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MEMBER BRIEFING

HMOS AND HEALTH PLANS PRACTICE GROUP

TIERED PHYSICIAN NETWORKS: A NEW TWIST ON AN OLD ISSUE

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Over the last few years, there has been a flurry of activity involving the design and implementation of tiered physician networks, challenges to the legality of such networks, and regulating these networks. Although the tiered network initiative is relatively new, the underlying concept of categorizing physicians for coverage purposes is not. Similarly, challenging and regulating such categorization is nothing new. This member briefing examines the origin of tiered physician networks, the legal challenges managed care organizations (MCOs) face from physicians and others in implementing such networks, and state efforts to regulate tiered network programs and the performance-based evaluations used to establish these programs.

At its core, a tiered network program offers financial incentives (e.g., lower out-of-pocket costs) to MCO enrollees to obtain healthcare services from physicians in a preferred or higher tier (i.e., tier one). The tiering initiative is an evolution of the basic tiering mechanism that has long been fundamental to health maintenance organizations (HMOs) and other MCOs—the division between participating providers and non-participating providers. Aside from signifying a provider's willingness to contract on terms acceptable to the MCO, inclusion of a provider in an MCO's provider directory also signifies that a provider has met the credentialing criteria and other qualifications used by the MCO in selecting providers. Having separate tiers of

participating providers is a refinement of that basic model, permitting MCOs to recognize quality and cost-effectiveness and provide signals and incentives to consumers to utilize providers who are so recognized. Such programs may also incentivize providers to work to satisfy the screening criteria used to qualify for preferred tiered status.

There are several forces that are driving tiered networks and the performance-based evaluations that underlie them. One force is employers who seek to control the costs of providing health benefits to employees while still providing employees with access to quality healthcare services. Another force is consumer-directed healthcare and consumers' need for information to make quality and cost-minded decisions. A third force is the federal government, which has sponsored and otherwise encourages pay-for-performance initiatives that reward the provision of quality care in a cost-effective way.[1]

Potential Bases for Challenge

Before tiered networks, physicians and other healthcare providers sought relief in the courts for their exclusion or termination from MCO participating provider networks. A key case in this area is *Harper v. Healthsource, Inc.*[2] In *Harper,* a physician who participated in the Healthsource HMO as a surgeon and primary care physician challenged the HMO's decision to terminate his participating surgeon status for failure to meet credentialing criteria. Healthsource members accounted for approximately 40% of the physician's patient panel. Among his many allegations, Dr. Harper claimed that the termination without cause provision in the participating agreement, or the termination in his case, was void as against public policy, and that the HMO violated state law in refusing to provide him with certain records related to the credentialing decision.[3] The court held that Dr. Harper was entitled to proceed upon the merits of his claim that the

[1] CMS Press Release, "Medicare 'Pay For Performance (P4P)' Initiatives," (Jan. 31, 2005).
[2] 674 A.2d 962 (N.H. 1996). *See also Potvin v. Metropolitan Life Ins. Co.*, 54 Cal. App. 4th 936; 63 Cal. Rptr. 2d 202 (1997) *affirmed and superseded by* 22 Cal. 4th 1060, 95 Cal. Rptr. 2d 496, 997 P.2d 1153 (2000).
[3] Dr. Harper claimed that Healthsource was "manipulating and skewing the records of treatment he had provided to several of his patients and that such inaccuracies adversely affected other subsequent reports." 674 A.2d at 963.

HMO's decision to terminate its relationship with him was made in bad faith or violated public policy.[4] According to the court, “[i]f a physician's relationship is terminated without cause and the physician believes that the decision to terminate was made in bad faith or based upon some factor that would render the decision contrary to public policy, then the physician is entitled to review of the decision.”[5] The court further noted that the public has a substantial interest in the relationship between an HMO and their preferred provider physicians because this relationship is perhaps the most important factor in linking a particular physician with a particular patient. “We conclude that the public interest and fundamental fairness demand that a health maintenance organization's decision to terminate its relationship with a particular physician provider must comport with the covenant of good faith and fair dealing and may not be made for a reason that is contrary to public policy.”[6]

Why Does Provider Tiering Pose New Legal Challenges?

Unlike the initial decision not to contract with a particular physician or the subsequent decision to terminate a physician’s participation status, physicians who are placed in a less advantageous tier are nevertheless allowed to remain in the MCO’s participating provider network. So what is all the fuss about? One reason is the public availability of a physician’s tiered status as well as the general or specific basis for the tier assignment. MCO marketing and benefit materials as well as provider directories include some sort of description of the tiered network, the basis for assigning a physician to one tier versus another, and the advantages to the consumer for seeking care from a physician in a higher tier. A related reason is that MCOs actively market tiered networks to employers. Thus, being a preferred tier presents better opportunities to grow and maintain a physician’s patient panel. Conversely, being in a higher-cost tier

[4] In his petition, Dr. Harper asserted that his efforts to correct errors made in patient records played a role in Healthsource's decision, and he argued on appeal that public policy should condemn "an insurance company which, upon receipt of a letter from a medical provider asking for assistance in correcting . . . records of patient treatments, terminates the doctor's services." 674 A.2d at 966-967.
[5] 674 A.2d at 966.
[6] *Id.*

could result in patient panel reductions. Finally, there is the concern for the potential interference with existing physician-patient relationships caused by tiered networks.

