

# AHLA Annual Meeting – June 2025

## Presentation Outline: Practical Considerations for Providers in Negotiating Network Contracts

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### A. Negotiating strategies and tactics (“Top 10”)

- 1) Consider alternatives to network participation
  - i. Remaining purely out-of-network likely means reduced volume and more out-of-pocket expenses for patients, but will likely result in higher payments from the payer.
  - ii. Repricing agreements with third parties (like MultiPlan) are a viable alternative to network participation – they reduce out-of-pocket expense for patients by prohibiting balance bills and may provide for competitive rates, although the payer typically can decide on a case-by-case basis whether to reprice individual claims.
  - iii. The option now also exists to pursue Independent Dispute Resolution under the No Surprises Act. That could be an option, for example, if you are a physician group that chooses to remain out-of-network with a payer, in a case in a facility at which your physicians routinely practice is in-network with the same payor. There are vendors who specialize in setting up a process for bringing these IDR challenges, usually under an arrangement in which the vendor takes a percentage of the IDR award.
- 2) Address payer offset rights proactively
  - i. Allow offsets by payer only if both parties agree that there’s been an overpayment.
  - ii. At the least, provide that the payer cannot take offsets while an appeal is pending in which the provider is challenging an overpayment determination by the payer to which the provider has timely objected in writing.
- 3) Take advantage of state prompt payment provisions
  - i. Make state prompt payment provisions a part of the contract, so as to ensure a viable cause of action under the contract (even if case law in the state does not recognize a private right of action to enforce the state prompt payment law) if the payer violates those provisions.
  - ii. Try making state prompt payment rules – like payment within X days of receipt of a clean claim and limitations on payers recouping payments made more than Y months prior to the recoupment attempt – applicable to all claims, including those involving members of self-funded employer plans not otherwise subject to state regulation.
- 4) Consider all of the ways in which your network agreement with a payer (the “Agreement”) might change

- i. Ensure a default rule that all amendments must be in a writing agreed to by both parties.
  - ii. Exceptions to the default rule, like to the extent the payer needs to amend the Agreement to conform to a change in applicable law, should be limited. For example, make such changes permissible only to the extent necessary to comply with the new law/rule and only if the new law/rule took effect after the effective date of the Agreement.
  - iii. Ensure that the provider can object to material changes to the payer's Provider Manual incorporated by reference into the Agreement and, if the parties are unable to resolve the objection, that the provider can terminate the Agreement before the new manual provision goes into effect.
- 5) Plan for potential expansion
  - i. Consider what will happen if the provider acquires another participating provider.
  - ii. The typical payer template allows the payer to choose whether to pay the "new" provider at: (a) the same rates the payer was paying that provider before; or (b) the rates in your Agreement. If the payer insists on that right to choose, at least try to limit the period for which that right applies – e.g., propose that after six months, all new participating providers will be reimbursed at the rates set forth in your Agreement.
- 6) Document value proposition
  - i. What makes the provider bring value to a payer in the areas of access, quality, and affordability.
  - ii. Can the provider bring immediate value to the payer.
- 7) Conduct data and analytics study
  - i. How do the provider's rates compare to market and its competitors.
  - ii. How are collections performing to expectations.
- 8) Define payer reliance and risks
  - i. How important is the payer participation as it relates to provider's strategy and objectives.
  - ii. What is the impact to the payer if the provider was out of network.
- 9) Summarize current state (existing contract)
  - i. What, if any, are the prevailing issues.
  - ii. What are the key provisions that the provider is trying to negotiate (e. g. new product).
  - iii. When was the last time the contract and/or rates were negotiated.
- 10) Evaluate current relationship
  - i. How would the provider characterize the relationship with the payer.
  - ii. Are there regular communications and activities between the parties.
  - iii. What is the relationship between the payer and the provider's competitors.

