Carbon Dioxide Emissions: Reading Between the Lines*, 8 J. NAT. RESOURCES & ENVTL. L. 357, 369–70 (1992–1993) (citing Peter D. Hart & Thomas Riehle, *Campaign Inevitables: War and Taxes*, NEWSDAY, Aug. 23, 1992 (Currents), at 31). This phrase was so impactful that it has recently been mentioned in connection with the presidential campaign of Bush's son, Jeb Bush. *See* Chuck Ross, *Jeb to Grover: Read My Lips, No New Tax Pledge!*, DAILY CALLER (Feb. 28, 2015), http://dailycaller.com/2015/02/28/jeb-to-grover-read-my-lips-no-new-tax-pledge/.

[5] The phrase quoted above was named by PolitiFact as the 2013 Lie of the Year, stating that President Obama's description was an oversimplification of this complex law and the promise became too sweeping. Angie Drobnic Holan, *Lie of the Year: 'If you like your health care plan, you can keep it,'* POLITIFACT (Dec. 12, 2013), http://www.politifact.com/truth-o-meter/article/2013/dec/12/lie-year-if-you-like-your-health-care-plan-keep-it/. President Obama later clarified his comments, stating that the ACA does in fact allow individuals to stay on their existing plans, but also requires that to the extent that an insurer wants to make changes to its plan(s), such plans must meet certain minimum quality standards to ensure the individuals do not just have insurance, but have sufficient insurance. *See* Barack Obama, U.S. President, Remarks by the President to ACA Coalition Partners and Supporters (Nov. 4, 2013) (transcript available at http://www.whitehouse.gov/the-press-office/2013/11/04/remarks-president-aca-coalition-partners-and-supporters).

the enactment of the Patient Protection and Affordable Care Act ("ACA"),[6] anywhere from 2.5 to 4 million individuals had their health plans cancelled due to insurance requirements under the ACA.[7] Now, as the ACA enters its fifth year, critics are vocal again as more and more health plans are creating networks that limit the number of physicians and providers who are participating in the plans, thereby forcing individuals to choose new doctors when purchasing certain health plans.[8]

Highlighting this problem were stories such as that of the Blank family. The Blank family resided in Washington state and sought to purchase insurance on their state health insurance exchange after their insurance policy was cancelled in 2013 for failure to provide certain mandated benefits.[9] The Blanks soon discovered, however, that their daughter Zoe's current health care provider, Seattle Children's Hospital ("SCH"), was not offered as an in-network provider on any of the available health plan options on the state exchange.[10] While perhaps not a problem for many, the Blank's daughter, Zoe, has a rare bone condition and requires specialty care, which she historically had received at SCH.[11] For the Blanks, they were forced to decide between affordable

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[6] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

[7] *Compare* ASSOCIATED PRESS, *Policy Notifications and Current Status, by State,* YAHOO! (Dec. 26, 2013), http://finance.yahoo.com/news/policy-notifications-current-status-state-204701399.html (reporting that over four million individuals lost their health insurance coverage); *with* Lori Robertson & Brooks Jackson, *'Millions' Lost Insurance,* FACTCHECK.ORG, (Apr. 11, 2014), http://www.factcheck.org/2014/04/millions-lost-insurance/; *and* Lisa Clemans-Cope & Nathanial Anderson, *How Many Nongroup Policies Were Canceled? Estimates from December 2013,* HEALTH AFF. BLOG (Mar. 3, 2014), http://healthaffairs.org/blog/2014/03/03/how-many-nongroup-policies-were-canceled-estimates-from-december-2013/ (noting that the number of individuals who lost their health insurance coverage was closer to 2.6 million).

[8] *See, e.g.*, Sarah Kliff, *Obamacare's Narrow Networks Are Going to Make People Furious – But They Might Control Costs,* WASH. POST (Jan. 13, 2014), http://www.washingtonpost.com/blogs/wonkblog/wp/2014/01/13/obamacares-narrow-networks-are-going-to-make-people-furious-but-they-might-control-costs/ (noting that the narrow networks within the ACA healthcare plans limit the individual's choice of physicians); Duke Helfand, *A Shift Toward Smaller Health Insurance Networks*, L.A. TIMES (Apr. 3, 2011), http://articles.latimes.com/2011/apr/03/business/la-fi-cheaper-insurance-20110402 (identifying that if individuals choose a physician outside of their network they will be required to pay for that service out-of-pocket).

[9] *See* Sandhya Somashekhar & Ariana Eunjung Cha, *Insurers Restricting Choice of Doctors and Hospitals to Keep Costs Down*, WASH. POST (Nov. 20, 2013), http://www.washingtonpost.com/national/health-science/insurers-restricting-choice-of-doctors-and-hospitals-to-keep-costs-down/2013/11/20/98c84e20-4bb4-11e3-ac54-aa84301ced81_story.html.

[10] *See id.*

[11] *Id.*

insurance that would not provide access to Zoe's specialists or forego needed subsidies in order to find insurance that would assure Zoe access to certain doctors.[12]

As more stories and situations like those of the Blank family emerge, industry observers are noting what appears to be a new reality for insurance plans in the age of health care reform.[13] As health insurers try to navigate the new limitations set forth under the ACA, including prohibitions on denying individuals with pre-existing conditions and limitations on the rating of patients,[14] insurers are looking towards models that will enable them to control costs without access to their usual tools.[15] What they have developed is not so much a new insurance model, but actually a concept that first arose during the rise of managed care; that is, limited provider networks utilized within health maintenance organizations ("HMOs").[16] These "new" insurance products, often referred to as narrow networks or high-performance networks,[17] offer beneficiar-

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[12] *See id.* (noting that to the extent SCH was not included on the insurance plans available on the insurance exchange, the Blanks will either have to purchase insurance outside the exchange offerings or consider a job change that would enable Mr. Blank to have employer coverage that would include SCH).

[13] *See* BILL EGGBEER & DUDLEY MORRIS, BDC ADVISORS, NARROW, TAILORED, TIERED AND HIGH PERFORMANCE NETWORKS: AN EMERGING TREND, http://www.wellcentive.com/downloads/Narrow%20Tailored%20Tiered%20and%20High%20Performance%20Networks.pdf.

[14] Patient Protection and Affordable Care Act, Pub. L. No. 111-148 §§ 1101, 2701, & 2704, 124 Stat. 119, 141, 155, 323 (2010) (codified at 42 U.S.C. §§ 300gg-1, 300gg-2, 300gg-3 (2012)) (requiring insurers to accept all applicants without regard to pre-existing conditions); *see also* 42 U.S.C. § 300gg-4 (2012) (prohibiting insurers from setting rates based on health status and gender and limiting the amount that insurers can increase premiums based on age).

[15] "Rating" is a process that insurers engage in to determine risk levels of certain individuals. Historically, health insurers would "rate" patients by a number of factors including previous medical history, family medical history, age, gender, tobacco use, and other health-related factors for purposes of purchasing insurance. Insurers would then use this rating to either deny coverage altogether or, alternatively, charge individuals substantially higher premiums. *See* BARRY R. FURROW ET AL., THE LAW OF HEALTHCARE ORGANIZATION AND FINANCE 271–72 (7th ed. 2013).

[16] *See* Jose L. Gonzalez, *A Managed Care Organization's Medical Malpractice Liability for Denial of Care: The Lost World*, 35 HOUS. L. REV. 715, 729 (1998). While HMOs actually date back to the 1920s, they became more popular in the late 1970s and experienced even greater popularity during the mid to late 1980s. *Id.* (citing Vernellia R. Randall, *Managed Care Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries*, 17 U. PUGET SOUND L. REV. 1, 21 & n.82 (1993)) (noting that the number of individuals enrolled in an HMO went from 13 million enrollees in 1980 to 31 million by 1988).

[17] NOAM BAUMAN ET AL., MCKINSEY & CO., MCKINSEY CTR. FOR U.S. HEALTH SYS. REFORM, HOSPITAL NETWORKS: UPDATED NATIONAL VIEW OF CONFIGURATIONS ON THE EXCHANGES (June 2014),

ies a more limited network of physicians typically in exchange for lower premiums.[18] These insurance plans are becoming increasingly common both on the federal and state health insurance exchanges as well as in insurance product offerings outside the exchanges.[19] As these limited provider networks become more prevalent, there is evidence of a number of similarities between the narrow networks of today and the HMOs that increased in popularity during the 1980s and 1990s.[20]

But, if narrow networks are in fact simply a redux of HMOs, can it be surmised that narrow networks are likely be a short-lived trend? Will narrow networks fall into disfavor and suffer the same consumer backlash and financial challenges as the HMOs of twenty-plus years ago? Or, is there something unique and distinct about the narrow networks arising in the current health insurance market that will create greater longevity for these insurance products that was not achievable with HMOs, despite their similarities? This article argues that the narrow networks that have emerged in the current healthcare marketplace are indeed unique and distinct from their HMO predecessors and, because of such distinctions, appear poised to experience greater success and longevity than HMOs.

Part II of this article will examine the history of limited provider organizations, specifically HMOs, including their rapid rise and then subsequent descent into disfavor with consumers and providers alike. It will then review the movement back towards limited provider networks, defining what constitutes a narrow network and highlighting current prevalence of these products on the insurance market.

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http://healthcare.mckinsey.com/sites/default/files/McK%20Reform%20Center%20-%20Hospital%20networks%20national%20update%20%28June%202014%29_0.pdf; EGGBEER & MORRIS, *supra* note 13, at 2; *see also* Joseph Berardo, Jr., *High Performance Networks Entice Health Plan Sponsors: Narrow Networks of Service Providers Can Improve Outcomes and Control Costs*, SHRM (Aug. 8, 2014), http://www.shrm.org/hrdisciplines/benefits/articles/pages/narrow-networks.aspx.

[18] *See* Sara Hansard, *Higher Cost-Sharing, Narrow Networks, Here to Stay in ACA Health Plans*, BLOOMBERG (Oct. 6, 2015), http://www.bna.com/higher-costsharing-narrow-b57982059160/.

[19] *See* Reed Abelson, *More Insured, But The Choices Are Narrowing*, N.Y. TIMES (May 12, 2014), http://www.nytimes.com/2014/05/13/business/more-insured-but-the-choices-are-narrowing.html?_r=0; *see also* GARY CLAXTON ET AL., KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS, 2013 ANNUAL SURVEY 207 (2013), https://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20132.pdf.

[20] *See* Valarie Blake, *Narrow Networks, the Very Sick, and the Patient Protection and Affordable Care Act: Recalling the Purpose of Health Insurance and Reform*, 16 MINN. J.L. SCI. & TECH. 63, 78 (2015) (citing Vicki Yates Brown & Barbara Reid Hartung, *Managed Care at the Crossroads: Can Managed Care Organizations Survive Government Regulation?*, 7 ANNALS HEALTH L. 25, 25–27 (1998)).

Part III will then review the existing legal structure (much of which arose during the time of HMOs) surrounding narrow networks, including examination of a few recent lawsuits against insurers under both federal and state law and the state and federal statutes designed to protect both providers and consumers. This Part will identify some of the challenges for providers and consumers with the existing legal structure in connection with taking action against limited provider networks.

Next, Part IV will consider the advantages and disadvantages of narrow networks and forecast the potential outlook for narrow networks based on such factors. Part IV will also examine the current activities of certain "high-cost providers," such as academic medical centers, to create their own alternative networks or alternative product offerings, and what impact such activities might have on the sustainability of narrow networks.

Finally, in Part V, this article will conclude that narrow networks are likely to realize more sustained longevity and success than their HMO predecessors because of the following three distinctions between narrow networks and HMOs: (a) unlike HMOs,[21] narrow networks, especially those offered on federal and state health insurance exchanges,[22] are consumer-driven products, responding to a specific need for insurance offerings at a lower cost; (b) existing laws in place to protect against potential ills of limited provider networks are either too narrowly focused on HMOs or too discretionary for consistent application and enforcement against modern narrow network products; and (c) so long as large and influential high-cost providers continue to create alternative structures rather than fight exclusion from narrow networks,[23] there is a greater likelihood of a co-existence of both narrow networks and alternative networks (which cater to different segments of the population) and

[21] *See* Barry R. Furrow, *Managed Care Organizations and Patient Injury: Rethinking Liability*, 31 GA. L. REV. 419, 421 (1997) (noting that HMOs were marketed to and largely purchased by large employers and government entities, not individual consumers).

[22] While transparency is still an issue in terms of communication from insurers to consumers regarding insurance products (discussed in more detail below), an online exchange in which consumers can compare insurance options side-by-side and compare premiums provides greater transparency than the previous small group and individual insurance markets of the past. Karen Pollitz & Larry Levitt, *Health Insurance Transparency under the Affordable Care Act*, HENRY J. KAISER FAM. FOUND. (Mar. 8, 2012), http://kff.org/health-reform/perspective/health-insurance-transparency-under-the-affordable-care-act/ (last visited Sept. 1, 2015).

[23] It is acknowledged that a consumer-driven response to the need for these high-cost providers in their networks could arise, but such challenges could be more dubious in terms of success without support of the high-cost providers themselves.

thus greater longevity of narrow networks.[24]

II. HISTORY OF LIMITED PROVIDER NETWORKS: PRECURSORS TO NARROW NETWORKS

As narrow networks have increasingly started to generate headlines, both proponents and critics note that networks limiting or restricting the selection of providers are not new in the health care industry.[25] One of the first examples of a limited provider network was the HMO.[26] HMOs are generally defined as an entity that limits its members to "an exclusive network of providers, permitting their member to go to non-network providers only in special circumstances, like medical emergencies."[27] While HMOs can vary in their structure and organization, HMOs are typically associated with a payment scheme in which the network providers are paid a "capitated" monthly rate—a flat-fee per month for each beneficiary/enrollee[28] of the HMO—regardless of the cost of services provided to such beneficiary during the particular month.[29] In fact, many state laws include capitation payment as part of the definition of an

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[24] While it is outside the scope of this article, for a discussion of the potential ethical issues created by the possibility of a system in which narrow networks and other alternative networks are proceeding simultaneously. *See generally* Blake, *supra* note 20.

[25] *See* Julie Appleby, *HMO-Like Plans May be Poised to Make Comeback in Online Insurance Markets*, KAISER HEALTH NEWS (Jan. 22, 2013), http://khn.org/news/hmo-limited-networks-comeback-in-exchanges/.

> Nearly half the exchange plans in 13 states with early filings will be of the narrow-network type, according to an unpublished McKinsey & Co. analysis of 955 plan offerings. Enrollees in such plans will have limited or no coverage if they seek care outside their plan network. In exchange, subscribers will enjoy lower premiums than they would pay for plans with broader networks, insurers say. Insurers believe millions of exchange subscribers of modest incomes will accept that tradeoff. That would be a big change from the 1990s, when Americans largely rejected HMO-driven restrictions on provider choice and access. Up until recently, only a small fraction of people in employer-based and individual plans have been enrolled in HMOs.