As the lawsuits and other challenges that have been brought to date regarding tiered networks demonstrate, regardless of the force behind the tiered network initiative, these programs expose MCOs to potential liability. The features (or flaws) that are areas of exposure to liability include:

- Lack of transparency with providers, members, and the general public in the measurement methodology and process
- Failure to include providers and members in developing methodology
- Errors in data/wrong data used
- Over-reliance on cost measures
- Questionable quality measurement methodology
- Wrongful inclusion or exclusion in tiered provider network based on rankings
- Communications to patients and providers
- Lack of or failure to adequately implement dispute remedies
- Sharing information

Potential Causes of Action

As with exclusion and termination decisions, there are a number of avenues by which tiering programs could become legally risky. Claims could potentially be made by aggrieved providers, by law enforcement officials, or MCO regulatory bodies, or in some instances by enrollees themselves. The grounds for possible challenges are many:

1. Breach of Contract. Participating but disaffected physicians could claim that exclusion from the MCO's top tier or ranking is a breach of the physician's provider agreement with the MCO. At a very basic level, a physician could claim that the provider agreement contains an implicit, even if not explicit, commitment by the MCO to give the

physician the full benefits of "participating provider" status. A physician could seek to claim that a commitment to give equally preferred status to all participating providers, in contrast to non-participating providers, was a fundamental *quid pro quo* for any price discount or concession given by the physician to the MCO. In short, the physician would claim that the "steerage" advantages of participating provider status were part of the consideration from the MCO in exchange for price concessions by the physician. There may also be specific contract language or other evidence to support such a claim.

2. Defamation/Libel. A physician could claim that communications to enrollees or other providers of his placement in a lower tier constitutes defamation or libel. In essence, the physician would claim that the MCO had wrongfully labeled the physician as providing poorer quality care than other providers.[7]

Taking Pennsylvania[8] as an example, in order to make a *prima facie* case for defamation against the MCO, a plaintiff provider must prove: (1) the defamatory character of the communication; (2) its publication by the defendant; (3) its application to the plaintiff; (4) the understanding by the recipient of its defamatory meaning; (5) the understanding by the recipient of it as intended to be applied to the plaintiff; (6) special harm resulting to the plaintiff from its publication; (7) abuse of a conditionally privileged occasion.[9]

3. State Unfair Trade Practices and Consumer Protection Law. A state Attorney General could claim that communications made in connection with the development and implementation of a tiering program constitutes an unfair method of competition or unfair or deceptive act or practice in violation of the state's unfair trade

[7] State law will determine whether the implication, not just the literal statement, can be the basis for a claim. For example, under Pennsylvania law, a publisher can be held liable "for the implications of what he has said or written, not merely the specific, literal statements made." *Dunlap v. Philadelphia Newspapers, Inc.*, 448 A.2d 6, 15 (Pa. Super. Ct. 1982).

[8] 42 Pa. Cons. Stats. § 8343 (2007).

[9] *See also Offen v. Brenner,* 402 Md. 191; 935 A.2d 719 (2007). Under Maryland law, to present a prima facie case of defamation, a plaintiff must establish four elements: (1) that the defendant made a defamatory statement to a third person, (2) that the statement was false, (3) that the defendant was legally at fault in making the statement, and (4) that the plaintiff thereby suffered harm. A defamatory statement is one which tends to expose a person to public scorn, hatred, contempt or ridicule, thereby discouraging others in the community from having a good opinion of, or associating with, that person.

practices and consumer protection law. These laws typically prohibit, among other things, disparaging the goods, services, or business of another by false or misleading representations of fact, making a statement that is false or maliciously critical of or derogatory to the financial condition of any person, and that is calculated to injure such person, or engaging in any other fraudulent or deceptive conduct that creates a likelihood of confusion or of misunderstanding. Specifically, for example, a state Attorney General could claim that the MCO engaged in unfair and deceptive practices by making misleading implied representations to members or referring providers that physicians not in the top tier or ranking render inferior healthcare services compared to physicians listed in a higher tier or ranking. A state Attorney General could claim that the tiering or ranking methodology employed by the MCO, as presented, conveys a relative quality representation and that the methodology is flawed and does not accurately measure the quality of a provider's care or the provider's efficiency.[10]

4. Unfair Insurance Practices Act. These state laws, which are enforced by the state commissioners of insurance, bar an MCO from making, publishing, issuing, or circulating any estimate, illustration, circular, statement, sales presentation, omission or comparison, advertisement, or announcement, thath is untrue, deceptive or misleading, that misrepresents the benefits, advantages, conditions, or terms of any coverage policy or that misrepresents the financial condition of any person.[11]

5. Tortious Interference with Contractual Relations. Providers could claim that the tiering initiative communications wrongfully interfere with their business and contractual relations with patients. In order to succeed on a claim of tortious interference with contractual relations, a provider must prove: (1) the existence of a contractual or beneficial relationship, (2) the defendants' knowledge of that relationship, (3) the defendants' intent to interfere with the relationship, (4) the interference was tortious, and a loss suffered by the plaintiff that was caused by the defendants' tortious conduct.

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[10] *See* Complaint at 3, 5, *Washington State Medical Association v. Regence Blue Shield* (Wash. Super. Ct., No. 06-230665-1SEA).