**B. *Why good rates are often not enough (e.g. recoupments, downgrading, payment policies, site of service, etc.)***

## 1) Overview

- i. Obtaining healthy rates and collections can be sourced in 2 ways:
  - 1. Rates negotiated in payer agreements and corresponding fee schedules that align with provider expectations and market **(Expected Rate)**
  - 2. Sometimes the second category can be more challenging...the collection of the rate **(Actual Rate or Yield on Expected Rate)**. This is where such elements as prior authorization, downgrading, appeals, payment policies, etc. come into play

## 2) Expected Rate

- i. Providers should conduct an internal analysis and assessment of their current rates compared across similar payers and products. This will help to visually identify outliers and opportunities to close any rate gaps.
- ii. Involve those leaders involved in the overall process, including discharge planning, care coordinators, registration, pharmacy, case managers, etc.
- iii. With the introduction of “price transparency”, negotiated rates are becoming more mainstream. Providers should try to identify the charges and negotiated rates from comparative providers in their markets (“Peer Group”). Compare your rates to the Peer Group by Payer by service, if possible and identify any gaps.
- iv. Develop an approach to close any gaps that align with goals and objectives.

## 3) Actual rate (Yield on Expected Rate)

- i. Measure – In a lot of cases, providers do not monitor the yield on their payer contracts due to the administrative resources needed and the complexity of payer fee schedules and adjudication rules. Providers are resorting to contract management systems (CMS) to monitor yield by payer by product.
- ii. Root causes – When a provider has identified a variance (actual rate  $\neq$  expected rate), root cause analysis will identify the **target areas of focus for the denial or underpayment**. Prioritization is critical to identify key areas using criteria (such as ease of implementation/acceptance, economic impact, timeliness of execution).
- iii. Some key target areas that commonly affect the Yield:
  - 1. Prior authorizations (PA) – review per payer policies for updated lists of PA services; monitor federal and state regulations; seek “gold carding” if applicable
  - 2. Appeals and reconsiderations – file timely appeals and reconsiderations; keep good documentation records; seek payer timelines as well on responses
  - 3. Claim adjustments (overpayments and timelines) – clearly outline the timing and processes for handling claim adjustments
  - 4. Downgrades/medical record requests – consider granting access to provider’s EHR to expedite the process; demand reasons and

resources used to make decisions; leverage federal and state regulations, if applicable

5. Payment policies – limit applicability to non-economic or administrative changes; use CMS processes as leverage; if billing changes are necessary, look for universal application across all payers
  6. Site of service – carefully review payer contract language on applicability; this is sometimes found in the “Amendment” section of the contract which allows payers to amend from “time to time”.
- 4) Approaches/solutions to enhance payer contract performance
1. Establish Joint Operating Committees between provider and payer to promote communication on strategic and operational issues
  2. Propose amendments to contract provisions or fee schedules that clarify or remove language that align with the objectives when the parties executed the contract.
  3. Consider involving regulatory agencies as needed to address chronic issues – CMS. Departments of Insurance, etc.
  4. Develop and share payer performance scorecards to drive performance changes in key metrics
  5. Initiate and follow pre-arbitration process to resolve disputes
  6. Communicate with key stakeholders (patients, employers, brokers, etc. – more discussion to follow)

**C. *Value based payment components to network participation - What's new and how to tackle what's old and no longer working***

- 1) Overview – While reimbursement is still predominately based on a fee-for-service (FFS) chassis, value-based (VB) reimbursement can take many forms and serve as a supplemental revenue stream.
- 2) Considerations when evaluating a value-based contract – “Go v. No-Go”
  - i. Risk – Providers need to determine their risk tolerance level. Those levels range from:
    1. None – stay in the FFS world
    2. Upside only – can earn savings but share of those savings is reduced
    3. Share risk – provider and payer equally share in savings and losses. Provider % is usually higher than upside only level.
    4. Full risk – for more mature health systems, they are willing to assume full risk and earn 100% of any savings.
  - ii. Investments – Providers will need to make some investments to be successful in a value-based contract, including, but not limited to, the following:
    1. Human resources – Often providers will hire or assign an executive to lead their value-based programs.
    2. Data systems – Need to be able to monitor real-time data for clinical measures, referrals, etc.

