



## **An Assessment of Legal Issues Raised in “High Performing” Health Plan Quality and Efficiency Tiering Arrangements: Can the Patient Be Saved? \***

Sara Rosenbaum, J.D.<sup>1</sup>  
Sarah Kornblet, J.D.<sup>2</sup>  
Phyllis C. Borzi, J.D., M.A.<sup>3</sup>

September 2007

An emerging trend in health quality performance incentivization is the use of physician quality tiering arrangements by health insurers and health benefit service plans that furnish benefits and coverage via provider networks. This analysis examines the growth of physician quality tiering arrangements and considers their legality.

### **Background**

A rarity as few as 25 years ago, physician networks are now the norm in health insurance coverage and health benefit service plans. In 2006, only 7 percent of all employers offered a “conventional” plan, that is, a plan whose terms of coverage are not tied to a provider network; at 54 percent, preferred provider organizations (PPOs) represented the most common type of plan offering that year.<sup>4</sup> Similarly, both Medicare Advantage plans (which as of 2007 enrolled 8.7 million beneficiaries)<sup>5</sup> and Medicaid managed care arrangements (which enroll more than half of all beneficiaries)<sup>6</sup> rely on provider networks. In the case of publicly sponsored plans in particular, receipt of non-authorized, out-of-network care can potentially result in total coverage exclusion except for specified exempt services (e.g., emergency care and family planning services and supplies in the case of Medicaid).

---

\* This analysis is one of a series of legal analyses funded through a grant from the Robert Wood Johnson Foundation as part of an ongoing project on Legal Barriers to Health Information. This analysis was originally published in the October 8<sup>th</sup> edition of BNA’s *Health Policy Reporter* and is reproduced with permission of BNA.

<sup>1</sup> Hirsh Professor, Health Law and Policy, Chair, Department of Health Policy, The George Washington University School of Public Health and Health Services

<sup>2</sup> Research Associate, Department of Health Policy, The George Washington University School of Public Health and Health Services

<sup>3</sup> Research Professor, Department of Health Policy, The George Washington University School of Public Health and Health Services

<sup>4</sup> Kaiser/HRET, Employer Health Benefits, 2006, Exhibit 4.3. <http://www.kff.org/insurance/7527/upload/7527.pdf> (accessed August 18, 2007).

<sup>5</sup> Kaiser Family Foundation, Medicare Advantage Fact Sheet (June 2007) <http://www.kff.org/medicare/upload/2052-10.pdf> (accessed August 18, 2007).

<sup>6</sup> Kaiser Commission on Medicaid and the Uninsured, Medicaid Managed Care (2001) <http://www.kff.org/medicaid/upload/Medicaid-and-Managed-Care-Fact-Sheet.pdf> (accessed August 18, 2007).

The concept of tying compensation to the quality of care is hardly a new one. Nor (as illustrated by credentialing activities among hospitals and managed care organizations) is the notion of conditioning any, or the level of, physician membership in health care arrangements on the quality of their care. As efforts to link practice quality to financing have increased, health plans have begun to test the use of provider network tiers, that is, network classification arrangements that rank their providers on certain quality and efficiency measures selected and calculated by the plan administrator.<sup>7</sup> One recent study that examined the use of tiered networks in “high performing” employer-sponsored health plans suggests that these arrangements may be more common among plans offered by self-insuring employers. No comparable information exists on the growth of tiering arrangements in Medicare or Medicaid managed care plans, or in plans offered by other sponsors, including public employers or health plans offered under specialized coverage arrangements such as TriCare. Reported shortages of participating specialty providers in the case of Medicaid and TriCare may slow the use of tiering in these plan markets.

An additional rationale for the growth of physician tiering might be the health care quality liability exposure faced in numerous jurisdictions by entities selling hybrid health care and coverage products to employer sponsored and other group-sponsored health plans.<sup>8</sup> Judicial rulings over the years has applied both vicarious and corporate liability theories in finding culpability in the case of managed care entities when plaintiffs’ liability claims are framed as matters of health care quality rather than coverage. Physician tiering thus might be viewed as one aspect of the duty incurred by hybrid health service entities to establish standards and oversee the quality of network care, much as hospitals engage in standard setting and continuous quality oversight of the performance of their medical staff.