[11] *See* Cal Ins Code § 790.03 (2008). Misleading communications about the tiering initiative could be targeted as misleading consumers about their benefits, if consumers are misled about the criteria on which providers are assigned to the tiers used for determining benefit levels.

Unlike other torts in which liability gives rise to nominal damages even in the absence of proof of actual loss it is an essential element of the tort of unlawful interference with business relations that the plaintiff suffers an actual loss.[12]

6. Fraud. A physician could make a fraud claim in the event that the provider is induced to contract with the MCO or to participate in the tiering initiative on false pretenses. Thus, if the physician relies on a false statement by the MCO to his detriment he could purse a fraud claim against the MCO.

7. Conspiracy. In general, in order to succeed on a claim of civil conspiracy, a provider "must show that two or more persons combined or agreed with intent to do an unlawful act or to do an otherwise lawful act by unlawful means."[13] Unlike a claim for tortious interference with contractual relations, "[p]roof of malice, i.e., an intent to injure, is essential in proof of a conspiracy."[14] To the extent an MCO collaborates with providers and/or consultants in developing a tiering or ranking system, excluded and/or disaffected providers could try to use that interaction to support a conspiracy claim. In one instance, providers have claimed that a health plan conspired with other insurers to create an improper provider ranking program.[15]

The above legal grounds could be asserted in support of demands for monetary damages or for injunctive relief.

Legal Actions Addressing Provider Tiering

Both private plaintiffs and state law enforcement officials have brought actions against particular provider tiering programs.

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[12] *Nextmedia Outdoor, Inc. v. McClary et al.*, 2007 Conn. Super. LEXIS 1997.
[13] *Skipworth by Williams v. Lead Indus. Ass'n*, 690 A.2d 169, 174 (Pa. 1997).
[14] *Id. See also Williams v. Aetna Fin. Co*., 83 Ohio St. 3d 464, 700 N.E.2d 859, 868 (1998). Under Ohio law, the element of "malice" required to establish a civil conspiracy is defined as, "that state of mind under which a person does a wrongful act purposely, without a reasonable lawful excuse, to the injury of another."
[15] Complaint at 34-35, *Fairfield County Medical Association. v. Cigna Corp.,* No. CV-075002943 (Conn. Super. Ct., filed July 26, 2007).

1. Washington Regence litigation. In *Washington State Medical Association v. Regence Blue Shield,*[16] the plaintiffs sued after Regence excluded nearly 500 doctors from its "Select Network," which provided services to Boeing employees and their families.[17] Plaintiffs sought monetary damages and an injunction to prevent Regence from implementing a plan alleged to have used a "flawed methodology," relied on old data, and focused on the amount charged rather than patient medical records to determine quality and efficiency.[18] On August 8, 2007, the parties reached a settlement agreement to implement a performance measurement program that includes the "meaningful input" of providers, relies on timely and relevant data, gives providers advance notice of their scores, and allows providers to appeal their score. The plaintiffs had alleged a violation of Washington State's Consumer Protection Act, defamation, libel, intentional interference with contract, and breach of contract.

2. Connecticut CIGNA litigation. In *Fairfield County Medical Association v. Cigna Corp.*,[19] plaintiffs alleged that CIGNA and its co-defendants conspired in the "unilateral implementation of purported 'elite' physician designation programs."[20] The plaintiffs seek monetary damages and injunctive relief claiming that defendants excluded them from the "elite" provider designation programs based on inaccurate data that does not actually measure quality of care.[21] Plaintiffs allege that this tiered network constitutes a breach of their contract with the defendant MCOs, tortious interference with their contractual relations with their patients, libel, and violation of the Connecticut Unfair Trade Practices Act. The litigation remains ongoing.

3. New York State Attorney General's Office (OAG) Actions & Agreements. The New York Attorney General has made public announcements of concerns

[16] (Wash. Sup'r. Ct., No. 06-230665-1SEA) (complaint filed Sept. 21, 2006).
[17] *See* Complaint at 2-3, *Washington State Medical Association v. Regence Blue Shield* (Wash. Super. Ct., No. 06-230665-1SEA).
[18] *Id*. at 3-5.
[19] No. CV-075002943 (Conn. Sup'r. Ct., filed July 26, 2007).
[20] Complaint at 2, *Fairfield County Medical Association. v. Cigna Corp.*, No. CV-075002943 (Conn. Super. Ct., filed July 26, 2007)
[21] *Id.* at 4.5.

regarding specific plans' tiering initiatives and has reached settlements with CIGNA, Aetna, Empire, United HealthCare, and GHI/HIP about their programs.

Attorney General Andrew Cuomo publicly warned United HealthCare, Aetna, and CIGNA to cancel their plans to release "quality of care" provider rankings or face legal action, including the threat of injunction.[22] The OAG indicated concern that consumers were being steered to "Premium Designation" providers based on faulty data and criteria and encouraged to select inexpensive doctors rather than quality doctors, and that the insurance companies' profit motives would have an adverse impact on the accuracy of their quality rankings.[23]

Attorney General Cuomo announced that his office was conducting an "industry-wide inquiry" of insurance companies' existing and planned tiering programs, specifically "CIGNA Care Network," "Aetna Aexcel," Empire's "Blue Precision," and United Healthcare's "Premium Designation Program." The OAG's investigation included a review of documents, meetings with representatives from various insurers, medical societies and organizations, and experts in the field of measuring physician performance.[24]

In a similar letter to Preferred Care, dated October 18, 2007, the OAG requested that Preferred Care, a subsidiary of MVP Healthcare, "refrain" from launching its

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[22] *See* Letter from Linda A. Lacewell, Counsel for Economic and Social Justice, State of New York Office of the Attorney General, to Thomas J. McGuire, Esq., Regional Deputy General Counsel, United Healthcare (July 13, 2007).

