FEATURED ARTICLE

The Wide World of Narrow Networks: How Health Care Providers Can Adapt and Succeed

Julie A. Simer and J. Scott Schoeffel

What is the issue? Narrow provider networks have become increasingly popular due to growing pressure on health plans to control health care premiums, in particular, for health plan products offered on health benefit exchanges. Today’s narrow networks differ from the health maintenance organizations of the 1980s and 1990s and focus to a greater extent on measuring quality and providing value. Medical professionals, hospitals, laboratories, and other health care service providers are finding it difficult to provide care at the lower rates offered for narrow network products and remain competitive.

What is at stake? To obtain lower health insurance premiums, consumers must accept a limited choice of providers. Lower premiums translate into less money for health plans to pay providers. Successful negotiation of the narrow network landscape can impact the financial viability of providers who operate on increasingly slim profit margins.

What should attorneys do? Attorneys can equip providers with essential tools to successfully navigate the narrow network environment. This article discusses the strategies that can help health care providers adapt and improve their profitability in today’s environment.


Author biographies appear on the next page.
Julie A. Simer is a Shareholder at Buchalter Nemer. She represents many types of health care businesses, with a particular emphasis on hospitals, health systems, and their operational challenges. Contact her via email at jsimer@buchalter.com.

J. Scott Schoeffel is Special Counsel in Buchalter Nemer’s Health Care Practice Group. Contact him via email at sschoeffel@buchalter.com.
Simer and Schoeffel: Narrow Networks

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Introduction: Narrow Networks Have Evolved

Consumers are understandably selective about their health care providers. When health insurance companies (health plans) have tried to limit that choice, consumers have turned to state legislatures to help them preserve their right to choose providers. Prior to the 1980s, some states adopted legislation to ensure consumer choice.1 These “freedom-of-choice” provisions were of three varieties: (i) prohibiting an insurer from influencing or attempting to influence a consumer to use a particular health care provider, (ii) requiring that consumers have complete freedom of choice between physician and non-physician providers, and (iii) requiring the insurer to contract with all providers willing to meet its terms under “any-willing provider” laws.2 This pro-consumer trend continued through the 1970s and 1980s with the adoption of state coverage mandates—which typically required health insurers to cover specific persons, services, or providers3—and prices for health care insurance began to skyrocket.4

State laws governing access did not apply to self-insured plans, however, so by the mid-1980s, some of them began offering narrow networks.5 By the early 1990s, narrow networks were permitted for fully insured plans in most states and prices stabilized.6 A short time later,

3 The Regulation of Private Health Insurance, at 13.
4 Peter Kongstedt, Health Insurance and Managed Care: What They Are and How They Work 15 (4th ed. 2016) [hereinafter Health Insurance and Managed Care].
6 Id.
however, the managed care backlash hit. Consumers complained they could not see their preferred providers and were being denied care.\textsuperscript{7}

In response, health plans began offering new products, such as preferred provider networks (PPOs), which allowed consumers to utilize services from providers outside the health plan’s network without first seeing a primary care “gatekeeper,” an unpopular requirement of HMOs.\textsuperscript{8} The quid-pro-quo, however, was that in exchange for the right to see non-network providers, the consumer was required to pay a larger share of the provider cost. Once again, costs began to creep up.

As commercial and governmental payers began looking for new ways to slash health care costs, it was inevitable that they would return to the idea of limiting consumer choice to a smaller range of health care providers that offer services at lower prices. Thus, narrow networks became more prevalent. Between 2007 and 2013, the percentage of employers whose largest plan included a narrow network increased from 15\% to 23\%.\textsuperscript{9} Health plans have distinguished the new narrow networks from those of the past by trumpeting an increased emphasis on quality metrics and pay-for-performance programs.\textsuperscript{10} In addition to aggressive out-of-network benefit control, the new products include new performance management tools, including data transparency, pay for performance standards, and care coordination instead of medical necessity review.\textsuperscript{11}