Physician tiering typically appears to be targeted at specialized, selected high cost procedures; tiering techniques and methods may be tied to physician performance against evidence based guidelines and consensus standards specified by the plan, with actual performance calculated via proprietary algorithms. Both the tiering measures and the tiering algorithms may be proprietary (and therefore opaque) with substantial variation from plan to plan.<sup>9</sup> Performance assessments may be limited to what can be ascertained through claims data at the individual provider level, and results may or may not be aggregated to practice group level. Plans also can vary in the proportion of network physicians designated as high performers.<sup>10</sup>

In addition, plans may show much variation in the techniques they employ to incentivize member selection of high performing physicians. Research suggests that incentives can range from shared information regarding physician performance to tiered cost sharing and outright exclusion from the network of “low performing” physicians. How aggressively to incentivize enrollee choice is a matter of plan design.<sup>11</sup>

---

<sup>7</sup> Deborah Draper, Allison Liebhaber, and Paul Ginsburg, High Performance Health Plan Networks: Early Experiences (Center for Studying Health Systems Change Issue Brief 111, May 2007).

<sup>8</sup> See e.g., *Boyd v. Albert Einstein*, 547 A.2d 1229 (1987); *Jones v. Chicago HMO* 730 N. E.2d 1119 (2000). See esp. corporate liability discussion in *Aetna v. Davila*, 542 U.S. 200 (2004).

<sup>9</sup> High Performing Health Plan Networks, op. cit.

<sup>10</sup> Id.

<sup>11</sup> Id.

Even though health plans have credentialed and overseen network performance for many years, with new terms and monikers, such as physician tiering, often comes a new generation of legal challenges that attempt to portray market conduct as somehow a major departure from existing conduct. The potential for this type of challenge understandably increases when the affected group – in this case physicians facing close scrutiny and transparency with respect to their performance – fears a significant impairment in its livelihood. Information has long been used – in many health care settings – to measure the quality of physician performance. At heart, physician tiering is simply the latest technical and structural approach to quality performance measurement. But because it is heralded as an innovation in product structure and performance, tiering appears to have triggered the inevitable legal response.

In sum, while there has been little systematic analysis of the legal aspects of tiering *per se*, there is much precedent to draw on in assessing the legality of tiering as an aspect of plan structure and the liability of insurers and health plans for use of tiers. For example, to the extent that tiered physician networks are viewed as an aspect of plan design, federal law would accord self insuring private employers governed by the Employee Retirement Income Security Act (ERISA) virtually total discretion over the inclusion of tiered networks in their plans; in the case of employer-sponsored plans that purchase health insurance products, tiering would be permissible unless prohibited by state insurance law.<sup>12</sup> Participant information about practice tiers would be required as part of ERISA's member information requirements.<sup>13</sup> Claims disputes related to cost-sharing differentials tied to physician tiers presumably could form the basis of an ERISA claims appeal.<sup>14</sup> In the case of insured plans in states whose insurance laws include an external appeals process, coverage determinations tied to tiers also presumably might be appealable.<sup>15</sup>

The use of tiered networks for some or all services would be possible in Medicare or Medicaid-sponsored plans, except to the extent that some aspect of the tiering arrangement is found to violate one or more federal (and in the case of Medicaid, state as well) legal requirements.<sup>16</sup>

Although there exists no systematic study of state insurance laws that specifically regulate the use of tiered physician networks, news stories<sup>17</sup> suggest that physician groups may oppose tiering, and furthermore, that regulators may be raising access, quality, and consumer protection matters as part of their general regulatory oversight functions.<sup>18</sup>

### **What Types of Legal Issues Might be Alleged in Legal Claims Against Physician Tiering?**

---

<sup>12</sup> *Metropolitan Life Insurance v. Massachusetts*, 471 U.S. 724 (1985); *Jones v. Kodak Medical Assistance Plan*, 169 F.2d 1287 (1999); see generally, Sara Rosenbaum, *Law and the American Health Care System* (2007) Part Two.