M.P. McQueen, *Less Choice, Lower Premiums*, MOD. HEALTHCARE (Aug. 17, 2013), http://www.modernhealthcare.com/article/20130817/magazine/308179921.

[26] *See* Appleby, *supra* note 25.

[27] FURROW ET AL., *supra* note 15, at 268.

[28] The terms "beneficiary" and "enrollee" mean individuals who are enrolled in or a beneficiary of a health plan. The terms are often used interchangeably when addressing individuals who have purchased health insurance and, for purposes of this article, such terms have the same meaning.

[29] *See* FURROW ET AL., *supra* note 15, at 314 (defining capitation and stating that under this model "the provider becomes the true insurer – i.e. risk bearer – with respect to the patient").

HMO.[30] Thus, an entity that restricts its enrollees to receiving care from a specific limited set of providers may nevertheless fail to qualify as an HMO so long as it does not reimburse such providers on a capitated or prepaid basis.[31]

The concept of the HMO first developed in the 1920s with the development of pre-paid group practice health plans.[32] Because of views by the American Medical Association ("AMA") that such prepaid plans were akin to "communism," there was little wide-spread adoption of HMOs until the 1970s.[33] HMOs moved into more wide-spread acceptance in the 1970s when the United States Congress enacted a law requiring employers with more than twenty-five employees to offer their employees at least one federally-qualified HMO.[34] Following this legislation, HMOs saw an increase not only in the number of enrollees electing HMOs, but also the number of entities organizing as HMOs.[35]

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[30] *See, e.g.*, TENN. CODE ANN. § 56-32-102(8) (West 2015) (requiring that services are paid on a prepaid basis); N.Y. PUB. HEALTH LAW § 4401(2) (McKinney 2013) (defining an HMO plan as one in which the enrolled member is entitled to services "in consideration for a basis advance or periodic charge"); KY. REV. STAT. ANN. § 304.38-030(5) (West 2010) (defining HMO as undertaking to provide services that are paid "on a per capita or a predetermined, fixed prepayment basis"); 215 ILL. COMP. STAT. ANN. 125/1-2(7) (West 2015) (defining an HMO as an entity that provides or arranges for services, which payment consists of "arranging on a per capita prepared basis, through insurance or otherwise"); FLA. ADMIN. CODE ANN. r. 69O-191.024(9) (2015) (defining an HMO as an entity that provides services in exchange for payment on a "prepaid per capita or prepaid aggregate fixed sum basis").

[31] *See* EGGBEER & MORRIS, *supra* note 13, at 6–7 (noting that new models will have a combination of new reimbursement that may include forms of capitation, but will also utilize performance-based contracts, bundled payments, and shared savings/risks).

[32] *See* Randall, *supra* note 16, at 20 (noting conflicting sources about the origins of the first prepaid group health plan, but that generally HMOs stemmed from the concept of a farmer's co-op in Oklahoma and formation of a prepared group health delivery plan by Drs. Ross and Loss in Los Angeles).

[33] *Id.* Physicians were actually quite hostile to prepaid medical plans because it prevented the common practice of charging patients based on an ability to pay; that is, charging more for professional services to patients who could pay higher rates. Physicians feared that prepaid health plans would minimize their compensation to the amount paid by the poorest of patients. *See* Reuben Kessel, *Price Discrimination in Medicine*, 1 J.L. AND ECON. 20, 33 (1958). Thus, the AMA labeled these early prepaid group health plans as "socialized medicine" or "communism" and led most states to pass laws prohibiting operation of managed care plans. Randall, *supra* note 16, at 20–21.

[34] Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914 (codified as amended at 42 U.S.C. § 300e-9 (2012)). The definition of an HMO under this legislation included a requirement that the organization was paid via a periodic, fixed payment. § 2, 87 Stat. at 915.

[35] Jack F. Monahan & Michael Willis, *Special Legal Status for HMOs: Cost Containment Catalyst or Marketplace Impediment?*, 18 STETSON L. REV. 353, 360 (1989) (noting that by March of 1988, there were 648 HMOS with 31 million members, which represented an increase of 25% per annum).

Just as HMOs began to hit their stride, however, they came under fire by consumer advocates and other disgruntled employees due to the lack of consumer choice regarding providers and care.[36] Part of this angst was fueled by stories from the media about the "horrors" of HMOs.[37] An investigative reporter for the *New York Post* published a series of articles titled "What You Don't Know About HMOs Could Kill You," featuring stories of managed care companies that made promises to consumers in their promotional materials, only to fail to deliver the care when the policy holders became ill.[38] The stories were shocking to consumers, complete with pictures of victims, including one of a dead baby and the baby's grieving parents, and one of a woman who was denied a badly needed spinal surgery.[39] One article told the story of Tom Kerwin who saw his primary care physician through Health Insurance Plan of Greater New York ("HIP"), then one of the largest HMOs in the area.[40] Mr. Kerwin was told he had a common cold, but continued to get sicker and sicker.[41] Finally, Mr. Kerwin went to an out-of-network physician, who did some blood tests and promptly sent Mr. Kerwin to the hospital following a diagnosis of hepatitis.[42] Mr. Kerwin was at NYU Medical Center for one month, but his insurer, HIP, refused to pay for the services, presumably because he received his diagnosis from an out-

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[36] *See* SABRINA CORLETTE ET AL., GEORGETOWN UNIV. CTR. ON HEALTH INS. REFORM & URBAN INST., NARROW PROVIDER NETWORKS IN NEW HEALTH PLANS: BALANCING AFFORDABILITY WITH ACCESS TO QUALITY CARE 2 (May 2014), http://www.urban.org/sites/default/files/alfresco/publication-pdfs/413135-Narrow-Provider-Networks-in-New-Health-Plans.PDF (noting that a backlash from providers and consumers regarding HMOs led to changes in laws regarding network adequacy).

[37] *See* David B. Bernard & David J. Shulkin, *The Media vs. Managed Health Care: Are We Seeing a Full Court Press?*, 158 ARCHIVES INTERNAL MED. 2109, 2109–11 (1998) (reviewing eighty-five articles about managed care published in various leading newspapers and finding that two-thirds of the articles portrayed HMOs unfavorably thus discouraging participation); *see generally 184 Patient HMO Horror Stories*, KAISER PAPERS, http://horror.kaiserpapers.org/shoddy.html (last updated July 6, 2015) (featuring stories that were compiled by a disgruntled consumer in hopes that "lawmakers feel enough pressure from their constituents to introduce and pass legislation reining in the power of the insurance companies") (Note that the website is not affiliated with Kaiser Permanente); Kathy Kristof, *HMO Horror Story: Why Are Consumers Skeptical? Ask Jan Gribbon*, L.A. TIMES (Jan. 2, 1993), http://articles.latimes.com/1993-01-02/business/fi-2570_1_hmo-horror-story.

[38] William Sherman, *A News Reporter Explains His 'HMO Horror Stories,'* MANAGED CARE (Sept. 1997), http://www.managedcaremag.com/archives/9709/9709.reporterview.html.

[39] *Id.*

[40] Susan Rubinowitz, *Council Panel Told Very Sick Have a lot to $weat About*, N.Y. POST, Apr. 2, 1996, at 6.

[41] *Id.*

[42] *Id.*

of-network physician.[43] Many stories such as these were circulated during the mid to late-1990s regarding some of the issues that enrollees faced in connection with their HMOs, including denial of necessary services, high medical bills for receiving services from out-of-network providers, and delayed services due to limitation in the network.[44]

Around the same time, some of the new plans that appeared during the HMO boom began to experience financial difficulties.[45] In fact, a sister organization of HIP, Health Insurance Plan of New Jersey ("HIP-NJ") collapsed about a year after the exposé in the *New York Post*, citing various reasons including poor management, increased competition, and too little financing in the face of the increased competition in the HMO field.[46] Director of the Standard & Poor's health industry unit stated at the time, "All over the country, the solvency guidelines are a joke and we have found that one-third of the H.M.O. companies do not have adequate capital. It's like treating managed care as if it has the same risk

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[43] *Id.*

[44] *See supra* note 37 and accompanying text; *see also* Cathy Burke, *Dying Woman Denied Doc She Needs*, N.Y. POST, Sept. 21, 1995, at 5 (sharing the story of a 30-year old woman whose HMO, Health Insurance Plan of New Jersey, refused to authorize anyone other than its own neurosurgeon to perform a delicate tumor procedure even though he had never done a similar surgery before and the woman's physician had done the surgery over 500 times); William Sherman, *Mom Recalls How Baby Died as She Pleaded for Help*, N.Y. POST, Sept. 18, 1995, at 4 (telling the story of a baby whose heart condition was not diagnosed timely following a discharge from the hospital just one day after discharge per requirements of the family's HMO plan); William Sherman, *Ex-New Yorker is Told: Get Castrated so we can $ave*, N.Y. POST, Sept. 18, 1995, at 5 (telling the story of a 76-year old man who was told by his HMO that rather than take the physician-prescribed medication to keep his prostate cancer at bay he should undergo castration as a "cost effective" alternative to the costly medication). The articles from September 1995 were part of a series titled *HMOs: What you don't know can kill you*.

[45] *See* Barbara A. Noah, *The Managed Care Dilemma: Can Theories of Tort Liability Adapt to the Realities of Cost Containment?*, 48 MERCER L. REV. 1219, 1246 (1997); *see also* Wayne Guglielmo, *The HMO Graveyard: What Caused the Biggest Failure Yet*, MED. ECON. (Oct. 25, 1999), http://medicaleconomics.modernmedicine.com/medical-economics/content/hmo-graveyard-what-caused-biggest-failure-yet?page=full ("[T]he Florida-based Weiss Ratings, an insurance rating agency, recently ranked 576 of the nation's HMOs on their fiscal solvency. One hundred [of those ranked] failed to make the grade."). New Jersey Citizen Action's Anthony Wright stated, "For many HMOs, it has become harder and harder to achieve the savings they once sought. Companies that aren't especially well managed will fail." *Id.* Guglielmo noted that one possible solution to the HMO solvency problem might be a "Darwinian struggle—with stronger companies muscling aside or taking over weaker ones." *Id.*

[46] Ronald Smothers & Christopher Drew, *Failed H.M.O. Exposes Shortcomings in a Changing Industry*, N.Y. TIMES (Dec. 27, 1998), http://www.nytimes.com/1998/12/27/nyregion/failed-hmo-exposes-shortcomings-in-a-changing-industry.html.

characteristics as selling Coca-Cola."[47] As new HMOs flooded the market, insurers would try to control costs by driving down prices paid to providers, but the resulting competition forced many of these newly formed organizations into financial ruin, rendering many insolvent.[48]

To guard against these insolvencies, and the risks that many consumers' claims would go unpaid,[49] states began enacting laws in the 1990s designed to protect states and consumers from HMO financial instability and from the ill effects of cost-cutting measures, like those highlighted by the *New York Post*.[50] Model legislation known as the Model HMO Act[51] swept through the states, resulting in forty-seven states enacting some sort of HMO legislation to govern the operation and requirements for HMOs.[52] In addition to extensive provisions pro-

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[47] *Id.* Part of the issue highlighted in the article was one of HIP-NJ's former partners, Pinnacle Health Enterprises, who was in the midst of bankruptcy liquidation proceedings and had been acquiring most of HIP's assets; when the state asked Pinnacle Health Enterprises to put up a large cash reserve in order to assure continued care of its insureds, Pinnacle refused, as they were not subject to state regulation. *Id.*

[48] *See* Guglielmo, *supra* note 45; *see also* James B. Ross & Criss Woodruff, *Analysis of Health Carrier Insolvencies*, 47 TRANS. SOC'Y ACTUARIES 545, 562 (1995) (noting that the Office of Health Maintenance Organizations concluded that of 25 failed HMOs, "[t]he loss of these HMOs was brought about by the failure of management—administrative and medical—to control the utilization and costs of services; to react promptly and effectively when those problems were clearly identified").

[49] To the extent that the HMO was unable to pay a claim to a provider for services rendered, the provider would then seek payment from the consumer for unpaid medical claims. *See* John C. Van Gieson, *Lawmakers Tackle HMO Problem*, ORLANDO SENTINEL (May 8, 1988), http://articles.orlandosentinel.com/1988-05-08/business/0040050042_1_hmo-gunter-subscribers (noting lobbying efforts with state legislatures intending advocating for subscribers of bankrupt HMOs who are targeted for collection). Many states enacted balance billing laws in order to protect against patients from having to be responsible for HMO insolvency. Balance billing is when a health care provider seeks payment from the patient for the difference between the amount the provider charges and the amount that the insurer reimburses the provider for the service. *State Restriction Against Providers Balance Billing Managed Care Enrollees*, KAISER FAM. FOUND. (2013), http://kff.org/private-insurance/state-indicator/state-restriction-against-providers-balance-billing-managed-care-enrollees/. Forty-nine states and the District of Columbia prohibit HMOs from balance billing patients for services provided by in-network providers. *Id.* Notably, only thirteen of the states have the same restrictions for out-of-network providers. *Id.*

[50] Jay M. Howard, *The Aftermath of HMO Insolvency: Considerations for Providers*, 4 ANNALS HEALTH L. 87, 95 (1995).

[51] Developed by the National Association of Insurance Commissioners ("NAIC"), the HMO Model Act, among other things, required HMOs to seek a certificate of operation and further contained certain network requirements to protect against insolvency *See* HEALTH MAINT. ORG. MODEL ACT § 1 *et seq.* (NAT'L ASS'N OF INS. COMM'RS 2003), http://www.naic.org/store/free/MDL-430.pdf.

[52] Note that District of Columbia, Hawaii, Oregon, and Wisconsin did not adopt the Model HMO Act, but have similar laws in each of those jurisdictions that govern HMOs (like

tecting providers and consumers against insolvency,[53] there were provisions that protected consumers from denials of payment for care at out-of-network providers and other aspects of HMO management that enabled HMOs to put cost savings before coverage for services.[54] Thus, with new regulations enacted, declining market acceptance, and increased insolvency, HMOs began to decline in the early 2000s.[55]

A. Movement Towards Narrow Networks

As HMOs began to fall out of favor, preferred provider organizations ("PPOs")[56] began to emerge as the dominant managed care plan for group plan insurance.[57] Towards the early to mid-2000s, the PPO became the "health benefit design of choice for private employers and consumers."[58] Many cite the rise in popularity of the PPO over the years as being a result of the reaction and backlash towards the restrictive and limiting HMO products.[59] For example, the PPO provides nearly an unlimited choice of providers (although at differing costs) for consumers and fewer risks to providers based on a fee-for-service reimbursement structure.[60] This popularity for PPOs has remained true for the last dec-

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those governing insurance companies). *See* Howard, *supra* note 50, at 95.