[23] *Id*.

[24] *See* In the Matter of Connecticut General Life Insurance Company And Cigna Healthcare Of New York, Inc: Agreement Concerning Physician Performance Measurement, Reporting And Tiering Programs Pursuant To Executive Law Section 63, Subdivision 15 at 3 (effective date, October 29, 2007)(*available at* www.oag.state.ny.us/press/2007/oct/CIGNA%20Settlement%20Final.pdf); In the Matter of Aetna Life Insurance Company and Aetna Health Inc.: Agreement Concerning Physician Performance Measurement, Reporting And Tiering Programs Pursuant To Executive Law Section 63, Subdivision 15 at 3 (effective date, November 13, 2007) (*available at* www.oag.state.ny.us/press/2007/nov/Aetna%20Life%20Insurance%20Company.pdf); Attorney General of the State of New York, Agreement Concerning Physician Performance Measurement, Reporting and Tiering Programs at 2 (effective date November 14, 2007)(*available at* www.oag.state.ny.us/press/2007/nov/agreement_11_14.pdf); In the Matter of United Healthcare Of New York, Inc., United Healthcare Insurance Company Of New York, Oxford Health Plans, Inc., Oxford Health Insurance, Inc.: Agreement Concerning Physician Performance Measurement, Reporting And Tiering Programs, at 2 (effective date, November 15, 2007)(*available at* www.oag.state.ny.us/press/2007/nov/United%20Final%20Executed.pdf).

proposed physician-ranking program.[25] OAG questioned Preferred Care's methodology for assessing patient satisfaction, failure to adequately use patient questionnaires about physician performance, sample size, and reliance on cost measures in its quality and efficiency rankings.[26] The OAG also requested that GHI/HIP, which had not yet implemented a physician ranking program, "submit any proposed physician-ranking program for [ ] review …[to] ensure that consumers are not deceived or misled even inadvertently."[27]

On October 29, 2007, Attorney General Cuomo announced that CIGNA had reached a settlement agreement with the OAG establishing standards to ensure the accuracy and transparency of its tiered programs and to further develop a physician ranking program that was not based solely on cost.[28] Aetna and Empire entered into substantially similar agreements with the OAG on November 13, 2007 and November 14, 2007, respectively. United HealthCare and GHI/HIP also entered into substantially similar agreements on November 15, 2007 and November 20, 2007. Under these agreements, CIGNA, Aetna, Empire, United HealthCare, and GHI/HIP (hereinafter, the Settling MCOs) will maintain insurance programs that rely on national standards to measure quality, will be able to rely on cost measurements and comparisons, take measures to ensure more accurate provider comparisons, disclose to both providers and consumers how the program is designed (and any changes to the program), and establish independent appeals and compliance mechanisms.[29]

According to the OAG, the principal objectives of these settlement agreements are to establish and maintain "*accuracy* and *transparency* of information, and *oversight*"

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[25] *See* Letter from Linda A. Lacewell, Counsel for Economic and Social Justice, State of New York Office of the Attorney General, to Denise Gonick, Esq., Executive Vice-President and Chief Legal Officer, MVP Health Care and Preferred Care (October 18, 2007) (*available at* www.oag.state.ny.us/press/2007/oct/Preferred%20Care%20Final.pdf).
[26] *Id*. at 2-4.
[27] *See* Letter from Linda A. Lacewell, Counsel for Economic and Social Justice, State of New York Office of the Attorney General, to Nicholas P. Kambolis, Associate General Counsel, HIP Health Plan of New York and Timothy F. Smith, Assistant Vice President, Legal Services, GHI, at 2 (October 18, 2007) (*available at* www.oag.state.ny.us/press/2007/oct/GHI%20HIP%20Final.pdf).
[28] *See generally, id*; In the Matter of Health Insurance Plan of Greater New York and Group Health Incorporated: Agreement Concerning Physician Performance Measurement, Reporting And Tiering Programs (effective date November 20, 2007).
[29] *Id.*

of the insurance companies' physician performance measurement, reporting, or tiering programs.[30]

Under the terms of the agreements with CIGNA and Aetna, those Settling MCOs did not admit to the Attorney General's Findings, and the Attorney General accepted the agreements in lieu of commencing a statutory or other proceeding against the Settling MCOs pursuant to New York State Executive Law § 63(12).[31] CIGNA and Aetna voluntarily accepted the terms and conditions of the agreements and waived any right to challenge them in a proceeding pursuant to New York law.[32] The Empire, United HealthCare, and GHI/HIP agreements do not contain similar provisions. However, none of the agreements limits the Attorney General's power to "investigate or take other action with respect to any non-compliance at any time by [the insurer] with respect to this Agreement."[33] The agreements also do not and should not be construed to "deprive any consumer or other person or entity of any private right under the law."[34] If CIGNA, Aetna, or Empire violate the terms of their respective agreements, evidence of such violation will be "prima facie proof of a violation of General Business Law § 349 in any civil action or proceeding thereafter commenced by the Attorney General."[35] The United HealthCare and GHI/HIP agreements contain no such provision regarding the effect of a breach.

