State Laws and Regulations Governing Preferred Provider Organizations

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PREFACE

In 1984, the Committee on Energy and Commerce of the U.S. House of Representatives asked the Federal Trade Commission to study state laws and regulations that affect preferred provider organizations (PPOs). Because the U.S. Department of Health and Human Services was already funding a study of PPOs, it expanded the scope of the study to include the committee's request.

This report describes the legal review and presents a complete set of study findings. Companion volumes provide a summary of these findings and an annotated bibliography covering all aspects of preferred provider organizations.


P. A. Lindsey, State Laws and Regulations Governing Preferred Provider Organizations: General Annotated Bibliography, R-3442/3-HHS/FTC, August 1986.

A description of the design for the broader study may be found in:


This research was conducted as part of The Rand Corporation's Health Sciences Program, and with subcontract assistance by the law firm of Memel, Jacobs, Pierno, Gersh, and Ellsworth, under Contract HHS-100-84-0073. The Rand Corporation researchers are Elizabeth Rolph, Paul Ginsburg, and Susan Hosek. J. Peter Rich, Karen Keenan, and Gary Gertler conducted the work at Memel, Jacobs, Pierno, Gersh, and Ellsworth.
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Woodrow Eno of the Health Insurance Association of America was exceptionally helpful in providing us with an understanding of how state laws are being applied and may be affecting insurers. In addition, we were greatly assisted by the many other individuals whom we interviewed in the process of our research. Without their cooperation, this undertaking would not have been possible.

Any sins of omission or commission that remain are, of course, our own.
CONTENTS

PREFACE .................................................. iii

ACKNOWLEDGMENTS ........................................ v

FIGURES AND TABLES .................................. ix

Section

I. INTRODUCTION ......................................... 1
   Methodology ........................................... 3
   Organization ........................................... 5

II. A PPO: BACKGROUND AND DEFINITION ............ 6
    Preferred Provider Organizations ................ 7
    Types of PPOs ......................................... 9
    Formation of PPOs ..................................... 11
    The PPO Marketplace .................................. 11

III. PREFERRED PROVIDER ORGANIZATIONS AND THE REGULATION OF THIRD PARTY PAYERS .................. 13
    ERISA Preemption of State Insurance Law ........ 13
    State Regulation of Third Party Payers .......... 16

IV. OBSTACLES TO PPOs IN THIRD PARTY PAYER REGULATION ............................................. 21
    Potential Obstacles in the Law ..................... 21
    Incidence of Potentially Restrictive Provisions .. 25
    Application of Potentially Restrictive Provisions .. 28
    Obstacles in Summary ................................ 32

V. PAVING THE WAY FOR PPOs: ENABLING MEASURES ......................................................... 34
    Enabling Statutes and Regulations .................. 34
    Provider and Consumer Protection Provisions .... 41
    Provider and Consumer Protection Provisions:
    What Directions? .................................... 52

VI. OTHER LAWS AFFECTING PREFERRED PROVIDER ORGANIZATIONS ........................................ 54
    Hospital Rate-Setting Statutes ...................... 54
    Antitrust Laws ....................................... 57
Professional Licensure Acts and Prohibitions Against
the Corporate Practice of Medicine, Referral
Fees, and Fee-Splitting ............................... 60
Peer Review Immunity ................................. 63
Medical Malpractice Liability ......................... 64
Other Legal Provisions ................................. 65

VII. FINDINGS AND CONCLUSIONS ..................... 66
Preexisting State Laws ................................. 66
State Enabling Statutes, Regulations, and Policies ... 67
Laws Protecting the Consumer ......................... 68
The Uneven Playing Field ............................. 69

Appendix
A. SUMMARIES OF THE PPO ENABLING STATUTES,
   REGULATIONS, AND FORMAL POLICIES ........... 71
B. COMPILATION OF APPLICABLE LEGAL
   AUTHORITIES ..................................... 89

BIBLIOGRAPHY ......................................... 183
FIGURES

1. Results From a National Survey of PPOs ......................... 12
2. States With Any-Willing-Provider Provisions .................. 43
3. States With Differential Caps .................................. 46

TABLES

1. PPO Relationships ............................................... 8
2. State Statutes That Could Restrict PPO Functions ............. 26
3. Application of Freedom-of-Choice and Antidiscrimination
   Statutes to PPOs Sponsored by Commercial Insurers
   and Health Service Corporations ............................... 29
4. States With Enabling Measure By Year of Adoption .......... 35
5. Ten States With Greatest PPO Activity ....................... 40
I. INTRODUCTION

A preferred provider organization (PPO) is a new form of health care delivery in which payers contract with a select group of providers\(^1\) to provide care for enrollees through their health insurance or health benefits plans under conditions that give the payer some control over costs. Enrollees are given economic incentives to choose the selected providers, although they are free to go to other providers.

PPOs are attractive because they seem to offer something for everyone. The payer hopes to contain costs. Enrollees save money or receive additional benefits by choosing a selected provider. Providers hope to increase their patient loads as enrollees are channeled to them; in return, they agree to the cost-control requirements of the payer.

Because PPOs appear to be a promising approach to cost control, in 1984 the House Committee on Energy and Commerce requested the Federal Trade Commission to provide it with information about the origins, purposes, and effects of state laws that might apply to PPOs. The committee wanted to know (1) whether these laws limited the cost control capabilities of PPOs, and (2) whether the laws provided adequate protection for the consumer. This study was conducted for the Department of Health and Human Services and for the Federal Trade Commission in response to the committee’s request.

The statutes and regulations governing preferred provider organizations fall into three categories. First, there is a set of provisions that has evolved over the years to govern insured health care delivery. These provisions generally also apply to preferred provider organizations. Some of these provisions may be interpreted as prohibiting some functions essential to the effective operation of a PPO. Second, some states are adopting new statutes and regulations expressly intended to facilitate and regulate the activities of PPOs. Finally, there are a variety of laws and regulations that do not concern insured health care but may affect PPOs.

We addressed the following questions:

- What laws and regulations apply to preferred provider organizations?

\(^1\)As used in this report, the term “provider” refers to any individual or institution licensed to deliver health care services. This includes hospitals, physicians, and nonphysician practitioners such as psychologists and podiatrists.
• What is their origin and underlying rationale?
• How do they affect the development and effectiveness of preferred provider organizations?
• Do they offer consumers adequate protection?

Our analysis is based on data from a variety of sources, including an extensive literature review; a comprehensive legal review, and extensive interviews documenting how statutes and regulations are being implemented.

Our basic conclusions are as follows:

1. Several types of state laws that predate PPOs sometimes have been interpreted as precluding the channeling and selective contracting activities necessary to the effective operation of PPOs. They are: (a) the antidiscrimination and freedom-of-choice statutes found in most insurance codes, (b) the antidiscrimination, freedom-of-choice, and “any willing provider” statutes frequently found in the legislation regulating health service corporations, and (c) health maintenance organization (HMO) acts. However, because interpretation of these laws differs from state to state, they appear to have imposed some barrier to PPOs in only about half of the 51 jurisdictions.

2. States are responding quickly to smooth the way for PPOs by adopting enabling legislation or regulations. At present, 22 states have enabling provisions and only three states expressly prohibit the selective contracting and channeling activities essential to PPOs.

3. To protect providers and consumers from possible adverse consequences, enabling measures often impose their own restrictions on the activities of preferred provider organizations. It is, however, too soon to assess the effects of these restrictions on the cost containment capability of PPOs.

4. The provisions in the new enabling measures, as well as preexisting consumer protection regulations, protect consumers in PPOs, but it is too early to assess their adequacy.

5. The provisions of the Employee Retirement Income Security Act of 1974 (ERISA) exempt self-insured employee health benefit plans from state regulations, giving authority to the Department of Labor, which exercises minimal control. These plans now account for 40 percent of the health insurance market.
6. Because PPOs arrangements are subject to the regulations that apply to the benefit plans they serve or to their sponsoring entities, they may be regulated in very different ways. This variation may create an imbalance between plans that are less regulated and those that are subject to greater regulations.

METHODOLOGY

Data for this analysis have been gathered from a variety of sources. We conducted a thorough review of the existing literature on preferred provider organizations. Because PPOs are a recent phenomenon, the literature contains little of an analytical nature. Most of the material is brief and descriptive and appears in trade journals rather than in scholarly publications. The results of the literature review are reported separately as an annotated bibliography in Lindsey (1986).

We also conducted a comprehensive legal review of provisions that might facilitate, permit, or restrict the development or operation of PPOs or that are designed to protect consumers or the public interest in all 50 states and the District of Columbia.

The types of legal authority we examined included:

- **Statutes**, which represent the strongest form of legal authority. State statutes generally govern activities carried on within a particular state unless they are preempted by federal law governing those activities.

- **Regulations**, which are rules promulgated by a particular federal or state agency under authority provided by statute and often are required to be published for public comment before they can become effective. If regulations are consistent with, and do not extend beyond the scope of, their authorizing statute, they have the force of law.

- **Judicial decisions**, which also have the force of law but may be overridden by statute (subject to constitutionality and judicial interpretation). Appellate court decisions have binding authority within the jurisdictional area of the court that renders the decision and a lesser type of authority, termed “persuasive authority,” outside the jurisdictional area. Trial court decisions are binding only upon the parties but, if they are published, may also have persuasive authority.

- **Opinions of the Attorney General**, which do not have the force of law but provide significant guidance concerning the interpretation that a court might adopt concerning a particular legal issue.

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2See MacDonald et al. (1985).
Finally, the published opinions or bulletins of a particular agency (e.g., a state department of insurance) represent that agency's policy on a particular subject and give an indication of how the agency will deal with particular matters. Opinions and bulletins do not have the force of law, but in practice they have an effect upon the activities of those regulated which approximates the effect of a regulation, although opinions and bulletins may be more easily overcome by agency decision or legal challenge.

The areas of law we examined include:

1. Any statutes, regulations, or formal policies that expressly authorize, regulate, or prohibit PPO arrangements.
2. Insurance code provisions requiring that an insured person retain the freedom to choose a health care provider or prohibiting insurers from discriminating between insured persons of the same class of risk.
3. Prohibitions against the “corporate practice of medicine,” the payment of compensation in return for patient referrals, and fee-splitting.
4. Licensing statutes and regulations applicable to physicians, dentists, podiatrists, optometrists, pharmacies, clinical laboratories, psychologists, and public hospitals that may limit a provider's ability to participate in PPO arrangements.
5. State peer review statutes that protect physicians who participate on peer review committees from liability for defamatory statements that may be made during the peer review process in the course of reviewing the quality of care provided by their peers.
6. Statutes and regulations governing HMOs that may apply to PPO arrangements.

In addition, we reviewed other areas of law that could potentially inhibit the development of PPO arrangements, such as the areas of hospital rate-setting, antitrust, securities, franchising, certificate of need, and medical malpractice liability.

Having documented the legal provisions that might apply to PPOs, we gathered information on their application, the rationales underlying their passage and/or application, and their effect on the development of PPOs in a series of lengthy interviews, both in person and by telephone, with representatives from each of the following categories of participants: governors' offices, state legislatures, departments of insurance, Blue Cross/Blue Shield plans, commercial insurers, third party administrators, multihospital chains, preferred provider orga-
nizations, business coalitions, and trade associations representing providers, insurers, and PPOs. Although the type of information that we wanted remained the same for each type of respondent, our interview format was open-ended to accommodate the great variety of experience that participants have had.

ORGANIZATION

The discussion that follows describes our findings in detail. In Sec. II, we define and describe the various types of preferred provider organizations. Section III identifies the laws that govern third party payers. Section IV analyzes the ways in which these laws may be applied to inhibit the cost-containment activities of PPOs. In Sec. V, we review the contents of new preferred provider enabling legislation. We also explore the rationale behind the adoption of these provisions and examine whether they affect the functioning of PPOs. Section VI describes other types of laws that may affect the formation and development of PPOs. In Sec. VII, we present our findings and conclusions.

Because states are moving so rapidly to facilitate the spread of PPOs, the information in this report that describes statutes and regulations at the state level may rapidly be outdated. However, our conclusions about how types of laws affect PPOs remain valid.
II. A PPO: BACKGROUND AND DEFINITION

Over the past two decades, health care costs have risen dramatically. Between 1965 and 1984, the nation’s per capita expenditure in constant dollars increased by 143 percent, and the percentage of gross national product devoted to health care rose from 6.1 to 10.6 percent. These increases have been attributed to many causes, including an explosion in the development of more expensive health care technologies and the extension of insurance coverage both to new benefits and to new populations. But perhaps most crucial to the upward trend was the apparent willingness with which payers—governments, insurers, and employers—tolerated the increases. Patients, covered by comprehensive insurance, had little reason to be price sensitive, and payers did not move to contain the costs for some years after the increases began.

Payers, however, are now actively demonstrating their concern about escalating costs in a variety of ways.

- The federal government, in an effort to gain control over its burgeoning Medicare costs, has made a dramatic move from cost-based reimbursement to prospective, fixed price payment for most hospital charges.
- States are turning to selective contracting as a tool to contain their Medicaid outlays, and several have adopted hospital rate-setting or rate review statutes to control inpatient charges.
- Employers, particularly large employers, are turning to self-insurance and assuming direct responsibility for controlling the health care costs of their employees. As payers, these employers are developing the expertise to monitor costs and negotiate prices.
- Commercial insurers and Blue Cross/Blue Shield plans also show growing interest in alternative delivery systems. They are under increasing pressure from their clients to check the continuing escalation of premiums. Furthermore, they fear that they will become the object of significant cost-shifting if they alone take no steps to control provider charges.

Although commercial insurers and some employers have supported hospital rate-setting proposals, the private third party payer is now generally turning for cost control to techniques that encourage
competition. Payers are becoming more discriminating consumers, searching for low-cost providers and using market power to negotiate price for their enrollees. They find themselves with new leverage, because there is a growing provider surplus, particularly in inpatient, acute care facilities. This new market activity is prompting both payers and providers to develop new relationships and institutional structures that can better serve their respective interests in the changing economic environment.

PREFERRED PROVIDER ORGANIZATIONS

One particularly attractive new form of health care delivery is the preferred provider organization. A PPO is a fee-for-service alternative to traditional health insurance in which insured persons are given financial incentives to use a panel of preferred providers with whom the payer has contracted to provide care for the enrollees.

The concept of payers selectively contracting with a panel of providers for health care is not new. In fact, the Blue Cross and Blue Shield plans rest on a variant of the model. But only recently has the contracting relationship been perceived and exploited as a cost-containment device, and it is in this new role that both payers and public policymakers have become eager to see preferred provider organizations succeed.

Recent growth in the number of PPOs and those eligible to use them has been extraordinary. According to one estimate, in 1981 fewer than 10 PPOs had contracts under which they enrolled and served enrollees.

By 1986, that number had jumped to almost 150 PPOs, with many more in the formative stages. Two-thirds of the current roster of PPOs have become operational since June of 1984. Similarly, eligibility figures have jumped from an estimated 1.3 million late in 1984 to 5.75 million in June of 1985. Of these 5.75 million eligible enrollees, 44 percent lived in California, 10 percent in Colorado, and 7 percent in Florida. The remaining were distributed throughout the other states, with New England and the mid-Atlantic states experiencing particularly low activity.

Patterns of physician participation mirror enrollment trends. According to one survey, only 5 percent of the nation’s physicians had contracted with PPOs in the spring of 1983. Two years later, 28 percent held contracts, and today the proportion is probably considerably higher.

1Barger (1985), p. 4.
3Ibid.
A PPO Arrangement

A PPO is not a specific entity, but rather a network of contractual arrangements among an indemnity plan, those it insures, and the preferred providers, with a third party administrator or other broker sometimes serving as a middleman between the indemnity plan and the preferred providers.⁴

The goals of each PPO participant and the functions necessary to achieve those goals can be summarized as follows (see Table 1). In concept, the PPO is designed to help each participant achieve his goal. Payers enjoy new opportunities to contain their health benefit costs. Providers hope to increase their patient loads as enrollees respond to incentives to use participating providers, and they also often expect more rapid claims settlement as they enter into a direct relationship with the payer. Enrollees can reduce their costs or expand their benefits by choosing a selected provider, yet they can retain the option of choosing another provider.

Definition of a PPO

There is no legally accepted, standard definition of a PPO, although a number of varying definitions have been included in state statutes

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⁴Thus, a more appropriate label would be preferred provider arrangement or PPA—a term that, in fact, is coming into increasing use. However, preferred provider organization or PPO remains the most commonly used term and therefore is used in this discussion.
and regulations. The following is a broad definition that would encompass all but certain idiosyncratic PPOs.

A preferred provider organization is an arrangement under which enrollees in a health benefits indemnity plan may obtain enhanced benefits or other financial reward in return for using the services of health care providers under contract directly or indirectly with such a plan or its agent.

In addition to applying channeling incentives intended to direct patients to a panel of preferred providers, PPOs have other common characteristics. For example, the preferred providers often negotiate price and agree to cooperate in a utilization review process that is more comprehensive than in traditional plans. This utilization review process typically includes (1) prior authorization of nonemergency hospital admissions and prompt review of emergency admissions; (2) concurrent review, discharge planning, and certification of extended hospital stays; and (3) retrospective review of outpatient services.

The providers who may participate in a PPO arrangement are usually limited to a select panel, but the selective contracting varies. In some cases, contractors have sufficient data to screen providers on the basis of historic patterns of cost and quality. More often, they ask providers to make bids to determine their eligibility. They may also establish only minimal criteria for eligibility and work with large panels, then choose to winnow out high-cost providers from the initial pool. This selectivity is considered by many to be a key element of a PPO arrangement because, in return for agreeing to the PPO's terms, the participating providers are promised increased patient volume resulting from enrollees' financial incentives to use those providers rather than nonpanel providers.