[53] *See* HEALTH MAINT. ORG. MODEL ACT §§ 8, 13–14, 16, 18–19 (requiring, for example, (1) certain net worth amounts; (2) minimum deposit; (3) hold-harmless clause be contained in all contracts between providers and enrollees from HMO debts; (4) assurances regarding continuation of services in event of insolvency; and (5) minimum notice requirements for cancellation of policies).

[54] *See* HEALTH MAINT. ORG. MODEL ACT §§ 8–9, 13 (requiring each enrollee have a contract within thirty days of enrollment, contract terms be fair and not misleading or deceptive, HMO to retain full responsibility on a prospective basis for the provision of health care services pursuant to the plan and demonstrate consumer satisfaction, enrollees to be notified of any changes to their contracts or policies, including updates to directories of HMO providers who are in-network).

[55] CTRS. FOR MEDICARE AND MEDICAID SERVS., OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING AND EVALUATION, AN OVERVIEW OF THE U.S. HEALTH CARE SYSTEM CHART BOOK 26 tbl.1.18 (Jan. 31, 2007), http://www.slideshare.net/johnny1090/HealthCareChartBook01312007.

[56] A PPO is a system of "health care providers who agree to provide services on a discounted basis to subscribers." FURROW ET AL., *supra* note 15, at 269. A PPO does not typically limit its subscribers to seeing in-plan providers, but out-of-network providers may cost the subscriber more in out-of-pocket expenses. *Id.*

[57] *See* Robert E. Hurley et al., *The Puzzling Popularity of the PPO*, 23 HEALTH AFF., no. 2, Mar. 2004, at 56–68, http://content.healthaffairs.org/content/23/2/56.full.html.

[58] *Id.* at 56 (noting that "more than 100 million people[] now receive their care through [PPO] arrangements, far surpassing enrollment in health maintenance organizations").

[59] *See id.*

[60] *See id.* at 56–57.

ade.[61] The Kaiser Employer Health Benefits 2014 Annual Survey noted that 77% of employees with health insurance provided by their employers work in firms that offer one or more PPO plans[62] and 55% of all firms offer a PPO plan (with 73% of large firms (200 or more workers) offering a PPO plan).[63] While PPOs have been a popular offering, the rise in the prevalence of PPOs has come in a decade where health care costs have also been soaring nationally.[64] Many believe that the reimbursement mechanisms and structure of PPOs have been contributing factors to such run-away spending, thus leading to the need for reforms under the ACA in 2010.[65] Thus, rising health care costs and some of the changes to the insurance marketplace that have come about as a result of the ACA have led the insurance industry to revisit the idea of limited provider networks akin to HMOs.

As the name implies, a narrow network is generally a health insurance plan that incentivizes or requires its beneficiaries or subscribers to use a limited number of physicians, hospitals, or other providers. McKinsey & Company has categorized narrow networks into three types (collectively, "Narrow Networks"): (a) narrow network—approximately 31% to 70% of hospitals participating in the network; (b) ultra-narrow network—less than 30% of the hospitals participating in the network; and (c) tiered network—hospitals are listed in tiers, with different co-payment requirements depending on the tier in which the hospital is listed.[66] Because of an increasing emphasis on quality, cost, and efficiency of care, Narrow Networks are also sometimes referred to as "high performance networks."[67]

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[61] *See* GARY CLAXTON ET AL., KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2014 ANNUAL SURVEY 2, 77 ex.5.1 (2014).

[62] *Id.* at 70. It should be noted that 85% of all firms surveyed offer only one type of health plan. Small firms (3–199 workers) were most likely to offer only one plan at 86%, whereas only 56% of all large firms (200 or more workers) offered only one plan. *Id.* at 71 ex.4.1.

[63] *Id.* at 73 ex.4.3.

[64] *See* Hurley, *supra* note 57, at 64–65 ("Thus, it does not appear that PPO arrangements have played much of a role in cost containment despite the fact that more than half of all commercially covered lives are in PPOs. What they do seem to deliver is cost displacement by moving costs from employer-sponsors to individuals, which, nonetheless, has the real effect of moderating the rate of increase in employers' contributions for benefits.").

[65] *See id.*; *see also* Cathy Schoen et al., *Confronting Costs: Stabilizing U.S. Health Spending While Moving Toward a High Performance Health Care System*, COMMONWEALTH FUND (Jan. 10, 2013), http://www.commonwealthfund.org/publications/fund-reports/2013/jan/confronting-costs (noting some possible reforms to reimbursement to combat runaway health care spending).

[66] BAUMAN ET AL., *supra* note 17, at 2.

[67] *See* EGGBEER & MORRIS, *supra* note 13, at 1.

Narrow Networks represent approximately 48% of all federal and state exchange networks in the United States and an even larger percentage (60%) of exchange networks in the largest city in each state.[68] This finding is likely due, in part, to the manner in which a Narrow Network is defined. Because a Narrow Network must exclude, by definition, approximately 30% of the hospitals in a given area, a Narrow Network option is simply not possible in certain geographic areas of the country.[69] While quite prevalent on the federal and state exchanges, Narrow Networks have also seen some growth in insurance plan offerings of large employers.[70] According to the Kaiser Family Foundation, from 2007 to 2014 the percentage of employers whose largest plan included a Narrow Network increased 4% (from 15% in 2007 to 19% in 2014).[71] The highest prevalence of Narrow Network options for employers is in the Northeast, where 27% of employers' largest plan includes a Narrow Network.[72] Conversely, employers with their largest plan including a Narrow Network plan actually decreased for employers in the Midwest to only 8% of employers in 2014, from a high of 17% in 2010.[73] For those employers that do offer a Narrow Network as their largest plan, 59% reported that both quality and cost/efficiency were criteria in their decision to offer the network.[74]

Despite some increases, employers still remain somewhat cautious of Narrow Network options, with only 6% of employers with 50 or more employees reporting that they believe Narrow Networks will be an effective cost containment strategy.[75] One phenomenon emerging in the large employer market that may impact plan selection and plan offerings is

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[68] BAUMAN ET AL., *supra* note 17, at 4.

[69] *See* Bob Semro, *Narrowing Provider Networks Is All About Cutting Costs, But It Also Can Lead to Lower Premiums*, HUFFINGTON POST (Oct. 3, 2014), http://www.huffingtonpost.com/bob-semro/narrowing-provider-networ_b_5928554.html ("In rural areas, where provider competition can be limited, narrower networks will be much harder to create. For example, one insurer in Colorado intends to maintain its broad networks in rural parts of [t]he state but more narrow networks in the Denver area.").

[70] *See* CLAXTON ET AL., *supra* note 61, at 220 ex.14.5.

[71] *Id.* It should be noted that the increase from 2007 to 2013 was an 8% increase from 15% to 23%. Overall the statistics from 2013 to 2014 were noted to not be statistically significant. *Id.*

[72] *Id.*

[73] CLAXTON ET AL., *supra* note 61, at 220 ex.14.5 (noting the following percentages: 13% in 2007, 17% in 2010, 12% in 2011, 15% in 2013, and 8% in 2014).

[74] *Id.* at 221 ex.14.6. It should be noted that when broken down between cost/efficiency vs. quality, only 3% of employers noted that they were choosing Narrow Networks for quality reasons whereas 33% of employers noted they were choosing the network for cost/efficiency purposes. *Id.*

[75] *Id.* at 7.

employers offering benefits through a "private exchange." A "private exchange," created most commonly by a consultant or insurer, allows employees to choose between various health benefit options, often times coupled with a defined contribution.[76] While it is estimated that only 2% of large employers utilized a private exchange in 2014 (including notables such as Walgreen's, Sears, and DineEquity), 13% are considering offering benefits through an exchange and such exchanges are expected to have significant growth, with some projecting that nearly 40 million individuals will purchase insurance through private exchanges by 2018.[77]

Employees purchasing through a private exchange are making choices regarding health insurance in much the same way as individuals purchasing insurance on a federal or state exchange.[78] To the extent that an employee can compare a variety of insurance options, including the associated premiums, that individual is more likely to make a selection based on premium costs than in a situation where the employee can only select one option or can only choose between two different types of plans (e.g., PPO vs. HMO).[79] With the projected growth of private exchanges and the continued use of federal and state insurance networks, increases in Narrow Network offerings may not be spurred solely by insurers in an effort to control costs, but also in reaction to an increasing demand on the part of consumers who, when able to compare and contrast plans, desire to purchase insurance that is more cost effective.[80] Thus, unlike HMOs, which were focused on cost containment for employers and government entities, Narrow Networks are responding to a

[76] CLAXTON ET AL., *supra* note 61, at 7–8; *see also* ALEX ALVARADO ET AL., KAISER FAMILY FOUND., EXAMINING PRIVATE EXCHANGES IN THE EMPLOYER-SPONSORED INSURANCE MARKET (Sept. 2014), http://files.kff.org/attachment/examining-private-exchanges-in-the-employer-sponsored-insurance-market-report. A defined benefit contribution is where the employer pays the employee a fixed amount of money per month towards health and ancillary benefits (e.g., $300) and then the employee is responsible for paying any difference between the defined benefit (e.g., $300) and the total cost for which the employee is responsible (e.g., $600). *Id.* at 1.

[77] *See* ALVARADO ET AL., *supra* note 76, at 2–4.

[78] Yevgeniy Feyman, *Are Private Exchanges The Future Of Health Insurance?*, FORBES (Oct. 15, 2014), http://www.forbes.com/sites/theapothecary/2014/10/15/are-private-exchanges-the-future-of-health-insurance/ (noting that private exchanges are analogous to the federal and state exchanges).

[79] This is especially true since the enactment of the ACA. With individuals facing the possibility of penalties for failure to maintain health insurance and regulations imposed on employers to prevent individuals from abandoning employer coverage due to costs, individuals are less likely to simply forego employer-sponsored coverage. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 1501, 1511, 124 Stat. 119, 244, 252 (2010).

[80] *See* Semro, *supra* note 69.

specific consumer demand through federal and state exchanges and potentially through the emergence of private exchanges.

III. LEGAL RESTRICTIONS ON NARROW NETWORKS

The recent re-emergence of Narrow Networks has revealed that consumers and providers still remain relatively skeptical of networks that limit provider choice.[81] Thus, determining whether Narrow Networks will experience more sustained success than HMOs will be greatly impacted by the current legal structure and potential legal challenges to these types of organizations.

A. ACA Compliance Challenges

Since the launch of the health care insurance exchange in 2014, two major lawsuits have been filed in response to the formation and operation of Narrow Networks. On October 4, 2013, Seattle Children's Hospital ("SCH") filed a lawsuit against the Washington State Insurance Commissioner, alleging violations of the ACA related to exclusion of SCH as an in-network provider from nearly all insurers participating in Washington state's health care insurance exchange, Washington Healthplanfinder.[82] Specifically, SCH argued that: (a) the ACA requires that all "qualified health plans" included in Washington Healthplanfinder are required to include ten "essential health benefits" and "essential community providers";[83] (b) included in the definition of "essential health benefits" are "pediatric services, including oral and vision care";[84] (c) included in the definition of "essential community providers" is "community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care provid-

[81] *See* Abby Goodnough, *New Law's Demands on Doctors Have Many Seeking a Network*, N.Y. TIMES (Mar. 2, 2014), http://www.nytimes.com/2014/03/03/us/new-laws-demands-on-doctors-have-many-seeking-a-network.html; EGGBEER & MORRIS, *supra* note 13; Kliff, *supra* note 8.

[82] *See* Somashekhar & Cha, *supra* note 9; Pls. Mot. Partial Summ. J. 1, Seattle Children's Hospital's Appeal of OIC's Approvals of HBE Plan Filings, No. 13-0293 (Wa. Office of the Ins. Comm'r Jan. 17, 2014); *see also* Premera Blue Cross's Memorandum at 7, Seattle Children's Hospital's Appeal of OIC's Approvals of HBE Plan Filings, No. 13-0293 (Wa. Office of the Ins. Comm'r Aug. 11, 2014) (noting contracts and tiers in which SCH is a participant).

[83] 42 U.S.C. § 18022(b)(1) (2012); *Id.* § 18031(c)(1); Petition for Judicial Review at 5, Seattle Children's Hosp. v. Office of the Ins. Comm'r of the State of Wa., No. 13-2-34827-6 (Wa. Super. Ct. Oct. 4, 2013) [hereinafter SCH Petition for Review].

[84] 42 U.S.C. § 18022(b)(1).

ers defined in [42 U.S.C. § 256b(a)(4)],"[85] which definition includes "[a] children's hospital excluded from the Medicare prospective payment system";[86] (d) SCH meets the definition of both providing "essential health benefits" and is an "essential community provider" under the ACA;[87] and therefore (e) the Washington State Office of the Insurance Commissioner is required to include SCH in each of its qualified health plans on the insurance exchange due to requirements under the ACA.[88] As a result of this improper exclusion, SCH officials argued that families enrolling in the plans will face significantly higher cost-sharing amounts in order to receive care at SCH as opposed to other hospitals that were considered in-network for the plans.[89] About a month after SCH filed its lawsuit, *The Washington Post* ran its story about the Blank family, highlighting the difficulty of maintaining the right balance of access to care and cost control.[90]

From the perspective of the insurance companies and the Office of the Insurance Commissioner, including high-cost providers like SCH as an in-network provider can be extremely costly under the current reimbursement structure.[91] SCH, and other academic medical centers ("AMCs"), typically have a much higher overhead due to the highly specialized services they provide.[92] Specialty services typically require more expensive medical equipment and more medical testing and diagnostic capabilities, as well as additional costs associated with teaching and training of residents and medical students.[93] Because of the higher prices associated with specialty providers, networks that include such providers typically charge consumers higher premiums than networks

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[85] *Id.* § 18031(c)(1).

[86] *Id.* § 256b(a)(4)(M).

[87] SCH Petition for Review, *supra* note 83, at 5.

[88] *Id.*

[89] *Id.* at 4.

[90] *See* Somashekhar & Cha, *supra* note 9.

[91] *Id.* (noting that a pediatric appendectomy at SCH costs about $23,000, while at another community hospital, the cost is closer to $14,200).

[92] *See generally* John A. Kastor, *Accountable Care Organizations at Academic Medical Centers*, 364 NEW ENGL. J. MED. e11(1) (Feb. 17, 2011).