<sup>13</sup> *Law and the American Health Care System* op. cit.

<sup>14</sup> 29 U.S.C. §§ 1132, 1133.

<sup>15</sup> *Rush Prudential HMO Inc. v. Moran*, 536 U.S. 355 (2002).

<sup>16</sup> Both federal Medicare Advantage and Medicaid managed care standards require that services be accessible but in neither case do standards specifically prohibit tiering.

<sup>17</sup> See, e.g., Ellen Nakashima, *Doctors Rated but Can't Get a Second Opinion*, *Washington Post* (July 25, 2007) p.

A1.

<sup>18</sup> *Id.*

As with so many issues in health law, the evolution of health system structure and operations can result in legal disputes. When these disputes arise, courts turn to long-standing legal principles in scrutinizing new practice and financing arrangements. Thus, while “tiered networks” and “high performing plans” might represent new terminology in health care “system-speak,” the concept of partial or full exclusion from a health care group based on quality and efficiency is hardly a new one in health law. Network exclusion is a long-standing issue in health law, whether the context is health care institutions such as hospitals, or health insurers, HMOs, or health service benefit plans. The fact that longstanding legal principles bear on these evolving practices can be seen in legal actions to date, including privately mounted challenges by physicians,<sup>19</sup> and at least one investigation by a state attorney general.<sup>20</sup>

Regardless of the legal theory chosen (and as discussed below, there may be a range of viable theories depending on the plan sponsor, and therefore, the applicable law), certain basic attributes in current health plan practices are sure to trigger one or more theories and allegations: (1) secrecy in both the standards used and the weights used to perform rankings; (2) the absence of a transparent rational basis for the methods chosen; and (3) the absence of a process by which physicians can examine the data on which their rankings rest and challenge errors in data or methodology.

Where the health plan is sponsored by a self insuring private employer, ERISA preemption law might exempt the plan from liability under state law, at least to the extent that a court is persuaded that the law involves an attempt to regulate plan design or to unreasonably bind plan administration rather than promoting the safety and quality of health care.<sup>21</sup> Regardless of ERISA preemption however, depending on how it is effectuated, tiering might be alleged to violate certain federal laws not preempted by ERISA. Furthermore, even where ERISA preemption frees an employer-sponsored health plan from state regulation, the companies that design tiering arrangements may work in both the self-insured and fully insured markets, making it a practical impossibility to use network design approaches that violate applicable law in some of their markets. For this reason, paying attention to the legal risk exposures created by tiering practices is important.

The following is a rapid scan of the types of legal allegations that could be expected in response to tiering practices and in light of underlying legal principles:

#### 1. Allegations of violation of statutory or common law fair process/due process requirements

---

<sup>19</sup> See *Washington State Medical Assoc. et. al. v Regence BlueShield* (No. 06-2-30665-1SEA, filed Nov. 29, 2006, Seattle WA Superior Court) (settlement announced August 2007, BNA Health Law Reported 12:153, August 9, 2007). Another example occurred in St. Louis, Missouri, where United HealthCare attempted to introduce a high-performance network in 2005. Providers rebuffed the plan, alleging design flaws, deceptive representations regarding the cost of care, and exclusion of certain groups of providers from the rankings system.

<sup>20</sup> Doctors Rated, op. cit. reporting on a New York State investigation. See letter dated July 13, 2007 from Attorney General Cuomo to United Healthcare indicating plans to seek an injunction against tiering on the basis of potential violations of consumer fraud laws.

<sup>21</sup> *Travelers Insurance Company v. Pataki*, 63 F.3d 89 (1995).