In order to ensure compliance with the terms of their respective agreements, and facilitate the collection and presentation of relevant information to consumers and physicians, the Settling MCOs must appoint an independent Ratings Examiner (Rx) to conduct oversight.[36] The Rx must be a nationally-recognized standard-setting

[30] *See* Cigna Agreement at 4; Aetna Agreement at 3; Empire Agreement at 3; United Healthcare Agreement at 3; GHI/HIP Agreement at 2 (emphasis added).
[31] *See* Cigna Agreement at 3; Aetna Agreement at 3.
[32] *See* Cigna Agreement at 11; Aetna Agreement at 11.
[33] Cigna Agreement at 11; Aetna Agreement at 11; Empire Agreement at 11; United Healthcare Agreement at 9; GHI/HIP Agreement at 11.
[34] Cigna Agreement at 13; Aetna Agreement at 12; Empire Agreement at 12; United Healthcare Agreement at 10; GHI/HIP Agreement at 12.
[35] *See* Cigna Agreement at 13; Aetna Agreement at 12; Empire Agreement at 13.
[36] *See* Cigna Agreement at 10; Aetna Agreement at 9; Empire Agreement at 9; United Healthcare Agreement at 8; GHI/HIP Agreement at 9.

organization, nominated and paid for by the Settling MCO, and approved by the OAG.[37] The Settling MCOs must promptly complete and maintain their physician performance measurement and reporting process with the Rx.[38] The Settling MCOs with existing tiered programs must hire their oversight monitor within 30 days of entering into the agreement.[39] For future tiered programs, at the time the program is made public, each Settling MCO must document that it has already completed or has applied to complete a review by the oversight monitor.[40] The Settling MCOs must also "directly and prominently" display this information on their websites and other appropriate locations.[41]

The Settling MCOs' agreements outline specific procedures relevant to each of the stated objectives: accuracy and transparency in developing performance measurements, use of data, and oversight.[42] Performance ratings may include "quality of performance" and "cost-efficiency" measurements.[43] The agreements also set standards for data collection, including that the Settling MCOs must "use the most current claims or other data to measure physician performance, consistent with the time period needed to attain adequate sample sizes and to comply with the requirements of [the agreement]."[44] The Settling MCOs must utilize their best efforts to ensure that their data is accurate, including establishing a process for medical record verification, if necessary.[45] In determining a physician's performance for quality and cost-efficiency,

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[37] *See* Cigna Agreement at 10; Aetna Agreement at 9; Empire Agreement at 9; United Healthcare Agreement at 8; GHI/HIP Agreement at 9-10.
[38] *See* Cigna Agreement at 10; Aetna Agreement at 9; Empire Agreement at 10; United Healthcare Agreement at 8; GHI/HIP Agreement at 10.
[39] *See* Cigna Agreement at 7; Aetna Agreement at 6; United Healthcare Agreement at 7; GHI/HIP Agreement at 7-8.
[40] *See* Cigna Agreement at 8; Aetna Agreement at 7; Empire Agreement at 7; United Healthcare Agreement at 7; GHI/HIP Agreement at 8.
[41] Cigna Agreement at 8; Aetna Agreement at 7; Empire Agreement at 7; United Healthcare Agreement at 6; GHI/HIP Agreement at 7.
[42] *See generally,* Cigna Agreement; Aetna Agreement; Empire Agreement; United Healthcare Agreement; GHI/HIP Agreement.
[43] *See* Cigna Agreement at 4; Aetna Agreement at 3-4; Empire Agreement at 3; United Healthcare Agreement at 3; GHI/HIP Agreement at 3.
[44] Cigna Agreement at 10; Aetna Agreement at 9; Empire Agreement at 9; United Healthcare Agreement at 7-8; GHI/HIP Agreement at 9.
[45] *See* Cigna Agreement at 10; Aetna Agreement at 9; Empire Agreement at 9; United Healthcare Agreement at 8; GHI/HIP Agreement at 9.

the Settling MCOs are required to use appropriate risk adjustment to account for the characteristics of the physician's patient population.[46]

The Settling MCOs' agreements take numerous steps to ensure that quality and cost efficiency measures are not conflated. Any public information must separately calculate and disclose measures of cost-efficiency and measures of quality of performance.[47] If individual scores for quality of performance and cost efficiency are combined for a total ranking, the proportion of each measure must be clearly disclosed.[48] The Settling MCOs must include patient experience as a factor in measurements.[49] CIGNA, Aetna, and Empire must rely on nationally-recognized evidence and quality standards from entities whose work in the area of physician quality performance is "generally accepted in the healthcare industry" such as National Quality Forum (NQF) or the AQA.[50] They also must disclose the extent to which their ratings rely on any or all of these guidelines.[51]