[93] *See* ASSOCIATED PRESS, *Mayo's Dominance Skews Health Insurance Exchange in SE Minnesota*, TWINCITIES.COM (Oct. 28, 2013), http://www.twincities.com/localnews/ci_24405205/mayos-dominance-skews-health-insurance-exchange-southeastern-minnesota (noting that Mayo Clinic's costs are higher on average than other non-academic settings, thus increasing premiums of exchange plan offerings in the Rochester area); *see also* Kastor, *supra* note 92, at e11(2) ("The supervision and teaching of trainees, whether in the hospital or in an outpatient clinic, take time, and time costs money.").

including less costly and less specialized providers.[94] Thus, in the case of SCH, the Office of the Insurance Commissioner has an interest in assuring that the insurance offerings on the exchange are affordable to consumers and insurers on the exchange have an interest in assuring that they have a product that will be appropriately competitive in terms of quality and price with other insurance offerings in the marketplace.[95] Therefore, the Insurance Commissioner and insurers both argued that including high cost providers like SCH thwarts each party's efforts to provide necessary coverage on the exchange.[96]

It is difficult to glean what the outcome would have been in connection with this case. Following an administrative law judge's order denying the State of Washington's motion to dismiss, and ordering a hearing regarding whether the Office of the Insurance Commissioner was in fact complying with the ACA,[97] SCH settled the case against the insurers and the commissioner when each of the insurers elected to include SCH as an in-network provider in its exchange offerings.[98] While SCH could not confirm at the time that the settlement meant that SCH was in all of the network offerings on Washington Healthfinder, an SCH spokesperson, Stacey Dinuzzo, did state, "we know we are in the plans that will cover the majority of the population that will utilize the exchange."[99]

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[94] *See* ASSOCIATED PRESS, *supra* note 93.

[95] Bridgespan Health Company explained its position that it met network adequacy rules under state and federal law when it stated:

> Consistent with the emphasis on consumer access, the state network adequacy rule allows for an adequate carrier network even where "the health carrier has an absence of or insufficient number or type of participating providers or facilities to provide a particular covered health care service," provided the carrier ensures "the covered person obtains the covered service from a provider or facility within reasonable proximity of the covered person at no greater cost to the covered person than if the service were obtained from network providers and facilities . . . ."

BridgeSpan Health Co.'s Memorandum, Seattle Children's Hospital's Appeal of OIC's Approvals of HBE Plan Filings, No. 13-0293 (Wa. Office of the Ins. Comm'r Aug. 11, 2014) (citation omitted), http://www.insurance.wa.gov/laws-rules/administrative-hearings/judicial-proceedings/documents/13-0293-bridgespan-hearing-brief.pdf.

[96] *See* Somashekhar & Cha, *supra* note 9.

[97] Seattle Children's Hospital Appeal of OIC's Approvals of HBE Plan Filings, No. 13-0293 (Wa. Office of the Ins. Comm'r Feb. 20, 2014) (order granting motion to dismiss).

[98] Lisa Stiffler, *Seattle Children's, Regence Settle Dispute Over Insurance Networks*, SEATTLE TIMES (Sept. 2, 2014), http://blogs.seattletimes.com/healthcarecheckup/2014/09/02/childrens-hospital-regence-settle-dispute-over-insurance-networks/. SCH settled first with Coordinated Care Corporation and Premera Blue Cross (and its subsidiary LifeWise) as well as signed a contract with Molina Healthcare of Washington. *Id.* Finally, in September of 2014, SCH settled with Cambia Health Solutions, which is the parent company of Regence BlueShield and BridgeSpan Health. *Id.*

[99] *Id.*

B. Network Adequacy Challenges

While the SCH dispute centered primarily on specific required services and providers under the ACA, there are other federal laws,[100] in addition to certain state laws,[101] that impose obligations on insurers to maintain an "adequate" insurance network, also known as "network adequacy" standards.[102] Network adequacy is generally understood as the ability of a health insurance plan to provide the benefits indicated in the plan through access to a sufficient number of physicians and other providers as participants in the network (also known as "in-network").[103] For example, under the ACA, plans on the federal and state exchanges are required to maintain a network that is "sufficient in numbers and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay."[104] While network adequacy laws were drafted to specifically guard against insurers limiting access to certain providers as a means of cutting costs, utilization of the laws for the purpose of taking action against limited provider networks has seen minimal success.[105] One of the biggest challenges with enforcement of these laws is that what constitutes "sufficient" remains somewhat opaque.[106] The law under the ACA, for example, gives states and insurers broad discretion in determining the adequacy of their network for compliance with this rule, making it difficult for any uniformity in application.[107] The Centers for Medicare & Medicaid Services ("CMS") have identified that this lack of clarity has led to some confusion in implementation and has indicated publicly that it will become more involved in network adequa-

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[100] 42 U.S.C. § 1396a(a)(30)(A) (2012).

[101] "Network adequacy" laws vary from state to state. For a description of various approaches, see Blake, *supra* note 20, at 95–100.

[102] 45 C.F.R. § 156.230(a)(1) (2015).

[103] SALLY MCCARTY & MAX FARRIS, STATE HEALTH REFORM ASSISTANCE NETWORK, ISSUE BRIEF: ACA IMPLICATIONS FOR STATE NETWORK ADEQUACY STANDARDS 1 (Aug. 2013), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf407486.

[104] 45 C.F.R. § 156.230(a)(2) (2015).

[105] *See* Justin Giovannelli et al., *Implementing the Affordable Care Act State Regulation of Marketplace Plan Provider Networks*, COMMONWEALTH FUND (May 2015), http://www.commonwealthfund.org/publications/issue-briefs/2015/may/state-regulation-of-marketplace-plan-provider-networks (noting that while many states have network adequacy laws, breadth and enforcement is variable).

[106] Paul Demko, *Providers, Advocates Seek Tougher Rules on Network Adequacy*, MOD. HEALTHCARE (Nov. 20, 2014), http://www.modernhealthcare.com/article/20141120/NEWS/311209971.

[107] *See* 45 C.F.R. § 156.230(a) (2015).

cy reviews.[108]

Network adequacy is not limited to the ACA context, but also arises in connection with Medicaid, more commonly in connection with the means by which states set their rates for Medicaid. Title 42 U.S.C. § 1396a(a)(30)(A) requires that states adopt payment rates that "are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."[109] Like the provision under the ACA, enforcement of this provision has been challenging at best, both for consumers in an effort to assure a sufficient number of providers are participating and for providers in an effort to assure that they are paid sufficiently for services provided.[110] In a recent U.S. Supreme Court opinion, *Armstrong v. Exceptional Child Center, Inc.*,[111] the Court held that there is no implied private right of action under the Supremacy Clause for individuals (in this instance, Medicaid providers) alleging that states' reimbursement rates for certain services failed to comply with section 1396a(a)(30)(A), known as Section 30(A), nor is there an ability to proceed in equity under the Medicaid Act.[112] Thus, with no private right of action, the only enforcement mechanism left to require states to pay sufficient rates to enable network adequacy is through the internal administrative process through CMS and possible revocation of a state's Medicaid funding.[113]

States have also enacted differing laws regarding requirements for health insurers operating in their states to maintain an adequate network.[114] The NAIC has proposed a model law intended to address network adequacy, which has been adopted by some states.[115] Even in those

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[108] Letter from Center for Consumer Information and Insurance Oversight to Issuers in the Federally-facilitated Marketplaces (Feb. 20, 2015), at 23 (commenting that it will "assess provider networks using a 'reasonable access' standard," which will focus on access to hospital systems, mental health providers, oncology providers, primary care providers, and dental providers, if applicable).

[109] 42 U.S.C. § 1396a(a)(30)(A) (2012).

[110] *See* BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 864 (7th ed. 2013) (noting that "all courts of appeal have held that providers cannot enforce 42 U.S.C. § 1396a(a)(30)(A) . . . under § 1983).

[111] 135 S. Ct. 1378 (2015).

[112] *Id.* at 1385–87.

[113] *Id.* at 1387.

[114] *See* NAT. ASS'N OF INS. COMM'RS, HEALTH INS. & MANAGED CARE COMM., PLAN MANAGEMENT FUNCTION: NETWORK ADEQUACY WHITE PATER 1 (June 27, 2012), http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf.

[115] *See* MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT § 2 (NAT'L ASS'N OF INS. COMM'RS 1996), http://www.naic.org/store/free/MDL-74.pdf. As of the first quarter of

states in which it has not been adopted, many states have existing laws that are related to network adequacy.[116] Many are limited, however to only certain kinds of plans, such as HMOs or PPOs.[117] The extent of these plans can vary greatly by state law and can range in the kinds of limitations imposed, including but not limited to provider-to-enrollee ratios, maximum travel distances, maximum appointment wait times, minimum number of providers willing to accept new patients, and minimum percentages of providers in the network's service area.[118]

While there are a number of laws and areas of that law that contain network adequacy requirements, enforcement of such requirements is often subjective in nature, challenging for individuals to enforce, and limited to only certain types of organizations. For example, New Hampshire insurance law requires health carriers[119] to "maintain a network that is sufficient in numbers, types, and geographic location of providers to ensure that all services to covered persons will be accessible without unreasonable delay."[120] Despite the requirements of this law, New Hampshire experienced some challenges with the narrow offerings provided through its exchange plans in 2014.[121] Following complaints from

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2015, Colorado, Mississippi, Missouri, Montana, Nebraska, and Tennessee had enacted all or parts of the proposed model act. *Id.* app. ST.

[116] *Id.* Additionally, the following states have adopted related laws, although not portions of the model act: Alabama, Arkansas, Florida, Georgia, Illinois, Kansas, Louisiana, Maine, New Hampshire, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, and Washington. *Id.*

[117] *See* MCCARTY & FARRIS, *supra* note 103.

[118] *See id.*

[119] New Hampshire defines "health carrier" as "an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurance company, a health maintenance organization, a health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services." *See* N.H. REV. STAT. ANN. § 420-J:3 (West 2015).

[120] *Id.* § 420-J:7. The statute also requires New Hampshire's insurance commissioner to develop rules establishing

> (a) [w]aiting times for appointments for non-emergency care[;] (b) [c]hoice of and access to providers for specialty care, specifically addressing the needs of the chronically ill, mentally ill, developmentally disabled or those with a life threatening illness[;] (c) [s]tandards for geographic accessibility, which shall include standards for access to the provision of durable medical equipment requiring a prescription . . . [;] (d) [h]ours of operation for the carrier, including any entities performing prior approval or pre-authorization functions.

Id.

[121] *See, e.g.*, Tracy Jan, *With Health Law, Less-Easy Access in New Hampshire*, BOS. GLOBE (Jan. 20, 2014), http://www.bostonglobe.com/news/nation/2014/01/20/narrow-hospital-networks-new-hampshire-spark-outrage-political-

excluded providers and consumers alike,[122] *The Boston Globe* reported that ten of the state's twenty-six hospitals were excluded from insurer Anthem's network, resulting in many residents having to drive miles to receive care that could have been provided closer.[123] Anthem stated that its network was "adequate" under state law because most specialists are accessible within a one-hour drive for 90% of the plan's membership.[124] While individual attempts to remedy the situation were unsuccessful during the plan year,[125] the Department of Insurance reported in late 2014 that there would be "increased competition and selection during 2015."[126] It further noted that New Hampshire's health insurance exchange offerings in 2015 include five carriers (as opposed to only Anthem in 2014), sixty medical plans, and all twenty-six acute care hospitals.[127]

C. Antitrust

In addition to laws regarding network adequacy, another area of federal law that may impact the sustainability of Narrow Networks is antitrust law. Although antitrust challenges against health plans have had an inconsistent history due to application of the McCarran-Ferguson Act, which exempts the business of insurance from most aspects of antitrust law,[128] a class action was recently filed against the Blue Cross Blue Shield Association and its affiliates (collectively, the "Blues") alleging that the Blues have engaged in an anti-competitive conspiracy to lower

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attacks/j2ufuNSf9J2sdEQBpgIVqL/story.html.

[122] Petition for Hearing, *In re* Frisbie Mem'l Hosp., No. 13-038-AR (N.H. Ins. Dep't Nov. 6, 2013). The petition was denied. *See In re* Frisbie Mem'l Hosp., No. 13-038-AR (N.H. Ins. Dep't Dec. 11, 2013) (agency order) (denying petition on the basis that neither Frisbie Memorial Hospital nor Ms. McCarthy was an "aggrieved person" and therefore the department was not required to conduct a hearing).

[123] *See* Jan, *supra* note 121 (noting that the policy that Nancy Petro purchased on the health insurance exchange, while only $26 a month once subsidies were applied, requires Petro to drive 50 miles for blood work when there's a hospital three miles from Petro's house).

[124] *Id.* (noting Anthem has further argued that while ten hospitals may be excluded, the network still covers 77% of the state's primary care physicians and 87% of its specialists).

[125] *See* Petition for Hearing, *supra* note 122, at 6.

[126] N.H. INS. DEP'T, NETWORK ADEQUACY: PUBLIC INFORMATION RELEASE, MARKETPLACE ISSUER NETWORKS FOR THE 2015 PLAN YEAR, at 5 (Nov. 14, 2014), http://www.nh.gov/insurance/consumers/documents/pres_updated_network11.12.14.pdf.

[127] *Id.*

[128] *See* 15 U.S.C. §§ 1012, 1013 (2012). The McCarran-Ferguson Act exempts from application of antitrust law activities that are in the "business of insurance," so long as such activities do not constitute "boycott, coercion, or intimidation." *Id.* § 1013.

prices paid to providers and increase premiums paid by beneficiaries.[129] The plaintiffs, providers and suppliers, assert two *per se* violations of Section 1 of the Sherman Act:[130] namely, a market allocation conspiracy and a price fixing conspiracy.[131] In connection with the claims, plaintiffs argue that the Blues have carved up the insurance market ("market allocation") resulting in a decrease of competition in the market for healthcare insurance.[132] By way of example, the plaintiffs note that under Blue Cross Blue Shield of Alabama (the state in which the lawsuit was filed) "at least 93 percent of the Alabama residents who subscribe to full-service commercial health (whether through group plans or through individual policies) are subscribers of BCBS-AL."[133] The plaintiffs further claim that this market dominance has reduced the number of healthcare professionals that practice in certain areas due to the fact that when the Blues' plans dominate certain service areas, they pay lower than competitive prices.[134] The case is still in the midst of litigation and thus its outcome is as of yet unknown,[135] but the federal district court in Alabama rejected the defendants' attempt to claim exemption under the McCarran-Ferguson Act, finding its conduct did not meet the factors for the "business of insurance."[136] Thus, Narrow Networks may have some

[129] Complaint at 4, *In re* Blue Cross Blue Shield Antitrust Litigation (MDL No. 2406), No. 2:13-CV-20000-RDP (N.D. Ala. July 1, 2013) [hereinafter BCBS Ala. Complaint].

[130] 15 U.S.C. § 1.

[131] BCBS Ala. Complaint, *supra* note 129, at 4–5, 113.

[132] *Id.* at 4.

[133] *Id.* at 14.

[134] *See id.* at 133.

[135] Amy Yukanin, *Alabama Anti-trust Case Against Blue Cross Will Move Ahead, Judge Rules*, AL.COM (Nov. 9, 2015), http://www.al.com/news/index.ssf/2015/11/alabama_anti-trust_case_agains.html (noting that the court allowed the Alabama portion of the lawsuit to proceed).