While earlier narrow networks may have been based on profiling individual physicians or groups, the new narrow network products are being negotiated with large organized groups of hospitals and physicians.\textsuperscript{12}

\textsuperscript{7} Id.
\textsuperscript{8} Health Insurance and Managed Care, at 9.
\textsuperscript{9} Deborah Farringer & Thomas Bartrum, They’re Back! The Rise of the Narrow Network in Health Care Exchanges and How It May Impact Academic Medical Centers, AHLA CONNEcTIONS, Jan. 2015, at 11 [hereinafter They’re Back!].
\textsuperscript{10} Id.
\textsuperscript{12} Id.
The concept behind the narrow network is that providers will agree to lower prices in expectation of more consumers and that insurers will share some of the savings with consumers. Those in favor of narrow networks claim that because family doctors, specialists, and hospitals are all part of the same network, they are more effective at coordinating care.

**Narrow networks are thriving**

In April 2015, McKinsey & Company (McKinsey) compared data from all networks offered on the 2014 and 2015 health benefit exchanges and observed that, in the current market, narrow hospital networks could be categorized into three types: (i) narrow, with approximately 31% to 70% of hospitals participating in the network; (ii) ultra-narrow, with less than 30% of the hospitals participating in the network; and (iii) tiered networks, where hospitals are listed in tiers with different co-payment requirements, depending on the tier.

The McKinsey study found that narrow networks are highly prevalent. Close to half of the 2015 networks that consumers can choose from are narrowed, and almost two-thirds of the networks are narrowed in the largest cities. Large cities tend to have more provider and insurer competition, as well as excess bed capacity, factors that are generally associated with higher rates of narrowing.

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14 Id.
16 Id.
17 Id.
18 Id.
A study of physician networks by the Leonard Davis Institute of Health Economics at the University of Pennsylvania found the distribution of narrow provider networks offered by health plans on the exchanges was similar to that of the hospital networks. The University of Pennsylvania study categorized physician networks into “T-shirt sizes” based on the number of physicians in the network: extra-small (less than 10%), small (10%-25%), medium (25%-40%), large (40%-60%), and extra-large (more than 60%). Eleven percent of the physician networks were extra-small, 30% were small, 24% were medium, 24% were large, and 11% were extra-large.

Yet, the narrow network trend is not limited solely to plans offered on the exchange. Employers have turned to narrow networks when they think the plans can deliver better care at lower costs. For example, 30% of the very largest employers offered narrow networks in 2015 as compared to only 21% in 2008.

Consumers need accurate information

Narrow networks present consumers with a difficult choice. Families must decide between the expensive premiums or changes in employment that may be necessary to achieve greater provider choice, versus the more affordable premiums and limited provider options offered by narrow networks. A consumer may not even realize that her selec-

20 Id. at 3.
21 Id.
22 They’re Back!
24 Id.
25 They’re Back!
tion of a plan based on the premium price may result in no longer having in-network access to her regular provider.26

Many consumers do not appear to understand the choices available to them or the impact of those choices.27 Forty-four percent of those who bought a health plan offered on a health benefit exchange for the first time in 2015 reported they did not know the network configuration associated with their plan.28 Even when consumers understand their choices, they often make their selection based on incomplete information. They may choose a primary care physician (PCP) recommended by a friend, a specialist recommended by their PCP,29 or a hospital recommended by a specialist.30 Although quality report cards are available on the internet,31 consumers may ignore them. As information about provider quality and cost becomes easier to obtain, consumers may begin using it to make a meaningful choice. Nonetheless, narrow networks may continue to drive consumer behavior.

Some commentators point out that narrow networks can force consumers to change physicians or drive long distances if a key hospital is not included in the plan, especially in states with few insurers selling through the Patient Protection and Affordable Care Act (ACA) marketplace.32 Consumers who choose to go out of network may face large out-of-pocket costs.33 To retain their market share, providers must make sure that they are included within the health plan options offered to consumers and that they rank high in the publicly available quality information.