In sum, the essential elements of a PPO are (1) a select group of participating providers; (2) effective financial incentives for enrollees to use those providers; (3) some type of utilization review; and, to a significantly lesser extent, (4) negotiated provider fees.

**TYPES OF PPOs**

As noted above, the term "preferred provider organization" most descriptively refers to a contractual arrangement, not a particular type of entity. PPO arrangements may be sponsored by various types of providers, payers, or brokers, or by a combination of these types of sponsors. Generally, however, a PPO arrangement is initiated by a

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5Gabel and Rmann (1985).
single sponsor, such as Blue Cross, an insurance company, a hospital, a physician group or other provider organization, or a third party administrator or other broker. The major types of PPO sponsorship are briefly described below.

**Provider-Sponsored PPOs**

Provider-sponsored PPOs are usually formed by physicians, hospitals, or physician-hospital joint ventures, although they may be sponsored by any type of provider. Such PPOs aggregate providers willing to participate in PPO arrangements but cannot themselves have enrollees. They can, however, market their services to self-insured employers, to payer-sponsored PPOs or to broker-sponsored PPOs that are under contract to a payer.

**Payer-Sponsored PPOs**

Payer-sponsored PPOs may be formed by Blue Cross or Blue Shield, by self-insured employers or multiple employer trusts, by employee welfare benefit plans, or by commercial insurance companies. Instead of the traditional system where the payer passively reimburses the provider for services rendered, in such a PPO the payer or its agent takes an active role in selecting the preferred providers and fostering efficient use of health care resources.

There are basically two forms of payer-sponsored PPOs: insured and self-insured. In an insured PPO, an insurance company or a Blue Cross or Blue Shield plan bears the insurance risk. The economies of the PPO arrangement are passed on to employers and employees in the form of (1) premiums that are lower than those for a corresponding traditional indemnity plan and (2) reduced employee cost-sharing. In a self-insured PPO, the employer, multiemployer trust, or union trust fund is at risk rather than a separate insurance company or Blue Cross or Blue Shield plan.

Employers and union trust funds typically contract with a third party administrator (TPA) to administer their self-insured plans. The TPA may be a TPA company, a commercial insurance company, or a Blue Cross or Blue Shield plan that provides administrative services only (ASO) to the self-insured plan, rather than assuming insurance risk. The self-insured plan may develop a PPO on its own or may use the PPO network developed by its TPA.⁷ Thus, the same PPO provider

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⁷ Although insurance companies and Blue Cross/Blue Shield plans generally do not indemnify the self-insured plans that they serve on an ASO basis, there is an increasing trend for such indemnity companies to agree to include in their ASO contract with self-
panel may be used by an insurance company’s insured and self-insured
ASO clients, although the provider fee schedules, levels of employee
cost sharing, and other details will differ from plan to plan.

Broker-Sponsored PPOs

Broker-sponsored PPOs may be formed by third party administra-
tors or other independent entrepreneurs who act as “brokers” between
providers and payers. A broker receives administrative fees from the
payer, the providers, or both, in return for the broker’s services in
forming, managing, and monitoring the network. These services typi-
cally include contracting, utilization review, and claims administration.
Such brokers are often regulated under state third party administrator
licensing laws. However, those laws do not specifically regulate their
PPO activities. Rather, state regulation of such PPOs depends upon
whether the PPO indemnity risk is assumed by an insurance company
or Blue Cross or Blue Shield plan or by a self-insured plan.

FORMATION OF PPOs

To form a PPO, a sponsoring entity or group typically approaches
the other parties necessary to form the required contractual network of
one or more payers, an enrolled population, and a comprehensive
grouping of institutional and professional providers. Each of these
contracting parties or groups is subject to a different set of regulatory
controls, and therefore each such regulatory scheme must be conducive
to that organization’s or group’s participation in the PPO arrangement
if it is to be formed or operated in the manner contemplated. Thus,
whether a particular PPO arrangement will succeed or fail, or even
come into existence, may be dependent on the law of the state in which
it is to be formed as well as any overriding federal law.

THE PPO MARKETPLACE

To understand the relative influence of the various regulatory
environments on the activities of preferred provider organizations, it is
important to know which types of plan sponsors recruit the largest
share of enrollees.

insured plans some form of “stop-loss” guarantee of the maximum level ofclaims experience or percentage increase in overall health care costs over the life of the contract. Such arrangements are sometimes referred to as “managed premium PPOs” or “guaranteed premium” PPOs.
Figure 1 shows how PPOs and enrollees are currently divided among the various types of sponsors. Hospital-sponsored PPOs account for more PPOs and more enrollees than any other sponsor, probably because they entered the market first and have been operating longest. However, their dominance may be short-lived. Blue Cross and Blue Shield plans (health service corporations) are now aggressively marketing PPO offerings. Insurers, slower to develop interest in PPOs, are now also launching a variety of PPO offerings. Moreover, both investor-owned and nonprofit multihospital chains are joining with insurance companies to offer nationwide PPO networks. If their current rate of growth continues, Blue Cross and Blue Shield plans and the commercial insurers will soon dominate the PPO market.


Fig. 1—Results from a national survey of PPOs
III. PREFERRED PROVIDER ORGANIZATIONS
AND THE REGULATION OF
THIRD PARTY PAYERS

The body of law that governs health benefit plans evolved during a period when different types of entities developed and marketed single, identifiable products. In particular, commercial insurers marketed pure indemnity coverage, whereas Blue Cross/Blue Shield marketed service benefit plans. Therefore, regulations designed to correct problems or to satisfy needs specific to a product could be directed at the organization responsible for that type of product.

Today, these old distinctions are blurred. Different entities now market similar, overlapping products. Yet the tradition of regulating the entity and not the product persists. Consequently, preferred provider organizations, similar in nature but sponsored and marketed by different organizational entities, are subject to the laws that apply to the parent entity. Organizations under the control of insurance companies, third party administrators or brokers, Blue Cross/Blue Shield plans or other health service corporations, and HMOs each fall under the jurisdiction of a different set of state statutes and regulations. At the same time, ERISA\(^1\) preempts regulatory control over employee benefit plans underwritten by employers and/or unions, subjecting them to rules quite different from those governing plans underwritten by other insurers.

ERISA PREEMPTION OF STATE INSURANCE LAW

Before discussing the specific application to PPOs of state laws governing third party payers, we consider the significant degree to which many health plans are exempt from state regulation.

Self-Insured Benefit Plans

Under ERISA, employee welfare benefit plans may be exempt from certain state laws. This principle is termed “ERISA preemption” and has the effect of relieving self-funded plans and Taft-Hartley trust

\(^1\)The Employee Retirement Income Security Act, P.L. 93-406, 88 Stat 829.
funds from state insurance regulation. Thus, PPO arrangements where these plans are the payers generally are exempt from the restrictive state insurance laws discussed in this study.

In lieu of state regulation, ERISA authorizes the Department of Labor to establish some minimal reporting, disclosure, and fiduciary standards as required by the legislation. Under the provisions of ERISA, self-insured benefit plans remain exempt from all the restrictions and levies currently imposed upon insurers and their products by the various states.

In practice, the application of ERISA to self-insured health benefit plans is very problematic, because these plans are financed and administered in a variety of ways. Employers may undertake the full task of administration and claims management but few have the expertise. More commonly, employers contract with commercial insurers, health service corporations (Blue Cross or Blue Shield plans), or third party administrators to administer the plan and process claims. They also typically purchase “stop-loss” insurance—coverage protecting against unexpected or catastrophic losses. They may even enter into a “guaranteed” or “managed” premium arrangement—an arrangement that combines features of self-funding and indemnity insurance. Thus, the most frequently used arrangements may not represent a clean separation between insurance companies and self-insured employers.

Application of ERISA to PPO Arrangements

The distinction between self-funded plans that are exempt from insurance regulation and insured plans, where regulatory jurisdiction over the insurer is retained by the states, has been the subject of considerable litigation. For example, uncertainty often arises as to whether particular state law provisions, e.g., hospital rate-setting requirements, are the types of state law that are intended to be preempted by ERISA. For the purposes of this study, the most important area of such uncertainty is whether a self-insured PPO may be subject to state insurance regulation if it is sponsored or otherwise implemented by an insurance company or Blue Cross/Blue Shield plan under an ASO contract. There appears to be a trend among the courts to conclude that if the insurance company or Blue Cross/Blue Shield plan agrees to indemnify the self-insured plan in any respect, the ERISA preemption does not apply to such a PPO. Such indemnifi-
cation may include stop-loss or other reinsurance coverage, either directly or under an indirect “guaranteed premium” or “managed premium” PPO arrangement.

In one such case, *Michigan United Food v. Baerwaldt* ("Michigan United Food"),⁵ the federal Sixth Circuit Court of Appeals also interpreted the ERISA preemption provisions somewhat narrowly, holding that a self-funded plan that purchased stop-loss coverage was subject to the various mandated benefits under Michigan insurance law. The court took the position that the issue presented in the case was the same as that presented in the United States Supreme Court’s 1985 decision in *Metropolitan Life Ins. Co. v. Massachusetts* ("Metropolitan").⁶ *Metropolitan* concerned the applicability of a Massachusetts mandated benefit law to employee benefit plans. The Supreme Court concluded in *Metropolitan* that such laws are not preempted with respect to employee benefit plans that are insured.

It is not clear that the Supreme Court intended its holding in *Metropolitan* to apply to plans that merely purchase stop-loss coverage or enter into “guaranteed premium” or “managed premium” PPO contracts with insurers, as opposed to those that also purchase group health insurance coverage, for the following reasons. First, although the self-funded plans involved in *Michigan United Food* were responsible for paying for their employees’ health benefits up to an amount agreed upon with the insurer, the plans actually did purchase group insurance policies covering those benefits from the insurer.⁷ It appears that the insurer paid the claims but was fully reimbursed for such payments by the plans up to the stop-loss amount. Second, even if it were assumed that the benefits were not covered by group health insurance and instead were paid directly by the plans, and that therefore the only insurance involved was stop-loss coverage, an argument can be made that where only stop-loss coverage is provided, the connection with an insurer is too tangential to vitiate ERISA preemption. The court did not analyze this issue in *Michigan United Food* but instead addressed it with the following sentence: “The stop-loss nature of the plans does not alter our conclusion.”⁸

In a recent federal district court case in Pennsylvania, *The Insurance Board Under the Social Insurance Plan of Bethlehem Steel Corporation and Subsidiary Companies v. Muir*, an ASO arrangement between a self-insured plan and Pennsylvania Blue Shield was found to

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⁷767 F.2d at 310.
⁸I.D. at 312.
be subject to Pennsylvania insurance law even without any stop-loss agreement, and therefore ERISA was found not to preempt the state insurance commissioner from enforcing state mandated benefit laws, despite the ERISA regulation of the self-insured plan.⁷

Given the current ambiguities in case law, local policy determines how state insurance departments exercise control over these “mixed” plans. Some departments are choosing to be aggressive in defining the scope of their authority; others choose to regulate only fully insured products. In this uncertain situation, it is not uncommon to find self-insured employers among the chief supporters of state legislation that would expressly authorize the formation of preferred provider organizations. With passage of authorizing legislation, self-insuring employers can be assured that whether their plans fall under federal or state authority, the plans will be acceptable.

If precedents established in Michigan United Food and Muir are followed by other courts and extended to “guaranteed premium” and “managed premium” PPOs as well, it could emerge that the ERISA preemption from state law proves to be of lesser importance for self-insured PPOs than is currently believed, and that the impediments or restrictions found in state law as they apply to insurer-sponsored PPOs may extend as well to PPOs that serve self-funded plans if those plans contract for any type of outside indemnification.

Alternatively, self-insured employers and union trust funds might decide not to purchase stop-loss coverage, particularly if they are large enough to do so safely, or not to enter into a guaranteed premium or managed premium PPO arrangements, if the price includes subjecting the plan to state insurance regulation that would increase the plan’s costs substantially. However, this alternative may not be practical, particularly for medium-sized or smaller self-insured plans.

STATE REGULATION OF THIRD PARTY PAYERS

States generally have a distinct set of laws and regulations governing each type of third party payer.

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⁷*The Insurance Board Under the Social Insurance Plan of Bethlehem Steel Corporation and Subsidiary Companies v. Muir*, Civ. No. 85-0630 (M.D. Pa., February 28, 1986). It is worth noting, however, that the Maryland Insurance Commissioner had found earlier that an identical agreement covering Maryland employees was not a health insurance contract and declined to apply Maryland’s mandated benefit laws.
Commercial Insurers

Insurance is usually defined as the undertaking of a contractual obligation to pay a specified amount or benefit upon the occurrence of a certain contingency or event. Because the enrollee must pay premiums well in advance of the possible event, insurance poses special potential problems for the consumer and has therefore been subject to substantial regulation.

The McCarran-Ferguson Act, passed by Congress in 1945, identified insurance as a business “affected with the public interest” and specified that it should be regulated by the states. On the basis of this clear delegation of authority, all 50 states and the District of Columbia have adopted an array of statutes and regulations that govern the “business of insurance” to guarantee financial performance and fairness to enrollees. These controls fall into three categories:

- Standards for insurers that are prerequisites for doing business. Such standards specify financial surplus and reserve requirements, investment practices, and rules for determining the solvency of the insurer.
- Regulations governing the transaction of insurance business. They license brokers and agents, regulate claims procedures, rating policies, and advertising, and specify grievance procedures.
- Regulations governing the content of policies. States regulate policy content by requiring that insurance forms and proposed plans be submitted to insurance departments for approval.\(^8\)

Many states mandate that all policies cover certain specified services.

Preferred provider organizations serving plans not exempted by ERISA become subject to all the statutes and regulations governing insurance companies, if they are sponsored or controlled by an insurance company or if their services are offered as part of an insurer’s benefit plan.

Third Party Administrators and Brokers

Organizations created or offered by brokers or third party administrators are governed by the minimal regulations that govern these sponsors. At least 17 states (including, for example, Arizona, California,

\(^8\)Lanam (1984), p. 316.
Florida, and Michigan)\(^9\) regulate and license third party administrators and brokers under their insurance laws. Administrators and brokers are generally defined as any person or entity that collects any charge or premium from, or adjusts or settles claims on, health insurance policies for the benefit of others.

Thus, a PPO sponsor or other participant that engages in claims administration for the PPO may be regulated as a third party administrator or broker. These regulations may include fiduciary obligations with respect to the handling and depositing of insurance funds, as well as recordkeeping, maintaining books, reporting, and bonding requirements. However, because administrators and brokers only provide services and do not bear significant risk, these requirements are typically minimal.

**Health Service Corporations**

Health service corporations are entities that contract directly with providers to render health care services to their enrollees, as contrasted with insurance carriers, which indemnify enrollees against the costs of such care.\(^10\) Like commercial insurers, they assume the risk for the health care costs of their enrollees. Blue Cross and Blue Shield plans pioneered this direct coverage arrangement and still account for most such plans. Blue Cross and Blue Shield plans contract with providers for services. The rates may be discounted, and typically providers agree to accept plan payment plus any applicable copayment and deductible as full compensation. Providers under contract with health service corporations receive direct payment. In most instances, enrollees are free to obtain covered care from other providers. However, noncontract practitioners will not be paid directly, and they are free to charge patients more than the patient's benefit payment.\(^11\)

Because health service corporations bear risk and are usually organized as nonprofit entities with the understanding they will provide public benefits, they are subject to extensive state regulation. All but three states (Indiana, South Carolina, and Wyoming) and the District of Columbia have adopted special statutory controls governing health

\(^9\)Other states include Arkansas, Idaho, Illinois, Indiana, Kansas, Montana, Nevada, North Dakota, Oklahoma, South Carolina, Tennessee, Utah, and Wyoming.

\(^10\)Health service corporation is used in this report to describe a range of corporations meeting this description, including health service corporations, medical service corporations, and hospital service corporations.

\(^11\)The distinction between the Blue Cross/Blue Shield plans and commercial insurers regarding how payments are made is blurring somewhat as commercials begin to pay providers directly as a convenience.
service corporations. In most states, these statutes specify the character of the corporation and the reserve requirements. They also often require that benefits contracts, provider contracts, and rate schedules be approved by state departments of insurance. In concept, health service corporations may restrict the enrollee’s choice of provider to contract providers; in practice, however, the Blue Cross and Blue Shield plans typically have contracted with a very broad base of providers. Moreover, many states regulate the degree to which health service corporations may, in fact, be selective.¹²

Preferred provider organizations organized by health service corporations or offered through health service plans will be subject to the laws that govern the plans in each state, and these may differ from those imposed on preferred provider organizations under the control of commercial insurers or third party administrators.

Health Maintenance Organizations

HMOs provide or arrange for the provision of comprehensive health services to enrollees on a prepaid, capitated basis, and enrollees receive no reimbursement if they use outside providers except for emergency services. Thus, HMOs are entities that both bear risk and greatly restrict the enrollees' choice of provider. Forty-four of the 51 jurisdictions have specific HMO statutes.¹³ Statutes in most states regulate the structure and operations of an HMO and specify the minimum benefits package and reserve requirements for the organization. Because enrollees do not have the option of going to alternative providers once they have signed up with an HMO, many HMO acts have extensive provisions to ensure access and quality of care for enrollees.¹⁴ To be designated as a federally qualified HMO and thus become eligible for certain advantages under federal law, HMOs must comply with an additional set of requirements.