Disclosure and notice to both consumers and providers are important components of the agreements as well. The Settling MCOs must disclose to consumers where physician performance ratings for their existing programs can be found, explain the methodology for the ratings system, encourage consumers to consult with their own doctor when deciding about changes in their healthcare package, and indicate how the consumer may register a complaint with the insurer and the oversight monitor.[52] For any of the Settling MCOs' existing programs, this disclosure must occur within 30 days of

[46] *See* Cigna Agreement at 5; Aetna Agreement at 5; Empire Agreement at 5; United Healthcare Agreement at 4; GHI/HIP Agreement at 4.
[47] *See* Cigna Agreement at 4; Aetna Agreement at 4; Empire Agreement at 3; United Healthcare Agreement at 3; GHI/HIP Agreement at 3.
[48] *See* Cigna Agreement at 4; Aetna Agreement at 4; Empire Agreement at 3-4; United Healthcare Agreement at 3; GHI/HIP Agreement at 3.
[49] *See* Cigna Agreement at 5; Aetna Agreement at 4; Empire Agreement at 4; United Healthcare Agreement at 3; GHI/HIP Agreement at 3.
[50] Cigna Agreement at 5; Aetna Agreement at 4; Empire Agreement at 4; United Healthcare Agreement at 3; GHI/HIP Agreement at 3.
[51] *See* Cigna Agreement at 5; Aetna Agreement at 4; Empire Agreement at 4; United Healthcare Agreement at 4; GHI/HIP Agreement at 4.
[52] *See* Cigna Agreement at 7-8; Aetna Agreement at 6-7; Empire Agreement at 7; United Healthcare Agreement at 6; GHI/HIP Agreement at 6-7.

the company entering its agreement.[53] For future programs, disclosure must occur prior to implementation of the tiered program.[54]

At least 45 days before making available to consumers any new or revised quality or cost-efficiency or tiering, the Settling MCOs must notify their providers of the proposed change, explain the methodology and data used for particular providers, and inform providers of their right to make corrections and appeal.[55] At least 45 days prior to implementation of a material change to one of the Settling MCOs' programs, the company must inform its providers of the change and explain the new measures or other criteria for determining quality performance, cost-efficiency, or placement in a performance network.[56]

Under the terms of their respective agreements the Settling MCOs must allow their providers to submit supplemental materials relevant to the rankings process, correct errors, review data, and promptly appeal their rankings.[57] If a provider makes a timely appeal, the insurers are barred from changing the provider's quality and cost-efficiency rankings or designation until the appeal is completed.[58] The oversight monitor shall have oversight and review of the provider appeals process.[59]

The agreements also include provisions requiring the Settling MCOs to participate in any summit meetings the Attorney General convenes related to evaluating provider performance.[60]

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[53] *See* Cigna Agreement at 7-8; Aetna Agreement at 6-7; United Healthcare Agreement at 6; GHI/HIP Agreement at 6-7.
[54] *See* Empire Agreement at 7.
[55] *See* Cigna Agreement at 9; Aetna Agreement at 8; Empire Agreement at 8; United Healthcare Agreement at 7; GHI/HIP Agreement at 8.
[56] *See* Cigna Agreement at 5; Aetna Agreement at 5; Empire Agreement at 4-5; United Healthcare Agreement at 4; GHI/HIP Agreement at 4.
[57] *See* Cigna Agreement at 9; Aetna Agreement at 8; Empire Agreement at 8; United Healthcare Agreement at 7; GHI/HIP Agreement at 8.
[58] *See* Cigna Agreement at 9; Aetna Agreement at 8; Empire Agreement at 8; United Healthcare Agreement at 7; GHI/HIP Agreement at 8-9.
[59] *See* Cigna Agreement at 9; Aetna Agreement at 8; Empire Agreement at 8; United Healthcare Agreement at 7; GHI/HIP Agreement at 9.
[60] *See* Cigna Agreement at 11; Aetna Agreement at 10; Empire Agreement at 10-11; United Healthcare Agreement at 9; GHI/HIP Agreement at 10.

Although they are not identical, there are only a handful of notable differences among the Settling MCOs' agreements. The GHI/HIP agreement makes no mention of a specific tiered network plan or of an inquiry conducted by OAG; the agreement only refers to an "industry-wide inquiry" conducted by OAG.[61] At the time Empire entered its agreement, the "Blue Precision" program was only in its planning stages. Thus, Empire's agreement does not contain provisions regarding disclosures for existing programs. In addition, each company is required to submit a plan for the aggregation or pooling of data, as a supplement to test its own data to its oversight examiner.[62] However, CIGNA, Aetna, United HealthCare, and GHI/HIP are required to complete this task within three months of entering their respective agreements.[63] Empire must make this submission three months prior to the use of "Blue Precision."[64] Unlike CIGNA and Aetna, Empire, United HealthCare, and GHI/HIP were not required to pay a sum up to $100,000 to a nonprofit 501(c)(3) organization, insurer nominated and approved by the OAG, to facilitate consumers' meaningful participation in medical decisions.[65]

The requirements of these settlement agreements are not necessarily needed to be in compliance with the law, but they do provide guidance as to what at least certain authorities and perhaps providers would hope to find in an MCO's tiering program.