26 Id.
28 Id.
30 Id.
31 Id.
32 Narrow Networks Trigger Push-Back From State Officials.
33 Id.
For consumers to make meaningful provider choices, they must have accurate information about which providers are actually in the network. This became an issue when the health benefit exchanges were first introduced. Providers and consumers both struggled to understand which providers were included.

In 2014, lawsuits were filed in California against health plans alleging that insurers did not offer adequate provider networks, misled consumers about network size, and presented inaccurate directories of participating providers. Consumers “alleged that they received medical treatment with providers found through the insurance company’s website [or provider directories but] that their claims for payment were later rejected.” Consumers also accused health plans of “concealing their [limited] provider networks during [open enrollment.]” Health plans have acknowledged that some inaccuracies existed in their provider databases, but maintained that the vast majority of the listings were correct.

Providers should support efforts to improve transparency of quality information by regularly monitoring publicly available quality data regarding their services to ensure accuracy and by encouraging consumers to take an active role in utilizing this information.

**Providers need to know if they are included in a narrow network**

Providers may not always know they have been chosen for a health plan’s narrow network and what patient populations they are required to serve. For example, contract provisions such as the “all products” clause may require a provider to participate in any product a health

35  Id. at 7.
36  Id.
plan offers, including narrow network products. As a result, the provider may be bound to serve consumers with higher rates of illness for the same capitation payment. On the other hand, a provider may be unexpectedly and/or unknowingly excluded or “deselected” from the network. For example, hospitals with higher cost structures, such as academic medical centers, may be dropped from a network due to price. The Texas Medical Association reported that one physician had received a notice that his current agreement was being amended and that his signature was not required for the amendment to be effective.37 Such “notice amendments” seek to terminate providers by unilaterally amending existing agreements.

Providers must be diligent in monitoring the financial results of their participation in health plan networks to determine which ones are worth the membership. They should review their existing contracts to determine network participation, especially where compensation is based on capitation, and candidly address these issues during the contracting process.

Health plans must create and maintain adequate networks

In 2013, health care coverage became available on health benefit exchanges. To compete on the exchanges, health plans needed to develop lower-cost products, while meeting state network adequacy requirements and complying with federal medical loss ratio requirements. As one commentator noted, adjusting provider rosters is one of the few remaining ways insurers can lower costs.38

Health plans and plan sponsors assert that the ability to negotiate lower prices with a selected group of high-quality providers is necessary to drive down health care expenditures and achieve value-based

38 Narrow Networks Trigger Push-Back From State Officials.
Some evidence suggests that insurer networks tend to exclude lower quality providers because low quality health care often leads to more complications and higher costs. Proponents note that narrow networks allow the plan sponsor or insurer to coordinate care among a smaller, more controllable network of physicians, thereby saving costs on claims processing. Proponents further point out that many consumers are willing to accept more limited provider options within narrow network products to obtain lower premiums.

The McKinsey study found “no meaningful performance difference between broad and narrowed exchange networks based on Centers for Medicare and Medicaid Services (CMS) hospital metrics,” such as the composite value-based purchase score used to determine the value-based incentive payment for each hospital, as well as its three sub-components (outcome, patient experience, and clinical process scores).

Controlling costs is important, but consumer satisfaction depends on consumers having ready access to providers when they need care. Providers should advocate for minimum standards of network adequacy for their own benefit and for that of the consumer.

Legislators and regulators must ensure network adequacy

Complaints from health care providers excluded from a network or consumers denied access to a provider have resulted in regulatory action and legislation at the state level. Network adequacy requirements—found in both federal and state laws—obligate a health plan to maintain a provider network that guarantees certain services are available to enrollees.

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39 They’re Back!
40 Misunderstanding Narrow Networks.
41 They’re Back!
42 Id.
43 Hospital Networks: Evolution of the Configurations on the 2015 Exchanges.
44 Narrow Networks Trigger Push-Back From State Officials.
45 Appalachian Reg’l Healthcare, Inc. v. Coventry Health & Life Ins., 714 F.3d 424 (6th Cir. 2013) (citations omitted).
accessible to its consumers within specified times or distances from their homes.