[136] *In re* Blue Cross Blue Shield Antitrust Litig., 26 F. Supp. 3d 1172, 1193 (N.D. Ala. 2014). The McCarran-Ferguson Act exempts certain conduct of insurers from antitrust scrutiny. 15 U.S.C. §§ 1012, 1013 (2012). In order for the exemption to apply, the conduct must (1) be regulated by state law, (2) constitute the "business of insurance," and (3) not constitute a "boycott, coercion, or intimidation." *See id.* Therefore, to the extent an insurer's conduct does not constitute the "business of insurance," the insurer is not immune from broader antitrust liability. Critically, not all conduct by an insurance business constitutes the "business of insurance." *See* Grp. Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 211 (1979) ("The exemption is for the 'business of insurance,' not the 'business of insurers.'"). In order to determine what constitutes the "business of insurance," the Supreme Court has set forth a three factor test: "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 129 (1982). In Blue Cross Blue Shield of Alabama's case, the district court found that the allegations against Blue Cross

vulnerability under antitrust law; however, the McCarran-Ferguson Act and the preemption applicable to laws that regulate insurance could still make actions against insurers in a particular state dubious from an antitrust perspective.

D. State Consumer Protection Laws

In addition to federal laws, there are a number of state laws that also could impact the ability of Narrow Networks to sustain long term growth. State consumer protection laws were frequently used to target HMOs in the past and now are being used to target Narrow Networks.[137] In the recent case of *Brown v. Blue Cross of California d/b/a Anthem Blue Cross*, the plaintiffs filed a lawsuit on August 19, 2014, against Blue Cross of California d/b/a Anthem Blue Cross (collectively, "Anthem") alleging that Anthem misled consumers regarding the breadth of its provider networks, resulting in individuals being stuck with a plan without access to the physicians and providers with whom they have already established patient relationships.[138] The plaintiffs are all individuals who claimed that they relied on Anthem's misrepresentations; many of whom were previously insured with Anthem in PPO plans, and argued that Anthem effectively cancelled their PPO plans and transitioned their plans into exclusive provider organization ("EPO") plans without the enrollees' knowledge.[139] The complaint alleged against the defendant insurers violations of four California state laws: (1) breach of the implied covenant of good faith and fair dealing; (2) breach of contract; (3) engaging in unlawful, unfair, or fraudulent business acts or untrue or misleading marketing; and (4) negligence and negligent misrepresenta-

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of geographic market allocation do not constitute the "business of insurance" because such conduct does not relate to the spreading of risk. *See Blue Cross Blue Shield Antitrust Litig.*, 26 F. Supp. 3d at 1193. Thus, the plaintiffs survived a motion to dismiss and the litigation has proceeded.

[137] *See* Paul Demko, *Reform Update: Narrow-Network Concerns Spur Legal, Regulatory, Political Action*, MOD. HEALTHCARE (Sept. 26, 2014), http://www.modernhealthcare.com/article/20140926/NEWS/309269967 (noting that in addition to recent legislation and the *Brown* lawsuits filed in California, concerns are arising in other parts of the country; and the National Association of Insurance Commissioners is in the process of revising its model regulations).

[138] Complaint and Demand for Jury Trial at 2, Brown v. Blue Cross of Cal. d/b/a Anthem Blue Cross, No. BC554949 (Cal. Super. Ct. Aug. 19, 2014) [hereinafter Brown Complaint].

[139] *Id.* at 2–3 (stating that "Anthem foisted their Obamacare or 'skinny' networks of providers on their individual members[,] . . . without access to the providers on which they have relied for years or decades").

tion.[140] The plaintiffs asserted that they were effectively "uninsured" because they were unable to access the providers from whom they wish to receive services.[141]

In response to the plaintiff's assertions that Anthem gave misleading or incorrect information about the plans, Anthem claimed that the enrollees had all necessary materials at the time of enrollment and that Anthem had clearly stated that the plan was an EPO plan with limited out-of-network benefits.[142] In response to related consumer complaints, the California Department of Managed Health Care ("DMHC") investigated network-related complaints and a state senator backed a Senate bill (SB 964)[143] that attempted to increase enforcement efforts regarding existing laws concerning insurers maintaining adequate networks.[144] In November of 2014, the DMHC issued a report finding that Anthem violated state law by misleading consumers about the size of the provider network and were referred to the Office of Enforcement for Anthem's uncorrected deficiencies.[145] DMHC's findings were based upon a telephone survey in which it found that almost 13% of the physicians listed in Anthem's Covered California directory were not in the location listed,[146] and that nearly 13% of the physicians listed in the directory reported that they were not willing to accept new patients enrolled in plans from Covered California.[147]

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[140] *Id.* at 40–44.

[141] *Id.* at 3.

[142] Chad Terhune, *Anthem Blue Cross Sued Again Over Narrow-Network Health Plans*, L.A. TIMES (Aug. 19, 2014), http://www.latimes.com/business/healthcare/la-fi-anthem-network-suit-20140820-story.html.

[143] *See* S. Res. 964, 2014 Leg., Reg. Sess. (Cal. 2014). SB 964 was signed into law on September 25, 2014, 2014 Cal. Legis. Serv. ch. 573 (West), and it amends section 1367.03 of the California Health and Safety Code, adds section 1367.035 of the Health and Safety Code, repeals and adds section 1380.3 of the Health and Safety Code, and amends sections 14456 and 14456.3 of the Welfare and Institutions Code. Cal. S. Res. 964.

[144] Cal. S. Res. 964 (authorizing DHMC to develop standardized methodologies to be used by health plans in making annual reports on compliance). It further authorizes DHMC, among other things, to establish timeline requirements, including (1) waiting times for physician appointments; (2) timeliness of care in the event of illness; and (3) waiting time prior to screen or triage a patient needing care. *See id.*

[145] *See* CAL. DEP'T OF MANAGED HEALTH CARE HELP CTR, DIV. OF PLAN SURVEYS, FINAL REPORT NON-ROUTINE SURVEY OF ANTHEM BLUE CROSS 3–4, 18–19 (Nov. 18, 2014), http://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/303fsnr111814.pdf.

[146] *Id.* at 18.

[147] *Id.* The deficiencies that were cited as "not corrected" were (1) Anthem "operated as at variance when its internet website and online Provider Directory informed enrollees that numerous physicians were participating in [Anthem's] Covered California products, when and they were not" (in violation of section 1386(b)(1) of the California Health & Safety Code); (2)

In response to the allegations, Anthem raised several issues with the statistical analysis and also with the accuracy of DMHC's information.[148] Perhaps the most convincing argument Anthem made was that it cannot control what physician/provider offices say in response to a survey.[149] DMHC forwarded to Anthem all "negative" responses during the two-month pendency of the DMHC survey to enable Anthem to take necessary corrective action during the process of the investigation.[150] When Anthem reviewed these responses, it reported that 99% of the physicians/providers who were identified as "not available" in the DMHC survey did in fact have contracts with Anthem.[151] Based on this information, it appears possible that Anthem is not providing misleading or false information to consumers; but that certain physician/provider offices are either confused by the plans with which they maintain a contract, or physician/provider offices do not want to accept patients from such plans for whatever reason and communicate to consumers untrue or misleading information. Therefore, consumer challenges, like the *Brown* case alleging that the insurer has failed to provide sufficient coverage,[152] may be difficult to prove where there is evidence that at least some of the miscommunication and misinformation to the consumers may actually be the result of physician/provider communication and not solely insurer communication.

E. State Any Willing Provider Laws and Freedom of Choice Laws

As abuses by, and frustrations with, HMOs began to peak in the mid-to-late 1990s, there was a national movement pushed by the National Association of Insurance Commissioners ("NAIC") to attempt to ad-

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Anthem "failed to correct inaccuracies in its online Provider Directory, [Anthem] used (or permitted the use of) written or printed statements or items of information that were either untrue or misleading and which were disseminated, at least in part, for the purpose of inducing persons to enroll in [Anthem]" (in violation of section 1360(a)(1-2) and (b) of the Health & Safety Code); and (3) Anthem "failed to meet its statutory obligation to provide enrollees with accurate contracted provider lists, either upon request , or through provider listings set forth on [Anthem's] internet website" (in violation of section 1367.26 of the Health & Safety Code). *Id.* at 4.

[148] *See* Plan Response from Anthem Blue Cross of Cal., Inc. re the Final Report by Cal. Dep't of Managed Health Care (2014) (available at http://dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/303fsnrpr111814.pdf).

[149] *See id.*

[150] *Id.*

[151] *Id.*

[152] Brown Complaint, *supra* note 138.

dress these problems through state legislation.[153] The HMO Model Act prompted nearly all of the states to enact legislation that limits the actions and activities of HMOs.[154] Given that Narrow Networks have at least some commonalities with HMOs in terms of their network structure (although Narrow Networks may have a unique or distinct reimbursement structure), Narrow Networks must at least be generally aware of applicable state laws governing HMOs in order to ensure compliance with such laws.

One type of law that first emerged in response to the rise of HMOs and is now experiencing a reemergence in various states is a law known generally as an "any willing provider" law ("AWP Law").[155] While such laws may vary by state, AWP Laws generally require insurers to open their networks to any provider who is willing to accept the network's terms and conditions, including proposed payment rates.[156] Many state AWP Laws date back a number of years, with many limiting application of such laws to only specific kinds of providers, such as pharmacy and chiropractors.[157] As states struggle with the policy implications of Narrow Networks resulting from health care reform, a number of states have or are considering adopting, or fortifying, existing AWP Laws.[158] In fact, several states, including Alabama, Missouri, South Dakota, Texas, and Utah have all enacted new AWP Laws or amended existing laws within the last two years.[159] The most recent example is Measure 17 in South Dakota, which requires that insurers accept in their network plans all health care providers in a particular geographic area who are willing and qualified to meet the insurer's conditions for participation.[160]

In the same way that AWP Laws are designed to protect providers

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[153] *See generally* HEALTH MAINT. ORG. MODEL ACT § 1 *et seq.* (NAT'L ASS'N OF INS. COMM'R 2003), http://www.naic.org/store/free/MDL-430.pdf.

[154] *See* Howard, *supra* note 50, at 95.

[155] *See* Ashley Noble, *Any Willing or Authorized Provider*, NAT'L CONF. STATE LEGS. (Nov. 5, 2014), http://www.ncsl.org/research/health/any-willing-or-authorized-providers.aspx.

[156] *See id.* (noting that 27 states have some version of an "any willing provider" law).

[157] *Id.* For example, Connecticut law is limited only to pharmacies, as are the laws in the states of Delaware and Tennessee, just to name a few. *See* CONN. GEN. STAT. ANN. § 38a-471 (West 2015); 18 DEL. CODE ANN. § 7303 (West 2015); TENN. CODE ANN. § 56-7-2359 (West 2015). Kansas has multiple statutes, but there is a specific any willing provider law related to chiropractors. KAN. STAT. ANN. § 304.17A-171 (West 2015).

[158] *See* Jay Hancock, *"Narrow Networks" Trigger Push-Back From State Officials*, KAISER HEALTH NEWS (Nov. 25, 2013), http://kaiserhealthnews.org/news/states-balk-at-narrow-networks/.

[159] *See generally* Noble, *supra* note 155.

[160] S.D. CODIFIED LAWS § 58-17j-2 (West 2015).

and suppliers from exclusion, there are similar laws intended to protect the ability of consumers to choose their providers. These laws are typically referred to as "freedom of choice" laws ("FOC Laws").[161] FOC Laws endeavor to assure that a health plan's enrollees have an ability to receive patient care services from any qualified health care provider.[162] Although FOC Laws do protect an individual's choice of a particular provider or physician, the laws often times do not contain provisions guarding against any high out-of-pocket costs related to seeing an out-of-network provider.[163] While legislatures do not seem as focused on amending existing or enacting new FOC Laws, as with AWP Laws, many states still maintain actively enforced FOC Laws, which could potentially affect that ability of a Narrow Network to operate as contemplated.[164]

Although both AWP Laws and FOC Laws were drafted in hopes of protecting providers and consumers, the laws themselves tend to be limited in their application and have shown to drive up healthcare costs.[165] For example, given that most AWP Laws contain requirements regarding minimum qualifications and conditions, insurers can create quality metrics or other established criteria that will limit the number of providers that will be eligible without being in violation of the laws. Moreover, to the extent that Narrow Networks are premised on the idea that the providers in the network are less costly, providers may be unwilling to join the networks based on the financial terms established by the insurer for purposes of participation.[166] Lastly, the penalties that are associated

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[161] *See* FURROW ET AL., *supra* note 110, at 652 (defining "freedom of choice" laws or "free choice of provider" laws as a law that prohibits managed care companies/insurers from restricting their member to particular providers or, in the alternative, limits the amount of a cost-sharing obligation when individuals seek care from an out-of-network provider); *see also* J. Peter Rich & Susan M. Nash, *An Overview of Insurance Payment for Health Care Services and Employee Welfare Benefit Plans*, *in* 2 HEALTH L. PRAC. GUIDE § 18:7 (West 2015).

[162] *See* FURROW ET AL., supra note 110, at 652; *see also, e.g.*, CONN. GEN. STAT. ANN. § 38a-180.

[163] *See* Blake, *supra* note 20, at 99 n.210 (noting that "freedom of choice law[s]. . . still run[] the risk of exposing patients to high out-of-pocket costs, as the laws only guarantee access to care, not reimbursement for it").

[164] *See id.* (noting that 25 states have enacted some version of "Freedom of Choice" law).

[165] *See* Jonathan Klick & Joshua D. Wright, *The Effect of Any Willing Provider and Freedom of Choice Laws on Health Care Expenditures* 1, 15 (Univ. of Pa. Law Sch. Faculty Scholarship, Paper No. 438, 2012), http://scholarship.law.upenn.edu/cgi/viewcontent.cgi?article=1437&context=faculty_scholarship.

[166] Christopher J. Gearon, *Hospitals Get the Squeeze from Insurers' Narrow Networks*, U.S. NEWS & WORLD REP. (Apr. 10, 2014), http://health.usnews.com/health-news/hospital-of-tomorrow/articles/2014/04/10/hospitals-get-the-squeeze-from-insurers-narrow-networks

with violations of these laws are limited (typically only enforced through lawsuits by aggrieved parties) and thus provide little incentives for the insurers to dedicate much effort to compliance with the laws.[167]

In addition to the narrow application, the impact of AWP Laws and FOC Laws is even further diminished due to limitations under the Employee Retirement Income Security Act ("ERISA").[168] ERISA regulates employer-sponsored benefit plans, including the provision of health insurance.[169] In an effort to create a comprehensive scheme that would apply to all employee benefit plans (and thus encourage employers to create employee benefit packages), ERISA broadly preempts state laws from regulating employer-sponsored health plans.[170] As an exception to this broad prohibition, however, the law "saves" from preemption any state laws that regulate the business of insurance.[171] Thus, state laws that regulate managed care may be preempted under ERISA, unless a court determines that the law is "saved" on the basis that it regulates insurance.[172] Kentucky's AWP Law was reviewed for this very question in 2003 in which the U.S. Supreme Court upheld the law as being saved from ERISA preemption.[173] Such victory has not completely quieted this

("For hospitals, network exclusion can hit the bottom line, affecting patient referrals and declining volume, and increase costs. Patients going to non-network providers pay significantly higher out-of-pocket costs—sometimes the full tab—under many new ACA exchange plans. Hospital officials in some markets say if they don't agree to significantly lower reimbursements, insurers are excluding them from networks.").

