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MISSISSIPPI GOVERNOR RESCINDS EXECUTIVE ORDER REQUIRING BLUE CROSS OF MISSISSIPPI TO GRANT "IN NETWORK" STATUS TO EXCLUDED HOSPITALS

by James M. Burns

In early November, Mississippi Governor Phil Bryant rescinded an Executive Order (Executive Order 1327), issued only weeks earlier, that would have compelled Blue Cross of Mississippi to continue to offer "in-network" status to several Mississippi hospitals with whom Blue Cross had terminated its relationship as a result of a contract dispute with them. Governor Bryant's decision follows the initiation of a federal lawsuit by Blue Cross, claiming that Governor Bryant's Executive Order compelling it to retain its 'in-network" relationship with the hospitals violated its constitutional rights. Notably, however, Governor Bryant's latest action does not put the network exclusion issue to rest, as the Mississippi Insurance Department will continue to investigate whether Blue Cross's decision violates Mississippi law.

The dispute began last summer, when Blue Cross advised ten Mississippi hospitals (all owned by HMA) that it was modifying its reimbursements to the hospitals, claiming that they were overpaying for their services. The hospitals responded by filing a lawsuit against Blue Cross in state court (*Jackson HMA, d/b/a Central Mississippi Hospital Center, et al. v. Blue Cross Blue Shield of Mississippi*, Circuit Court of Hinds County, Mississippi) claiming that Blue Cross's decision to modify their reimbursement rates was a breach of contract, causing them more than $10 million in damages. Blue Cross responded to the lawsuit by providing 30-days notice that it was terminating its contract with each hospital altogether, removing the hospitals from its network.

The hospitals sought the Governor's assistance, claiming that Blue Cross's decision to terminate the parties' contracts would cause serious harm to Mississippi residents and that immediate relief was required to protect against that result. In response, Governor Bryant issued Executive Order 1327, in which he declared that "Blue Cross's exclusion of the hospitals from the BCBS network of providers threatens patient access to care" and, on that basis, ordered Blue Cross to resume the relationship pending further investigation by the Mississippi Department of Insurance. Blue Cross responded by filing a federal lawsuit challenging Governor Bryant's authority to issue the Executive Order.

Governor Bryant's subsequent decision (embodied in Executive Order 1328) rescinds the portions of Executive Order 1327 that compel Blue Cross to continue "in-network" status to the hospitals pending further

examination by the Insurance Department, and comes closely on the heels of a decision by U.S. District Court Judge Henry Wingate to grant a request by Blue Cross to temporarily block the Governor's Executive Order from taking full effect. With a full hearing on Blue Cross's motion set for November 5, and Blue Cross having agreed both to restore in-network status for four of the ten previously cancelled hospitals and to dismiss its lawsuit against the Governor, the Governor issued the modified Order.

As provided for in the new Executive Order, the Department of Insurance will continue its examination into whether Blue Cross's decision to terminate its contracts with the six hospitals that remain "out-of-network" adversely impacts patient care in the state, and whether Blue Cross's decision violates Mississippi law, which, among other things, requires an insurer to have a network sufficient to serve the needs of the public and also prohibits insurers from engaging in any "trade practice which is . . . an unfair or deceptive act or practice in the business of insurance."

The Mississippi action is the latest – but likely not the last – dispute between health insurers and providers about network access. While some states have tried to resolve these difficult issues with legislation (some with "any willing provider" legislation limiting an insurer's ability to refuse network admission to a provider in several states and, in Pennsylvania, with proposed legislation requiring certain providers to contract with "any willing insurer" being the most prominent examples), while other states have chosen to let market forces sort out such disputes, these issues remain difficult ones for both providers and insurers. As health care reform drives further efforts by both insurers and providers to reduce costs and become more efficient -- a dynamic that limited networks has the potential to enhance, in some circumstances -- these disputes are only likely to increase. Stay tuned.

HEARING HELD ON PENNSYLVANIA'S NOVEL "ANY WILLING INSURER" LEGISLATION

by James M. Burns

On December 18, 2013, the Pennsylvania House Health Committee held a hearing on Pennsylvania House Bills 1621 and 1622, two bills that would require that any health provider in the state that operates as part of an integrated delivery system (*i.e.*, a health system that also has its own health plan, as many larger systems do) contract with "any willing insurer" desiring to contract with the provider. The legislation, the first of its kind in the country, is essentially the reverse of the "any willing provider" legislation that has been enacted in over 30 states over the last several decades that require health insurers to accept every provider meeting its credentialing requirements into its provider network.

As explained by the bill's sponsors, Representatives Jim Christiana (R) and Dan Frankel (D), the legislation was initially designed to force University of Pittsburgh Medical Center (a larger Western Pennsylvania provider) to contract with Highmark Blue Cross, after UPMC announced earlier this year that it intended to terminate its "in network" status with Highmark at the end of 2014. However, the bill's sponsors have stated that their legislation is not intended solely to address this dispute, nor is it limited to these parties, and they claim that "if we want to pursue the best quality, highest value health care," we must have "full patient access and complete competition in the insurance market as well as the provider market."