**State attempts to regulate network adequacy**

According to a report by the Commonwealth Fund, by January 2014, nearly all states had rules intended to promote the sufficiency of health plans’ provider networks.\(^46\) For example:

- States such as California have passed legislation and adopted regulations requiring reporting on adequacy of provider networks.\(^47\)
- Maine requires that insurers disclose to a provider, upon request, the reason for the issuer’s decision not to offer the provider the opportunity to participate in the network.\(^48\)
- Washington’s network adequacy rules will require health plans to provide detailed reports on the location of doctors and hospitals in their networks and a more transparent process for the building and maintenance of provider networks.\(^49\)
- Massachusetts’s network adequacy law defines the elements that must be included in any methodology that health plans use to place providers in tiers.\(^50\)
- New York passed legislation that limits charges to consumers who receive emergency services to in-network out-of-pocket costs regardless of the provider’s network status. It imposes the same limitation on out-of-network nonemergency services where no in-network providers were available or the con-

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\(^{47}\) **Challenges Facing “Narrow” Provider Networks.**


\(^{49}\) **Challenges Facing “Narrow” Provider Networks; WASH. ADMIN. CODE § 284-43-203.**

\(^{50}\) **Challenges Facing “Narrow” Provider Networks; MASS. GEN. LAWS CH. 176J, § 11.**
sumer did not receive the mandated disclosures. The law also includes new disclosure requirements for provider networks and charges.\textsuperscript{51}

- The New Hampshire Insurance Department created an informal working group to review network adequacy standards and propose changes to the legislature\textsuperscript{52} following a legal protest by Frisbie Memorial Hospital and an individual consumer challenging Anthem’s decision not to include Frisbie and other hospitals in its network.\textsuperscript{53}

Some states are considering adopting any willing provider laws or fortifying existing ones.\textsuperscript{54} Although such laws vary by state, any willing provider laws generally require insurers to open their networks to any provider willing to accept the network’s terms and conditions, including proposed payment rates. States also have enacted freedom of choice laws requiring plans to pay providers based on consumer choice.\textsuperscript{55} These laws were intended for consumer protection but have had limited practical application “partly because they are narrowly drafted, often lack substantive penalties, and do not upset the fundamental economic dynamic that exists between providers and plans with respect to the financial terms of participation.”\textsuperscript{56}

\textit{The ACA regulates network adequacy on the exchanges}

The ACA establishes a national standard for network adequacy, requiring each health plan to ensure a sufficient choice of providers and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers.\textsuperscript{57} It also requires

\textsuperscript{51} \textit{Id.}; N.Y. Fin. Servs. Law §§ 601–08; N.Y. Comp. R. & Regs. tit. 23, §§ 400–400.10.
\textsuperscript{52} Challenges Facing “Narrow” Provider Networks.
\textsuperscript{53} \textit{Id.}
\textsuperscript{54} They’re Back!
\textsuperscript{55} \textit{Id.}
\textsuperscript{56} \textit{Id.} at 13.
\textsuperscript{57} 42 U.S.C. § 18031(c)(1)(B).
marketplace plans to include within their networks a sufficient number and geographic distribution of “essential community providers” that serve predominantly low-income, medically underserved individuals.\textsuperscript{58} The rules give states and insurers considerable discretion in interpreting when a network is “sufficient” and what constitutes “unreasonable” delay.\textsuperscript{59} “Even in federal exchanges, state departments of insurance were given responsibility for determining network adequacy.”\textsuperscript{60}

CMS issued guidance for qualified health plans (QHPs) operating in 2015.\textsuperscript{61} “Qualified health plans’ networks must include 30% of available essential community providers.”\textsuperscript{62} In the preamble for final Payment Parameter rules for 2016, CMS states that it is deferring any significant changes to its network adequacy standards until the National Association of Insurance Commissioners (NAIC) completes its work on updating the Managed Care Plan Network Adequacy Model Act (Model Act). The Network Adequacy Model Review Subgroup of the NAIC is working towards revising the Model Act by the end of 2015.\textsuperscript{63}