[167] *See, e.g.*, Matthew Heller, *Blue Cross Hit With $3.8M Verdict for Excluding Doctor*, LAW360 (Apr. 8, 2013), http://www.law360.com/articles/431183/blue-cross-hit-with-3-8m-verdict-for-excluding-doctor. In the case of *Nordella v. Anthem Blue Cross*, No. BC444364 (Cal. Super. Ct. 2010), Dr. Jeffrey Nordella filed a lawsuit against Anthem Blue Cross when he was excluded from its network on the basis that he "did not have board certification in family medicine, the medical specialty for which he applied to be listed in the network directory, and Anthem had a sufficient number of general practitioners." *Id.* Nordella filed a rather novel claim, stating that Anthem Blue Cross violated his right of fair procedure under California law when it denied his application to join the network. *Id.* According to Nordella's attorney, this was the first fair procedure case in California to result in a plaintiff's verdict since a jury awarded $1.3 million to a clinic in 2005. *Id.*; *see also* Edwin Brooks et al., *Health Briefs e-Newsletter*, AM. HEALTH LAW. ASS'N (May 7, 2013), https://www.healthlawyers.org/Members/PracticeGroups/Documents/PGpubs/Health_Briefs.pdf (noting that the reach of *Nordella*, which was decided via a jury verdict, may be confined to California or laws that include fair procedures language, but also cautioning providers to document their reasons for exclusion or termination).

[168] 29 U.S.C. § 1001 *et seq.* (2012).

[169] *See id.*

[170] *Id.* § 1144(a) & (b)(2)(B).

[171] *Id.* § 1144(b)(2)(A).

[172] *See* Stuart Circle Hosp. Corp. v. Aetna Health Mgmt., 995 F.2d 500, 502 (4th Cir. 1993).

[173] Ky. Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329 (2003).

debate in connection with other similar laws, however, and still does not address such laws relative to an employer's self-insured plan.[174]

Despite the enactment of new laws under the ACA, existing federal laws regarding network adequacy, antitrust, AWP Laws, and FOC Laws, and various state laws, all of which are designed to protect against the creation of limited networks that exclude providers and limit patient choice, providers and consumers are finding limited enforcement abilities under these laws. Newly-enacted laws under the ACA and existing network adequacy laws are vague in their application, leaving a great deal of discretion to regulators and administrators to determine adequacy.[175] Moreover, antitrust law has limited application due to an exception that largely cedes enforcement and regulation regarding the business of insurance to the states. Additionally, many of the state laws designed to address consumer protection and preserve physician/provider and patient choice were designed with HMOs in mind and do not reach the structural features of Narrow Networks in the same way or contain sufficient allowances that insurers are able to design plans that meet the strictures of the statutes.[176] Thus, the seemingly dizzying array of laws available to consumers for purposes of seeking action against a Narrow Network is actually quite limited due to application of the various laws.

IV. PROSPECTS FOR NARROW NETWORKS

As insurers have rolled out their Narrow Networks, critics have been concerned that the U.S. is just repeating the mistakes of its HMO past.[177] Indeed, many of the arguments from the *Brown* plaintiffs and cases involving network adequacy seem as if these are cases that could have been filed in 1988.[178] While these cases have some apparent simi-

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[174] Section 514(b)(2)(B) of ERISA provides that no employee benefit plan "shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company . . . for [the] purpose of [state regulation]." 29 U.S.C. § 1144(b)(2)(B). Therefore, this provision effectively makes self-insured employers exempt from state laws directed towards insurance companies, even if they are carrying on activities similar to insurance companies.

[175] *See* Giovannelli, *supra* note 105.

[176] *See* David L. Coleman, *'Any Willing Provider': A Toothless Tiger?*, MANAGED CARE MAG. (Apr. 1996), http://www.managedcaremag.com/archives/9604/9604.awp.html ("Arkansas' newly enacted law, for instance, requires plans to accept any provider who agrees to comply with the plans' 'terms and conditions.' Since that language 'can be read in lots of ways,' says Prudential's Yukon, 'we believe it can be interpreted as providing us with geographic access options.'").

[177] *See* McQueen, *supra* note 25.

[178] *See, e.g.*, Pegram v. Herdrich, 530 U.S. 211 (2000); Maio v Aetna Inc., 221 F.3d 472,

larities to past challenges against HMOs, the Narrow Network movement is sufficiently distinct from its predecessor movement. In analyzing the distinctions between HMOs and Narrow Networks, it seems clear that Narrow Networks may evade many of the historic challenges to other limited provider organizations.

A. Potential Advantages of Narrow Networks

Although the restrictive nature of HMOs was a large factor in why HMOs began to lose favor, there are some potential advantages for consumers in connection with Narrow Networks that might make consumers, now two decades later, willing to accept certain restrictions and limitations. Perhaps the most important aspect of Narrow Networks, especially for the millions of individuals previously unable to purchase health insurance (either because it was cost prohibitive or because they had pre-existing conditions), is the fact that Narrow Networks tend to have much lower premiums.[179] According to a study by McKinsey & Company, insurance products with a broad network[180] have average premiums that are 13% to 17% higher than Narrow Network offerings.[181] Moreover, nearly 70% of the lowest-priced products on the health insurance exchanges include Narrow Networks.[182] The ability of insurers and plan sponsors to keep these costs low is critical and essential to the structure and design of a Narrow Network.[183] In order for the insurer to negotiate lower prices with providers, the insurer needs to be able to assure the provider of a sufficient volume of patients, in exchange for the lower rate.[184] Further, the insurer needs to ensure that the care will be of a sufficient quality and efficiency, such that the selected providers will not be wasteful or otherwise harmful to the patients

493 (3d Cir. 2000); Shea v. Esensten, 107 F.3d 625 (8th Cir. 1997).

[179] *See* BAUMAN ET AL., *supra* note 19, at 6–7.

[180] A "broad network" is defined in the report as having more than 90% of the hospitals in the area participating in the applicable plan. *Id.* at 4.

[181] *Id.* at 6.

[182] *Id.*

[183] *See* Promedica Health Systems, Inc., Trade Reg. Rep. (CCH) ¶ 16,700 (F.T.C. Jan. 5, 2012); *see also* Joseph Burns, *Narrow Networks Found To Yield Substantial Savings*, MANAGED CARE MAG. (Feb. 2012), http://www.managedcaremag.com/archives/1202/1202.narrow_networks.html.

[184] *See* Jan, *supra* note 121 ("Anthem was only able to negotiate lower rates with in-network hospitals in exchange for the assurance that they would benefit from an influx of new patients by increasing the size of their service area. In other words, these hospitals had to be guaranteed greater market share.").

(which will in turn increase costs).[185]

Many Narrow Network advocates argue that formation of these limited networks, at lower premiums, is actually a necessary aspect of health care reform.[186] They argue that Narrow Networks fulfill goals of health care reform by virtue of their ability to utilize select groups of providers to drive down health care expenditures and move the industry towards a focus on value-based care.[187] A small network of providers and suppliers could also fulfill health care reform goals of better coordination of care, given that referrals outside the network are limited.[188] Thus, the providers within the network will work together for the care of all of the patients, which coordination may be aided through reimbursement mechanisms.[189]

Lower premiums do not simply provide benefits to the insurance industry and health care reform efforts generally; many consumers are also realizing the benefits. While critics contend that these Narrow Networks represent a loss of choice by the consumer,[190] proponents view these increased network options as an opportunity to provide more consumer control over health care spending and insert the consumer into the

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[185] *See id.*

[186] *See* Kliff, *supra* note 8; Jonathan Gruber & Robin McKnight, *Controlling Health Care Costs Through Limited Network Insurance Plans: Evidence from Massachusetts State Employees* 4 (Nat'l Bureau of Econ. Research, Working Paper No. 20462, Sept. 2014), http://www.nber.org/papers/w20462.pdf ("Overall, the findings suggest that the switch to limited network plans reduced spending without harming access to primary care or inducing shifts to more expensive tertiary care.").

[187] *See* Klick & Wright, *supra* note 165; *see also* Press Release, Centers for Medicare and Medicaid Services, Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume (Jan. 26, 2015) (available at http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html) [hereinafter CMS Press Release].

[188] Care coordination among providers should reduce duplication of services, and therefore, reduce spending on such duplicative services. *See Better Care at Lower Cost: Is it Possible?*, COMMONWEALTH FUND, http://www.commonwealthfund.org/publications/health-reform-and-you/better-care-at-lower-cost (last accessed July 10, 2015) ("[T]he costs for [chronically ill] patients really skyrocket when the care they receive is poorly coordinated: when patients are referred by their primary care provider to a specialist, move in and out of the hospital, and transition from the hospital to home care or a long-term care facility, all with little oversight or communication between providers. In this environment, patients may undergo the same lab tests multiple times, they may get the wrong combination of medications, and serious conditions may get misdiagnosed.").

[189] *See* CMS Press Release, *supra* note 187.

[190] *See* Lena H. Sun, *How a Narrow Network Can Really Mess with Your Choice of Doctors*, WASH. POST (June 24, 2015), https://www.washingtonpost.com/news/to-your-health/wp/2015/06/24/how-a-narrow-network-can-really-mess-with-your-choice-of-doctors/.

process of controlling health care costs overall.[191] Many of the HMO products that were rolled out in the 1980s and 1990s were subscribed to by employers that changed from broader, more expensive plans, to more narrow HMO offerings.[192] HMOs, most of which were defined by their capitation reimbursement structure, gave self-funded employers the ability to control health care costs due to the transfer of risk that enabled employers to push the responsibility to maintain health care costs to the providers.[193] Thus, many individuals found themselves in an HMO due to the fact that such HMO had been selected by their employer.[194]

In contrast, many of those selecting Narrow Networks today are doing so of their own volition. According to McKinsey & Company, almost half of the individuals who purchased Narrow Networks on a health insurance exchange were aware that they were purchasing a more limited network.[195] The primary driver for selection of these plans is cost; many consumers are willing to accept more restricted provider selections in order to realize lower premiums.[196] Moreover, the evidence fails to support a finding, at present, that consumers who are choosing lower-premium options are required to choose between quality and

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[191] *See Done Right, Narrow Networks Have Advantages for Patients*, ADVISORY BOARD COMPANY (Sept. 11, 2014), https://www.advisory.com/daily-briefing/2014/09/11/done-right-narrow-networks-have-advantages-for-patients (noting that in addition to saving money, patients involved in narrow networks visited their primary care provider more often and used the emergency department less than other patients).

[192] *See* Thomas Bodenheimer & Kip Sullivan, *Health Policy Report (Part 1 of 2): How Large Employers Are Shaping the Health Care Marketplace*, 338 N. ENGL. J. MED. 1003, 1003 (Apr. 2, 1998) (noting that Fortune 500 companies induced, or required, their employees to obtain health insurance from managed care insurers, especially HMOs).

[193] Capitation enabled employers and states the ability to budget known health care expenses because, under the model, the state or self-funded employer paid only a flat monthly fee for each patient and the provider was then responsible for controlling costs under the flat fee. *See* FURROW ET AL., *supra* note 110, at 657.

[194] *See* Bodenheimer & Sullivan, *supra* note 192, at 1004.

[195] *See* BAUMAN ET AL., *supra* note 17, at 3.

[196] *Id.* at 6–7; *see also* LIZ HAMEL ET AL., HENRY J. KAISER FAMILY FOUND., SURVEY OF NON-GROUP HEALTH INSURANCE ENROLLEES app. tbl.6 (June 19, 2014), https://kaiserfamilyfoundation.files.wordpress.com/2014/06/survey-of-non-group-health-insurance-enrollees-appendix-tables-final1.pdf (finding that at least 29% of respondents in the survey were "not too confident" or "not at all confident" that they will have enough money to cover medical costs for self and family, and 41% of the same respondents were "not too confident" or "not at all confident" that they will have enough money to pay for a major illness); Jan, *supra* note 121 ("[Anthem] formed its narrow hospital network after extensive market research, when consumers indicated they would be willing to trade a full network for lower premiums, said Lisa Guertin, president of Anthem in New Hampshire. The result is a 30 percent savings for individuals buying coverage in the marketplace . . . .").

price.[197] Preliminary reporting data suggests that Narrow Network options are performing at quality levels comparable to those of other broader networks.[198] In fact, one of the distinctions noted of "high-performance" networks is the fact that these organizations appear to have a greater focus on meeting identified quality metrics or measures in the provision of care and on promoting high-value care through alternative reimbursement mechanisms such as bundled payments and outcome driven payment (e.g., pay-for-performance programs).[199] Thus, there has been a shift to improving quality, reducing care variances, and minimizing unnecessary care.[200] Some of this might be in reaction to or in response to AWP Laws, which only require insurers to include "any willing provider" so long as the provider can meet the insurer's qualifications or criteria.[201] To the extent that insurers create quality metrics and require compliance with such networks, insurers have an ability to limit the network to only such providers who are able to meet such standards.[202]

B. Remaining Challenges of Narrow Networks

Despite many of the distinctions and advantages of Narrow Networks, there are nevertheless challenges and criticisms that remain. The primary critiques have been largely similar to those issues raised by the Blank family; that is, individuals and families are forced to choose between health insurance options that are affordable and ones that may provide access to providers that might be necessary or at least desirable from a care perspective.[203] The specific dilemma for the Blanks was described as the following: "So, Blank must make a choice. Should he take his insurer's suggestion and lose access to [SCH]? Should he go with one of the plans on the exchange that includes [SCH], even if that means picking an insurance company he has never heard of?"

He is leaning toward a third option: buying a private plan with Premera outside the exchange with a broader network, but that would

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[197] *See* BAUMAN ET AL., *supra* note 19, at 6–9.

[198] *Id.* at 9.

[199] *See* CORLETTE, *supra* note 36, at 3.

[200] *Id.*

[201] *See* Coleman, *supra* note 176.