At the hearing on December 18, 2013, UPMC representatives opposed the bills, maintaining that forcing parties to contract against their will would have anticompetitive effects and stifle innovation – claims that health insurers have made, typically without success, when opposing "any willing provider" legislation in other states. Highmark representatives, on the other hand, supported the proposed legislation at the hearing, and others – including a representative from a benefits management company – suggested that the bills should be expanded to cover all providers, not just those in integrated systems.

Since the hearing, UPMC and Highmark announced that they had settled a long running antitrust lawsuit between them, leaving open the possibility that the settlement might lead to a voluntary resumption of the parties' contractual relationship. Nevertheless, this development may not necessarily derail the proposed legislation, particularly given the sponsors' statements that the issue is bigger than just the UPMC/Highmark dispute. The Pennsylvania legislature reconvenes on January 7, 2014 for further proceedings. Stay tuned.

7TH CIRCUIT SUGGESTS FILED RATE DOCTRINE MAY NOT APPLY TO CLAIMS RELATED TO ILLINOIS PROPERTY/CASUALTY RATES

by James M. Burns

The 7th Circuit Court of Appeals recently questioned whether the Filed Rate Doctrine – an exemption doctrine that bars actions challenging the reasonableness of rates charged by entities that a subject to federal or state regulatory approval – applies to property and casualty insurers in Illinois.

Specifically, in *Cohen v. American Security Insurance Co.*, the 7th Circuit considered whether it was unlawful for a plaintiff's mortgage lender to purchase allegedly overpriced hazard insurance, at plaintiff's expense, in the event the insured let its own policy lapse ("forced placed insurance"). At the district court level, the court held that plaintiff's claims were barred by the Filed Rate Doctrine. On appeal, the 7th Circuit ultimately ruled that plaintiff's claims failed because "there was no deception at work" by the defendant mortgage lender and insurer, stating that because "maintaining property insurance was [plaintiff's] contractual obligation and she failed to fulfill it," and "the consequences of that failure were clearly disclosed to her" then "none of her claims for relief can succeed."

However, with language that could prove quite significant for all property and casualty insurers operating in Illinois, the 7th Circuit went on to question the lower court's Filed Rate Doctrine ruling. The Court stated that the Filed Rate Doctrine "protects public utilities and other regulated entities from civil actions attacking their rates if the

rates must be filed with the governing regulatory agency and the agency has the authority to set, approve, or disapprove them," but then noted that although American Security Insurance was required to file its rates with the Illinois Department of Insurance, "it is not at all clear that the Department has the authority to approve or disapprove property insurance rates." (As the Court further noted, Illinois is the *only* state that does *not* expressly authorize its Insurance Department to regulate property insurance rates.)

While the Court's statements about the application of the Filed Rate Doctrine to Illinois property and casualty rates in *Cohen* are clearly non-binding dicta, they should serve as a strong reminder to insurers that the regulatory scheme of "open competition" in Illinois with respect to p&c rates may very well come with a corresponding loss of Filed Rate Doctrine protections for challenges to insurer rates that could not be brought elsewhere.

SENATE PASSES AN ANTITRUST "WHISTLEBLOWER" PROTECTION BILL

by James M. Burns

On November 4, 2013, the United States Senate passed S. 42, the "Criminal Antitrust Anti-Retaliation Act," by unanimous consent. The legislation, introduced back in January of 2013 with bipartisan support (Senators Leahy (D) and Grassley (R)), provides protections to employees that provide information to the federal government about possible antitrust violations by their employer. Specifically, no employer may "discharge, demote, suspend, threaten, harass or in any other manner discriminate" against an employee that, in good faith, reports a potential antitrust violation to the federal government.

An employee whose rights under the Act has been violated may either file a complaint with the Secretary of Labor or commence his or her own private lawsuit in federal district court seeking relief for the alleged violation of the Act. Prevailing plaintiffs under the Act can obtain all of the following forms of relief: (1) reinstatement with the same seniority status that the employee would have had, absent the discrimination; (2) back pay, with interest; and (3) compensation for any special damages incurred, including attorneys' fees, expert witness fees and litigation costs.

The bill was received in the House on November 12, 2013, and, at present, is being "held at the desk" (*i.e.*, is awaiting either referral to a House Committee for further action or being placed on the House calendar for a vote). Given the apparent bipartisan support for the legislation, it would not be surprising if, rather than being sent to a House committee for further consideration, it is instead presented directly to the full House for vote (or unanimous consent) once Congress returns from its Christmas recess in January. If enacted, the legislation would be codified as Section 216 of the Antitrust Criminal Penalty Enhancement and Reform Act of 2004 (Public Law 108-237).