\textit{CMS’s position on Medicare Advantage network adequacy}

The American Medical Association requested that CMS instruct Medicare Advantage Organizations (MAOs) to delay the effective date of their contract terminations for the 2014 contract year.\textsuperscript{64} CMS responded it did not have authority to hold terminations in abeyance outside of notice and comment rulemaking, but would oversee net-

\begin{itemize}
\item \textsuperscript{58} 45 C.F.R. § 156.230; id. § 156.235.
\item \textsuperscript{60} \textit{They’re Back!}, at 12.
\item \textsuperscript{61} Leanne Gassaway, Creating an Affordable, Stable and Accessible System for Consumers; ACA—What’s Next?, 2015 California Society for Health Care Attorneys Annual Meeting and Spring Seminar, Huntington Beach, CA (Apr. 2015).
\item \textsuperscript{62} \textit{Id.}
\item \textsuperscript{63} NAIC, \textit{Network Adequacy Model Review (B) Subgroup}, \texttt{www.naic.org/committees\_b\_rftf\_namr\_sg.htm} (last visited July 27, 2015).
\item \textsuperscript{64} CHALLENGES FACING “NARROW” PROVIDER NETWORKS.
\end{itemize}
work changes and require MAOs to make adjustments as needed.\textsuperscript{65} CMS announced that “beginning in 2015, [it] will require MAOs to notify CMS when they are planning network changes that the MAO deems significant and CMS will determine, after consultation with the MAO, whether the planned change requires certain additional actions on the part of the MAO in order for the organization’s network to continue to meet Medicare standards.”\textsuperscript{66} CMS added that it intends to take appropriate compliance action against any MAO that fails to notify CMS of network changes that it ultimately deems significant. Further, CMS has made clear its expectation that MAOs take a conservative approach when determining whether a network change is significant and to notify CMS if there is any doubt about whether the planned contract terminations represent a significant change.\textsuperscript{67}

Although legislators and agency officials have been responsive to some extent, providers must continue to encourage state and federal officials to adopt and enforce regulations and legislation that compel health plans to contract with a sufficient number and type of providers so that consumers may have ready access to necessary services.

Providers Must Pursue Strategies to Adapt to Narrow Networks

The increasing complexity in insurance offerings portends increasingly narrowed network products, so flexibility and new approaches to pricing will be essential to providers’ survival in this new marketplace. While there is no simple formula to deal with the challenges posed by

\textsuperscript{65} \textit{Id.}
\textsuperscript{67} \textit{Id. at} 103.
narrow networks, there are a number of strategies that providers can employ to help stay competitive.

**Remain out of network**

Some providers avoid entering into a contractual relationship with certain health plans. Often these are non-acute care providers or providers who are significantly less prominent in their marketplaces than academic medical centers. In such cases, state regulation may dictate who is responsible for paying providers and how much providers can receive for out-of-network services. Some states adopt legislation or regulation to address these issues, but more often providers rely on equitable theories such as quantum meruit, detrimental reliance, unjust enrichment, or implied contract. Some states only recognize rights to payment in connection with emergency services.

The provider and the health plan may disagree on how much the provider will be paid for out-of-network services. Health plans typically have paid for out-of-network services at the usual, customary, and reasonable rate for the provider’s community, but some providers and insurers are agreeing to reimbursement at a percentage of the Medicare reimbursement rate.

Recently, more health plans are designed to push a higher portion of costs to consumers who seek care from out-of-network providers. In addition, health plans have used various arguments to defeat out-of-network provider claims by asserting: (i) ERISA preemption challenges to state payment rules, (ii) a defense that the out-of-network provider

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68 They’re Back!
69 Id.
70 Id.
71 Id.
72 Id.
73 Id.
74 Id.
75 Id.
failed to exhaust the plan’s administrative remedies even though the provider was not bound to do so by plan rules, or (iii) that the provider lacks standing because of a lack of contractual nexus between the health plan and the provider. Occasionally, health plans have used more aggressive tactics like dropping providers from the network or using notice amendments, mentioned above, to unilaterally terminate existing contracts with providers. Health plans have sued out-of-network providers for waiving copayments and cost-sharing amounts and have also exercised their right to make payments directly to consumers, thereby shifting additional collection responsibilities to providers.