If a preferred provider organization meets the definition of an HMO because it assumes risk on a prepaid basis and restricts enrollees' choice of provider or because it is sponsored by an HMO, then it will fall under the regulatory controls applicable to HMOs. Probably of greater consequence, if an existing HMO wants to develop a preferred provider option as a “wrap around” to its basic HMO product, its ability to do so will be governed by HMO regulations and regulators. Because

¹²For a more detailed description of these provisions, see Sec. IV.
¹³Alabama, Alaska, Hawaii, Louisiana, Mississippi, Montana, and the District of Columbia have no HMO act, although HMOs usually are regulated under other provisions in these states.
HMOs already offer a product and have panels in place, and because limiting the enrollee's choice of provider is one of their chief marketing drawbacks, the preferred provider option seems to be a natural extension of the HMO product line. However, whether or how they may develop such a product will depend upon the evolution of HMO regulation.
IV. OBSTACLES TO PPOs IN THIRD PARTY PAYER REGULATION

If preferred provider arrangements are to contain costs, they must be able to conduct certain activities. Purchasers must be able to negotiate price and contract selectively with providers. Purchasers must be allowed to offer incentives that will effectively channel subscribers to the selected providers. Obstacles to these activities will handicap preferred provider arrangements in their efforts to contain costs.

In the complex statutory and regulatory environment in which preferred provider arrangements are springing up, obstacles to these functions do exist. Occasionally they are there by design; more often, somewhat by accident. In the previous section, we described the legal context for regulating preferred provider organizations that are sponsored by or serve third party payers. In this section, we examine specific types of statutes that apply to third party payers and could hamper the cost-containment activities of PPOs. We then identify the states that have such laws and explore the various ways in which they have been applied.

POTENTIAL OBSTACLES IN THE LAW

With very few exceptions, states have not enacted legislation specifically intended to halt the development of preferred provider organizations by third party payers. However, statutes enacted in the past for other reasons may now be interpreted in ways that would inhibit the cost-containment activities of preferred provider organizations. Typically, these laws take the form of freedom-of-choice and antidiscrimination statutes, which may be interpreted so as to prevent a PPO from being selective in contracting with providers, or to limit its ability to channel its enrollees to the selected panel of providers. The laws also include the broad sweep of powers granted to state regulatory agencies by HMO acts, which agencies could apply to restrict the entry of HMOs into the PPO market.

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1Four states—Alabama, Texas, Mississippi, and Louisiana—have adopted statutes that effectively prohibit dental preferred provider organizations. These will be discussed in more detail below.

Many states prohibit commercial insurers and/or health service corporations from restricting an insured person's freedom to choose a health care provider. These laws have been patterned after a model statute developed by the National Association of Insurance Commissioners (NAIC) many years ago in response to a growing concern that Workers' Compensation insurance policies might limit reimbursement to certain hospitals, physicians, or other types of practitioners. The laws are intended to preserve the independence of the doctor-patient relationship, to ensure quality by allowing the enrollee to choose his provider, and to place providers beyond the economic reach of insurers.

Under the terms of preferred provider plans, enrollees continue to enjoy freedom in selecting providers, and therefore freedom-of-choice provisions may not present an obstacle to their development. However, the channeling provisions and selective contracting practices used by most PPOs may be interpreted as interfering with an enrollee's freedom to choose.\(^2\)

Such freedom-of-choice provisions are of three major types. The first type prohibits an insurer from influencing or attempting to influence a patient to use a particular health care provider. The second type requires that patients have complete freedom of choice between physician and nonphysician providers. Both of these types of provisions are discussed immediately below. In addition, a third type of freedom-of-choice provision, the so-called any-willing-provider provision, requires a PPO to contract with all providers that are willing to meet its terms. This type of provision is sometimes found in PPO enabling statutes, and is discussed in Sec. V.

Freedom of Choice of Particular Providers. The most common form of freedom-of-choice provision stipulates that the policy "may not require that the health service be rendered by a particular hospital or person."\(^3\) Although directed primarily at insurance companies, these laws apply variably. Many of the provisions apply only to health service plans, only to group disability policies, or only to individual policies, but not to all of the foregoing. Furthermore, some health service plan statutes require only that enrollees be afforded free choice among participating providers.

For insured PPOs, this type of freedom-of-choice provision could be interpreted as restrictive. Although PPOs generally do not require that

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\(^2\)Exclusive provider organizations and "lock-in" PPOs, both of which require the enrollee to use preferred providers to be eligible for any reimbursement, apply the most extreme form of such channeling.

\(^3\)This language is contained in the NAIC model statute.
a particular provider render services (with the exception of the
"exclusive provider organization" or "EPO" form), state insurance
departments may broadly interpret these freedom-of-choice require-
ments to prohibit financial arrangements that penalize an insured's use
of a nonpreferred provider. As noted above, such financial incentives
constitute a key element of a PPO. To control costs in an effective
manner while offering the potential of increased patient volume in
return for provider discounts, PPOs ideally should be able to contract
with a limited number of cost-effective providers.

**Freedom of Choice of Particular Category of Provider.** A
second type of freedom-of-choice provision requires that insureds be
guaranteed the freedom to choose a nonphysician practitioner, as
opposed to a physician, so long as the nonphysician practitioner is
functioning within the scope of his or her license. For example, a
Montana insurance provision prohibits interference with an insured's
exercise of free choice in the selection of any duly licensed physician,
dentist, optometrist, psychologist, or the like. Arguments supporting
such an extension of the freedom-of-choice concept typically note that
it extends the consumer's range of choice, it helps contain health costs
by opening the door to less expensive providers, and it is equitable
because it grants nonphysician practitioners deserved access to the
insured market.

However, many of these provisions also contain a clause requiring
equal reimbursement for services performed by nonphysician and phy-
sician practitioners. Thus, reimbursing nonpreferred nonphysicians at
a lower rate than preferred practitioners, whether or not nonphysician
practitioners are included in the preferred panel, may violate the equal
reimbursement provisions of these freedom-of-choice provisions.

**Antidiscrimination Provisions**

The insurance codes of virtually every state provide that health
plans sponsored by commercial insurers may not make or permit any
*unfair* discrimination between individuals of the same class and essen-
tially the same hazard in the amount of premium, policy fees, or rates
charged for any insurance policy or benefits provided thereunder.
These laws may also apply to health service corporations and/or
HMOs. Many PPO sponsors fear that these "antidiscrimination" stat-
utes may be administratively interpreted to prevent PPOs from chan-
eling enrollees by varying their benefit levels based upon the insured's
use of a preferred or nonpreferred provider.

However, there is also reason to believe that antidiscrimination stat-
utes need not be interpreted to prohibit channeling. In all but two
states with antidiscrimination provisions, the statutory language is qualified by the requirement that the discrimination be "unfair." Therefore, states may take the position that the differential between preferred providers and nonpreferred providers is not unfairly discriminatory because the preferred providers have agreed to discount their rates and to accept utilization controls and other restrictions, and because the insured still has the freedom to choose whether to obtain services from a preferred or a nonpreferred provider.

Mandated Benefits Provisions

Another type of restrictive insurance law is the category of statutes termed "mandated benefits" laws. Mandated benefits laws, which have been enacted in virtually every jurisdiction, require insurers to provide specific benefits to cover specified illnesses or procedures. For example, some mandated benefits laws require that benefits be provided to cover particular illnesses such as diabetes, alcoholism, or mental or nervous disorders, or procedures performed by certain nonphysician practitioners such as nurse midwives, acupuncturists, or social workers. Other provisions require that if an employer changes group insurance coverage, the new insurance must provide coverage at least as comprehensive as the prior coverage. These laws apply in the same manner to insured PPO arrangements as they do to traditional indemnity plans. Self-insured plans, including PPO arrangements serving these plans, are generally exempt from state mandated benefits laws under ERISA.4

Although mandated benefits laws do not, on their face, apply differently to an insured PPO than to any other type of insurance plan, they do prevent an insured PPO from providing less than the minimum mandated benefits and passing these cost savings on to the employer in the form of reduced premiums.5 Furthermore, insurers have found mandated benefits laws to be problematic, because their variation from state to state often makes it impossible to offer a single insured health plan to a regional or national employer. Therefore, mandated benefits laws may inhibit the development of regional and national insured PPOs. In contrast, PPOs serving self-insured plans

4Certain ASO arrangements in certain states such as Pennsylvania may not be exempt under local interpretation of the ERISA preemption provisions. See the discussion above.

5A study submitted by the Health Insurance Association of America to the Maryland House of Delegates, Committee on Economic Matters, in October of 1985 concluded that the direct cost of mandated benefits represents approximately 12-17 percent of the typical total health insurance premium in Maryland.
that are exempt from state regulation may offer less than the mandated complement of benefits and may tailor uniform health plans for regional and national employers.

Thus, although mandated benefits may represent less of a PPO regulation than an insurance regulation issue, they do appear to present an obstacle to the competitive flexibility of insured PPOs.

INCIDENCE OF POTENTIALLY RESTRICTIVE PROVISIONS

Table 2 identifies those states that have enacted freedom-of-choice and antidiscrimination provisions that apply to insurers and/or health service corporations.

As the table shows, 96 percent of the states have antidiscrimination statutes that apply to insurers. However, all save two states qualify their prohibition, specifically enjoining “unfair” discrimination. In addition to the antidiscrimination provisions that apply expressly to insurers, most states have insurance fraud statutes that apply to health service corporations as well as to commercial insurers. These statutes typically have provisions that may be construed as prohibiting discrimination in the structuring of plans, which will ordinarily be applied to require health service corporations to conform to the same standards that are required of commercial insurers.6

By contrast, the insurance codes of only 65 percent of the states contain a type of freedom-of-choice statute that might impede the development of PPOs, whereas in 55 percent of the states, there exists some variant of freedom-of-choice provisions that might hinder the channeling or selective contracting activities of health service corporations.7 Only two states—Ohio and Washington—have neither a freedom-of-choice nor an antidiscrimination statute that might be applied to insurers. Of these, only Washington places no restrictions on the selective contracting or channeling activities of the health service corporations.

Most jurisdictions have enacted comprehensive HMO acts. As Table 2 indicates, only seven of the 51 jurisdictions have no HMO act.8

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6Information from interviews.
7As the table illustrates, the array of freedom-of-choice provisions governing health service corporations is considerably more varied and particularistic than those governing insurers.
8In addition to state regulation, HMOs must meet certain federal standards to be federally qualified and thus eligible for certain benefits. Approximately 80 percent of the HMOs were federally qualified at one time, but that proportion appears to be declining.
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KEY:
- MD: Applies to physicians only.
- Hosp: Applies to hospitals only.
- Pharm: Applies to pharmacists only.
- a: Law also applies to some nonphysician practitioners.
- b: Statute also expressly permits corporations to vary benefits between plan members and nonmembers.
- c: Specifies a proportion or number of providers that must have contracts.
- d: Regulated as a Health Service Corporation.
APPLICATION OF POTentially RESTRICTIVE PROVISIONS

Although most states have statutes that may be interpreted so as to interfere with the activities of preferred provider organizations, the statutes have not been applied consistently. Moreover, the same states frequently interpret the same statutes differently at different times. For example, Pennsylvania's Department of Insurance initially approved PPO plan options. Later, the department reconsidered and began to interpret the state laws to require limits on the channeling incentives that a plan could apply. Finally, it determined that the law prohibited channeling (and therefore PPOs) altogether, and shortly thereafter Pennsylvania enacted a PPO enabling statute. However, there appears to be an evolutionary pattern among those states that have interpreted their statutes to interfere with channeling and selective contracting activities, which we will discuss in more detail below.

Several sources may provide statutory interpretation. The courts may interpret how these statutes apply to PPO activities. Insurance departments or other responsible regulatory agencies may also formally interpret the law in bulletins or opinions. They may also informally apply statutes in the course of approving insurance offerings. Thus far, there has been virtually no case law that directly prescribes the application of antidiscrimination, freedom-of-choice, and HMO legislation to PPO products. A few insurance departments have made formal interpretations, but most are applying the laws in an informal manner through their everyday regulation of insured products.

The absence of any statutory interpretation can often be as important to the development of preferred provider organizations as are interpretations. In the face of perceived ambiguity, sponsors may be unwilling to invest the time and capital to launch a product or an organization that, later, may be unable to function effectively.

Interpretation in the Various States

Table 3 describes how existing freedom-of-choice and antidiscrimination statutes are currently being interpreted in the 51 jurisdictions.

Twenty states have adopted enabling legislation expressly overriding freedom-of-choice and/or antidiscrimination statutes that may have posed barriers to selective contracting and the introduction of

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9The only known court decision construing an "unfair discrimination" provision is a Montana Blue Shield plan case, Montana Physicians Service v. Montana Department of Insurance, which held that that plan's longstanding PPO contract did not unfairly discriminate in benefits payable to subscribers.
Table 3
APPLICATION OF FREEDOM-OF-CHOICE AND ANTIDISCRIMINATION STATUTES TO PPOs SPONSORED BY COMMERCIAL INSURERS AND HEALTH SERVICE CORPORATIONS
(As of June, 1966)

<table>
<thead>
<tr>
<th>Prior Restrictions</th>
<th>PPOs Not Permitted</th>
<th>PPOs Permitted</th>
<th>Undetermined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enabling Statutes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>California</td>
<td>Georgia&lt;sup&gt;c&lt;/sup&gt;</td>
<td>Informal</td>
<td>but appears</td>
</tr>
<tr>
<td></td>
<td>Montana</td>
<td>Interpretation</td>
<td>positive</td>
</tr>
<tr>
<td></td>
<td>Ohio&lt;sup&gt;d&lt;/sup&gt;</td>
<td>Arizona</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Colorado</td>
<td>Alabama</td>
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<tr>
<td></td>
<td></td>
<td>Massachusetts</td>
<td>Alaska</td>
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<tr>
<td></td>
<td></td>
<td>Missouri</td>
<td>Connecticut</td>
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<td></td>
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<td>New Jersey</td>
<td>Delaware</td>
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<td></td>
<td></td>
<td>New York</td>
<td>Oklahoma</td>
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<tr>
<td></td>
<td></td>
<td>Tennessee</td>
<td>Rhode Island</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other</td>
<td>South Carolina</td>
</tr>
<tr>
<td></td>
<td>Legislation</td>
<td>Nevada</td>
<td>West Virginia</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formal Regulation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arkansas</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texas</td>
<td>(Kentucky)&lt;sup&gt;b&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Hampshire</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>North Carolina</td>
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<tr>
<td>Oregon</td>
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<tr>
<td>Pennsylvania</td>
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<td>Utah</td>
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<tr>
<td>Virginia</td>
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<tr>
<td>Wisconsin</td>
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<tr>
<td>Wyoming</td>
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</tbody>
</table>

<sup>a</sup>Statutes in these states had been interpreted or perceived to prohibit certain essential features of a PPO. These states have now adopted enabling statutes or regulations to overcome the obstacles.

<sup>b</sup>Kentucky is in the process of adopting regulations.

<sup>c</sup>Commercial insurers only.

<sup>d</sup>Health service corporations only.

channeling incentives.<sup>10</sup> In another two states—Arkansas and Texas—the insurance commission or commissioner formally authorized selective contracting and the imposition of channeling incentives, provided

<sup>10</sup>These statutes are discussed in detail in Sec. V and Appendix A.
that the PPOs conform to certain restrictions.\textsuperscript{11} Kentucky is now in the process of adopting similar regulations.

In a few of these 20 states—Pennsylvania, for example—insurance departments made it clear that they intended to apply existing statutes to preclude essential PPO activities by either commercial insurers, the Blue Cross/Blue Shield plans, or both. In others, potential sponsors of PPOs were sufficiently uncertain about how the laws would be interpreted to ask for clear statutory authority before creating preferred provider organizations. Where the law was perceived as ambiguous, potential sponsors believed that they faced years of expensive litigation, at best. At worst, they would lose the substantial investment required to organize and market a PPO. Because the laws were changed rather than left for administrative or judicial action, we cannot know how they ultimately would have been interpreted, but they can be judged to have posed a genuine obstacle to PPOs.

Only two states currently preclude preferred provider offerings by commercial insurance companies. In both Georgia and Montana, the Commissioners of Insurance have publicly stated that their state statutes prohibit commercial insurers from offering preferred provider plans. Although Montana also prohibits health service plan offerings, Georgia’s law expressly permits health service corporations to selectively contract with hospitals, and therefore PPOs are permitted. Conversely, commercial insurers encounter no difficulty in Ohio. However, according to statute, the health service corporations may not selectively contract with hospitals.

Column three of Table 3 identifies those states in which PPOs have been permitted to develop freely, despite the presence of potential statutory barriers.

In six states, insurance departments have made no formal ruling on the application of existing freedom-of-choice and antidiscrimination statutes to preferred provider organizations. However, informally they have made it clear that they intend to accept PPOs under the terms of current law. In Nevada, the legislature enacted a statute requiring insurers to undertake cost-containment activities; although the statute does not specifically mention preferred provider organizations, it is expected to create a hospitable environment for PPOs in that state.

The final column identifies those states that appear to have no certain policy at this time. Although some of these states may have permitted the marketing of some PPO options under state regulated plans, they do not have sufficient activity nor have they been sufficiently explicit regarding their intentions to describe them as “permitting

\textsuperscript{11}We discuss these in the next section.
PPOs.” In our telephone survey of insurance departments, seven departments informally suggested that their insurance and/or health service corporation laws should not restrict or prohibit selective contracting and/or the imposition of channeling incentives. Four other departments unofficially suggested that their statutes might present a problem. Finally, four other departments had no opinion on the matter.

Our survey did not extend to the departments of health, which often regulate HMOs in conjunction with insurance departments. Therefore, we do not have complete information on the impediments that HMOs face in states where they may elect to extend their offerings to include preferred provider options. However, examples of states that have taken action include Michigan and Minnesota. Michigan’s enabling statute specifies that HMOs may offer a PPO option as an adjunct to its HMO coverage. Minnesota requires that its HMOs offer their PPO products through an insurance subsidiary or partner, an alliance that is both difficult and costly to forge. The Federal Office of HMOs also requires that federally qualified HMOs must offer any PPO product through an insurance company. The insurance companies will then be regulated by the states in which they do business.