3. Operational expertise and design – May need to pull in operational leaders into your VB strategy that have experience on managing clinical outcomes and overall cost of care.
  - iii. Network composition and control – providers should look at how much of the overall network does it control within its system. The greater the number of providers the better control over...
    1. Clinical practices – adherence to quality standards of care
    2. Case management – management of high-risk patients
    3. Care coordination – coordination of the patient’s care plan
  - iv. Market factors – Providers should consider responses to some of the following market assessment questions:
    1. Do my competitors also participate in VB arrangements? Are they successful? Do they create a competitive advantage in the market?
    2. Are there particular payers in the market that align with the provider’s VB goals?
    3. Do I have enough members/patients in my panel to be successful?
    4. Are there certain products (commercial v. Medicare Advantage (MA)) to consider under the VB arrangement? Is the payer a 4-star or greater MA plan?
    5. What is my prior and current experience under the proposed model? Providers should request their performance had the proposed model been in place the last 2 years. Those results could help establish a baseline and guide the decision-making process. Include both the cost of care elements and the quality measurements.
- 3) Value-based contract components – While the value-based arrangements can be very complex, there are a few components to spend resources understanding in the negotiation phase:
- i. General
    1. Risk levels – In general, the more risk that the provider assumes the more upside to generate savings and revenues. (See Risk level assessment above)
    2. Quality measurements – These measures can be voluminous but should be universally measured and defined by industry accepted sources (CMS, HEDIS, Star ratings, etc.) Limit the # of measures and be consistent across multiple payers to create scale and operational efficiency.
  - ii. Cost of care arrangements – These are arrangements where the Provider is managing the total cost of care for a defined population.
    1. # of attributed members – It is important for the parties to understand how an “attributed member” is defined and counted. Also need to consider the persistency rates (measure of how long a member has been enrolled in the payer product.) Low persistency rates create a challenge to create value if members/patients disenroll from value-based products.

2. Revenue – If applicable, need to understand how revenues are generated and counted. Need to consider payers and products that align with Provider goals and objectives for revenue generation.
3. Expenses – Review how expenses are counted and require prior year's detailed experience. Request how incurred but not reported (IBNR) claims are accounted for.
4. Network composition – Request and review the providers in the network for the defined payer product. Check your typical referral patterns and assess future referrals under the VB arrangement.
5. Care management fees – To offset the investments required by a Provider, consider requiring care management fees as “seed money” for the investment. Typically, care management fees are then considered an expense for settlement purposes.
6. Stop-loss – Depending on the size of the attributed members and the risk tolerance, consider the purchase of stop-loss coverage for catastrophic claims that could have an adverse impact on the settlement amount.
7. Mid-period performance reports and advances – Request frequent reports to monitor performance throughout the performance period. Request advances in any mid-year surpluses for cash flow purposes.

**D. *Challenging the adequacy of payer networks and why such challenge matters when negotiating with payers***

1) Overview

- i. Larger or highly specialized providers in particular may be able to leverage members' desire to access such providers' services as part of negotiating, or renegotiating, a network agreement with a managed care plan administrator.
- ii. An initial argument by such a provider would be that the members, and thus (in a commercial context) the member's employers who serve as clients of the entity administering the plan, will want the provider to be in-network and will be disappointed if it is not.
- iii. The more consequential argument, if supported by the facts, would be that if the administrator does not include the provider in its network, in addition to disappointing the members, the administrator also will not meet applicable network adequacy requirements.
- iv. We consider here payer network adequacy requirements imposed on, in turn, Medicare Advantage plans, Medicaid MCOs, and commercial plans.

2) Medicare – CMS access standards

- i. The network adequacy standards for the Medicare Advantage Program are based upon federal guidance articulated at 42 C.F.R. § 422.116. A comprehensive chart included as a part of that regulation sets forth the mandatory access standards in terms of both time (minutes) and distance (mileage).