Improve efficiency to lower costs

The health care delivery infrastructure is more interconnected than it has ever been, and significant improvements have been made in how to use data to design better clinical care programs. Providers must continue to maximize the use of evolving technology to coordinate care and increase efficiency, which can reduce the overall expense of caring for a population of consumers. For example, when physicians in different specialties or at different care locations use the same electronic health record for a patient, costs may be reduced along with duplication, medical errors, or unnecessary tests.

Form strategic alliances

Hospitals are beginning to explore joint venture opportunities that provide access to capital and partnerships with hospitals and regional and/or national health plans. Anthem Blue Cross in California

76 Id. at 14.
77 Id.
78 Id.
80 They're Back!
recently joined forces with seven hospitals and health systems in California, including higher-priced academic medical centers, to create a new type of narrow network known as Vivity. The hospital systems intend to clinically integrate, refer to each other, and work together on best practices. The plan launched on January 1, 2015 with the California Public Employees’ Retirement System as the first client. Two hospital system partners put their own employees into Vivity, and Anthem is offering Vivity as an option for its own associates in the service area and to other large employers. Only time will tell whether other hospital systems will pursue a similar strategy.

Use data to evidence high performance

Provider reimbursement is increasingly tied to quality and outcomes, exposing providers to greater risk for the care they deliver. Providers should, therefore, focus on delivering and proving quality of care and consumer satisfaction. For example, a provider can develop a reputation for quality by becoming designated as a center of excellence for a particular procedure or service line.

Providers must be prepared to demonstrate their value to health plans through competent data collected on quality metrics and consumer satisfaction surveys. Health plans can differ in how they evaluate quality, so providers should understand the evaluation measures and formulas that will be applied by different health plans. To be able

82 Id.
83 Id.
84 Id.
85 Provider-Led Health Plans: The Next Frontier—or the 1990s All Over Again?
86 Id.
87 They’re Back!
to improve their quality rankings, providers need specific information about how these rankings are calculated.89 For Medicare Advantage plans, providers should meet with their health plan representatives to see what they can do to help improve the plan’s HEDIS/CMS Stars90 scores. For commercial plans, providers should get a detailed listing of predefined quality measures, benchmarks for incremental improvement, timeframes for achieving goals, methods for gathering information and calculating bonuses, and procedures to correct inaccurate data. Once this information has been obtained, it should be incorporated in the managed care contract.

**Offer a provider-sponsored health plan**

In the 1990s, a surge of providers created health plans, but many of those efforts failed.91 Today, provider-sponsored plans are reappearing and exchanges are giving them the opportunity to compete with traditional health plans. Consequently, providers are launching their own plans as a way to capture the entire premium dollar and hone skills in coordinating care and controlling costs.92 During the first year of the exchange, however, providers found that consumers were particularly cost-conscious when choosing plans, leading to increased pressure on provider-sponsored plans to offer lower-cost products.93 Providers should only adopt this competitive strategy if they are confident that they can manage their risk and remain profitable.

89 Id.
90 Healthcare Effectiveness Data and Information Set/CMS Five-Star Quality Rating System.
92 Id.
93 Id.
Negotiate for better tier placement

Tiered networks are a variation of narrow networks that offer consumers a broader array of provider options and more flexibility based on cost-sharing amounts. The higher tiers provide a wider choice of providers at higher cost-sharing amounts. Because the tiered network strategy shifts costs to the consumers using the services, rather than spreading the cost of more expensive care across the whole population, the best position for providers would be the tier with the lowest-cost share for consumers. Providers should, therefore, bargain for better tier placement to increase the volume of consumers in their patient population.