Because of the impact of network selection and de-selection on the livelihood of health professionals, accreditation standards for hospitals and operating standards for health plans typically recognize the obligations of the credentialing entities to accord fair process.<sup>22</sup> The concept of fair process is grounded in the common law, and it applies even when the selecting entity is private, in those situations in which the impact of de-selection is fundamental to the economic survival of the individual subject to exclusion.<sup>23</sup> In the case of publicly sponsored health plans of course, constitutional due process standards could be expected to apply.<sup>24</sup>

In recent years, as states increasingly have begun to regulate the practices of network-style insurance plans, selection and de-selection procedural requirements have become part of the state insurance law landscape. State laws regulating plans' network composition and selection criteria would be considered laws that are saved from ERISA preemption in the case of fully insured plans, while self-insured plans might be exempt.<sup>25</sup> (A plaintiff might try to argue that federal common law recognizes the principle of fair process as well, although such a claim has not yet been raised. As noted below, a breach of fiduciary duty might be a more likely claim).

## 2. Allegations of violation of federal laws regulating health plans, state insurance laws, and more generalized consumer fraud statutes

Where the tiering method is flawed or rests on flawed data, and misrepresentations are made regarding the quality of the tiers, allegations may involve liability under federal and state fraud statutes. In the case of state law, the fraud statutes alleged to have been violated may be either specific to the insurance industry or be part of more generalized consumer fraud laws. Thus, allegations of fraud feature prominently in legal actions to date.<sup>26</sup>

In the case of self-insured ERISA plans (which presumably would be shielded from the reach of state insurance laws and state consumer fraud statutes), the use of tiering might nonetheless be alleged to violate ERISA's disclosure and fiduciary requirements. This could be the case if material information about the tiering system is not disclosed, or if the tiering system itself is perceived as flawed in design and results. The latter situation might occur if performance information or methods are proved to be erroneous, where the cost of care is part of the equation, and where the plan fiduciary is perceived as having a financial conflict of interest.<sup>27</sup>

It is also conceivable that tiering practices if perceived to have been recklessly designed and driven by cost, could be alleged to have violated the Racketeer Influenced and Corrupt Organization Act (RICO), which has been applied to ERISA plan conduct involving fraud or

---

<sup>22</sup> *Law and the American Health Care System*, Part 3.

<sup>23</sup> *Id.* See also *Harper v. Healthsource New Hampshire*, 674 A.2d 962 (1996).

<sup>24</sup> *Law and the American Health Care System*, Part 3.

<sup>25</sup> *Kentucky Association of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003); *Law and the American Health Care System* part 2, *op. cit.*

<sup>26</sup> *Washington State Medical Assoc. v. Regence BlueShield* *op. cit.*; letter from Attorney General Cuomo to United Healthcare, *op. cit.*

<sup>27</sup> *Law and the American Health Care System*, Part 2; Sara Rosenbaum, Phyllis Borzi, *Is Health Care Quality Purchasing an ERISA Fiduciary Obligation?* BNA Pension and Benefits Daily 6:182 (Sept. 21, 2006).

concealment.<sup>28</sup> In this case, the allegation would be based on a theory that quality posturing is being used to deceive members into choosing the least expensive care.<sup>29</sup>

### 3. Allegations of violation of defamation and libel common law principles or statutes

Depending on the state, defamation might be a viable theory<sup>30</sup> if the tiering is found to be an unprivileged and false communication that causes damages. Where the tiering system is opaque, rests on an allegedly flawed and unreliable methodology, and allows for no fair process to correct data and resulting ranking errors, defamation can become a viable argument since the impact can be the loss of livelihood and impairment to reputation. In the case of injuries to a professional, the standard for defamation might be simple negligence. The fact that the plan is communicating to its members does not make its communications privileged. Furthermore, if the defamation causes hatred, contempt, ridicule or obloquy, and deprives a professional of his or her livelihood, it may be considered libelous.

### 4. Allegations of violation of federal and state laws applicable to certain categories of sponsored health plans

As noted, it is possible to advance a legal theory involving ERISA violations. To the extent that other laws governing specific classes of health plans also require material disclosures and obligate plans to ensure quality or to accord basic fair process protections to providers in their networks, these laws could be violated. For example, Medicare Advantage contains important disclosure and quality protections, both of which might be implicated by a flawed and opaque tiering arrangement.

### 5. Allegations of intentional interference with contract/breach of contract

Exclusion or the assignment to a lower tier could constitute a breach of contract in insurance arrangements. The violations could take two forms. The practice might violate the standards that plans are permitted to use in the selection of participating physicians. The practice might also violate plans' own agreement (or the terms of state regulated network agreements) that extend procedural protections to credentialing decisions, if a tiering decision is understood to be tantamount to a credentialing decision.