Although HMO entry into the PPO market does not appear to be a major issue at the moment, it may well become one shortly. Most states report growing interest among HMOs in their areas, and states with established HMOs report that their HMOs are energetically pursuing new benefit options that complement their existing offerings. Preferred provider products constitute just such a complementary offering.

**Evolutionary Process of Legal Interpretation**

More important than identifying the states currently opposing PPO activity is understanding the process underlying ultimate resolution of the conflict between adverse interpretations and the demand for PP0s. Those states restricting PPO activity constantly change. As one set of states resolves its conflicts, a new set determines that it has a problem. Our examination of states moving through various stages of acceptance over the past several years suggests that there is a predictable pattern to the process.

Before insurers and health service corporations in a state develop an interest in preferred provider organizations, there is no need to resolve any potential statutory conflict with their associated activities. At

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12This represents the office’s current policy, which is now under review.
some point, interest develops and sponsors decide either to test the acceptability of PPOs by organizing them or to press for clear authorization through enabling statutes or regulations. If they choose to press seriously for an enabling measure, they will generally be successful within a year or two.

If sponsors choose to test the applicability of state laws, a few PPO products may be approved before the insurance department reviews its policy regarding the new arrangement. At some point, however, the department will review the situation and decide whether or not PPO activities are consistent with state law. If the department decides that they are, sponsors will continue to develop the product, as they have, for example, in Colorado or Missouri. If, on the other hand, the department decides that such activities conflict with state law, or if a party chooses to bring suit, as the Texas Medical Association did, then potential sponsors will move to the legislative arena for an enabling statute.

Early signs suggest that a last step in the process may be the imposition of additional regulatory restrictions upon the activities of PPOs once the state has gained some familiarity with their operation and the problems they may cause. This step will be discussed in more detail in Sec. V.

OBSTACLES IN SUMMARY

Observers of health care financing hold a variety of views on the degree to which existing statutes and regulatory practices obstruct the development of preferred provider organizations. Frequently their views derive from their experience in a limited number of states. Thus, according to some, the legal environment greatly hinders the development of such arrangements, and, according to others, little stands in their way. This analysis of third party payer law has found the truth to be somewhere in between.

Forty-nine of the 51 jurisdictions have statutes that can be and, in some states, have been interpreted so as to limit the formation of PPOs. These laws, therefore, certainly constitute at least potential obstacles. However, only a limited number of states have actually interpreted them so as to prevent the formation on PPOs. Moreover, in virtually all cases where existing statutes have been perceived to be an impediment to the development of PPOs, the states have acted to clear the way. They have either adopted overriding legislation or formally interpreted the existing statutes in such a way that they no longer pose a threat. State policymakers appear eager to create a hospitable environment for preferred organizations.
Our review also suggests that there has been a slight trend in the direction of interpreting state statutes that predate PPOs more, rather than less, stringently over the past few years. The list of states whose laws may conflict with preferred provider activities has grown, not shrunk. As the nation gains more experience with PPOs, states appear to become increasingly sensitive to the problems that PPOs may create and more reluctant to allow them to develop free of tailored regulatory control. It is also possible that the more frequently enabling legislation is used to pave the way for preferred provider organizations, the more it may be viewed by other states as necessary.
V. PAVING THE WAY FOR PPOs: ENABLING MEASURES

Their evident support for preferred provider organizations notwithstanding, policymakers face pressing but competing policy objectives that they must somehow accommodate as they open the door to alternative health care delivery systems. Historically, freedom of choice, provider protection, and consumer protection have ranked high on the menu of competing health policy objectives. Therefore, as policymakers take steps to clear the way for PPOs, they may also feel compelled to perpetuate some of the traditional protections, despite the fact that some of the measures used to ensure such protections may limit the ability of preferred provider organizations to function as effective cost containers.

Three types of provisions pose particular problems for preferred provider organizations:

- Any-willing-provider provisions.
- Limits on the benefit or payment differentials preferred provider organizations may use to channel enrollees to panel providers.
- A broad range of consumer protection provisions.

In this section, we will (1) identify the states that have adopted enabling statutes or regulations and explore the context of their adoption, (2) review the contents of the new preferred provider enabling statutes, regulations, and policies and determine the degree to which traditional protective provisions have been incorporated, and (3) explore the rationale behind the adoption of these provisions, analyze their effectiveness, and assess whether they may be impairing the cost-containment functions of preferred provider organizations.

ENABLING STATUTES AND REGULATIONS

States explicitly authorize the conduct of essential PPO activities in one of three ways: enactment of enabling statutes by the legislature, promulgation of enabling regulations by the insurance department or commissioner or the issuance of formal policy by the insurance department or commissioner. Such enabling provisions have now been adopted in 22 states. All of these provisions “clear the way” for
preferred provider organizations by authorizing payers and, in some cases, other organizations to contract selectively and to impose channeling incentives—at least to some degree. In addition, the National Association of Insurance Commissioners is now drafting a model statute that it expects to recommend for use by states who now have no enabling legislation.\footnote{Many of the enabling statutes also place limits on how selective a PPO can be and on the extent of the incentives that are permissible. We discuss these limits and the rationales behind them later in this section.}

Table 4 identifies the states that have enacted enabling statutes or regulations and the year in which those statutes were adopted. The group of states is diverse and permits few generalizations. The previous statutory environments of these states were not exceptionally restrictive. Although Atlantic and New England states are under-represented, the group includes both urban and rural states and states covering a range of health care costs. Perhaps the most striking characteristic of the group is the increasing rate at which states are turning to enabling measures.

Table 4

<table>
<thead>
<tr>
<th>STATES WITH ENABLING MEASURE BY YEAR OF ADOPTION</th>
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<tbody>
<tr>
<td>------</td>
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<tr>
<td>Utah\textsuperscript{a}</td>
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\textsuperscript{a}By regulation.

\textsuperscript{b}By formal policy.

\footnote{Development of a model statute has been on NAIC's agenda for several years. Lack of consensus on its content coupled with some internal administrative changes has slowed completion of the project.}
Basic Provisions

In essence, enabling measures authorize specified entities to engage in certain activities or to offer health benefit plans that include certain provisions. All of the enabling measures open the way for the development of PPOs by expressly permitting certain parties to selectively contract with providers for the delivery of health care services and to apply channeling incentives. In 10 states, the enabling measures expressly override existing state freedom-of-choice and/or antidiscrimination statutes.

Although similar in the basic activities they permit, enabling measures vary considerably in whom they authorize to carry out the activities. In eight states—states with no preexisting statutory obstacles for health service corporations—the enabling provisions apply only to insurers, or insurers and third party administrators. In eight states, the measures apply to insurers and health service corporations, and in two instances also to third party administrators. Several other states made efforts to broaden the scope of their measures by making them applicable to all “group purchasers” (Louisiana), to “organizations” (Michigan), or to insurers and purchasers (Pennsylvania). Clearly, these states have continued the tradition of regulating the entity or organization and not the benefit plan. In many states, the provisions apply expressly to group plans, omitting reference to individual policies.

Although there is no indication that states with measures that apply only to a restricted set of sponsors intend to deny any group(s) entry into the PPO market, it is possible that these measures may be so applied in the future. For example, the MEWAs, which provide a form of self-funded coverage to a significant portion of the work force, are neither exempt from state regulations under the ERISA preemption nor explicitly authorized by many state enabling measures to service their employee benefit plans through preferred provider organizations.  

These states are Arkansas, Iowa, Florida, Kansas, Minnesota, Oregon, Texas, and Utah.

The eight states are California, Illinois, Indiana, Maryland, New Hampshire, North Carolina, Virginia, and Maine.

MEWAs are the vehicle through which groups of typically smaller employers can join together to underwrite and service common self-funded plans. Initially, it was not clear whether state regulation of MEWAs was preempted by ERISA, but P.L. 97-243 enacted in 1983 expressly authorized states to regulate these arrangements.
Context for Adoption of PPO Measures

Enabling proposals have made their way onto the policy agenda for a variety of reasons. In most cases, prospective PPO sponsors, Blue Cross and Blue Shield plans, or commercial insurers urged that legislation be adopted to authorize them unambiguously to offer plans that incorporate selective contracting and channeling incentives. In a few cases, state policymakers took the lead in initiating consideration of enabling legislation—in several instances, as part of a larger health care financing package. More often, however, policymakers worked jointly with a broad coalition of insurers, business, and, in some instances, hospitals to develop an acceptable statute or set of regulations. In six of the 22 states (Maryland, Michigan, Nebraska, New Hampshire, Oregon, and Wyoming), gubernatorial task force studies of health care financing provided the basis for state positions on enabling legislation.

It is difficult to characterize the context in which enabling measures succeed or fail, because it depends greatly upon the specific provisions of any particular proposal and upon the power and cohesiveness of the provider and payer groups within each state. Ordinarily, commercial insurers and the Blue Cross/Blue Shield plans, business coalitions, large employers, and chambers of commerce give enabling proposals very strong support. However, if either the Blue Cross/Blue Shield plans or the commercial insurers believe that they can compete more effectively under existing law, they may remain neutral. The groups supporting enabling measures argue that preferred provider organizations based upon selective contracting and channeling incentives offer an excellent vehicle for reducing inflated health care costs, but to be effective, PPOs must have unambiguous authority to carry out those functions.

Practitioners of all types frequently oppose enabling legislation for a variety of reasons. Often, they contend that restricting the enrollee's choice of practitioner potentially threatens the quality of the enrollee's care. In addition to quality concerns, practitioners appear reluctant to participate in a more competitive delivery system. Rather than welcoming competition as a way to capture a full patient load, many practitioners may fear that they cannot compete successfully and will, therefore, lose their current caseload under a more competitive system. Moreover, older, established practitioners—those who dominate their professional associations—typically have reasonably full practices. Therefore, a more competitive system offers them little benefit—only the possibility of loss. In some states, Texas for example, providers have opposed enabling measures that would permit insurers to organize
effective preferred provider organizations, whereas, at the same time, they organized their own to serve the self-insured market.\textsuperscript{6} State medical associations, often bolstered by support from the American Medical Association (AMA), have mounted powerful campaigns in many states.\textsuperscript{7} Some nonphysician practitioner associations have also energetically opposed enabling statutes and preferred provider organizations.\textsuperscript{8}

Rather than attempting to defeat enabling measures, practitioners may, instead, support such measures if they limit the ability of PPOs to be selective in contracting with providers.\textsuperscript{9} Some classes of practitioners view enabling measures as a means by which they might gain access to the insured market and, therefore, support such measures if they include any-willing-provider provisions, guaranteeing them the right to participate in PPOs. For example, many health benefit plans will not provide coverage if a service is rendered by a psychologist rather than a physician, causing patients to choose physicians over psychologists. Under the terms of a PPO enabling measure with an any-willing-provider provision that applied to psychologists, psychologists would gain parity.\textsuperscript{10}

Hospitals and enrollees have played less of a role in shaping the legal environment for preferred provider organizations. Hospitals are often neutral or sufficiently divided on the issue that they cannot take a position through their state association. Some see selective contracting as an opportunity to increase their market share; others fear a more price-competitive market. Potential enrollees, to the degree that they speak through organized labor, support enabling measures. On the other hand, senior citizen organizations may tend, as they did in Michigan, to oppose any provisions that may interfere with the enrollees' completely free choice of physician.

It is important to note that although these positions typify a particular group's political posture, they may well differ from one specific situation to another.

Although a number of states have enacted enabling legislation to pave the way for preferred provider organizations, similar legislation has failed to gain passage in other states. Although it is difficult to

\textsuperscript{6}Information from interviews.

\textsuperscript{7}Information from interviews. The AMA has no formal position opposing preferred provider organizations. However, the association opposes provisions that limit an enrollee's freedom to choose his provider.

\textsuperscript{8}For a clear statement of policy by the American Dental Association, see ADA (1985), pp. 27-28.

\textsuperscript{9}Information from interviews. Such provisions are discussed in detail below.

\textsuperscript{10}See American Psychological Association legislative support materials for states for more detail on this type of position.
gather a complete count of all the bills that have been introduced in the 50 legislatures over the past several years, notable examples of proposals that failed include bills introduced in Colorado, Arizona, Kentucky, Washington, Missouri, Texas, and Arkansas. In several of these states, Arkansas and Texas for example, practitioners successfully opposed enabling statutes. In others, Washington for example, non-physician practitioners supported an enabling measure that would require that they be included on PPO panels, and this measure was defeated by a coalition of payers and the medical association.

In three instances—Florida, Michigan and Wisconsin—certain practitioner groups were able to have their members removed from the statute’s purview. The 1983 Florida statute and the Michigan statute specifically excluded pharmacists from their definition of providers covered by the bill, although in Florida, the legislature rescinded the pharmacists’ exemption two years later. Similarly, the Wisconsin legislature placed dentists and optometrists outside the scope of its enabling statute.

In an additional four states, state dental associations successfully supported legislation that, in effect, precludes PPO arrangements. Texas passed such a bill in 1983, and Alabama, Louisiana, and Mississippi enacted similar statutes in 1985. These four “anti-PPO” laws entitle enrollees to complete freedom in choosing a dental practitioner and require that any dentist have the right to participate in any health policy or plan. The Texas law even precludes effective utilization review by denying the purchaser the right to require diagnostic aids (e.g., x-rays) as a precondition of reimbursement, and by prohibiting anyone from interfering with a dentist’s diagnosis and treatment. Six other states have enacted dual choice provisions requiring that if an insurer offers a dental preferred provider plan, it must also offer the enrollee a “traditional” plan. Connecticut, Massachusetts, Nevada, New Jersey, and Tennessee adopted their statutes in 1983, and Illinois enacted its statute in 1985.

Dentists have won special treatment for several reasons. The problems of oversupply affect dentists more acutely than other types of practitioners. Thus dentists as a group may well feel more threatened by the prospect of being placed in an unprotected negotiating situation.

\(^{11}\)In Arkansas, the Commissioner of Insurance effectively mooted the legislative defeat by issuing a Department Bulletin ruling that selective contracting and the imposition of channeling incentives are acceptable under current law. Similarly, the Texas State Board of Insurance adopted regulations that both permitted and controlled selective contracting and the imposition of channeling incentives.

\(^{12}\)Information from interviews.

\(^{13}\)It is interesting to note that Texas also recently enacted legislation to enable the formation of “single service” HMOs, including dental HMOs.
and therefore fight harder than other groups. At the same time, dental coverage, although growing rapidly, is not responsible for a major share of the purchaser's expenses, and therefore insurers have not opposed the dentists with the same energy with which they might oppose physicians on the same issue.

Effects of Enabling Measures on PPO Development

It is difficult to determine how instrumental enabling measures have been to the development of PPOs, especially since 13 of the 22 measures were adopted in 1985 and 1986. Table 5 identifies the 10 states with the most preferred provider activity as defined by the number of PPOs in each state and by the size of those PPOs as reflected in the number of physicians and the number of hospitals they have empanelled.

As Table 5 shows, only five states of this most active group have enabling statutes or regulations; therefore, it seems reasonable to

<table>
<thead>
<tr>
<th>State</th>
<th>No. of PPOs</th>
<th>No. of Practitioners Empanelled</th>
<th>No. of Hospitals Empanelled</th>
</tr>
</thead>
<tbody>
<tr>
<td>California$^b$</td>
<td>75</td>
<td>97,105</td>
<td>1,710</td>
</tr>
<tr>
<td>Ohio</td>
<td>26</td>
<td>10,778</td>
<td>140</td>
</tr>
<tr>
<td>Florida$^b$</td>
<td>23</td>
<td>16,751</td>
<td>174</td>
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<tr>
<td>Illinois$^b$</td>
<td>21</td>
<td>8,684</td>
<td>211</td>
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<tr>
<td>Colorado</td>
<td>16</td>
<td>4,775</td>
<td>39</td>
</tr>
<tr>
<td>Texas$^b$</td>
<td>11</td>
<td>9,625</td>
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<tr>
<td>Massachusetts</td>
<td>10</td>
<td>5,780</td>
<td>76</td>
</tr>
<tr>
<td>Michigan$^b$</td>
<td>8</td>
<td>4,360</td>
<td>120</td>
</tr>
<tr>
<td>Arizona</td>
<td>9</td>
<td>6,884</td>
<td>63</td>
</tr>
<tr>
<td>Missouri</td>
<td>9</td>
<td>4,695</td>
<td>52</td>
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$^a$These numbers may differ somewhat from those noted in Sec. II, beca they are from a different survey taken at a different time.

$^b$States with enabling legislation or regulations. Note that Texas is in this group, although its insurance commission only very recently began approving insurer-sponsored PPOs. The PPO activity in Texas reported by the AAPPO served the self-insured market and was, therefore, not covered by the state prohibition.
conclude that enabling provisions are not prerequisites for the growth of preferred provider organizations. Although our failure to find a strong correlation between enabling statutes and PPO development is, in part, due to differences in the original state statutes, it may be more directly linked to several other factors. Of greatest significance, in states where conditions are ripe, PPO sponsors will create unregulated arrangements to serve the extensive self-insured market.\textsuperscript{14} Also, state departments of insurance vary in the interpretations they have given similar statutes, and PPO sponsors vary in their willingness to test state interpretations, behavior that has lead to PPO activity not explained by the presence or absence of enabling statutes.