1. Network access standards are categorized by provider type and county designation. For instance, compliant networks must make primary care providers in a “large metro” area (defined, in part, as having a population greater than or equal to 1 million persons with a population density greater than or equal to 1,000 persons per square mile) available at a maximum of 10 minutes and a maximum of 5 miles from beneficiaries. An explanatory note clarifies that “time and distance metrics measure the relationship between the approximate locations of beneficiaries and the locations of the network providers and facilities.” 42 C.F.R. § 422.116(d)(1)(i).
2. When necessary due to utilization or supply patterns, CMS may set the maximum time and distance standards for providers and facility types for specific counties. 42 C.F.R. § 422.116(d)(3).
- ii. Medicare Advantage plans must also ensure both that:
  1. At least 85 percent of the beneficiaries residing in micro or rural counties, or CEACs [Counties with Extreme Access Considerations], have access to at least one provider/facility of each specialty type within the published time and distance standards; and
  2. At least 90 percent of the beneficiaries residing in large metro and metro counties have access to at least one provider/facility of each specialty type within the published time and distance standards. 42 C.F.R. § 422.116(d)(4).
- 3) Medicaid – State imposed access requirements (using Pennsylvania as a test case)
  - i. Chapter 9 of Title 28 of the Pennsylvania Code sets forth the network access requirements for entities contracting with the single state agency to serve as Medicaid Managed Care Organizations in Pennsylvania. The regulations provide, in pertinent part, that “[e]xcept as otherwise authorized in this section, a plan shall provide for at least 90% of its enrollees in each county in its service areas, access to covered services that are within 20 miles or 30 minutes travel from an enrollee’s residence or work in a county designated as a metropolitan statistical area (MSA) by the Federal Census Bureau, and within 45 miles or 60 minutes travel from an enrollee’s residence or work in any other county.” 28 Pa. Code § 9.679(d) (emphasis added).
  - ii. In the event that a plan is unable to meet the travel standards described in subsection (d), it “shall inform the Department in writing and provide a written description of why it is unable to do so and its alternative arrangements to ensure access to health care providers of these services.” 28 Pa. Code § 9.679(f).
- 4) Commercial – Enforcement of access standards for commercial plans (using a relatively recent situation involving the adequacy of the payer network maintained by Blue Cross and Blue Shield of Illinois (“BCBSIL”), as affected by the network status of a provider called the Springfield Clinic, as a test case)
  - i. On March 21, 2022, the Illinois Department of Insurance (the “Department”) announced a series of fines totaling \$339,000 against

Health Care Service Corporation (HCSC), the parent company of BCBSIL, for violating the material change notice requirement of the state's Network Adequacy and Transparency Act (the "NATA"). See <https://idoi.illinois.gov/news/press-release.24655.html>. The fines marked the first sanction issued by the Department against a payer in connection with the NATA.

- ii. The termination of a network agreement between BCBSIL and Springfield Clinic, a provider that served approximately 100,000 consumers in central Illinois, led to the Department finding the NATA violation. Specifically, a provision within the NATA requires that if there is a "material change" in the network, the payer must submit updated network adequacy filings to demonstrate that the change has not rendered the network inadequate. Under NATA, insurers are required to report to the Director any material change to an approved network plan within 15 days after the change occurs. BCBSIL submitted its updated network adequacy filings to the Department regarding the termination of the Springfield Clinic from the BCBSIL network some 244 days late, along with another filing that was 95 days late.
- iii. The Department fined BCBSIL yet again in March 2023. These subsequent fines resulted from a targeted market conduct examination for network adequacy, which included a review of BCBSIL's participating providers at the time. The results of the examination identified several violations of the NATA, including allegations that BCBSIL failed to properly apply maximum time and distance standards to reflect proper availability of providers and failed to audit for each network plan at least 25% of its provider directories to verify the accuracy of the information in those directories.
- iv. The Department initiated its targeted market conduct exam for network adequacy in November 2020, posted the results of the exam in March 2023, and fined BCBSIL \$605,000 for the violations. Further, it appears as though BCBSIL then failed to cooperate with the Department's plan of corrective action, which included updating BCBSIL's provider directories. Accordingly, on November 3, 2023, the Department fined BCBSIL yet again, this time for \$231,900 for failing to properly update the provider directories as required both by the NATA and the plan of corrective action imposed by the Department on BCBSIL following the initial finding of statutory violations.

**E. *Direct messaging to purchasers (member and employers) - enlisting assistance from patients and health plan sponsors while steering clear of tortious interference***

- 1) Providers may seek to enlist third parties in connection with negotiating or renegotiating a network contract with an entity that administers health plans (like a Cigna, Aetna, or United), including third parties such as:



- i. Self-funded employer plans, for which the entity serves as the third-party administrator (“TPA”); and
  - ii. The members enrolled in the self-funded and fully-insured health plans administered by the entity.
- 2) To determine what communications with third parties are permissible, start by analyzing the existing network agreement (provided this is a renegotiation, as opposed to the provider joining a network for the first time).
  - i. TPA templates often include provisions stating that the provider can communicate openly with members about making medical decisions, the rates paid by the plan to the provider for covered services, and the provider’s participation in other payer networks.
  - ii. The templates, however, often also specifically prohibit the provider from advocating for a member to change his or her insurance coverage or otherwise interfering in the contractual relationship between the insurer and the insured.
  - iii. Note that in the case of a member of a fully-insured plan, the administrator can allege interference in its own insurance policy contract with the member, given that the administrator both administers and underwrites the plan at issue. In the case of a self-funded employer plan, by contrast, the administrator (in its role solely as TPA) would have to argue that it has been damaged by interference in the insurance policy contract between the member and his or her employer, which underwrites the plan, based (presumably) on the TPA having its own fiduciary duty to administer that self-funded plan and to the members of that plan.
  - iv. It is less common to see TPA network contract provisions addressing directly a provider’s communications with the self-funded employer plan clients of the administrator, but note that the administrator and those plans also have a contractual arrangement (i.e., the contract with the employer pursuant to which the entity serves as the TPA) with which the TPA could in theory allege interference by the provider.
- 3) Case law in which a TPA alleged tortious interference by a provider.
  - i. *Arapahoe Surgery Center, LLC v. Cigna Healthcare, Inc.*, 171 F. Supp.3d 1092 (D. Colo. 2016)
    - 1. In a counterclaim, Cigna alleged that Arapahoe, which operated ambulatory surgery centers (“ASCs”) that were out-of-network with Cigna, engaged in billing practices that tortiously interfered with the contracts between Cigna and members of the health plans Cigna administered.
    - 2. Arapahoe adopted a billing policy under which it charged its out-of-network ASC patients no more than what those patients would have paid had they gone to an in-network ASC instead.
    - 3. Cigna argued that the patient cost sharing provisions of its health plans required that to be eligible for out-of-network benefits, the members of its plans had to be financially responsible for and pay

both: (a) a higher cost share responsibility (i.e., a higher co-payment, co-insurance, and/or deductible) than in-network patients; and (b) a balance bill equal to the difference between the allowed amount set by the patient's health plan benefits and the provider's full billed charges. By inducing its Cigna member patients not to pay the higher out-of-network cost share amount or the balance bill, Cigna alleged in its counterclaim for tortious interference with contract, Arapahoe therefore also induced those members to breach the terms of their insurance policies.

4. The court agreed with Cigna and denied Arapahoe's motion for summary judgment on Aetna's claim of tortious interference. A reasonable jury, the court concluded, could find that the health plan contracts at issue required higher cost share payments by out-of-network patients and that such patients' failure to pay those higher amounts did indeed constitute a breach of those contracts.
  5. The court also held that a reasonable jury could infer the requisite intent by Arapahoe to interfere with the insurance policies at issue, due to the ASCs' admitted practices of offering to provide out-of-network services at in-network rates, and of accepting much lower cost share payments from patients than provided for by their actual benefits plans.
- ii. *Kissing Camels Surgery Center, LLC v. Centura Health Corporation*, 2016 WL 8416760 (D. Colo. 2016).
1. This is a companion case to *Arapahoe*, arising out of the same set of facts, but involving Anthem, United, and Aetna as the plans bringing a counterclaim for tortious interference with contract against the ASCs. Once again, the plans alleged that the facilities were failing to hold out-of-network members responsible for the cost sharing and balance bill amounts dictated by their benefits plans.
  2. Among other things, the plans argued, the providers' failure to charge the member patients more in out-of-pocket expenses – while still seeking full payment of the allowed amount set by the members' benefit plans from the payers – constituted tortious interference in the insurance policy contract between the insurer and the insured.
  3. This decision ruled on a motion by the ASCs to dismiss the counterclaim for tortious interference.
  4. The court denied the motion to dismiss, citing the decision in *Arapahoe* and finding that the same result applied in this case.
  5. The court also let Aetna pursue a different tortious interference theory, namely that improper referrals to the out-of-network plaintiff ASCs by Aetna network physicians also harmed the separate contractual relationship between Aetna and its in-network ASCs, to which the network physicians should have been directing their referrals instead.