State Legislative Activity

Tiered networks and their underlying performance-based evaluations have and continue to be a source of state legislative activity. While there is no model law, there are several common elements of these laws including:

1. The MCO must make available to the physician his economic profile including the written criteria by which the physician's performance is measured.[66]

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[61] GHI/HIP Agreement at 1.
[62] *See* Cigna Agreement at 10; Aetna Agreement at 9; Empire Agreement at 8-9; United Healthcare Agreement at 8; GHI/HIP Agreement at 9.
[63] *See* Cigna Agreement at 10; Aetna Agreement at 9.
[64] *See* Empire Agreement at 9.
[65] *See* Cigna Agreement at 11; Aetna Agreement at 10.
[66] *See e.g.,* Miss. Code Ann. § 83-41-409 (2007); Tenn. Ann. Code § 56-32-230(e) (2007); CRIR 14-000-022 §5.7.4 (2007); and Tex. Ins. Code § 1301.058 (2007).

2. The MCO must give the physician an opportunity to review data and to submit corrections and additions of explanations.[67]

3. The MCO must adjust the physician's economic profile to recognize characteristics of the physician's practice that may account for variations from expected costs. State law may also dictate the specific factors or characteristics to be considered, including, but not limited to:[68]

- Specialty utilization
- Practice patterns
- Information comparing the physician to his/her peers in the same specialty
- Case mix
- Severity of illness
- Age of patients

4. Meaningful provider involvement in the development of profile methodology including collection methods, formatting methods, means for release, and dissemination.[69]

5. Periodically reevaluate the quality and accuracy of practice profiles, data sources, and methodologies.[70]

Possible Federal Preemption of State Law Challenges

As tiering and related activities are being challenged at the state level, MCOs might pause to consider the legal basis for the challenge and what is being challenged. Depending on the answers to those questions, such challenges and/or the basis for the challenge may be preempted by federal law. Preemption also may be an increasingly

[67] *See e.g.,* Tenn. Ann. Code § 56-32-230(e) (2007).
[68] *See e.g.,* Ca. Ins. Code § 10123.36(a)(2007); Conn. Gen. Stat. § 38a-478f (2007); KRS § 304.17A-525(1) (2008); ORC Ann. § 1735.05 (2008); CRIR 14-000-022 §5.7.3 (2007); and Tex. Ins. Code § 1301.058 (2007).
[69] *See e.g.,* N.D. Cent. Code § 26.1-36-41(2) (2007) and Tenn. Code Ann. § 56-32-230(e)(1) (2007).
[70] *See e.g.,* N.D. Cent. Code § 26.1-36-41(2) (2007).

important issue as the federal government as a customer/purchaser focuses on quality and efficiency.

ERISA Preemption

The Employee Retirement Income Security Act (ERISA)[71] broadly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan...."[72] State causes of action are also preempted. By virtue of ERISA's "savings clause" states can regulate "the business of insurance."[73] However, through its so-called "deemer clause," ERISA prevents states from regulating self-funded employee benefit plans.[74] Thus, in the context of employee benefit plans, ERISA permits states to regulate tiered network programs to the extent that the state regulation is in the form of insurance regulation. However, ERISA's savings clause does not extend to self-funded plans, which often times are administered by state-licensed MCOs.

Applying an ERISA preemption analysis to challenges brought by the New York Attorney General, the first question to consider is the basis for the investigation. Although the target MCOs were asked to explain how they complied with certain provisions of the New York insurance code focused on provider rights, the underlying basis for the investigation appeared to be New York's consumer protection law and not enforcing New York's insurance laws. Moreover, although New York law gives the Attorney General the authority to enforce some portions of the insurance code, the question is raised whether that is in fact what the attorney general was doing. If not, and he was acting pursuant to state consumer protection laws or other non-insurance law, was there an ERISA preemption argument?[75] The complicating factor with respect to an ERISA preemption argument is that where an MCO both insures and administers

[71] 29 U.S.C. § 1001 *et seq.*
[72] 29 U.S.C. § 1144(a).
[73] 29 U.S.C. § 1144(b)(2)(A). *See Metropolitan Life Ins. Co. v. Mass.*, 471 U.S. 724 (1985).
[74] 29 U.S.C. § 1144(b)(2)(B). *See FMC Corp. v. Holliday*, 498 U.S. 52 (1990).
[75] It should be noted that the laws in other states may differ as regards to the authority of the attorney general to bring enforcement actions based on provisions of the insurance code.

employee benefit plans that utilize tiered networks, separating the two activities may not be practical or worth the effort in order to assert ERISA preemption.[76]

Preemption under the Medicare Modernization Act of 2003

The Medicare Modernization Act broadened the scope of federal preemption with respect to the Medicare Advantage program. Federal law provides that "[t]he standards established under this part [Part C, Medicare Advantage program] shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA [Medicare Advantage] plans which are offered by MA organizations under this part."[77] The legislative history confirms the breadth of federal preemption: "The conference agreement clarifies that the MA program is a federal program operated under Federal rules. State laws, do not, and should not apply, with the exception of state licensing laws or state laws related to plan solvency."[78] With respect to preemption generally, the Centers for Medicare & Medicaid Services (CMS) clarified that there must be a federal standard in order for a state standard to be preempted:

> The preemption in section 1860D–12(g) of the [Social Security] Act is a preemption that operates only when CMS actually creates standards in the area regulated. To the extent we do not create any standards whatsoever in a particular area, we do not believe preemption would be warranted.[79]

Although the full scope of the MMA's preemption is not yet clear, key to the question of whether there is preemption is identifying any federal standards in the area. With respect to tiered physician networks and the quality analyses that underlie them, several federal standards are relevant:

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[76] *See* Rosenbaum, Knornblet and Borzi, *An Assessment of Legal Issues Raised in "High Performing" Health Plan Quality and Efficiency Tiering Arrangements: Can the Patient Be Saved?* (Sept. 2007) *available at* www.rwjf.org/programareas/resources/product.jsp?id=22571&pid=1142

[77] 42 U.S.C. § 1395w-26(b)(3). *See also* 42 C.F.R. § 422.402.