**PROVIDER AND CONSUMER PROTECTION PROVISIONS**

Twenty-two states have adopted enabling statutes, regulations, or policies that authorize payers, and, in some cases, other organizations to selectively contract and negotiate price with providers and to channel enrollees to panel members. However, only three of the 22 states—California, Iowa, and Nebraska—have enacted completely permissive measures. The remaining 19 states have each chosen to include provisions that constrain in some fashion the activities of preferred provider organizations. In four of the remaining 19 states—Kansas, Michigan, Minnesota, and Oregon—the statutory restrictions are minor, consisting only of weak consumer information requirements. Enabling statutes in the 15 remaining states contain provider and consumer protection provisions that could significantly inhibit the cost-containment functions of preferred provider organizations.

There is no discernible pattern in enabling provisions that relates to timing or state demographics. Permissive and restrictive statutes have been adopted without regard to region and in both urban and rural states. Moreover, there has been no trend over time. The first set of regulations to govern PPOs, promulgated by Utah’s Department of Insurance in 1981, was highly restrictive. California then enacted an extremely permissive statute in 1982. Each year’s new crop of enabling statutes has included both types of measures.

Although the adoption of restrictive provisions appears to depend upon the concerns of individual states, such provisions do occur with reasonable frequency and they do address a few strongly held policy objectives. They are important because they reflect concerns that can

\textsuperscript{14}The characteristics associated with a market ripe for PPO development include excess provider capacity, high health care costs, a mobile and growing population, and a high proportion of self-insurance among local industries. See Barger (1985), p. 12.
be expected to remain part of the regulatory environment for preferred provider organizations for some time.

We now turn to a detailed consideration of the three types of protective provisions: any-willing-provider provision, differential limits, and consumer protection measures.

Any-Willing-Provider Provisions

Broadly defined, any-willing-provider provisions require that all providers meeting predetermined criteria be entitled to reimbursement for services that they may render to enrollees. The payer may not limit the panel of providers except according to specified criteria. Such provisions, therefore, may severely limit the ability of PPOs to contract selectively with providers. They may prevent PPOs from excluding providers who do not conform to subjective criteria or to a particular view that the PPO may have regarding its market niche. They may also impair the PPO’s ability to negotiate lower prices (in the case of payer-sponsored PPOs) or to retain market share (in the case of provider-sponsored PPOs), because the PPO cannot deliver volume to its providers if it cannot restrict its panel size. Larger panels will also magnify the difficulties of conducting strong utilization and peer review programs and may increase administrative costs.

Incidence of Any-Willing-Provider Provisions. In eight states, as Fig. 2 shows, providers have persuaded policymakers to add any-willing-provider language to the enabling provisions. In several states—including Arkansas, Missouri, and Texas—practitioners were powerful enough to derail enabling legislation altogether on the grounds that selective contracting impairs the enrollee’s freedom of choice. Subsequently, however, Arkansas and Texas authorized PPOs through an insurance department official statement and new regulations, respectively. In most other jurisdictions where enabling legislation has been considered, practitioners, particularly the medical associations, have unsuccessfully fought for such language.¹⁵

Two of the eight enabling measures with any-willing-provider provisions, those found in Illinois and Louisiana, apply only to physicians or “noninstitutional” providers. Three of the eight, those adopted in Illinois, Indiana, and New Hampshire, require PPOs to establish reasonable terms and conditions before contracting with any providers and to use these as the basis of an “open” contracting process. Price, as well

¹⁵As noted above, hospitals have been divided on the issue of preferred provider organizations and selective contracting. Therefore, state hospital associations do not necessarily oppose permissive enabling statutes or give strong support to any-willing-provider provisions.
as other defensible criteria, are acceptable. The Utah statute specifies that the terms and conditions must relate "solely" to price and quality, whereas the Texas regulations specify that they must relate to cost, quality, and/or accessibility. The Texas regulations also provide for a review procedure including an advisory panel of physicians for applicants wishing to appeal the denial of their applications to become panel members.

Similarly, four states—Indiana, New Hampshire, Texas and Wyoming—prohibit the use of "gatekeepers," primary care physicians who must refer enrollees to the provider if he is to receive reimbursement. Providers argue that gatekeepers, acting as agents for the PPO, can restrict the enrollee's freedom of choice in the same way that selective contracting can.

Nonphysician practitioners have won special protection in six of the states with enabling provisions: Arkansas, Indiana, New Hampshire, Texas, Utah, and Virginia. These states require that panel membership be open to some extended set of providers licensed to provide services that will be rendered under the terms of the benefit plan.\textsuperscript{16}

\textsuperscript{16}The extended group of providers varies from state to state. Indiana's provision, for example, applies to optometrists, dentists, and pharmacists, whereas Utah's applies to all licensed practitioners.
However, they do not require equal reimbursement schedules. Moreover, nonphysician practitioners have also won the right to equal consideration for panel membership in Michigan, Nebraska, and North Carolina. These states require a mandatory open application process but permit PPOs to selectively contract with providers who apply.

Although this picture accurately reflects today's legal constraints, the environment is still somewhat unstable. Practitioners in states that do not offer any-willing-provider protection continue to press legislatures to amend such provisions into the enabling statutes. Thus far, they have been unsuccessful. However, the array of freedom-of-choice provisions currently found in the insurance and health service corporation codes testifies to the practitioners' strength as a political force.

**Rationale.** Providers have argued the need to include any-willing-provider provisions in enabling statutes on several grounds. Ordinarily, their logic parallels that of the arguments made in support of preexisting freedom-of-choice statutes. In states where one payer dominates the market (usually the Blue Cross/Blue Shield plans), medical practitioners have also argued that they need protection from the possibility of being excluded from that payer's panel, thereby being made to suffer severe economic consequences.

**Consequences for PPOs.** Enabling statutes with any-willing-provider provisions have been in place only a short time, and thus far, no states have adopted regulations governing the implementation of the provisions. At the same time, preferred provider organizations are in their infancy and generally have not yet developed complex or restrictive criteria for screening providers, particularly practitioners. Therefore, it is impossible, at this point, to assess how such provisions will ultimately affect the development and effectiveness of preferred provider organizations. However, in the absence of more conclusive evidence, it is worth reviewing the expectations and early, anecdotal evidence.

Our interviews suggest that various sponsors of preferred provider organizations view the any-willing-provider provisions quite differently. A small subset representing, for the most part, provider-sponsored organizations believe that the latitude offered by the statutes in setting terms and conditions is sufficient to permit PPOs to be effectively selective. On the other hand, a few hospital-based PPOs report that it is not worth their while to market preferred provider plans if they

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17These views were shared by the AAPPO and CaPP Care, the largest physician-sponsored PPO.
cannot use them to channel enrollees exclusively into their own facilities.\textsuperscript{16}

A major share of the sponsors report that the any-willing-provider provisions have not yet affected them in any way. However, they are fearful that the provisions will ultimately force them to adopt rigid, objective contracting standards, greatly limiting their ability to select quality providers and to otherwise respond flexibly and creatively to market conditions. Of the several constraints found in enabling statutes, most sponsors believe that any-willing-provider provisions pose the greatest threat to their effective operation.

**Differential Limits**

Most PPO plans offer some set of financial and/or service incentives to encourage enrollees to use panel providers. The typical health benefit plan requires that the enrollee pay a share of the costs of his health care. Plans with a PPO option commonly waive part or all of the enrollee’s cost sharing if he uses a panel provider. The plan pays a higher share of a panel provider’s fees than a nonpanel provider’s fees, with the enrollee paying the difference in each case. The decrease in the enrollee’s cost sharing (for example, from 20 percent to 10 percent or nothing) gives him an incentive to use a panel provider.\textsuperscript{19}

**Incidence of Differential Limits Provisions.** As Fig. 3 indicates, 11 states have chosen to limit the difference between what the purchaser pays if the enrollee elects to visit a panel provider and what the purchaser pays if the enrollee is served by a nonpanel provider. These legal limitations have taken several forms.

The enabling statutes of four states—Maine, Maryland, Michigan, and Utah—have limited the percentage by which insurers can reduce reimbursements for nonpanel providers, while Florida has imposed similar limitations informally through the regulatory process.\textsuperscript{20} Typically, these laws prohibit payers from reimbursing nonpanel providers at less than between 75 and 85 percent of what they would pay a panel provider.\textsuperscript{21} The following is a brief description of these statutes and regulations.

\textsuperscript{16}For example, Intermountain Health Care in Utah may withdraw its preferred provider product from the insured market rather than be subjected to the provisions of Utah’s new statute.

\textsuperscript{19}Actual payments are affected by the fee discounts negotiated or offered by most PPOs. If panel providers discount their usual fees, they will be paid a larger share of a lower fee for patients covered by the plan with the PPO option. The plan typically pays nonpanel providers a smaller share of a fee that usually is higher than the fee charged by the panel providers. Thus the difference in the actual amounts paid to panel and nonpanel providers may not be as great as originally supposed.

\textsuperscript{20}Kentucky is also in the process of formally adopting such regulations.
provider.\textsuperscript{21} Utah prohibits a differential in excess of 25 percent. Maine, Maryland, and Florida employ a 20 percent cap on payment differentials, and Michigan has temporarily adopted a mandatory 15 percent differential.\textsuperscript{22} In all instances, the legal language anchors the differential at the rate or average rate the payer pays comparable panel providers. Thus, the greater the discount the PPO can negotiate with its panel members, the lower its fee schedule for nonpanel providers may be.\textsuperscript{23}

Four states—Arkansas, Texas, Utah, and Wisconsin—have chosen to limit the difference between benefits accorded to enrollees who use panel members and those who do not. Limitations on benefit

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{states_differential_caps.png}
\caption{States with differential caps}
\end{figure}

\textsuperscript{21}The laws often stipulate that the payer or insurer shall reimburse the nonpanel provider at a certain rate. However, often insurers do not reimburse providers; they indemnify enrollees. For the purposes of this analysis, we are interpreting them to mean that enrollee reimbursement is limited as the law provides.

\textsuperscript{22}The differential provision in the Michigan statute expires by its terms as of July 1, 1987. For a fuller explanation, see Appendix A. PPOs report that the cap applied by the Florida Department of Insurance may vary between 10 and 20 percent.

\textsuperscript{23}Concerns of this sort may be moot, because it remains unclear if or how insurance departments will be able to determine what PPOs pay panel members. Reimbursement patterns, particularly in this volatile, procompetitive marketplace, are hard to determine and are constantly shifting.
differences have the direct effect of capping coinsurance and deductible requirements for those who use nonpanel providers. They may also limit the extra services a payer is allowed to offer as incentives to enrollees who use panel members. Arkansas limits benefit differentials to 25 percent, whereas Texas imposes a 30 percent cap with a supplementary provision that deductibles for the two types of providers must be approximately comparable. Utah limits the deductible a payer may require if an enrollee is served by a nonpanel provider to $100 per person and $300 per family annually, and Texas regulations stipulate that any difference in deductibles must be reasonable. By contrast, Wisconsin permits insurers to levy surcharges on enrollees who elect service by nonpanel providers. Surcharges are not to exceed $2,500 per person or $5,000 per family and are subject to approval by the Insurance Commissioner.

In principle, capping fee differentials and capping benefit differentials should have the same effect—that of limiting the enrollee’s out-of-pocket expenses when he elects service by a nonpanel provider. Since the enrollee is expected to be responsible for that portion of the provider’s fee that the benefit plan does not cover, capping fee differentials caps the enrollee’s copayment and thus limits an enrollee’s exposure.

Finally, in a provision related to the differential limit, seven states require that a PPO provide some coverage of services obtained from nonpanel providers. This provision prohibits exclusive provider organizations (EPOs) which, like HMOs, pay only for emergency services by nonparticipating providers.

Rationale. Two sets of concerns have led to the imposition of differential limits. Like the any-willing-provider provisions, differential limits can be a provider issue. Providers support such provisions as a means of constraining the ability of PPOs to divert their patients to the PPO’s panel members. Providers have lobbied particularly hard for differential limits in Maryland and Michigan, where the Blue Cross/Blue Shield plans serve a major share of the market. Providers feared that if the Blue Cross/Blue Shield plans institute very strong channeling measures, providers not on panels will suffer extreme economic consequences. Michigan enacted its relatively restrictive 15 percent differential limit explicitly as a temporary measure to help providers through the transition to a more competitive delivery

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24These amounts may be adjusted by the Insurance Commissioner.

25Interestingly, two states—Nebraska and New Hampshire—include language in their enabling statutes that expressly allows enrollees to be held liable for the payment difference when they visit nonpanel providers.
environment—thus the “sunset” provision requiring that the limit expire in 1987.26

A number of insurance departments and state policymakers share the providers’ interest in differential limits, but their motivation is to protect the enrollee. Their foremost concern is that the PPO plans not coerce enrollees into visiting panel providers; otherwise, they believe, the PPO becomes a closed panel offering and should be subject to broader access and quality regulation like an HMO. If the enrollee cannot reasonably protect himself by choosing among a broad variety of providers, then he must be protected through regulation.

Whether a differential is coercive rather than merely effective channeling is, of course, a subjective decision, and lawmakers quickly acknowledge this. However, most states seem to be concluding that capping differentials at 20 to 25 percent offers both effective channeling and adequate consumer protection.

Our interviews suggest that insurance departments are growing uneasy over the issue of large differentials and that differentials may become the subject of increasing regulation. The Florida Department of Insurance, independent of the state’s enabling statute, is now informally applying differential limits, and several other departments are seriously considering the possibility.27

**Consequences for PPOs.** By limiting differentials, state lawmakers may impair a preferred provider organization’s ability to channel enrollees to low-cost providers, thereby hampering its ability to contain costs. However, it is too early to judge what effect the limits may have. The conventional wisdom suggests that differentials of 20 percent are adequate to channel enrollees to panel members, and most states permit differentials of at least 20 percent. Moreover, many PPOs currently report using positive channeling incentives such as extra benefits rather than cost disincentives, and most differential limits do not apply to this case.28

Some PPOs or sponsoring organizations are, nonetheless, apprehensive that differential limits may cause problems in the future. They worry that the conventional wisdom may not be accurate and that the limits may prove to be too low to allow effective channeling. They also note that the differential limits may pose some serious implementation problems, because rules for calculating the value of benefit packages and provider payments will be difficult to develop.

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26Information from interviews.
27Information from interviews.
28Jonathan Gabel, private communication.
Consumer Protection Measures

Although preferred provider organizations fall under the regulatory control of their sponsoring entities, some question the adequacy of the consumer protection offered under those controls. Preferred provider organizations are created to contain costs, typically through influencing treatment patterns (utilization review) and limiting the enrollee’s freedom to choose providers (selective contracting and channeling). The new level of concern for cost containment coupled with the use of these rather powerful controls suggest that perhaps the consumer may require some additional protection beyond that required in the fee-for-service setting where the enrollee has complete freedom of choice and no outside interest influences the provider’s choice of treatment.

As we discussed above, the insurance industry has been subject to years of control, and by now, there is a well-defined logic underlying regulatory intervention that is likely to extend to preferred provider organizations as they mature. In the main, lawmakers have chosen to protect the consumer through regulatory controls in two situations; when an entity bears risk, as in the case of the typical indemnity or health service plan, and when the enrollee loses his freedom to choose among a broad range of providers, as in an HMO.

Preferred provider organizations are a new and rapidly evolving delivery system. Lawmakers and regulators now question whether they are likely to bear financial risk and employ channeling mechanisms that restrict enrollees’ freedom to choose their providers to a degree that warrants regulatory controls—even when those controls may inhibit the ability of PPOs to contain costs.

Incidence of Consumer Protection Provisions. As Fig. 4 shows, 14 of the 22 states that have adopted enabling measures included some provision(s) designed to protect enrollees. Although the provisions vary greatly, we have characterized the packages adopted by each state according to their strength.

Four states—Illinois, Maine, North Carolina, and Pennsylvania—make provisions for overseeing the solvency of preferred provider organizations. The Illinois and Maine provisions extend only to PPOs sponsored by third party administrators, a group not otherwise closely regulated in those states. The Pennsylvania statute provides that if a preferred provider organization is found to be bearing risk, then it will be subject to fiduciary requirements determined by that state’s Department of Insurance.

Although risk-bearing is often discussed as a reason for regulation, most states do not view preferred provider organizations as bearing risk. In fact, however, various participants in PPO arrangements are beginning to assume more risk in connection with PPO plans. For
example, Humana’s Care Plus, the insuring entity, has agreed to limit premium increases over a several-year contract for coverage through its preferred provider plan. In some other cases, providers are bearing some small risk through payment structures based, in part, on limited capitation mechanisms.\textsuperscript{29}

In all cases, however, either the risk is borne by an entity that already operates under close supervision or the risk is very small. The insurer, the health service corporation, or the HMO—not the PPO—continues to receive the premiums, and that entity indemnifies the enrollee or pays the provider on the basis of services rendered or some close approximation. Since the financial stability of these entities is already extensively regulated, most states see little need to seek additional control.\textsuperscript{30}

The remaining consumer protection provisions reflect an effort to assure accessibility, availability, and quality of care, given that the enrollee’s freedom to choose providers is somewhat restricted. In contrast to the comprehensive regulations that govern most closed panel

\textsuperscript{29}See Fox and Anderson (1986).

\textsuperscript{30}Except, of course, if the employer is self-insuring, in which case the ERISA preemption places it beyond the reach of state regulation.
delivery systems, these provisions appear quite mild and reflect a reluctance to regulate in anticipation of problems rather than in response to them.  

Seven states—Florida, Maine, North Carolina, Oregon, Pennsylvania, Texas, and Utah—require that PPOs make certain information regarding panel members and, in some cases, other plan characteristics, available to enrollees. However, no state yet requires PPOs to present the full complement of information that would allow enrollees truly to compare costs and benefits of coverage under the PPO option and the traditional option, as the AFL-CIO and others have recommended. Advocates of better information argue that such would enable potential enrollees to protect themselves without regulatory intervention that might disrupt the market.  

