

Legal Brief

Patient Choice and Network Participation

This Legal Brief was drafted for general informational purposes only. It is not meant to be a comprehensive guide, nor should it be construed as legal advice. The information in this brief is current as of July 1, 2016; readers should consult the most recent versions of referenced statutes, regulations and cases to ensure there have been no material changes.

Summary

No health insurer, including the South Dakota Medicaid program, may obstruct patient choice by excluding a health care provider licensed under the laws of the state of South Dakota from participating on a health insurer's panel of providers if the provider is located within the geographic coverage area of the health benefit plan and is willing and fully qualified to meet the terms and conditions of participation as established by the health insurer.

Discussion

Per SDCL §58-17J-2, No health insurer, including the South Dakota Medicaid program, may obstruct patient choice by excluding a health care provider licensed under the laws of this state from participating on the health insurer's panel of providers if the provider is located within the geographic coverage area of the health benefit plan and is willing and fully qualified to meet the terms and conditions of participation as established by the health insurer.

A "Health benefit plan," is defined as, any hospital or medical expense policy or certificate, hospital or medical service plan, nonprofit hospital, medical-surgical health service corporation contract or certificate, provider sponsored integrated health delivery network, self-insured plan or plan provided by multiple employer welfare arrangements, health maintenance organization subscriber contract of more than six-month duration, or any health benefit plan that affects the rights of a South Dakota insured and bears a reasonable relation to South Dakota, whether delivered or issued for delivery in South Dakota. The term does not include specified disease, hospital indemnity, fixed indemnity, accident only, credit, dental, vision, Medicare supplement, long-term care or disability income insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, automobile medical payment insurance, or any plan or coverage exempted from state regulation by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 18;

A "Health insurer," is defined as, any entity within the definitions set forth in subdivisions §58-17F-1(11), (12), and (15), any entity offering a health benefit plan as defined by §58-17F-2, all self-insurers or multiple employer welfare arrangements, and self-insured employer-organized associations. The term does not include any entity exempted from state regulation by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 18;

A "Health care provider," is defined as, any individual or entity within the scope of the definition of health care provider as defined by subdivision 58-17F-1(9).

A February 23, 2016 court ruling by Circuit Court Judge, Lawrence Long states, there is a three-step process that providers are to follow to be eligible for participation within a health benefit plan's network/provider panel. The process includes: 1) the group/provider shall supply the health benefit plan a list of services for which it wishes to be included on the health benefit plan's panel of providers; 2) for each service requested, the health benefit plan must offer, in good faith, a set of terms and conditions for participation; and 3) the group/provider shall upon review, chose to accept or reject each set of terms and conditions offered by the health benefit plan for each service on a "take-it-or-leave-it" basis.

Under the court's ruling, health benefit plans are not required to standardize all of its contracts, nor does the court ruling establish some kind of price-fixing scheme – a health benefit plan may retain different reimbursement rates for different providers, or for similar services. Rather, the health benefit plan is only required to offer groups/providers the opportunity to participate for each service requested under the set of terms and conditions in which the health benefit plan has fixed in good faith.

Conclusion

While health benefit plan participation falls upon the individual groups/providers, no health insurer may obstruct patient choice by excluding a health care provider who is willing and qualified to meet the terms and conditions established by the insurer. Various aspects of Initiated Measure 17 remain subject to litigation. Accordingly, physicians with questions concerning specifics are encouraged to confer with their own legal counsel.

SL 2015, ch 278 (Initiated Measure 17), § 2, eff. Nov. 13, 2014.



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