[202] *See id.*

[203] *See* Somashekhar & Cha, *supra* note 9; *see also* Blake, *supra* note 20, at 69 (noting that Narrow Networks create a distributive justice problem that prevents the sickest of patients from receiving necessary tertiary care because they are unable to pay for it).

force him to give up the estimated $400-per-month subsidy he would be eligible for under the health law.[204]In fact, critics have commented that the situation with the Blank family was precisely what the ACA endeavored to avoid.[205] If one of the goals of the ACA was to expand coverage to those individuals who were uninsured *and* underinsured, a system that enables only those who can afford greater access to receive it or a system that maintains job-lock in order for individuals to avoid a situation of having insufficient options on a healthcare exchange arguably does not fulfill that goal.[206]

Additionally, although the intent of an exchange is to create greater transparency and opportunities to compare products, it appears that many individuals remain either confused or entirely unaware of what insurance product they are buying.[207] Consumer studies have shown that of those individuals who purchased Narrow Network options on a health insurance exchange, approximately 26% were unaware of the breadth of their selected network.[208] Not surprisingly, those individuals who were previously uninsured were twice as likely to be unaware of the breadth of their health insurance as individuals who were previously insured.[209] These results suggest consumers are selecting plans based on the cost of the premium, but may be unaware that purchasing a particular policy may inhibit them from seeing their treating physician or from seeking care at the same hospital as they did before.[210]

While the ACA was intended to create more transparency in the health care market, it is evident from the *Brown* lawsuit that network selection and insurance plan structure remains confusing for many.[211] The

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[204] *See* Somashekhar & Cha, *supra* note 9.

[205] *See* Blake, *supra* note 20, at 66–67, 70 (noting that creation of a dual system in which those who can afford more specialty services will have access to such specialty services seems contrary to the intention behind health care reform).

[206] *See* CENTENNIAL, HARVARD BUS. SCH., REPORT ON GLOBAL BUSINESS SUMMIT: IMPACT OF PUBLIC POLICY ON CONSUMER-DRIVEN HEALTH CARE 1 (2008), http://www.hbs.edu/centennial/businesssummit/healthcare/impact-of-public-policy-on-consumer-driven-health-care.html (noting that an estimated eleven million people reported wanting to change jobs, but feeling locked in their current job because they need to keep their insurance).

[207] *See* BAUMAN ET AL., *supra* note 19, at 13–14.

[208] *Id.* at 14.

[209] *Id.*

[210] *See id.* at 15. This statement is not to suggest that insurance companies are necessarily hiding the breadth of their networks or not providing sufficient information to the consumer that the plan might be a more limited network. Rather, it is simply stating that individuals sometimes are unaware of what they are purchasing, which can be the result of a multitude of factors.

[211] *See* Brown Complaint, *supra* note 138, at 2–3.

Brown case also highlights the challenges in trying to achieve greater transparency. The issues cited by the plaintiffs seem to be a result of a multitude of factors including challenges with consumer knowledge, consistent and up-to-date information from insurers regarding providers in a particular network, and both knowledge and communication from providers themselves regarding such networks.[212] With such an array of issues, it can be challenging to consider what sort of additional information or communication would drastically alter the current situation.

C. Current Outlook for Narrow Networks

Between "essential provider" lawsuits, antitrust lawsuits, state consumer protection lawsuits, AWP Laws, FOC Laws, HMO Model Act restrictions, and other state consumer protection laws, there are a dizzying array of legal avenues available to aggrieved consumers and providers against Narrow Networks. Despite the many avenues, litigants often face an arduous battle in achieving success against exclusive provider networks, such as Narrow Networks. As addressed in Part III above, many of the existing laws were drafted in reaction to complaints and frustrations brought about by HMOs and other limitations posed by managed care plans in the 1980s and 1990s, and are inadequate to address limited provider networks that insurers have been establishing in recent years.[213] Even those laws that were put in place as part of health care reform, such as laws addressing network adequacy, remain challenging to enforce due to the large amount of subjectivity that is applied in connection with enforcement.[214] Thus, if Narrow Networks either maintain current pace or continue to rise both on and off exchanges, there are few existing legal barriers to their continued growth at the present time.

Moreover, the presence of health care insurance exchanges as a means for individuals to purchase insurance has drastically changed the dynamics since the height of HMO popularity.[215] In the past, individuals who did not have access to insurance through their employer or a government program were forced into the individual and small group mar-

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[212] *See supra* text accompanying notes 148–152.

[213] *See generally supra* Part III.

[214] *See supra* notes 119–127 and accompanying text.

[215] *See* Blake, *supra* note 20, at 72 ("Historically, insurers have used a variety of techniques to [manage risk]: denying sick people coverage altogether; imposing preexisting condition, annual, or lifetime coverage limits; heightening cost-sharing; and refusing to cover certain procedures. This effect was felt most strongly in individual and group markets, where no pool was large enough to spread the risk."(footnote omitted)).

kets, which often times meant high premiums and significant challenges in the ability to compare one plan to another.[216] Now, on the exchanges, without barriers such as denials or premium hikes due to pre-existing conditions, individuals are able to compare insurance plans and know at the point of enrollment what the monthly premiums will be for the respective plans.[217] Challenges with transparency remain, but evidence suggests that the majority of individuals who are purchasing Narrow Networks are purchasing these plans with knowledge that the network is more limited than broader networks,[218] primarily (or perhaps exclusively) because the premium is more affordable.[219] Of the millions of Americans who are now able to access more cost-effective health insurance, many still fear that they will not be able to cover related medical expenses, despite having insurance coverage and despite expected subsidies and credits.[220] Thus, although Narrow Networks may have re-emerged for reasons similar to the initial rise of HMOs (namely public policy and industry concerns regarding rising costs),[221] much of the success of Narrow Networks is being driven by consumer demand for these products. The cost savings under HMOs were being realized not by consumers, but by large employers, state governments, and insurers.[222] In contrast, while insurers are also motivated by cost savings, at least some of the Narrow Network trend is being facilitated by the market that has been created for a low-cost insurance option. The presence of a consumer-driven market in which individuals are given the option of purchasing limited provider networks at a lower cost makes this movement distinct from limited provider networks of the past.

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[216] *Id.*

[217] It should be noted that while an individual does know at the time of enrollment the amount the monthly premium will be for the year, this amount may not be the amount paid once the individual pays his/her taxes. All subsidies and credits provided to a particular individual are determined based on the individual's stated income at the time of enrollment. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1401, 124 Stat. 119, 213 (2010). To the extent that the individual has an annual income for the year that was different than the income estimated at the time of enrollment (either higher or lower), then the subsidies and credits available may be different than originally predicted. Thus, the individual may owe more, as reimbursements for subsidies and credits paid, but not owed under the law, or less, if the estimated income was actually greater than predicted.

[218] *See* BAUMAN ET AL., *supra* note 19, at 14.

[219] *Id.*

[220] *See* Hamel, *supra* note 196, at app. tbl.6.

[221] *See* Bodenheimer & Sullivan, *supra* note 194, at 1003.

[222] *Id.* at 1004.

D. Reaction of Excluded Providers

In addition to consumer-driven demand, Narrow Networks are potentially being fueled by some of the unlikeliest of providers: namely, AMCs and other high-cost specialty providers (collectively "High-Cost Providers"). Ordinarily, High-Cost Providers would seem to be the best litigants to fight exclusion from a Narrow Network for two reasons: (a) they are likely to be the most commonly excluded from Narrow Networks due to their high cost of services relative to other providers rendering the same or similar services;[223] and (b) they are usually large organizations with greater financial resources than smaller community providers, which may provide these High-Cost Providers with the requisite bargaining power and litigation wherewithal to withstand a lengthy and potentially costly legal action with a large insurer.[224] High-Cost Providers appear to be pursuing other business models in lieu of Narrow Network participation, however, which may have a significant impact on the ability for providers more generally to object to or fight Narrow Network exclusion.[225]

Just as modern Narrow Networks are looking to exclude High-Cost Providers, these same providers were targeted in the 1990s as HMOs attempted to squeeze out specialty providers due to their more expensive rates.[226] Many High-Cost Providers at the time responded by attempting

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[223] *See* BAUMAN ET AL., *supra* note 19, at 10 (noting that AMCs are included in 96% of all broad networks in the country, but are only included in 40% of ultra-narrow networks, and noting further that products including AMCs have premiums that are, on average, 9% higher than products without AMCs).

[224] *See* Chapin White et al., *Understanding Differences Between High- and Low-Price Hospitals: Implications for Efforts to Rein In Costs*, 33 HEALTH AFF. 324, 330 (2014) ("But high-price hospitals also clearly enjoyed dominant market positions. Both their large size and their membership in even larger hospital systems made it difficult for health plans to negotiate lower prices with them.").

[225] *See, e.g.*, Stiffler, *supra* note 98; *see also* Tammy Worth, *Cash-Only Looks Good to Doctors*, HEALTHCARE FIN. (June 30, 2014), http://www.healthcarefinancenews.com/news/cash-only-looks-good-doctors.

[226] *See* Milt Freudenheim, *Longtime Missions Pressed by H.M.O.'s* [sic], N.Y. TIMES (May 20, 1997), http://www.nytimes.com/1997/05/20/business/longtime-missions-pressed-by-hmo-s.html ("The squeeze on academic medical centers like New England Medical is particularly brutal in Boston, which has seven prestigious teaching and research hospitals and far too many hospital beds, and where costs per patient are among the nation's highest. But dozens of teaching hospitals across the country face similar challenges, and they are responding by reaching out for business partners. . . . [Harvard Pilgram H.M.O.] says the whole point of managed care is to cut costs by making deals with a few providers of health care, and New England Medical just plain represents too much fat. 'To us, it is a redundant hospital,' said Patrick H. Mattingly, a senior vice president of Harvard Pilgrim.").

to compete with other providers to obtain more HMO patients in order to maintain market share, largely by making an effort to reduce expenses. Such efforts were met with mixed results,[227] as many High-Cost Providers were unable to provide services to HMOs at a price that would compete effectively with other providers and thus, lost market share and resulting revenues.[228] Other High-Cost Providers were forced to shut down or merge with other entities as they witnessed volumes dry up and were unable to sustain their businesses.[229]

Rather than again try to fight exclusion or compete in the market with lower-cost providers, High-Cost Providers today seem to be instead charting new paths outside the individual insurance market and promoting their services to a market entirely different than insurers. For example, while the Mayo Clinic is participating in one Narrow Network option in its area through Medica,[230] the Mayo Clinic's involvement in the state exchange plans has been somewhat limited.[231] In fact, its presence in the area seemed to increase premiums on average for exchange plans in that region, even for plans in which the Mayo Clinic was not participating.[232] Therefore, rather than focus on participation in plans offered on the health insurance exchanges, the Mayo Clinic seems to instead be adopting an alternative approach outside its state health insurance exchange.[233]

The Mayo Clinic has developed the Mayo Clinic Care Network, which is described as "a network of like-minded organizations which share a common commitment to improving the delivery of health care in their communities through high-quality, data-driven, evidence-based medical care."[234] The Mayo Clinic Care Network currently has thirty-

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[227] *See* James Reuter & Darrell Gaskin, *Academic Health Centers in Competitive Markets*, 16 HEALTH AFF., no. 4, July 1997, at 248–50.

[228] *Id.*

[229] *See* Freudenheim, *supra* note 226.

[230] Bob Herman, *Narrow Network Including Mayo to Debut on Minnesota Exchange*, MOD. HEALTHCARE (Oct. 11, 2014), http://www.modernhealthcare.com/article/20141011/MAGAZINE/310119951.

[231] Patrick Howley, *Hospital Cited by Obama as Health-Reform Model for the Nation Accepts Only One Kind of Insurance Plan Under Obamacare*, DAILY CALLER (Feb. 23, 2014), http://dailycaller.com/2014/02/23/hospital-cited-by-obama-as-health-reform-model-for-the-nation-accepts-only-one-kind-of-insurance-plan-under-obamacare/ (noting that the only insurance exchange offering that was accepted at the Mayo Clinic for the 2014 enrollment period was the Blue Cross Blue Shield silver plans).

[232] *See id.*

[233] *See generally Mayo Clinic Care Network*, MAYO CLINIC, http://www.mayoclinic.org/about-mayo-clinic/care-network (last accessed June 18, 2015).

[234] *Id.*

six member organizations.[235] "Membership" allows the member-entities certain opportunities, including: the ability to advertise as a member of the Mayo Clinic Care Network; access to disease management protocols, clinical care guidelines, treatment recommendations, and reference materials, all developed at the Mayo Clinic; and access to Mayo Clinic physicians for purposes of treatment advice and consultation.[236] The benefits for the Mayo Clinic are to create brand recognition and to collaborate with the medical community and patients outside of Rochester, Minnesota,[237] which it hopes will lead to an increase in more complex and challenging cases being referred for treatment at the Mayo Clinic's main facilities in Minnesota, Arizona, and Florida. This pipeline for cases is helpful and beneficial for the Mayo Clinic, as an AMC, because those more complex and challenging cases provide good training for residents and also valuable medical information for fulfilling its research mission.[238] So long as the Mayo Clinic is receiving a sufficient volume of patient referrals outside of local insurance exchange networks, being part of its local exchange networks, including some Narrow Network offerings, is not so critical for purposes of long-term sustainability.[239]

The Mayo Clinic is not alone in forging new opportunities to grow patient volumes outside of the more traditional routes of network participation.[240] In the wake of health care reform and emergence of accounta-

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[235] *Members of Mayo Clinic Care Network*, MAYO CLINIC, http://www.mayoclinic.org/about-mayo-clinic/care-network/members (last accessed Jan. 16, 2016) (noting itself as the only a member of the Cancer Care Network).

[236] *See Mayo Clinic Care Network*, *supra* note 233.

[237] The Mayo Clinic is headquartered in Rochester, Minnesota, but also owns and operates a hospital in Phoenix and Scottsdale, Arizona, as well as a hospital in Jacksonville, Florida. At these locations, all physicians, nurses, and other administrative and professional staff are employed by the Mayo Clinic. Entities that are members of the Mayo Clinic Care Network retain autonomy and are not owned or operated by the Mayo Clinic. The physicians and other healthcare professionals providing services at those entities do not have an employment or independent contractor relationship with the Mayo Clinic. *See About the Mayo Clinic Care Network*, MAYO CLINIC, http://www.mayoclinic.org/about-mayo-clinic/care-network (last visited Sept. 1, 2015).

[238] *See generally* Kastor, *supra* note 92.

[239] *See* PETER J. NELSON, CTR. OF THE AMERICAN EXPERIMENT: POLICY IN DETAIL, THE MAYO CLINIC: HIGH QUALITY YES, BUT LOW COST? 3 (Sept. 8, 2009), http://www.americanexperiment.org/publications/policy-in-detail/the-mayo-clinic-high-quality-yes-but-low-cost (showing that volumes alone do not enable a large academic medical center such as Mayo Clinic to generate revenues and noting that there is evidence that the Mayo Clinic likely supports losses on lower reimbursement on the Medicare side by higher commercial insurance payments); *see also* Joe Robertson, *Health Care Reform - The Impact on Academic Medical Centers: An Academic Health Center Executive's Perspective*, INSIGHTS (Spring 2010), http://www.willamette.com/insights_journal/10/spring_2010_1.pdf.