Nine of the 14 enabling measures with consumer protection language require that preferred provider organizations offer enrollees adequate access, availability of service, and/or adequate coverage for emergency care. Although in most cases, regulations specifying what PPOs must do to meet these objectives have not yet been promulgated, there is little concern that they will be onerous. In most cases, the same issues have already been resolved in the context of HMO regulation. However, PPOs argue that such regulation is unnecessary, because they must provide a high quality product or fail in the marketplace.  

Michigan and Utah have enacted the strongest quality assurance provisions. Going well beyond the customary concern for access and availability, these two states require the PPO to conduct quality assurance programs or reviews to monitor the care rendered. Several states, including Utah, also require that PPOs establish grievance procedures.

The 14 enabling measures with consumer protection language also contain an additional assortment of minor provisions. For example, Michigan and Wisconsin require that insurers who offer PPOs also give enrollees the option of choosing a traditional indemnity plan, and several states link the right to selective contracting to the obligation of passing on cost savings to enrollees.  

**Advocacy for Consumer Protection.** There is no association organized for the sole purpose of representing enrollee interests. Instead, two groups represent their interests; organized labor (principally the AFL-CIO) and insurance departments, whose job it has long

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31Several of those we interviewed observed that there were no problems at the moment and that they were waiting to see what problems might emerge, before pressing for more regulatory authority.
34Information from interviews.
been to protect enrollees. The AFL-CIO has argued for consumer protection provisions at the national and state levels. In particular, it supports extensive information requirements, grievance procedures, emergency admitting requirements, and solvency requirements.\(^{35}\) Insurance departments vary greatly in their support of consumer protection provisions. In a few states, they have sought reasonably broad regulatory control over PPOs. In most states, however, they are awaiting a clearer indication of need.

**Adequacy of the Provisions.** It is impossible, at this early stage in the evolution of preferred provider arrangements, to evaluate either the effect of these new consumer provisions or the adequacy of the array of consumer protection provisions—both old and new—that govern PPOs as creatures of either their sponsoring entities or of the plans that they serve. Preferred provider organizations continue to evolve rapidly, developing new risk-sharing, channeling, and selective contracting techniques as they change. Over time, the degree to which these new techniques constrain the enrollee's freedom of choice or cause the PPO to assume significant financial risk is likely to determine how much additional regulatory control may be warranted.

Although state regulators have not pressed for significant new powers to control PPOs, they appear to be educating themselves regarding the possible problems that this new delivery mechanism may pose for the consumer. Several gave every indication that they were watching PPOs carefully and were prepared to deal with problems as they arose. However, they did not want to act prematurely before they understood what the problems would be.\(^{36}\)

**PROVIDER AND CONSUMER PROTECTION PROVISIONS: WHAT DIRECTIONS?**

Preferred provider organizations have not elicited a new wave of regulation. The generally cautious regulatory interventions that states have thus far supported clearly mirror traditional regulatory patterns and interests. Any-willing-provider provisions and limits on fee differentials attempt to perpetuate existing practices that insulate providers from the pressures and effects of competition and preserve for the enrollee the ability to choose his provider. Requirements that enrollees receive reimbursement for the services of nonphysician practitioners reflect a political contest that precludes preferred provider organizations by some years. Similarly, the consumer protection regulation incor-


\(^{36}\)Information from interviews.
porated in PPO enabling measures is firmly rooted in earlier insurance regulation.

Provider protection measures tend to be clearer and more immediately articulated than consumer protection provisions, because they are sponsored by relatively well organized, experienced interest groups and they address immediate problems. It is not likely that new, unforeseen problems will prompt a rethinking of the need for additional provider protection, although practitioners may ultimately add any-willing-provider provisions in a few more states by yet stronger lobbying efforts.

Conversely, the evolution of consumer protection measures appears to be moving slowly. Consumer interests are not as effectively focused as provider interests. But more important, as we noted above, the adverse effect that preferred provider organizations may have on consumer interests is less clear and less immediate. Thus, the consumer protection measures that are now in place may well not represent the regulatory environment that will evolve. State lawmakers and regulators clearly appear to be showing some sensitivity to the tradeoffs inherent in regulating a procompetitive health care delivery system. At the same time, they are sensitive to the issues of quality of care that PPOs may raise. Given the immaturity of the preferred provider product, it will take more time and experience to know how the regulatory balance will ultimately be struck.
VI. OTHER LAWS AFFECTING PREFERRED PROVIDER ORGANIZATIONS

In addition to third party payer regulation, other laws may affect PPO formation and development. They include laws governing hospital rate review, antitrust, medical practice, peer review, medical malpractice liability, certificate of need, and securities and franchises.

HOSPITAL RATE-SETTING STATUTES

During the 1970s, two distinct and apparently incompatible rationales on how to contain costs emerged.1 Relying on the intellectual traditions of the early 1970s, one school believed that cost containment could best be achieved through governmental regulation, particularly governmentally controlled prices or rate-setting. The second school, gaining credence late in the 1970s, argued that costs could best be contained through the natural, competitive interactions of a free market in health care delivery. Although most states appear increasingly interested in procompetitive mechanisms, some have clearly elected to follow the path of regulation. The question, then, is whether procompetitive mechanisms like PPOs can function effectively in the context of price regulation.

PPO sponsors argue that effective cost containment depends, among other things, upon effective negotiation.2 To contain costs most effectively, purchasers of care or preferred provider organizations must be able to obtain the services of providers at the lowest possible price. Therefore, they must be able to negotiate. Hospital charges account for about 75 percent of a purchaser's expense, and if states dictate these prices, purchasers may lose their ability to negotiate this important component of their coverage.

Nine states have enacted rate-setting laws that require hospitals to charge governmentally established rates for all privately reimbursed

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1See, for example, Havighurst (1977) and Weiner (1978).
2As we noted in Sec. II, price negotiation is only one of several components of an effective cost-containment program. Since cost = price x use, controlling both admissions or visits and the use of expensive procedures through a strong utilization review program is also essential to cost containment. In fact, some argue that utilization review is by far the most important component. See Boland (1986b).
inpatient care. Typically, the rates are set according to complex formulas based upon each hospital's past costs for given services and/or treatment of various diagnostic categories and, in several states, upon the average costs for hospitals of various types (e.g., teaching hospitals, tertiary care centers, or hospitals carrying a large indigent caseload). Some of these laws leave substantial room for a PPO either to negotiate price or to choose low-cost facilities as panel members; others do not.

These nine states regulate discounts in a variety of ways. New York has perhaps the strictest provisions; nonetheless, it offers examples of the various types of discounting that may occur in these states. The New York Prospective Hospital Reimbursement Methodology establishes the payment rates, giving New York's Blue Cross plan an automatic 12 percent discount below other payers. Other payers may negotiate with hospitals for a discount of up to 2 percent but only in return for prompt payment of claims. According to the law, HMOs may freely negotiate rates with hospitals.

Several other rate-setting states automatically discount prices for Blue Cross plans. However, the Blue Cross plans in these states are not then free to negotiate additional discounts.

In addition to New York, seven other states offer some opportunity for other payers to negotiate discounts, but in some cases, the opportunity is very limited. In Connecticut, legislation permits payers to negotiate discounts of up to 2 percent for prompt payment and an additional 1.5 percent for administrative services. In Maine, Maryland, Massachusetts, New Jersey, and Washington discounts are now allowed upon application only when the state rate-setting commission determines that they are economically justified and will not result in cost-shifting. Commission approval is difficult, if not impossible, to get. Finally, Wisconsin treats its hospital fee schedule as a ceiling. Private payers may negotiate discounts from the established rate schedule, and although the discounts should be cost-justified and result in no cost-shifting, they are not subject to approval by a rate-setting commission.

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3The states are Connecticut, Maryland, Massachusetts, Maine, New Jersey, New York, Washington, West Virginia, and Wisconsin.

4According to our interview information, until February of 1986, when Washington's rate-setting commission reaffirmed its regulatory requirement that discounts be approved, that provision had been largely ignored. Washington's regulations also stipulate that rates may not "result in policies which limit access to individuals who are unable to pay or for whom the hospital receives less than anticipated charges for or costs of necessary health care services...." See Washington Administrative Code [WACS 261-40-170(2)].

5Based on interview information.
In general, restrictions on the negotiation of discounts reflect the fact that these states do not want hospitals simply to shift their cost from one group of patients to another that may be in a less advantageous bargaining position. Payment schedules also typically reflect some surplus over cost to be used for indigent or uncompensated care, and states want hospitals to preserve this margin. Without it, states would have to increase their level of public assistance.

In addition to using negotiating latitude offered in the rate-setting laws, preferred provider organizations also have the option of selecting low-cost providers. Rates in all the rate-setting states are based, at least to a substantial degree, on each hospital’s historic costs. Therefore, rates for similar services will vary from hospital to hospital, and the PPO can selectively contract with low-cost providers without having to negotiate price.

Maryland’s response to this strategy deserves note, however. In 1984, Maryland’s Blue Cross plan contracted with a number of low-cost hospitals in the Baltimore area for its PPO. The area’s high-cost hospitals (primarily teaching hospitals with heavy indigent caseloads) persuaded the legislature to prohibit preferred provider organizations from considering teaching costs and the cost of indigent care, among other costs, when the PPO establishes its cost criteria to guide selective contracting. Maryland did not want this new delivery system to lure insured patients who were subsidizing teaching and indigent care from the facilities that needed them.

It is difficult to assess how much of a barrier to the effective functioning of PPOs rate-setting measures may pose. In theory, a strong utilization review program, coupled with the practice of contracting with lower-cost institutions, would appear to offer preferred provider organizations considerable opportunity for cost containment, in spite of restrictions on their ability to negotiate price. In practice, however, many sponsors of PPO arrangements believe that negotiating price is crucial to their ability to contain costs, and they are therefore reluctant to set up preferred provider organizations in states with strict rate-setting laws. For example, Maryland’s Blue Cross plan abandoned plans for a PPO once the new statute constrained its ability to choose low-cost hospitals. Similarly, New York is often cited as a state that has little PPO activity because it has strict rate-setting regulations.\footnote{For example, Maryland rates are based entirely on each hospital’s historic costs. On the other hand, New Jersey uses a rate formula that gives equal weight to the hospital’s historic costs and to statewide average costs. No state relies on average costs to a greater degree than New Jersey.}

\footnote{Dempkowski (1989).}
Notably, of the nine rate-setting states, only one—Massachusetts—seems to have significant PPO activity.\footnote{See Sec. V, Table 5.} Sponsors and potential sponsors report that rate-setting rules impose a variety of handicaps.\footnote{Information from interviews.} Generally the rules deprive PPOs of their ability to negotiate alternative pricing structure—for example, charges based upon per diem or diagnostic related group schedules rather than on disaggregated hospital charges. It is difficult to contract with low-cost providers and, at the same time, meet geographical and service requirements. It is also likely that their utilization review programs are not yet well enough developed, particularly in new PPOs, to supplant discounting. Moreover, several PPOs noted that processing applications for discounts in states that require this procedure is slow and cumbersome, further damping their interest in doing business in those states.

**ANTITRUST LAWS**

State and federal antitrust laws were enacted to ensure competitive environments for businesses. When providers, who are otherwise competitors, work together in the creation and management of a PPO, it is possible that they will act to restrict price, quality, or range of services in an anticompetitive manner. In principle, any participant in a preferred provider organization might violate the antitrust laws, however, providers are the only competitors participating in any particular PPO. When working together through a PPO, they are most likely to be drawn together in a manner that may facilitate and encourage anticompetitive agreements.

Depending on their sponsorship, size, and organization, PPOs could raise such antitrust issues as price fixing, exclusive dealing, monopolization, geographic allocation of markets, and other types of anticompetitive behavior. Of these issues, the one most frequently raised by preferred provider organizations is whether participating providers are engaged in illegal price fixing, which is, per se (in its own right) unlawful and punishable by treble damage awards.

Although this discussion is not intended to constitute a complete examination of pertinent aspects of antitrust law and its application, how antitrust laws appear to be affecting the development of preferred provider organizations warrants a brief review.
Application of State and Federal Antitrust Laws to PPOs

With regard to state laws, we have found no unusual provisions, regulations, or judicial interpretations. No states have challenged PPOs under their antitrust laws. To the contrary, the Ohio Attorney General issued an opinion to the insurance department declaring that most PPOs appear to be legal under his reading of federal antitrust law, and in its 1985 session, the California Legislature exempted "groups of providers and groups of purchasers formed for the purpose of creating efficient-sized contracting units" from any but the antitrust laws pertaining to the conduct of "other presumptively legitimate enterprises."10 Similar legislation was introduced, but not passed, in Arizona and as part of Maine's PPO enabling act.

In considering the application of antitrust laws, the federal government has recognized that PPOs have the potential to enhance competition in the markets for both the financing and the provision of health care services. In Arizona v. Maricopa County Medical Society11 ("Maricopa"), the Supreme Court established an important precedent with regard to the rules governing the determination of price fixing. The Court held that the physician organization in question had illegally fixed prices under the per se rule when its members agreed on maximum fee levels for their charges under an insurer's program. However, it reiterated that price restraints essential to the ability of a new product to compete in the marketplace may be analyzed under the rule of reason, rather than the stricter per se rule.12 The court's more recent ruling in National Collegiate Athletic Association v. Board of Regents of the University of Oklahoma13 reaffirms that the legality of joint ventures among competitors that create a new product through the achievement of otherwise unobtainable efficiencies is to be judged under the rule of reason, even though, as a necessary consequence of the joint arrangement, price competition among the participants may be restricted.

Shortly after the Maricopa decision, the Department of Justice warned the Stanislaus (California) Foundation for Medical Care that it

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12The 1985 California law, discussed above, referred to PPOs' "creation of a new product within the health care marketplace" in an apparent reference to the Maricopa decision.
would sue for violation of the Sherman Antitrust Act, because the pro-
gram required that physicians not participate in any other program and
the Foundation had a high rate of physician participation. Under these
circumstances, it would be difficult, if not impossible for competing
programs to be developed. The Foundation dissolved its program
before suit was brought.

In other federal court cases, providers excluded from a PPO have
alleged that the PPO is engaged in anticompetitive behavior. A
number of cases have upheld PPO arrangements against antitrust chal-
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Legal challenges have enabled the courts and the Department of
Justice to define some boundaries of acceptable behavior. These bound-
aries have been supplemented by less formal policy statements at the
federal level.

Both the Federal Trade Commission and the Department of Justice
clearly believe that PPOs may have competitive potential and should
not be discouraged. Both have informally approved particular PPO
arrangements, noting that they do not appear to violate the antitrust
laws, and, in fact, may be procompetitive.\(^ {15} \) In addition, a policy state-
\ent made by J. Paul McGrath of the Department’s Antitrust Divi-
sion\(^ {16} \) has given further, reasonably unrestrictive definition to the
boundaries that antitrust law imposes upon the organization and
activities of preferred provider organizations. In particular, these have
dealt with what constitutes a horizontal restraint of trade (competitors
acting in concert to directly or indirectly restrict competition), and
what may be defined as concerted refusal to deal with other market
participants so as to restrict competition.

\(^{14}\)For example, see Ball Memorial Hospital, Inc. v. Mutual Hospital Ins., Inc., 784 F.2d
1325 (7th Cir. 1986).

\(^{15}\)See Advisory Opinion Letter from Emily H. Rock, Secretary, Federal Trade Com-
mission, to Irwin S. Smith, M.D., President, Health Care Management Associates (June
Letter from William F. Baxter, Assistant Attorney General, Antitrust Division, Depart-
ment of Justice, to Dr. Irwin S. Smith, President, Health Care Management Associates
(September 21, 1983); Business Review Letter from William F. Baxter, Assistant Attor-
ney General, Antitrust Division, Department of Justice, to Donald W. Fish, Esq., Senior
Vice President and General Counsel, Hospital Corporation of America (September 21,
1983).

\(^{16}\)See “Remarks of J. Paul McGrath, Antitrust Division, Department of Justice,
Before the 33rd Annual ABA Antitrust Spring Meeting,” March 22, 1985.
Effects on PPO Arrangements

Those we interviewed indicated that the effect of antitrust provisions on the organization and operation of PPOs has changed over time. With no case law or administrative interpretations of existing statutes to distinguish acceptable from illegal arrangements, early provider-sponsored PPOs describe themselves as having gone to considerable lengths to avoid antitrust violations. Thus, the Supreme Court's *Maricopa* ruling, despite its statements about the general applicability of the rule of reason, only reinforced their concern, because it applied the per se rule in the specific case under consideration.17 Their feeling of vulnerability has prompted most provider-based PPOs to adopt an indirect and reportedly cumbersome approach in fee negotiations between providers and payers.18

However, their experience over these last several years has done much to reassure provider groups that they may sponsor preferred provider organizations and conduct the business of the PPO in a reasonable and efficient fashion without fear of antitrust action. By now, PPOs have been organized in over half the states, yet only a handful have been the subject of any legal action whatsoever, and although less experienced providers continue to express concern and to query the FTC regarding the legality of PPO arrangements, those with more experience appear to be turning their attentions to other issues. Thus, what was once considered the foremost impediment to the development of PPOs now engenders substantially less concern.

PROFESSIONAL LICENSURE ACTS AND PROHIBITIONS AGAINST THE CORPORATE PRACTICE OF MEDICINE, REFERRAL FEES, AND FEE-SPLITTING

Most states prohibit corporations from employing physicians and other medical professionals to provide patient care services, with a few specific statutory exceptions (e.g., professional corporations, HMOs, and public hospitals). A common related type of professional licensure act provision prohibits physicians and other medical professionals from splitting their professional fees with any other person or entity. In addition, many states have provisions that prohibit physicians and other medical professionals from furnishing inducements, which may

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17The court held that the establishment of maximum fee levels by physicians participating in a medical society-sponsored program for offering services to insurers constituted price fixing in violation of the Sherman Antitrust Act because there was insufficient integration of the competitors' business; for example, insufficient risk-sharing.

