EXPERIENCE EXCHANGE

Provider exclusions in US private health insurance contracts

Michael M. Costello*

Department of Health Administration & Human Resources, University of Scranton, PA, United States

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ABSTRACT

Two national newspaper articles published in the Fall of 2018 addressed the issue of private health insurance provider contracts that act to exclude specific health systems from health plan networks. Inevitably, the question arises: Are such agreements illegal restraints of trade actionable under federal and state antitrust laws? A long-standing tenet of antitrust law is that it exists to protect competition not competitors. Excluding providers may be a legitimate outgrowth of the contracting process and therefore legal. However, an examination of the contracting process may reveal anticompetitive intent to restrain trade. The specific facts surrounding provider exclusion must be analyzed carefully in an effort to determine if there is illegal restraint of trade.

Key Words: Health insurance, Insurance contracts, Antitrust

1. INTRODUCTION

Certain health systems and hospitals believe that their continued viability depends on access to private health insurer patients. As insurer network participants, these systems and hospitals hope that if they are offered as choices within the insurer network, they will capture a share of the insured patients needing their services.

These hopes are often dashed when insurers refuse to consider them as network participants. The health insurers may refuse to negotiate provider agreements, thereby denying system and provider access to their patients. Such refusals often frustrate the hospitals and the systems who question the fairness of being denied an opportunity to contract.

Concerns about provider exclusion often result from the health insurer-health care provider market dynamic.

According to the Wall Street Journal, citing research data from University of California, Berkley, about 77% of American citizens live in "highly concentrated" hospital markets, meaning that there are a limited number of health systems and hospitals with which health insurers can negotiate to provide care to the insurer's beneficiaries, thereby exhibiting provider market power.[1]

An example of provider restriction by a health insurance company in the New York metropolitan area is contained in the same Wall Street Journal article cited above. The Northwell Health system had discussed with Cigna Corp. the creation of a new health plan "that would offer low-cost coverage by excluding some other health care providers." However, a previously executed separate contract between New York-Presbyterian and Cigna prohibited the insurance company from offering any plan that did not include that health care system. The Northwell proposal could not move forward. Partly as a result of that failed effort, Senator Chuck

*Correspondence: Michael M. Costello, JD, MBA; Email: michael.costello@scranton.edu; Address: Department of Health Administration & Human Resources, University of Scranton, PA, United States.

Grassley, chairman of the U. S. Senate Judiciary Committee, asked the Federal Trade Commission to investigate whether insurer-hospital system contracts were limiting competition and leading to higher health care costs.[2]

The refusals to contract can reasonably lead the hospitals and health systems to ask: If a hospital or health care system is denied the opportunity to negotiate a provider agreement with a health insurer in the same geographic market, does the system or hospital have a potential anti-trust claim against the health insurance company? While the McCarran Ferguson Act of 1945 granted certain anti-trust exemptions to the insurance industry, those exemptions are not a complete bar to anti-trust litigation.[3]

2. DISCUSSION

The legal right of parties to negotiate and enter into binding agreements has long been recognized in U. S. law. The U. S. Supreme Court famously recognized the right to contract as a liberty protected by the Due Process Clause of the Fourteenth Amendment to the U. S. Constitution (Lochner v. New York).[4]

Giannaccari and Van den Bergh (2017) write:

> Freedom of contract is a fundamental principle of legal orders worldwide. Firms, even those enjoying significant marketpower, are generally free to negotiate and conclude contracts with the parties with whom they want to deal.[5]

A somewhat similar observation was made by McCarthy and Thomas (2002) who write that managed care contracting may be "just the product of the normal give and take of commercial negotiations between parties of varying levels of bargaining strength."[6]

A health insurance plan may have several legitimate reasons as to why it chooses not to consider contracting with a specific hospital or health system.

(1) The hospital or health system may operate a competing insurance plan. Giancarri and Vanden Bergh write that "U. S. courts have displayed a marked reluctance to impose on economic actors obligations to deal with their rivals."[7] If a given health care system has its own health insurance plan, or owns a significant interest in a competing insurer, that system might reasonably conclude that other plans would not contract with it unless those other plans saw a competing business reason for doing so. This can be viewed as evidence of reasonable business competition between two firms.

(2) Contractual Exclusivity. A health insurance company may already be under contract to a competing health system that negotiated and obtained an exclusive contract covering a specific geographic market. If that health system made a proposal to the health insurance company that the insurer believed guaranteed attractive pricing and sufficient provider capacity for the company's insureds, that insurance company may have had sufficient reason to grant exclusivity.

(3) Quality and Reputation. An insurer may have developed internal criteria based upon reported quality of care measurers. and hospital regulation and recognition. Since those measures are objectively verifiable through third party sources, the insurance company may have compiled a list of the facilities with whom the company would contract.

(4) Insured's Request. If the insurance company provides employee health insurance to one or more large employers, those companies may request that the insurance company contract only with specific providers in order to satisfy covered employees. If the employer believes it is in their best interest to enter into such a contract, this would most likely be viewed as a reasonable business decision.

However, although the health insurer's right to contract would provide a strong defense to an anti-trust claim, there are at least two somewhat narrow exceptions on which a potentially successful anti-trust claim might be sustained. The first would involve an insurance company possessing monopsony power in a health insurance market. In such a situation, the insurance plan under challenge might be "the only game in town." Under these circumstances the plan's refusal to contract with a specific health system might be viewed as detrimental to consumer welfare and individual economic freedom for insureds.

Van den Bergh writes:

> Most antitrust commentators advance economic objectives as the goals competition policy should aim at. In their analysis, they mention different concepts of efficiency . . . (and) total welfare and consumer welfare. Other anti-trust scholars stress the protection of the competitive process and individual economic freedom, rather than (total or consumer) economic welfare as the main (economic) goal of anti-trust. Finally, some commentators argue that competition law should also aim at non-economic objectives and create scope for considering other goals of public interest.[8]

A second argument for anti-trust relief might be based on

an improper interference in the competitive process. Hovenkamp (2005) identified several examples of monopolistic practices identified from case law including:

> "unilateral refusals to deal, including 'essential facility' violations".[9]

Tim Wu (2018) is somewhat critical of the consumer welfare argument, but writes:

> Courts should assess whether the targeted conduct is that which "promotes competition or whether it is such as may suppress or even destroy competition" the standard prescribed by Brandeis in his Chicago Board of Trade opinion issued in 1918.[10]

The most egregious form of anti-competive behavior would be a boycott in which the insurance company conspired with a competitor health system to exclude the system in question. If proven, such behavior might constitute a per se anti-trust violation meaning that the health insurer would not be able to argue a reason for the exclusion. If the excluded system could not demonstrate boycott behavior, an anti-trust claim would revert to a rule of reason analysis in which the insurer would offer arguments as to why it excluded the system.

3. Conclusion

Hospitals and health care systems may feel disadvantaged when a specific health insurance plan refuses to negotiate a provider agreement and thereby excludes the system from its provider network. However, health insurance companies are not public utilities that must contract with all providers within the insurer's coverage area. The 14th Amendment to the U. S. Constitution has been interpreted to insure freedom to contract. Health insurers may have legitimate business reasons for refusing to contract with specific providers. But if the providers can show that the insurer possessed monopsony power in the relevant market and/or the refusal to contract materially lessened competition, the system might have a reasonable argument.

Conflicts of Interest Disclosure

The authors declare they have no conflicts of interest.

References

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