[240] Historically, AMCs are similar to most other providers in that they rely primarily on

ble care organizations ("ACOs"), some AMC's have formed ACO-like organizations often referred to as clinically integrated networks ("CINs").[241] The goal of these CINs is not dissimilar to the goal of the Mayo Clinic Care Network: that is, to provide coordination of care among providers so that complex and specialized care that can only be provided at AMCs is available when necessary, while more common and standard care that is available at community hospitals must be utilized at such hospitals.[242] One example of this model can be seen in the Vanderbilt Health Affiliated Network ("VHAN"), which is associated with Vanderbilt University Medical Center in Nashville, Tennessee ("VUMC").[243] VHAN is the "largest provider-organized network of doctors, regional health systems and other health care providers in Tennessee and seven surrounding states"[244] with twelve participating provider organizations and over forty hospitals.[245] The network is intended to promote more efficient and better coordinated care for patients of the member organizations and for its participating providers through the use of technology, enabling access to medical records and coordinated clinical protocols.[246]

While CINs like VHAN may contract with insurance companies, the primary "client" or target for this type of organization is frequently large employers.[247] Indeed, VHAN is the network that is offered to all Vanderbilt University employees and is also the primary network offered to many of its member organizations.[248] By marketing this network

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receiving a significant volume of patients through participation in local insurance networks. As noted above, because AMCs are a critical provider in many areas of the country, they generally have had success in negotiating high rates from insurers that help compensate for high overhead. *See, e.g.*, NELSON, *supra* note 239, at 2.

[241] A CIN is generally defined as a network of independent providers who "collectively commit to quality and cost improvement" and features, *inter alia*, a physician-led governance structure and an "IT infrastructure to identify improvement opportunities and facilitate exchange of patient information between participants." Sarah O'Hara, *The Care Transformation Alphabet: What's the Difference Between CI, ACO, and PCMH?*, ADVISORY BOARD COMPANY (Sept. 24, 2014), http://www.advisory.com/research/care-transformation-center/care-transformation-center-blog/2014/09/deciphering-the-reform-alphabet.

[242] *See id.*

[243] *See Vanderbilt Health Affiliated Network*, VAND. U., http://hr.vanderbilt.edu/benefits/vanderbilt-affiliates/ (last accessed June 19, 2015).

[244] *Id.*

[245] *Id.*

[246] *Id.*; *see also* O'Hara, *supra* note 241.

[247] Dennis Butts et al., *The 7 Components of a Clinical Integration Network*, BECKER'S HOSP. REV. (Oct. 19, 2012), http://www.beckershospitalreview.com/hospital-physician-relationships/the-7-components-of-a-clinical-integration-network.html.

[248] *See Vanderbilt Health Affiliated Network*, *supra* note 243.

to large employers, such as local municipalities and large corporations within the service area, the member organizations and physicians are seeking patients from a market entirely outside of any local health insurance exchange product. Similar to the Mayo Clinic, the goal behind this sort of organization for VUMC is to limit those services provided by VUMC (an AMC) to only those highly specialized and complex cases that require such care while all other care is provided at a lower cost facility.[249] Because the organization is being marketed to employers as opposed to individuals, the value proposition to the employer-consumer is that VHAN's care will be more efficient and of better quality, thus saving employers money and ensuring healthier and more productive employees.[250] Therefore, CINs are able to shift the focus away from premiums by emphasizing savings that may be achieved through overall cost of care managed across a continuum of providers.[251]

One other example of High-Cost Providers trying to focus on opportunities outside of the individual insurance marketplace is an organization known as Vivity.[252] Anthem Blue Cross describes Vivity as "an integrated health system in Los Angeles and Orange counties . . . [that is] a first-in-the-nation partnership between an insurer and seven competing hospital systems that will align financial risk/gain to enhance the health of Anthem Blue Cross Vivity members."[253] Like the previously-described networks, the member organizations include hospitals typically considered High-Cost Providers that might otherwise be fearful about exclusion from Narrow Networks.[254] Vivity is unique and distinct from other types of provider groups because it focuses on a reimbursement structure that is not paid based on traditional fee-for-service reimbursement. Rather, its reimbursement structure is based on providing financial incentives to the member organizations encouraging them to work together to better coordinate care, thereby providing more efficient and less costly care.[255] Like VHAN and other CINs, the primary target audience for Vivity is large group employers; thus, it is not currently includ-

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[249] *Id.*

[250] *See* Butts, *supra* note 247.

[251] *See* O'Hara, *supra* note 241.

[252] *See Vivity FAQs*, ANTHEM BLUE CROSS, http://www.vivityhealth.com/pdf/faqs.pdf (last accessed June 19, 2015).

[253] *Id.*

[254] The member organizations include Cedars-Sinai, Good Samaritan Hospital, Huntington Memorial Hospital, MemorialCare Health System, PIH Health, Torrance Memorial Medical Center, and UCLA Health. *See id.*

[255] *Id.*

ed in individual health insurance exchanges.[256]

Although the Mayo Clinic Care Network, VHAN, and Vivity are each diverse in terms of their legal structure, affiliations, and associations of their member organizations, there are several notable common goals of each. Each organization involves historically High-Cost Providers that recognized that, under health care reform, there was a need to provide a different solution in order to avoid a situation under which they were being excluded from insurance networks due to costs.[257] Each provider has also focused on the fact that it is unlikely that High-Cost Providers can eliminate much of what makes them High-Cost Providers. If, instead, care can be coordinated in a way that provides "the right care, at the right time, in the right place, at the right price"[258] then such High-Cost Providers can nevertheless provide a value proposition to certain consumers for networks that include their services. Lastly, these organizations are not organizations that are competing in the same market as those products being offered on the individual marketplace.[259]

To the extent that High-Cost Providers can realize success outside of Narrow Networks, opposition to these organizations will be lacking the voice of large providers such as the Mayo Clinic[260] and institutions

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[256] *See Vivity FAQs*, *supra* note 252.

[257] To the extent that High-Cost Providers are excluded from Narrow Networks and Narrow Networks become the dominant type of network, both on and off the health insurance exchanges, the ability for such High-Cost Providers to sustain themselves is at risk due to a lack of patients who are able to seek care with High-Cost Providers due to limitations in those patients' networks. Therefore, if High-Cost Providers are economically incapable of lowering their costs, it becomes necessary for the High-Cost Providers to consider alternative methods to ensure that patients are able to seek their services and that the High-Cost Providers are still able to bill and collect for such services. *See* Robertson, *supra* note 231.

[258] This phrase could be considered a variation on the "Triple Aim," which was a concept first proposed by Donald M. Berwick and the Institute for Healthcare Improvement in 2008. *See* Donald M. Berwick et al., *The Triple Aim: Care, Health, And Cost*, 27 HEALTH AFF. 759 (2008). The "Triple Aim" is a framework for the provision of health care services that seeks three goals: (1) improving the patient experience of care (including quality and satisfaction); (2) improving the health of populations; and (3) reducing the per capita cost of health care. *See The IHI Triple Aim*, INST. HEALTHCARE IMPROVEMENT, http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx (last accessed Jan. 16, 2016).

[259] *See generally* Mayo Clinic Care Network, *supra* note 233; *Vanderbilt Health Affiliated Network*, *supra* note 243; *Vivity FAQs*, *supra* note 252.

[260] In 2014, the Mayo Clinic treated 1.3 million people from all 50 states and 143 countries. They have 4,200 staff physicians and scientists, 2,400 residents, fellows, and other trainees, and 52,900 allied health staff (clinic and hospitals). *See Mayo Clinic Facts*, MAYO CLINIC, http://www.mayoclinic.org/about-mayo-clinic/facts-statistics (last visited Jan. 16, 2016). The Mayo Clinic reported total revenue from current activities of $9,760,600,000 and $834,800,000 in income from current activities. *Id.*

like Cedars-Sinai as a member of Vivity[261] to effectively negotiate or bargain with large insurers and will feature fewer health care industry leaders speaking out against Narrow Networks. While the negative impact on High-Cost Providers as a result of the HMO movement in the 1990s helped to spur action of legislatures across the country to enact laws that would greatly limit the activities of HMOs,[262] current High-Cost Providers are not affected proportionally to the extent that they are successful in selling their services to a different segment of the market and such services provide sufficient financial stability.

V. CONCLUSION

Insurers, providers, and consumers are all attempting to predict the future of healthcare as health care reform and the health insurance exchanges start to take shape. If current trends continue, Narrow Networks appear to be a key aspect in that future marketplace. According to a McKinsey Center for U.S. Health System Reform study, 90% of networks considered "broad" in 2014 remained broad in 2015 and 83% of Narrow Networks in 2014 remained narrow in 2015.[263] For those who are assuming, predicting, or just hoping that Narrow Networks are simply "HMOs 2.0" and will quickly fall out of disfavor just like HMOs in the late 1990s, it appears unlikely under the current legal and business landscape. While there are certainly similarities between these organization types, there are some key distinctions and differences that seem to indicate that the outlook for Narrow Networks appears quite distinct from the fate of HMOs.

Perhaps the most important change from today versus the managed care movement of the 1980s and 1990s is that aspect of individual choice that is present in today's individual insurance marketplace. Un-

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[261] Anthem Blue Cross Vivity includes participation of seven hospitals, all ranked in the top 30 in Los Angeles and Orange County areas by *U.S. News & World Report*, each with affiliated entity networks. *See Vivity FAQs*, *supra* note 252. The network includes 6,000 doctors and a total of 14 hospitals. *See* Austin Frakt, *Some Facts About Vivity*, INCIDENTAL ECONOMIST (Oct. 2, 2014), http://theincidentaleconomist.com/wordpress/some-facts-about-vivity/.

[262] *See* Reuter & Gaskin, *supra* note 227, at 248–50.

[263] NOAM BAUMAN ET AL., MCKINSEY & CO., MCKINSEY CTR. FOR U.S. HEALTH SYS. REFORM, HOSPITAL NETWORKS: EVOLUTION OF THE CONFIGURATIONS ON THE 2015 EXCHANGES 3 (Apr. 2015), http://healthcare.mckinsey.com/2015-hospital-networks (noting that of those networks that changed, 53% of hospital configurations for the 2015 enrollment period remained the same in 2015 and 47% of the hospital configurations in 2014 changed by a median of only two hospitals for 2015).

like HMOs, which were largely adopted by public and private employers in an attempt to save money and curb increases in health care expenditures, individuals today are able to access health insurance options through federal and state exchanges and make a conscious choice for narrower network products because such products offer a lower premium.[264] Thus, Narrow Networks are responding to a consumer demand for low cost options, despite the fact that such options may involve some limitations. Moreover, the public outcry related to these networks and the limitations that such networks impose that became so much a part of the descent of HMOs[265] is quieted somewhat by the fact that individuals are knowingly electing limitations in exchange for the cost savings. Unlike an employee who is unknowingly forced into a limited provider network due to the decision of his/her employer and is then harmed as a result of such limitations, an individual who knowingly purchases a Narrow Network because it is sold at a lower premium is hard-pressed to feign disgust and disappointment when the limitations that were explained to the consumer in the beginning are then imposed.[266]

Another key factor in the potential success of Narrow Networks lies in the legal remedies available to consumers and providers aggrieved by Narrow Networks. While there appears to be any number of legal remedies available to disgruntled consumers, excluded providers, or others negatively impacted by Narrow Networks, such legal remedies remain elusive as meaningful challenges to these types of organizations. Many existing state laws were drafted specifically to address issues related to HMOs and are thus too narrow to apply to Narrow Networks. Even older laws and more newly enacted laws that appear broader in scope afford a great deal of discretion to insurers and government agencies for purposes of interpretation of the law, making enforcement of such laws challenging. Moreover, although allegations such as those in the *Brown* case in California have yet to be adjudicated in court, and despite the fact that SCH seemed to declare victory after being added to the Washington State exchange plans, there are a number of factual distinctions between those two cases that render dubious the applicability of those facts to a

[264] *See* FURROW ET AL., *supra* note 15, at 347–49.

[265] *See supra* notes 36–44 and accompanying text.

[266] An exception, of course, to this would be those consumers who were unaware of the breadth of their network at the time of purchase. Like the *Brown* litigants, however, plaintiffs in these scenarios may find it difficult to prevail in a lawsuit where the insurer can show that the information provided was sufficient to appropriately inform a reasonable consumer about the type of plan that was being purchased.

great deal of other cases.[267] Lastly, insurers are now keenly aware of existing legal restrictions in place regarding exclusion of providers and the need to provide information to consumers regarding the breadth of a network. Many of these laws date back over ten years and thus, insurers are aware of the limitations and how such networks would need to be structured in order to be less susceptible to legal challenge.

Finally, one other key distinction lies at the provider level. In the 1980s and 1990s, many providers felt as though they had few options as HMOs and limited networks began to spread rapidly.[268] Many feared that failure to join a network might result in so few patients that maintaining a practice would be next to impossible.[269] Then, after joining en masse, many of those providers lost so much money through capitation that it was nearly impossible to continue providing services through the HMO and maintain a viable business.[270] Unlike HMOs, nearly all Narrow Network models contemplate alternative reimbursement structures that may include *some* capitation or bundled payment models, but not *solely* capitation. Thus, providers are potentially more willing to participate in these networks, which appear to contain somewhat less risk than previous models.[271] More importantly, those providers who are most likely to be excluded due to cost, such as academic medical centers, seem to have anticipated that limited provider networks under health care reform would come to pass. Therefore, many of these High-Cost Providers are pivoting their business model to insulate themselves from an anticipated and fateful exclusion from various networks. Assuming their shifts in focus to other models and other consumers, namely large self-funded employers, are successful, High-Cost Providers are unlikely to feel the need to take action when excluded from Narrow Network op-

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[267] *See supra* text accompanying note 24.

[268] Elisabeth Rosenthal, *Doctors Slow to Join H.M.O.'s Now Often Find Doors Shut*, N.Y. TIMES, June 25, 1994, at 1 (noting that private doctors who had originally spurned HMOs found themselves with a severe drop in volume when they failed to join, leaving them desperate to join).

[269] *Id.*

[270] *See* Ken Terry, *Do Doctors Give HMO Patients a Fair Shake*, MED. ECON. (Feb. 21, 2000), http://medicaleconomics.modernmedicine.com/medical-economics/content/do-doctors-give-hmo-patients-fair-shake?page=full (noting an example of a physician who changed her practice by setting a hard cap on the amount of time she would spend with HMO patients due to the low reimbursements she received from those patients providers).

[271] This is not to say that insurers are not still shifting risk from the insurer to the providers in many of these new reimbursement models. Perhaps somewhat less risky than capitation, value-based purchasing, shared savings, and bundled payment models all shift risk to the providers to provide more coordinated and less costly care in order to collect for services rendered. *See* FURROW ET AL., *supra* note 161, at 657–59.

tions.

This confluence of increased consumer choice on the individual marketplace, alternative reimbursement structures, and alternative models for High-Cost Providers indicates that Narrow Networks appear poised to experience more sustained and long-term growth than HMOs. As these new models begin to take shape, what is clear is that insurers and providers learned enough from the HMO movement that they are likely to avoid some of the same challenges that plagued limited provider models of the past.