18Information from interviews. Also, see Rich (1984).
include discounts, in return for patient referrals. If a PPO arrangement is improperly structured, from a legal standpoint it conceivably could be found to violate each of these laws, as discussed below.

The Corporate Practice of Medicine

The prohibition against the corporate practice of medicine is a doctrine of long standing based on the inability of corporations to meet state statutory requirements for professional licensure, which normally include requirements as to age, educational background, and moral character, and which can be met only by an individual. The doctrine reflects a concern that a business corporation might control the discretion of a health care provider in a manner that would be detrimental to the quality of patient care. The doctrine often is reflected by state law provisions that, either specifically or by interpretation, prohibit employing physicians to provide patient care services.

However, PPO arrangements should not violate the corporate practice of medicine doctrine. The preferred providers are independent contractors with the PPO, rather than its employees, unless the PPO so controls medical decisionmaking or takes such a large percentage of the physicians’ fees (see the discussion below regarding fee-splitting) that it appears to constitute an employment relationship. However, in a state with a prohibition against the corporate practice of medicine, a PPO must be careful to avoid holding itself out as rendering professional services unless the PPO is organized as a professional medical corporation or medical group partnership, two types of entities that typically are permitted to employ physicians and hold themselves out as practicing medicine, despite the fact that the entities themselves are not licensed to practice medicine.

In sum, the corporate practice of medicine doctrine so far, has not significantly restricted PPO arrangements; however, future attempts by lay PPO participants to retain greater percentages of professional fees for their services or to control medical decisions by physicians and other health professionals in the context of utilization review could conceivably run afoul of the doctrine.

Referral Fees

The laws of many states prohibit payment of referral fees, rebates, or kickbacks in exchange for patient referrals. This type of provision might be violated by a PPO or similar entity if the negotiated discount is determined to constitute a form of rebate or kickback.
In states with specific PPO enabling acts, it may be argued that these laws, like freedom of choice and antidiscrimination laws, were not intended to preclude the legitimate activities of PPOs. Nevertheless, in California, a state that has a specific PPO enabling act and is considered to have one of the most favorable legal environments for PPOs, a trial court recently held a discount arrangement to be a violation of California's antirebate statute.

In United Food and Commercial Workers Union, LOCAL 889 v. Kanarek, ("United Food"), in what appears to be a unique decision, the primary issue before the Los Angeles trial court was whether a dentist's agreement to provide a discount to union members, in return for the union's agreement to refer its members exclusively to the dentist, violated California Business and Professions Code Section 650, which prohibits certain professionals, including doctors and dentists, from offering or giving money or anything else of value as an inducement for patient referrals. The court determined that the discount granted by the dentist's agreement with the union constituted something of value and thus violated the statute.

As a trial court decision, United Food is binding only on the parties to the case, and the decision is now being appealed. Since the issue arose in the context of a contract dispute between the parties and not as a result of an investigation by a state agency charged with enforcing the provision, it is possible that the trial court was not aware of the implications of its decision for PPO arrangements generally. In view of the strong support for PPO arrangements demonstrated by the California Legislature, a California appeals court could find that there has been an "implied repeal" of Section 650 insofar as it might apply to any PPO arrangement, or a state or federal court could conclude that this type of contractual arrangement is not covered by Section 650 because of the ERISA preemption.

Fee-Splitting

Although almost every state prohibits at least one type of health care practitioner from splitting fees, only about half the states expressly prohibit physicians from splitting professional fees with other persons. As with referral fees, these provisions often are found in the professional licensure act provisions pertaining to unprofessional conduct. In some instances, the fee-splitting prohibition may be included in the same provision as the prohibition against referral fees. Even

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where there is no express prohibition, however, fee-splitting, in the sense of dividing professional medical fees between physicians or other health professionals and lay persons or entities when the portion retained by the lay person or entity is not earned, is often prohibited under the corporate practice of medicine doctrine discussed above.

A fee-splitting statute might be violated by a PPO if, when paying the preferred provider, the PPO takes part of the provider’s fee as payment for services rendered to participating providers by the PPO. This risk of fee-splitting liability can be minimized if the percentage or flat fee represents the reasonable value of legitimate services rendered by the PPO to the provider. The risk can be eliminated if the PPO is paid for these services by the purchaser, rather than by the provider.

PEER REVIEW IMMUNITY

A major means by which a PPO can influence costs incurred by its preferred providers is through utilization review and quality assurance activities conducted by a PPO peer review committee or committees. Most states have enacted statutes that provide immunity from liability for defamatory statements that physicians may make during quality of care reviews and exempt them from testifying about the content of peer review discussion. However, the express language of these statutes generally applies only to hospital-based peer review committees (the leading exception being California, which extends these immunities to the peer review committees of insured PPOs).21 No such statutes apply to noninsured PPOs.

Since peer review committee immunity statutes generally do not cover PPO arrangements, physicians may be reluctant to participate in utilization review for PPO arrangements because of the perceived risk of being sued for defamation or being required to testify regarding peer review discussions. Thus, control over the use of health care resources, which is one of the essential functions of a PPO arrangement, may be impaired. However, at least 18 jurisdictions have statutes which appear to be broadly enough worded to include insured PPOs22 and statutes in only three states23 appear to preclude any coverage for PPO arrangements. Nevertheless, although we are not aware of any significant problems in this area, the uncertainty in the remaining states,

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23These states include Delaware, Idaho, and Wyoming.
coupled with a few cases (for example, Wickline, discussed below) expanding utilization review liability and increasingly scarce insurance for utilization review malpractice, could affect the introduction of vigorous utilization review by PPO participants, particularly by those other than insurance companies.

**MEDICAL MALPRACTICE LIABILITY**

The threat of vicarious medical malpractice liability is one final consideration that could serve as an obstacle to PPO formation or successful operation. If one member of the preferred provider panel commits medical malpractice, the PPO arrangement could become the “deep pocket” target of litigation.

In California as well as in other jurisdictions, hospitals have been held liable for negligently selecting or monitoring a physician on their staff who later commits malpractice. In a similar vein, an analogous tort theory could be asserted against a PPO based upon a theory of negligent selection or monitoring of its preferred provider panel. This “corporate negligence” theory would assert that the PPO has certain duties to its enrollees, the breach of which constitutes negligence for which the enrollees should be permitted recovery in their malpractice litigation against both the physician and the PPO.

Thus, PPOs and similar entities must take care to undertake appropriate screening of provider credentials and to monitor the quality of care provided by participating providers. Even the appearance in the PPO’s promotional literature of such terms as “quality care” or “preferred providers” may be sufficient for a court to conclude that the PPO arrangement “warrants” that it is offering only quality, preferred care. Overall, these concerns should lead organizers of PPOs to maintain detailed records and to actively control the operation and management of the PPO.

An additional potential source of liability for a PPO is represented by the utilization review component that typically is included in a PPO arrangement. An unreported 1982 California trial court decision in Wickline v. State of California (“Wickline”), currently on appeal, held that a Medi-Cal patient who suffered injury after being discharged had a negligence cause of action against the Medi-Cal program utilization reviewers and the state. The jury awarded $500,000 to the patient, whose leg had to be amputated following complications that developed after the discharge. Under the principle of this case, a PPO that

operates an aggressive utilization review program could be held liable for any damages alleged to have resulted from a utilization review determination.

Another potential problem for PPOs in this area is that insurance premiums for physicians may increase based upon their participation in a PPO arrangement. In 1985, Physicians Insurance Company of Michigan, a malpractice insurer in Michigan, attempted to increase malpractice premiums dramatically for physicians who participate in PPOs in the belief that PPO-participating physicians are more likely to lose their malpractice suits than physicians who are not involved in PPOs. Although this increase was subsequently reversed by the Michigan Insurance Department, if the Wickline case is upheld on appeal and the precedent is extended to PPO physicians in California and other states, higher rates could follow.96

Increasing malpractice premiums combined with judicial determinations of liability for utilization review, as found in Wickline, may dissuade physicians from entering into PPO arrangements, thereby significantly slowing the development of PPOs. However, none of the PPOs we contacted reported finding that concerns regarding medical malpractice had constrained their activities thus far.27

OTHER LEGAL PROVISIONS

We surveyed the states' securities and franchise laws and their certificate of need programs for monitoring capital investments by health care providers. None of these areas of the law appears to unduly restrict PPOs. In most cases, PPOs can take some simple steps to avoid being hampered in their activities.

27Based on interview information.
VII. FINDINGS AND CONCLUSIONS

In the preceding sections, we reviewed the complex regulatory provisions that apply to PPOs. In this section, we present our conclusions about how these laws affect the development and effectiveness of PPOs and whether they adequately protect consumers.

PREEXISTING STATE LAWS

Legal Barriers Exist. All state laws applying to the sponsors of PPOs or to the plan itself also apply to the PPO. From this extensive array of provisions, several types of state laws that predate the innovation of preferred provider organizations have been interpreted as precluding the channeling and selective contracting activities necessary to the effective functioning of PPOs and to their ability to contain costs. These laws, designed to regulate insurers, health service corporations, and HMOs, are: (1) the antidiscrimination and freedom-of-choice statutes found in most insurance codes, (2) the antidiscrimination, freedom-of-choice and any-willing-provider statutes frequently found in the legislation regulating health service corporations, and (3) HMO acts.

The application of these laws is not unequivocal. The same or similar statutes exist in many jurisdictions, but they have been interpreted as restricting selective contracting or channeling in only some jurisdictions. Interpretation of the statutes appears to depend upon an idiosyncratic mix of political balance, market factors, and individual interpretation of the law in the different states.

Among the other state laws that might affect PPOs, hospital rate-setting statutes found in several states clearly restrict the ability of preferred provider organizations to negotiate price.

Two other types of provisions—antitrust laws and professional licensure acts—were once thought to pose problems for preferred provider organizations. However, experience and recent interpretations of the law suggest that they will not interfere with the effective functioning of reasonably well designed PPOs. Considerations of peer review immunity and malpractice liability have not affected PPOs thus far, but their utilization review programs could conceivably be hampered if the programs' records are not immune from public disclosure, or if PPO providers face a higher risk of malpractice litigation than do fee-for-service providers.
States Move Quickly To Clear the Way for PPOs. More significant than the fact that barriers may exist is the speed with which states have cleared them away. State policymakers show considerable concern about escalating health care costs and have proven themselves eager to facilitate the introduction of innovative cost-containment mechanisms. Within the short space of four years, 20 states have adopted legislation that specifically permits PPOs to employ selective contracting and channeling incentives, overriding any legislation to the contrary. Two states have taken similar action by regulation. Most of the remaining states either report little interest in PPOs or have made it clear that PPO practices do not violate existing law.

Only three states currently prohibit selective contracting and channeling activities, and it is likely that at least one of them will adopt enabling legislation in the near future.

STATE ENABLING STATUTES, REGULATIONS, AND POLICIES

Enabling Measures Often Impose New Barriers. At the same time that they have authorized selective contracting and channeling activities, many states have also imposed some limitations on preferred provider organizations. Of the 22 states with enabling statutes or regulations, 14 have enacted some form of consumer protection requirements, many of which will affect the operation of the PPO to some degree. Eight have adopted "any willing provider" provisions, and eight regulate the differential in benefits offered to enrollees who select panel members as opposed to nonpanel members. The former provision restricts selective contracting. The latter restricts the range of channeling incentives that a PPO can employ, although it preserves some measures of choice for the enrollee.

It Is Too Soon To Evaluate the Effects of Enabling Statutes on the Development of PPOs. Although enabling statutes override existing legal obstacles and appear to be stimulating significant PPO activity, there is no way to usefully assess their effects on the development of PPOs now. Both the PPO product and the regulatory environment governing it are very immature. The structure of PPOs and the means they use to achieve their cost-containment goals are still undergoing rapid evolution. Moreover, only a few have operated for even a couple of years; thus we have very little experience upon which to base an evaluation. Until the pace of organizational change slows and states understand and have dealt with the problems they see, it will be impossible to evaluate the effects of the new restrictive provisions.
New Enabling Statutes Provide a Useful Mirror of Competing State Concerns. Enabling statutes reflect a number of current state policy concerns. In their enabling sections, they demonstrate that states want to contain health care costs and are inclined toward procompetitive mechanisms to accomplish this objective. However, additional provisions insulating providers and consumers from the possible consequences of unrestricted competition suggest that state policymakers have some conflicting commitments to competing constituencies.

These commitments are not new. The traditional panoply of statutes governing third party payers often contains similar restrictions on any behavior that limits the enrollee’s choice of provider or that leads to different levels of reimbursement. The other types of protection measures found in enabling statutes can also be found in typical sets of provisions that govern third party payers. The history of support for these competing objectives, each with a strong constituency, suggests that policymakers will face some difficult tradeoffs whenever they open the door to reconsidering the regulatory provisions that govern preferred provider organizations.

LAWS PROTECTING THE CONSUMER

A Preexisting Array of Consumer Protection Provisions Continues To Protect Consumers Enrolled in PPO Plans. Preferred provider coverage must be offered under some type of health benefit plan, and various sets of statutes and regulations designed to protect the consumer continue to govern the sponsors and the contents of the plans. The regulations that apply vary depending upon whether the sponsor is a commercial insurer, a health service corporation, an HMO, or a self-insuring employer. Thus, although PPOs may be new delivery systems without any specifically tailored regulation, they are not unregulated. However, they may be regulated differently, one from another.

The Adequacy of Current Consumer Protection Provisions Cannot Be Assessed Yet. For the same reasons that it is not yet possible to assess the effects of enabling statute restrictions, it is premature to assess the adequacy of current consumer protection provisions. Our research has uncovered no evidence that PPOs are currently thought to offer a product of questionable quality. However, most are just beginning to deliver services. Their utilization review, selective contracting, and channeling practices have not yet matured. Neither has the regulatory environment in which they operate.
**Consumer Protection Is a Subject of State Concern.** Only 14 states have adopted consumer protection provisions that specifically control PPOs, and these provisions are quite modest. However, insurance departments and other state regulators in states actively guiding the evolution of health care delivery are watching PPOs closely. Neither lawmakers nor state regulators have had an opportunity to see what problems PPOs may engender, and they report themselves reluctant to establish significant regulatory controls until they have more experience. But there is every indication that they intend to deal with problems as they arise.

**A Large Segment of the Market—Self-Insured Plans—Is Subject to Minimal Consumer Regulation.** ERISA has preempted state control of self-insured health benefit plans and given regulatory authority to the Department of Labor. The department exercises minimal control over these plans, although they currently account for about 40 percent of the market, their share is growing, and, increasingly, newcomers to the self-insured market are smaller companies with little actuarial or servicing experience.

**THE UNEVEN PLAYING FIELD**

**The Playing Field for Preferred Provider Organizations Is Extremely Uneven.** Because PPOs are subject to the regulatory controls that apply to their sponsoring entities and to the plans they serve, they function in multiple regulatory environments. Although commercial insurers and health service corporations tend to be regulated in a similar manner, requirements applying to each often differ—sometimes along very important dimensions. Thus, the health service corporation in a state may be subjected to an “any willing provider” provision whereas the commercial insurer is not. Conversely, the commercial insurer may be subject to an antidiscrimination or freedom-of-choice provision, whereas the health service corporation is not. Because enabling statutes usually treat insurers and health service corporations alike, enabling statutes provide some new “evenness” for these two players.

HMOs operate in yet another regulatory arena, and most are subject to both state and federal control. Currently, federal and some state regulations do not permit federally qualified HMOs to offer PPOs directly. Other states are still considering the issue, and only a few enabling statutes authorize HMOs to offer PPO options.

The ERISA preemption that applies to self-insured plans has created yet another distinctly regulated group. A major factor in the
growth in self-insurance is the employers' desire to avoid state regulation of insurance. PPO regulation further increases the incentives to self-insure. This puts small employers, who are unable to self-insure, at a disadvantage. It also reflects inconsistent policy—state regulation for half of the market and very limited federal regulation for the other half.

The differences between the treatment of insured and self-insured plans, as well as the variation across states in the regulation of insured PPOs, has led some to consider the possibility of uniform federal regulation of PPOs. However, federal regulation would raise two major issues. First, it may not be practicable to regulate the PPO aspects of insurance plans at the federal level and the other aspects at the state level. Second, it would require a significant change in the division of responsibility between the state and federal governments. While initial interest in federal preemption of state laws affecting PPOs reflected concerns about inattention on the part of the states to old laws that might preclude effective PPOs, this study has found that most states recently have addressed the issues of PPO regulation and have acted to clarify or to change their policies. Thus, federal regulation at this point would require Congress to override recent policy decisions by the states.
Appendix A

SUMMARIES OF THE PPO ENABLING STATUTES, REGULATIONS, AND FORMAL POLICIES

ARKANSAS

Arkansas is unique in that the Insurance Commissioner of that state has issued a bulletin\(^1\) stating that it is the insurance department’s official opinion that it is permissible for insurers to form and/or participate in PPO arrangements. This official opinion was adopted following the Arkansas legislature’s failure to adopt specific PPO enabling legislation that was proposed in 1985 and opposed by physicians and other health professionals. The opinion overrides the application to PPOs of Arkansas’ insurance code provisions relating to freedom of choice of providers.

The opinion includes (i) an any-willing-provider requirement that PPO membership must be open to representatives of all professions under the Arkansas Medical Practice Act who are willing and able to meet the terms and conditions required by the PPO organization and (ii) a “limited benefit differential” requirement that the differential in benefits levels (i.e., deductibles and copayments) for services rendered by preferred and nonpreferred providers may not exceed 25 percent.