### 6. Allegations of restraint of trade

Physicians might allege that exclusions flowing from tiering constitute a restraint of trade. In the world of hospital exclusions, this type of claim has generally failed because of the broad latitude given hospitals under antitrust rule of reason theory to make decisions among economic competitors based on quality.<sup>31</sup> This tradition has carried over to health plans and has been reinforced by the extraordinary discretion under antitrust theory that is given purchasers to select their suppliers using both quality and price discounting criteria.<sup>32</sup> At the same time, such

<sup>28</sup> See e.g., *Humana v Forsythe* 525 U.S. 299 (1999)

<sup>29</sup> *Law and the American Health Care System*, Part 4. See *Humana, Inc. v. Forsyth*, 525 U.S. 299 (1999).

<sup>30</sup> *Washington State Medical Assoc. v. Regence BlueShield*, op. cit.

<sup>31</sup> Wilkes, *Law and the American Health Care System* Part 4.

<sup>32</sup> Kartell; Ambrose *Law and the American Health Care System* Part 4, op. cit.

claims are not out of the question, particularly where the plan's exclusionary decision rests on claims of quality and the challenger can show that the standards and methods used are fundamentally flawed and have no rational relationship to quality.

#### 7. Allegations of violation of civil rights laws

It is possible that plans' quality tiering decisions may result in the disproportionate exclusion or sanction of physicians with certain personal characteristics (such as race, national origin, sex or disability status). Were this to be the case, then plausible theories might arise under state human rights statutes and federal civil rights laws.<sup>33</sup>

#### **What Practices Might Save Physician Tiering?**

Despite the relative prominence given to tiering practices and potential legal liability in news accounts and sporadic legal actions to date, in fact, longstanding legal principles suggest that with reasonable adjustments, the use of quality tiering arrangements might be expected to pass legal muster. Indeed, a recent legal settlement entered into by Regence BlueShield and the Washington State Medical Association (WSMA) and involving a legal challenge to tiering by WSMA, underscores the fact that transparency in the process and methods, care in the development of the tiering measurement system, and the opportunity to appeal the assignment of a tier, can, in combination, do much to save the use of tiers from claims of unlawfulness. To the extent that tiering is understood as introducing an important new lever into quality improvement, taking care to design the system to meet minimum legal standards would be an essential aspect of legal risk management.

The summary of the Regence/ WSMA settlement consists of the following elements:

1. Prior to implementing any new or revised performance measurement program, the plan will give physicians an opportunity of meaningful input, including input on the data to be used, the methods used to compare physician performance, and the methods of communicating ratings and scores.
2. The insurer will make efforts to offer actual, advance notice (10 days) to physicians that new scores are forthcoming.
3. Physician scores will be posted in an electronic format, along with an explanation of the methodology, an explanation of the data relied on to calculate the score, and a means to identify the types of patients included in the calculation of the score.
4. Physicians will have the opportunity to make a timely appeal of their scores; where a score is challenged on a timely basis, it will be withheld until the appeal is completed. Where a physician's challenge is outside of the time limits permitted for an appeal, the score will be posted but with a clear notation that a challenge is underway.

---

<sup>33</sup> *Law and the American Health Care System Part 3.*

5. Determinations by the insurer regarding the accuracy of its scoring will be appealable to an independent external reviewer based on the same materials used in the external review.<sup>34</sup>

This settlement illustrates a basic aspect of law, namely that, even while permitting a broad array of conduct, the legal system places a premium on rational conduct that is visible to affected populations and allows their input. This emphasis under law on transparency can be seen in the legal concepts that apply to both government and private conduct; indeed, just as the Regence settlement is designed to shed sunlight on tiering, the emphasis on transparency in conduct can be seen in a recent court decision enjoining the United States Department of Health and Human Services from withholding Medicare physician claims information from public scrutiny under the federal Freedom of Information Act.<sup>35</sup>

In short, it is not classification based on quality that is illegal, nor is it the publication of information regarding health care quality that is illegal: it is undertaking these efforts in an opaque manner that tends to lead to a legal backlash.