- 4) Case law in which a provider alleged tortious interference by a health plan administrator: *Medical Diagnostic Laboratories, LLC v. Health Care Service Corporation*, 772 Fed. Appx. 637 (10th. Cir. 2019)
  - i. In-network health care providers of a Blue Cross plan submitted letters of recommendation to the plan arguing that plaintiff Medical Diagnostics (“MDL”), which was out-of-network with the plan, offered unique testing services not available from the plan’s network labs and should therefore be allowed to join the network.
  - ii. Blue Cross responded to the letter campaign by sending correspondence of its own back to the providers, in which it stated that its network labs were “able to provide the specific services” the providers believed only MDL could offer. In its response, the plan also reproduced text from its network agreements with the providers to the effect that the providers were required to refer members to participating labs, unless they got specific consent from the plan to refer members out-of-network. The plan concluded by threatening to terminate the providers if they referred members to out-of-network labs, like MDL, in violation of their participating provider contracts.
  - iii. Based on the foregoing facts, MDL sued Blue Cross for tortious interference with MDL’s prospective business relations with network providers and plan members, and also for defaming MDL in the correspondence the plan sent to the providers by suggesting that MDL did not provide unique services.
  - iv. The Blue Cross plan filed a motion to dismiss the complaint for failing to state a claim upon which relief could be granted, which the district court granted.
  - v. The Tenth Circuit affirmed. In short, the appellate court found that because the Blue Cross plan’s letters to the providers simply restated the network providers’ contractual obligations, the letters did not demonstrate “intentional or improper conduct or means” by the plan. The letters were thus not actionable, and plaintiff MDL failed to state a claim for tortious interference. The appellate court likewise dismissed the defamation count, on the ground that the letters the plan sent did not in fact suggest that the in-network labs provided the exact same services as MDL, as MDL had contended.
- 5) Other case law involving health plan administrators, physician and facility providers, and claims of tortious interference
  - i. *Aetna Life Insurance Company v. Huntingdon Valley Surgery Center*, 129 F.Supp.3d 160 (E.D. PA, 2015), *affirmed in part and vacated in part on other grounds*, 703 Fed.Appx.126 (3<sup>rd</sup> Cir. 2017).
    1. Aetna alleged among other things that FSM, the management services organization for Huntingdon Valley Surgery Center (“HVSC”), tortiously interfered with professional services agreements between HVSC’s physician-owners and Aetna, which required the physicians to refer members to in-network Aetna

facilities. While the physicians participated in the Aetna network, the HVSC facility itself did not.

2. Aetna alleged that FSM induced the physician-owners to breach their network agreements with Aetna by increasing both their individual equity stakes in HVSC (and thus their monthly distributions) based on how many Aetna members the physicians referred to the out-of-network HVSC facility.
  3. The district court denied FSM's motion for summary judgment as to Aetna's claim of tortious interference. It did so based on its finding that FSM had not demonstrated an absence of any genuine issue of material fact as to whether Aetna had shown that by making the referrals to HVSC, the physicians had breached their network agreements. Because Aetna could still demonstrate such breaches, it could carry its burden – at least in theory – of showing tortious interference.
  4. When the case reached the Third Circuit in 2017, the appellate court did not address the tortious interference claim. The discussion concerning the tortious interference claim was confined to a footnote, which noted that the claim was still before the district court.
- ii. In *Walnut Street Associates, Inc. v. Brokerage Concepts, Inc.*, 610 Pa. 371 (Pa. 2011), the Supreme Court of Pennsylvania adopted Section 772 of the Restatement (Second) of Torts providing that the giving of truthful information to a third party cannot support a claim for tortious interference with contractual relations.
1. Walnut Street Associates ("WSA") was a broker for health insurance provided to employees of Procacci Brothers Sales Corporation, which retained a third-party administrator, Brokerage Concepts Inc. ("BCI"). An employee of BCI disclosed to Procacci the amount of compensation WSA received as broker. After learning this information, Procacci fired WSA, which then sued BCI for tortious interference. The jury ruled in favor of WSA, the Superior Court reversed, and the Supreme Court affirmed the decision of the Superior Court.
  2. A cause of action for intentional and improper interference with existing contractual relations is well-established under Pennsylvania law. For example, in *Adler, Barish, Daniels, Levin & Creskoff v. Epstein*, the court cited the Restatement (Second) of Torts § 766, which provides that "one who intentionally and improperly interferes with the performance of contract" is subject to liability for ensuing pecuniary loss, and § 767, which lists factors for determining whether an actor's conduct intentionally interferes with an existing contract. 482 Pa. 416 (Pa. 1978).

