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# Avoiding Internal Legal Conflict When A Payor Is A Provider

By **Elliot Gordon** (September 10, 2020, 5:07 PM EDT)

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Historically, with a few notable exceptions, there has been a clear distinction between payors — health insurance companies — and providers, which include hospitals, physicians and other medical professionals. This line of demarcation is reflected not only in the regulatory regimes governing the health care system, but also in the litigation positions that payors and providers take on issues such as the following:

- What constitutes the usual, customary and reasonable rate for health care services;
- The validity of health plans' medical necessity and level of service guidelines;
- The enforceability of anti-assignment clauses and the standing of providers to bring reimbursement actions under the Employee Retirement Income Security Act;
- The rights of health plans to recoup overpayments; and
- Whether physicians can sue health plans for negligent delegation of duties.

Due to economic changes in the health care marketplace and the enactment of the Affordable Care Act, the line between payors and providers has been blurring in recent years. Health insurers have diversified their lines of business by acquiring provider entities, and provider organizations have obtained licenses to operate as health plans.

In 2017, UnitedHealth Group Inc. acquired DaVita Inc.'s primary and urgent care services, which at the time served roughly 2 million patients through nearly 300 clinics. This followed UnitedHealth's purchase of Surgical Care Affiliates Inc. earlier that year.

Similarly, the recent CVS Health Corp./Aetna Inc. and Cigna Corp./Express Scripts Holding Co. mergers are bringing together health plans and pharmacy benefit managers, two parts of the health care system that have sometimes had competing business interests or even been involved in litigation against each other.

More recently, Humana Inc. announced a $100 million investment in a primary care organization serving seniors. On the other side of the ledger, while Kaiser Permanente has long stood out as an integrated health care system, other hospitals systems have created health plans as well in recent years, such as Sutter Health in California and the University of Pittsburgh Medical Center in Pennsylvania. The enormous financial impact of COVID-19 on hospital revenues is very likely to accelerate these trends of vertical consolidation.

While much attention has been given to the financial, legislative and regulatory effects of these changes, there has been less focus on the litigation implications for companies that now operate as both providers and payors, as well as pharmacy benefit managers. In disputes encompassing the types of issues in which these entities traditionally have been at odds, parent companies, as well as joint ventures, will increasingly face the prospect of one side of their business taking a position that, if successful, could adversely impact another side of their business.

In fact, given the size and reach of some of these businesses, it would not be surprising to see the payor and provider sides of an organization take opposite positions on similar legal issues — without even realizing it. This can happen because many of these entities operate in a decentralized manner, with separate legal teams supporting different parts of the organization.

So what can these hybrid organizations do to prevent the inadvertent assertion of opposing legal positions and ensure that their legal departments and outside counsel make decisions based on the broader interests of the corporation?

First, corporate legal departments may want to establish protocols to ensure that a legal argument that might have a negative effect on other parts of the organization is scrutinized, particularly when such argument is raised at the appellate level, where a binding precedent can result. This requires all in-house litigation attorneys and outside counsel to be aware of the broader implications of their legal positions, so that a review of such positions can be made at the deputy general counsel or general counsel level or among business executives.

Second, corporate legal departments may want to encourage more direct communication among their various legal teams, especially on litigation issues that are likely to recur, so that a consensus can be reached, or a management decision can be made, that will serve as a guidepost for future cases.

Third, these issues should be discussed during meetings that bring together in-house attorneys and their outside counsel, and consideration should be given to including lawyers who represent both the payor and provider sides of the organization, so they can discuss important legal issues affecting the industry. The growing acceptance and use of virtual meetings in light of the COVID-19 pandemic makes it even easier to bring together such groups to discuss potentially conflicting legal interests within an organization.

Alternative dispute resolution can also mitigate the risks of conflicting legal interests within a corporation. In addition to the other benefits of early mediation, a confidential settlement process — if successful — can eliminate the need to advance certain arguments in open court that might have an adverse impact on a parent company's other divisions.

In addition, by including arbitration agreements in provider-payor contracts with third parties, companies can reduce the risks attendant to being both providers and payors. The confidential nature of arbitration proceedings mitigates the risks of taking certain positions in open court proceedings that

might lead to precedential decisions.

While there is always a risk that judicial review might follow an arbitration ruling, the limited scope of review, the potential for settlement following an arbitration decision and the low likelihood that judicial review will create judicial precedent on the underlying legal issue mean that the inherent tensions in legal positions that might benefit one part of an organization and harm another can be reduced or even avoided.

The blurring of the traditional lines between providers, payors and other parts of the national health care system is one of the major trends transforming the health care industry today. Just one of the many consequences of this shift is that these hybrid organizations may have legal interests and positions that collide. Both internal systems for addressing these conflicts and the use of alternative dispute resolution processes can serve to mitigate the challenges associated with this unintended consequence of the breakdown of the traditional payor-provider divide.

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