The use of transparent standards, accompanied by a transparent development process in setting tiers and assigning individual physicians to tiers, and a clear and accessible process for identifying and correcting errors that arise as tiering positions are assigned, should pass legal muster. The health benefit services and health insurance industry might voluntarily adopt such standards as part of health plan accreditation. Alternatively, the adoption of tiering standards and procedures by payers and regulators as part of health plan design and operational oversight would offer an alternative means of fostering tiering as a health quality tool. Thus, for example, standards could be developed by state insurance regulators in the case of insured plans, the HHS Centers for Medicare and Medicaid Services (CMS) in the case of Medicare and Medicaid plans, or by the United States Department of Labor in the case of ERISA-governed plans.

Even in the absence of express legal standards governing tiering, there are several reasons why use of transparent and reasonably designed tiering standards and methods, accompanied by a timely and fair process for correcting errors, ultimately could be expected to carry considerable weight in the event of a legal challenge. First, as noted, health plans sold to employers and other group purchasers may incur legal responsibility for the quality of their care as a matter of state tort law. Second, plan administrators who also act as plan fiduciaries arguably have an independent fiduciary legal obligation to ensure that services used by members are of appropriate quality and that plan assets are properly conserved.<sup>36</sup> Similarly, entities that sell health plans to Medicare and to state Medicaid agencies and other group purchasers have legal obligations to operate in accordance with standards of quality and efficiency, just as do the programs themselves. Thus, the imperative to establish ongoing evaluation mechanisms is strong,

---

<sup>34</sup> It is unclear if the scope of the review is de novo or on the record, but the summary of the settlement indicates that the evidence before the external reviewer will be that which was presented to the internal review.

<sup>35</sup> *Consumer Checkbook Center for the Study of Services v. United States Department of Health and Human Services* 2007 WL 2381005 (Aug 22, 2007).

<sup>36</sup> Sara Rosenbaum, Phyllis Borzi, *Is Health Care Quality Purchasing an ERISA Fiduciary Obligation?* BNA Pension and Benefits Daily 6:182 (Sept. 21, 2006).

particularly where the method is linked to the selection, certification, and ongoing oversight of health care providers and the expansion of information available to patients.

To be sure, the entities engaged in this effort are in a position to financially benefit from efficiency improvements and cost savings. But courts do not reject plan administration practices simply because of the potential to benefit, although scrutiny may be closer. Courts – including the United States Supreme Court<sup>37</sup> – recognize the inherent tension in health care between the goals of financing and quality and thus seek to reconcile, rather than overturn, modern health care arrangements and practices that seek to fuse quality, cost, and transparency. Indeed, this effort to find an accord between health care market trends and longstanding legal principles has been a hallmark of modern Supreme Court ERISA jurisprudence.<sup>38</sup> Similarly, because the law of fraud and quality arguably favor both information and transparency in the relationship between health care providers and patients,<sup>39</sup> there would appear to be no inherent reason why the use and publication of reliable patient information developed in a reasonable fashion would be actionable as defamatory or as a violation of principles of quality or fraud.

## Conclusion

Transparent tiering standards, a transparent development process in setting tiers and assigning individual physicians to tiers, and a clear and accessible process for identifying and correcting any errors that might arise in the tiering process should ensure the legal soundness of these systems. Indeed, the fact that the law fundamentally supports tiering when designed with care and transparency can be seen in the Regence/WSMA settlement itself, which concedes the inherent legality of tiering while introducing certain safeguards and principles into the use of this tool.

---

<sup>37</sup> *Pegram v. Herdrich*, 530 U.S. 211 (2000).

<sup>38</sup> See, e.g., *Pegram v. Herdrich* and *Aetna v. Davila*, in which efforts to classify as illegal certain plan design efficiency features, including the use of drug substitution and queuing for diagnostic services, were decisively rejected by the United States Supreme Court.

<sup>39</sup> *Law and the American Health Care System*, Part 3.