3. Refining this definition of “improper” interference, the Supreme Court turned to, and ultimately adopted, § 772.
  4. Section 772(b) of the Restatement (Second) of Torts provides as follows: “Truthful information. There is of course no liability for interference with a contract or with a prospective contractual relation on the part of one who merely gives truthful information to another. The interference in this instance is clearly not improper. This is true even though the facts are marshaled in such a way that they speak for themselves and the person to whom the information is given immediately recognizes them as a reason for breaking his contract or refusing to deal with another. It is also true whether or not the information is requested.”
  5. The Supreme Court thus held in *Walnut Street* “as a matter of law that BCI’s truthful statement to Procacci about WSA was not an improper interference, and cannot, on its own, support a claim for tortious interference with contractual relations.”
- iii. In *Aetna Life Insurance Company v. Behar*, 2019 WL 4195355 (S.D. Tex. August 5, 2019), the defendant hospital (North Cypress Medical Center, hereinafter “NCMC”) filed a motion to dismiss Aetna’s complaint, which alleged two tortious interference claims.
1. First, Aetna alleged that the hospital defendant had enticed physicians to breach their in-network agreements with Aetna by referring patients to NCMC’s out-of-network facility through a remuneration-for-referral scheme. Aetna required that non-emergency patient referrals be made to available in-network facilities rather than out-of-network facilities, such as NCMC. Defendants allegedly paid hundreds of millions of dollars in kickbacks to in-network physicians for patient referrals to NCMC.
  2. Second, Aetna alleged that the hospital defendants enticed Aetna members to receive out-of-network services through a discount program (implemented by NCMC) that breached the members’ obligations under the plans with Aetna to pay a greater portion of the costs for out-of-network services than for in-network services.
  3. The court denied NCMC’s motion to dismiss with respect to both claims of tortious interference claims.
- iv. Similarly, in *Aetna Inc v. People’s Choice Hospital, LLC*, *Aetna Inc. v. People’s Choice Hospital*, 2019 WL 12536916 (W.D. Tex. March 28, 2019), Aetna asserted two tortious interference claims against the defendants, which included entities that managed and operated Newman Memorial Hospital, as well as several laboratories and related entities.
1. First, Aetna asserted the defendants generally tortiously interfered with the network facility services agreement between Aetna and Newman Memorial Hospital (the “Aetna-Newman Agreement”) by causing the submission of fraudulent claim forms that caused the

insurance company to make improperly high benefits payments. Specifically, Aetna alleged that the defendants received reimbursement for the higher Aetna-Newman Agreements rates for tests of specimens from patients who in fact had no relation to Newman Memorial and whose specimens were never actually sent to the hospital. Aetna asserted that Defendants submitted these “fraudulent claim forms” because they knew that Aetna paid more for claims submitted using Newman’s name and billing information than it paid for claims submitted from out-of-network providers.

2. Second, Aetna asserted that the laboratory defendants in particular tortiously interfered with the network professional services agreement between Aetna and certain physicians, which required the physicians to refer lab work for Aetna members to Aetna’s in-network facilities when feasible. Aetna further alleged that the defendant labs provided kickbacks to the physicians so that, rather than complying with their contracts, they would instead send samples to the out-of-network defendant labs.
3. The court denied defendants’ motion to dismiss with respect to both claims of tortious interference. Of note, with respect to the first theory, the court observed that plaintiffs did not specifically allege a breach of the Aetna-Newman Agreement. Nonetheless, the court found that for purposes of withstanding the motion to dismiss, plaintiffs had adequately alleged “that submitting fraudulent claims and/or utilizing confidential information from an agreement may – on some set of demonstrated facts – constitute ‘interference’ in the sense that a party’s performance might be impaired.” With respect to the second theory, the court found that plaintiffs had sufficiently alleged the requisite “intent” and “willfulness” by the lab defendants given the contention that they had made “kickback” payments to referring physicians.

#### **F. *Questions and Answers***