Challenge network deselection

A provider’s patient base and revenue may be severely impacted if he or she is dropped from a health plan’s network, but providers can successfully contest such decisions. Many states require either “good cause” or “fair procedure” prior to termination of the provider’s network agreement or exclusion from the network. Many health plans set forth procedural requirements in the contract with the provider, such as the timing and manner of notice required.

The case of Fairfield County Medical Association v. United Healthcare of New England is an example of providers challenging deselection. In 2013, two professional organizations filed suit in federal court in Connecticut after 2,000 providers were terminated from United’s Medicare Advantage network. United claimed that the ACA’s rate reductions to

94 Implications of Narrow Networks and the Tradeoff between Price and Choice, at 2.
95 Id.
Medicare Advantage plans made it necessary for the health plan to trim its provider network by almost 20%. In December 2013, the court held (i) the plaintiffs had demonstrated a likelihood of success on the merits, (ii) the contract language did not support United’s position that it had a unilateral right to terminate the doctors without cause by amendment, and (iii) the Medicare Advantage regulations (42 C.F.R. § 422.202(d)) and the contract mandated at least 90 days notification of termination. United appealed the decision, but the U.S. Court of Appeals for the Second Circuit summarily affirmed the lower court, giving the terminated providers 30 days to challenge their removal by initiating arbitration proceedings.

Concentrate on contracting strategy

Providers must carefully consider their contracting strategy prior to entering into negotiations with a health plan, including the following important factors:

1. First and foremost, providers should evaluate their position in the local market to identify their value proposition and plan how to capture a greater share of the market. Providers should have a strong understanding of these local market dynamics before entering into negotiations with health plans.

2. Calculate a series of “break-even” price and volume points to determine whether they, as providers, can compensate for the impact of discounted prices.

99 Id.
100 Id.
101 Id.
103 Id. at 4.
104 Id. at 6.
3. Mitigate the risks associated with narrow network discount offers with contract terms such as the following:105
   • Volume thresholds and automatic increases if the volume thresholds do not occur;
   • Terms that limit the extension of discounted rates to other products;
   • Terms that allow the providers the option of inclusion in other narrow network products offered by the health plan, to prevent the health plan from forming exclusive relationships with other providers that might negatively affect the providers;
   • Bad debt protection, including a clear process for monitoring bad debt levels and provisions for any significant increases in bad debt;
   • Covenants to reopen negotiations in the event of unforeseen negative consequences for the providers; and
   • Terms that ensure that the providers receive access to network performance data.

4. Consider using innovative reimbursement models (such as a performance bonus contingent on meeting agreed efficiency and quality targets).106

5. Consider offering health plans preferential access or services for their members (e.g., dedicated private rooms or same-day appointments) in exchange for higher reimbursement rates.107

6. If the providers have strong brand recognition, consider developing highly competitive co-branded products with health plans.108

105 Id. at 10.
106 Id.
107 Id.
108 Id.
Step up marketing efforts

Providers today have more options for marketing themselves directly to consumers, thereby giving them an entry point into rapidly growing consumer segments. By creating an independent demand for their services through such marketing efforts, providers can encourage consumers to insist that their providers are included in the health plan network.

Conclusion

Consumers today, unlike those in the 1990s, seem more willing to accept restrictions on access to providers in exchange for access to lower premiums. Consumers “now appear to be much more open to narrow networks (in part because of their concerns about rising healthcare spending).”

Payers, providers, and consumers must accept that narrow networks are here to stay. Providers will need to work harder to achieve high quality scores to demonstrate the value of their services to the network. As the various players adjust to this “new normal,” there will be growing pains. Providers need to adopt effective strategies to compete in this new environment. They can choose to remain out of network or they can try to make their services more attractive by focusing on efficiencies to lower cost, collecting data on quality metrics and consumer satisfaction to demonstrate high performance, aggressively pursuing marketing to consumers, challenging network deselection, and pursuing joint ventures with other providers and/or health plans. This shift to narrower networks may mean a move toward making the health care delivery system more efficient and more responsive to consumers, and providers that accept this challenge and adapt will survive and succeed.

110 Id.
111 Id.