[78] H.R. Conf. Rep. No. 108-391, at 557 (2003).

[79] 70 Fed. Reg. 4194 at 4320 (Jan. 28, 2005).

1. While federal regulations prohibit discrimination against providers, these regulations do not prohibit:

- Use of different reimbursement amounts for different specialties or for different practitioners in the same specialty, or
- Implementation of measures designed to maintain quality and control costs consistent with MA organization's responsibilities.[80]

2. CMS has permitted tier cost-sharing based on provider. However,

- All members must be charged the same amount for the same service with the same provider, and
- All members must have reasonable access to providers at the lowest tier of cost-sharing.

3. CMS indicated that all parties—providers, patients, insurance plans, and payers—should participate in arrangements that reward both those who offer and those who purchase high-quality, competitively-priced healthcare.[81]

Whether these standards are sufficient to carry a preemption argument remains to be seen.

Recommendations

Given the current enforcement environment and heightened level of physician scrutiny, MCOs should develop their tiering program mindful of the potential legal risks. To minimize potential legal risk, MCOs should consider adhering to principles that can be distilled from other MCOs' experience and the litigation and enforcement activity summarized above. Adherence to all of the points listed below may not be required, insofar as the negotiated resolutions may reflect in part what the enforcement officials would consider corrective or prophylactic actions, but each MCO should thoughtfully

[80] 42 C.F.R. § 422.206.
[81] Memorandum from Abby L. Block, Director, Center of Beneficiary Choices, to Medicare Advantage Organizations *et al* (Sept. 19, 2007).

assess its ability to follow these strictures without undermining the efficacy of the program or adding undue delay or administrative expense or hassle.

1. Prior to implementing any new performance methodology, consider the viability of seeking meaningful input from the provider community and/or its participating providers on the data to be used for tiering and ranking, the methods used to compare provider performance, and the methods of communicating ratings, scores, and rankings.

2. Be explicit on which measurement elements are based on quality considerations, irrespective of cost measures, and which are based more fundamentally on cost-related factors.

3. Be careful to assure that all aspects of the program are considered and adopted by the MCO unilaterally, to mitigate any concerns that the MCO has conspired with other MCOs on the criteria, weighting factors, or benefit distinctions, or has conspired with one set of providers to disadvantage another. Thus, the MCO should be clear that while it is consulting with the affected provider community and with national standards for quality measurement, it is making its own decisions.

4. Except where justified and explained by specific plan needs, use a tiering or ranking methodology that relies on generally accepted national standards of quality and that employs appropriate risk adjustment and sampling mechanisms.

5. Assess whether the MCO's provider contracts pose any obstacle to, or authorization for, a provider tiering and ranking program. Consider adding language about the tiering program in the provider manual to enhance provider understanding and also to improve contractual defensibility of the initiative, insofar as compliance with the provider manual may be included in the provider agreement language.

6. Plan for the disclosure to providers of the nature and timing of the tiers, rankings, and criteria, and how they are designed and amended over time and for plain explanations of provider reimbursement mechanisms and member benefit levels, as they vary by tier or ranking.

7. Consider posting scores, rankings, and/or tiers in electronic format, along with an explanation of the tiering or ranking methodology, the source of data relied on, and the type of patients included in the calculation of the score.

8. Plan for disclosing to customer groups and enrollees how the program and criteria are designed and how providers are ranked. Consider adopting a process through which consumers could voice comments, concerns, and complaints about the program.

9. In communications with providers, clients, and enrollees alike, give strong consideration to use of prominent and carefully worded disclaimers and/or statements that describe the program, but disavow any implication that providers who are not included in a higher tier or ranking are inefficient or provide lower quality services. MCOs may wish to temper the degree and character of their explanations, to mitigate risk that they are making a definitive statement of relative quality or efficiency. MCOs should consider indicating that the tiers and rankings are based on specific measurement indicia and are by necessity imprecise, while doing so in a manner that does not undermine the propriety of its using them.

10. Consider whether to grant physicians an opportunity to make a timely, internal appeal of any initial and/or revised tiering, ranking, or scoring. MCOs might consider utilizing an independent external reviewer for the resolution of such appeals. Consider employing language that permits the internal review, but that does not create a contractual right for judicial review, particularly not on a de novo basis.

11. Consider retaining an independent rating ombudsman to monitor compliance with aspects of the new tiering or ranking program. The ratings ombudsman could provide compliance reports on a regular basis.

Conclusion

Whether tiered networks will provide the desired results in terms of quality and efficiency remains to be seen. What we do know is that tiered networks and the related performance-based evaluations pose significant challenges for MCOs, healthcare purchasers, and providers.

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