CALIFORNIA

California’s PPO enabling statute\(^2\) provides that an insurer or a hospital service plan (Blue Cross) may negotiate and enter into contracts for alternative rates of payment with institutional providers and may offer the benefit of such alternative rates to insureds who select such providers. This legislation specifically overrides the freedom-of-choice and unfair discrimination provisions. California is also the only state

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providing in its legislation that the state’s laws relating to immunity from liability and discovery privileges for medical and dental peer review apply to insurer-sponsored and hospital service plan-sponsored PPO arrangements.

The legislation also expressly authorizes the development of so-called “exclusive provider organizations” (EPOs) by insurance companies and hospital service plans and includes specific requirements relating to EPOs. It requires an EPO to include programs for the continual review of the quality of care of its professional providers, as well as review of the performance of medical personnel and utilization review of services, facilities, and costs by professionally recognized unrelated third parties. In addition, the EPO regulations require that the sponsor establishing an EPO assure subscriber access to the EPO. EPOs have not proliferated in California because they are viewed as less advantageous than PPOs because of this regulatory scheme and less marketable to subscriber groups than HMOs because they restrict freedom of choice of providers in the same manner without the same level of cost containment or state regulation.

In addition, Section 740 of the California Insurance Code provides that any person or other entity offering any type of health coverage shall be presumed subject to the jurisdiction of the department unless the person or other entity can show that it is subject to the jurisdiction of another agency. This statute was intended to regulate previously unregulated uninsured Multi-Employer Trust plans. The California Department of Insurance has not asserted jurisdiction over any PPOs on the basis of this statute because insurer-sponsored PPOs are by definition already subject to their regulation, self-insured PPOs are exempt under ERISA, and according to the department’s interpretation of Section 740, provider-sponsored PPOs do not themselves provide “health coverage” unless there is no other underwriting entity in the PPO arrangement in question (e.g., an insurer, reinsurer, self-insurer, or HMO). Subsequent legislative attempts to regulate provider-sponsored and broker-sponsored PPOs that contract with self-insured plans or to more tightly regulate insured PPOs under the jurisdiction of the insurance department have failed to pass the California Legislature.

Although Section 740 has not caused problems for PPOs in California, this type of provision may give a state insurance department regulatory power over PPO arrangements other than those sponsored by insurers or otherwise subject to insurance regulation. If so, freedom of choice and antidiscrimination laws may become expressly applicable to the PPO, whether or not it previously was regulated as an insurance company or sponsored by an insurance company. However, these laws
appear to have a minimal adverse impact on PPOs, since noninsurer-sponsored PPOs generally involve contracts with self-insured employers and Taft-Hartley trusts and therefore are exempt from state regulation under ERISA.

Attempts by the California Medical Association and others to restrict insurance-based PPOs by amending the PPO enabling statute or to bring noninsurer PPOs under insurance department regulation have not been successful. Thus, California has offered the least restrictive legal environment of all the states, and hence it is not surprising that all types of PPOs have flourished to a greater degree in California than in any other state. However, as discussed in greater detail in Sec. VI, a recent trial court decision in Los Angeles County could, if upheld on appeal, cause California to be the first state to prohibit physicians and other health professionals from granting discounts to self-insured PPOs.

To date the proliferation of PPOs in California has not resulted in significant reported problems. The continuing absence of reported abuses may constitute circumstantial evidence that at least certain restrictive requirements in other states are unnecessary, or that their potential benefits are outweighed by their detrimental impact on the competitive flexibility of insured PPOs.

FLORIDA

Florida's PPO enabling statute\(^3\) allows an insurer or group of insurers to negotiate and enter into contracts for alternative rates of payment with licensed health care providers. The statute expressly provides that alternative rates of payment do not constitute an unfair method of competition or an unfair or deceptive act. Since Florida's antidiscrimination statute is contained in the insurance code provisions defining unfair competition and unfair or deceptive acts, the PPO statute overrides the application of Florida's antidiscrimination statute to PPOs.

Representatives of insurance companies that have attempted to develop PPO arrangements in Florida have indicated that although no such requirement is contained in the statute, the insurance department has imposed varying limits of 10 percent to 20 percent on the differential between benefits for services of preferred and nonpreferred provid-

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ers. The department has also required that enrollees not be made to travel more than 50 miles to obtain services from a preferred provider.\(^4\)

**ILLINOIS**

Illinois' PPO enabling statute\(^5\) provides that an insurer, health service corporation, or an administrator may negotiate and enter into contracts or other arrangements with providers of health care services for alternative rates of payment and may offer such alternative rates to insureds in an individual or group policy or contract providing coverage for health services. This legislation specifically overrides all other statutory provisions that may be interpreted to inhibit PPOs, including both the freedom of choice and antidiscrimination provisions.

However, the statute also includes an any-willing-provider requirement that the PPO may not refuse to contract with any noninstitutional provider (i.e., a physician or other health professional) who meets the terms and conditions established by the PPO. These terms and conditions may not discriminate unreasonably against or among noninstitutional providers, but negotiated prices, or price differences based on geographic area or specialty, generally are permitted. The exception is emergency services, for which all providers must be paid on an equal basis, whether or not they are members of the PPO provider panel. In addition, insured PPOs are prohibited from unreasonably restricting access by and availability to insureds of health care services and all PPOs are required to include a utilization review program.

Finally, the Illinois PPO law requires that all administrators who arrange contracts, contract with, or administer contracts with a provider must register with the state's Department of Insurance, which shall establish criteria for such registration, including minimum solvency requirements and an annual registration fee. Under this provision, the insurance department has promulgated emergency rules providing for the regulation of PPO administrators.\(^6\) These rules provide for registration, annual fees, fiduciary and bonding requirements, as well as maintenance of records requirements.

\(^4\)Letter from Leslie Kitterman, Insurance Analyst, Health Section, Florida Department of Insurance and Treasurer, to an unidentified insurer that had filed PPO plan documents for approval (December 11, 1986).


\(^6\)Ill. Admin. Reg. 50 § 6501.10 et seq. (Emergency Rules).
INDIANA

Indiana’s PPO enabling statute\(^7\) authorizes insurers to enter into agreements with providers relating to the terms and conditions of reimbursement for health care services that may be rendered to insureds, including activities intended to reduce inappropriate care. The statute also expressly provides that an insurer may include incentives for the insured to use and select a preferred provider. In addition, the statute authorizes EPOs by allowing insurers to issue or administer policies that provide for reimbursement for health care services only if the services have been rendered by a preferred provider.

The Indiana statute by its terms overrides any other conflicting state laws including specifically Indiana’s freedom-of-choice and antidiscrimination provisions. Other provisions of the statute are similar to those of the Illinois statute. First, the statute includes an any-willing-provider requirement that no hospital, physician, or other provider willing to meet the terms and conditions may be denied or excluded from participation in the PPO. The statute also provides that the terms and conditions of the PPO agreement may not discriminate unreasonably among providers but expressly permits negotiated price differences among institutional providers, as well as those based on geographic area or specialty for other providers. Finally, access to and availability of health care services may not be unreasonably restricted by the PPO. Although the statute authorizes the Commissioner of Insurance to adopt rules setting forth standards for access and availability, no such rules have thus far been adopted.

IOWA

House Bill No. 570,\(^8\) which became effective on July 1, 1985, provides that an insurer may enter into contracts with health care service providers and may offer different levels of benefits to policyholders based upon such provider contracts.

Iowa’s enabling law appears to be among the least restrictive in the country. In view of the statute’s breadth and the relatively limited PPO activity in Iowa, however, an assessment of the statute’s restrictiveness will depend upon future regulations or insurance department policy statements.

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KANSAS

Like the California PPO enabling law, the Kansas PPO enabling statute\(^9\) provides that an insurance company may negotiate and enter into contracts for “alternative rates of payment” with health care providers and may offer the benefit of such alternative rates to insureds who select such providers.

Although this law appears to be nonrestrictive, the Kansas Insurance Department’s Bulletin 1986-16 requires PPO filings to be accompanied by a substantial amount of detailed information concerning the PPO’s operation.\(^9\) According to a representative of one insurance company that has attempted to organize a PPO in Kansas, this requirement has resulted in a “Catch-22” situation, since much of the information cannot be obtained until a PPO network has been established, yet the insurer cannot establish a PPO network until it files the material.

KENTUCKY

Until recently, the Kentucky Department of Insurance interpreted that state’s freedom of choice and antidiscrimination statutes to prohibit insured PPOs. That policy was recently reversed, and insured PPOs are now permitted in Kentucky without significant restriction. In addition, regulations authorizing PPOs currently are being developed.

LOUISIANA

Louisiana’s PPO enabling statute\(^11\) contains a legislative intent section that specifically acknowledges the legislature’s recognition that PPOs can reduce health care costs. The statute provides that any group purchaser (which includes insurers, self-funded organizations, third party administrators, and other intermediaries) may enter into a contractual agreement with any provider to provide for alternative rates of payment specified in advance whenever an enrollee chooses to have his or her health care services rendered by a preferred provider, and these agreements also may include incentives that encourage an enrollee to utilize the preferred providers. The Louisiana statute requires that the PPO include a “resource monitoring component” (i.e., utilization review and quality assurance) to ensure quality control,

access to patient care, and cost effectiveness, as well as procedures to encourage prompt payment for services rendered.

The PPO legislation also provides, however, that any licensed provider, other than a hospital, who agrees to the terms and conditions of the preferred provider contract cannot be denied the right to become a preferred provider and thus allows the PPO to be selective only with regard to hospitals. This type of restriction, while significant, appears less likely to pose a significant obstacle to a PPO then would a similar restriction applicable to hospitals.

MAINE

Maine recently amended its laws governing nonprofit service organization, insurers, and administrators to permit them to contract with a limited number of preferred providers. In selecting these providers, consideration may be given to price differences among providers, geographic accessibility, specialization, and projected use by beneficiaries and insureds. The act specifically states that selective contracting does not constitute unreasonable discrimination among providers.

The act imposes some restrictions on PPOs. It requires that the PPO plan provide coverage for services obtained from nonpreferred providers, thereby excluding EPOs. Like Michigan, it specifies what the payment differential between preferred and nonpreferred providers should be. Nonpreferred providers must be paid at least 80 percent of the amount that would have been charged for the same service by preferred providers. This provision may be difficult to implement, particularly in PPO plans that embody risk sharing or that negotiate fees for bundles of services. Most important, it limits the flexibility of any PPO plan to design new fee arrangements with preferred providers or new incentives for enrollees to choose these providers.

The act also includes a number of other provisions, including a requirement that employee benefit programs that include a PPO plan include an annual open enrollment period during which employees in the PPO plan may choose any other plan offered by their employer. The act specifically permits PPO plans to embody risk sharing by providers (including prepaid capitated rates), but plans that do so must file for state approval. Finally, PPOs must present their proposed plans to the Superintendent of Insurance including a listing of the preferred providers and the terms of such provider agreements, and the superintendent is required to disapprove any arrangement that contains "unjust, unfair, or inequitable" provisions. In addition, PPOs

1986 Me. Legis. Serv. 288.
must report annually on their claims experience by category of service: hospital services, outpatient surgery or other ambulatory care, and professional services by specialty.

MARYLAND

Maryland’s PPO enabling statute\(^{13}\) provides that an insurance company or nonprofit health service plan may administer a health benefit program under which an insurer or a nonprofit health service plan may offer preferred provider policies or preferred provider contracts that limit the number and types of providers of health care services eligible for payment as preferred providers. The statute expressly provides that with respect to institutional providers, alternative rates that have been approved by Maryland’s Health Services Cost Review Commission will not be deemed to constitute unfair discrimination. However, the statute expressly prohibits EPO arrangements, under which enrollees will receive no health plan coverage for nonemergency services they receive from nonpreferred providers.

The statute also includes a relatively mild type of “limited benefit differential” requirement mandating that any payment made to a nonpreferred provider may not be less than 80 percent of the amount that would have been paid to a preferred provider for similar services in the same geographic area unless the insurer demonstrates to the satisfaction of the Commissioner of Insurance that an alternative level of payment is more appropriate.

However, another statute governs how costs may be calculated by insured PPOs in determining which hospitals are most cost-efficient and therefore should be selected as preferred providers. This statute also states that it is not permissible for a hospital to engage in “cost-shifting” from PPO health plans to non-PPO health plans.

MICHIGAN

Michigan’s PPO enabling statute\(^{14}\) provides that an organization (a term which includes insurers and hospital service corporation) may enter into “prudent purchaser agreements” with one or more health care providers to control health care costs, assure appropriate use of health care services, and maintain quality of health care. The statute


specifies that such agreements will not be considered per se violations of Michigan’s prohibitions against restraint of trade.

Rather than imposing a strict any-willing-provider requirement, the Michigan statute takes an apparently less restrictive approach by requiring merely that all providers in the PPO’s service area be given the opportunity to apply for membership, but that the number of prudent purchaser agreements should be sufficient to ensure reasonable levels of access to health care services for enrollees. The number of agreements necessary to assure reasonable levels of access to health care services is to be determined by the PPO sponsor. The PPO sponsor must, however, arrange for the preferred panel to include providers that are located within a reasonable distance from the recipients of such health care services, if in fact any providers are located within that reasonable distance.

The Michigan statute prohibits PPOs from discriminating between physician and nonphysician providers. In addition, the statute includes a “limited payment differential” provision which provides that a nonpreferred provider shall receive payments that are 85 percent of the amount payable for the same services when rendered by a preferred provider. This provision is similar to the one in the Maine PPO enabling act, although it should be noted that the 85 percent differential is a “sunset” provision that is automatically repealed in 1987 if the Michigan Legislature does not formally enact it again.

The Michigan PPO statute also requires that if an insured is offered coverage in a preferred provider arrangement, the insured must also be offered a traditional health insurance plan. Finally, the Michigan statute expressly authorizes EPOs and requires that if an insured is offered an EPO arrangement, he or she also must be offered a PPO arrangement and a traditional health insurance plan.

MINNESOTA

Minnesota’s PPO enabling statute specifically overrides the Minnesota antidiscrimination provisions in providing that, under group health insurance policies, the payment of differing amounts of reimbursement to insureds who elect to receive health care goods and services from providers designated by the insurer is not unfairly discriminatory, provided that the insurer files each year with the Commissioner of Insurance summary data regarding the financial reimbursement offered to the preferred providers. In addition, the statute

requires the insurance company to file an annual statement, and
requires the Insurance Commissioner to maintain a record of all pro-
posed PPO arrangements and any complaints submitted relative to
those arrangements.

In the absence of any additional policy statements or enforcement
history, it is not possible to discern the impact of the financial reim-
bursement and other regulatory provisions of this legislation on
insurance-based PPOs. However, this regulatory approach appears to
be more conducive to the formation of PPOs than the provisions of
many enabling statutes, although the level of uncertainty may result in
a chilling effect because of the significant start-up costs associated with
a PPO arrangement.

NEBRASKA

Nebraska's PPO enabling statute\footnote{16Neb. Rev. Stat. § 44-4101 et seq. (1984).} provides that an insurer, a health
service corporation, and specified other types of entities may enter into
contracts with health care providers to purchase health care services on
a bid or negotiated basis at alternative rates of reimbursement and may
offer the benefit of such contracts to its insureds. These preferred pro-
vider policies or contracts are authorized to limit the numbers and
types of providers of health services eligible for payment as preferred
providers. The statute expressly provides that price differences among
the providers because of individual negotiation, market conditions,
patient mix, method of payment, or difference in geographical areas
will not be deemed to be unfair discrimination.

However, the Nebraska statute also appears to include a type of
antidiscrimination, or indirect freedom-of-choice provision requiring
that the terms and conditions of the policies may not discriminate
against or among health providers. The statute also expressly prohib-
its EPO arrangements. Nevertheless, Nebraska appears to have one of
the more hospitable state law climates for insurance-based PPOs, rival-
ing that of California, Iowa, North Carolina, Oregon, Pennsylvania,
and Wyoming.

NEVADA

Nevada has enacted a law that, although it does not specifically
authorize PPOs, is designed to encourage plans with many of the same
features as PPO plans. Senate Bill No. 286,\textsuperscript{17} which became effective July 1, 1985, provides that an insurer must encourage insureds to use services and facilities that are the most efficient or that tend to reduce or control the cost of health care. In addition, the Commissioner of Insurance is prohibited from approving any proposed policy of health insurance unless he determines that the insurer has adopted and is using “three or more practices . . . that control or reduce the cost of health care.”

Although this provision is particularly ambiguous, it does appear to be a type of PPO enabling act. Until regulations or policies are issued that define what types of cost-control or reduction provisions are acceptable, this law might not effectively encourage PPO arrangements and because of its ambiguity. However, by mandating, rather than merely permitting, PPO-type controls (e.g., utilization review, provider selectivity, patient incentives to use preferred providers), the Nevada law could serve to spur the development of insured PPOs to a greater degree than standard PPO enabling legislation.

NEW HAMPSHIRE

New Hampshire's PPO enabling statute\textsuperscript{18} provides that insurers, including health service corporations, may enter into agreements with providers relating to the terms and conditions of reimbursement for health care services. Like Indiana's PPO enabling statute, the New Hampshire statute provides that negotiated price differences among institutional providers and those based on geographic area or specialty for other providers will not constitute unreasonable discrimination. PPO agreements may cover the amount to be charged the insured for services rendered, as well as the terms and conditions for activities intended to reduce inappropriate care, but may not unreasonably discriminate against or among providers.

However, the New Hampshire statute also includes, in addition to prohibiting PPOs from restricting the accessibility and availability of health care services, an any-willing-provider provision mandating that no hospital, physician, or other provider willing to meet the terms and conditions prescribed by the PPO may be denied the right to enter into

a PPO agreement. The statute also prohibits EPOs. The statute also appears to prohibit “gatekeeper” arrangements where the primary care physician is placed at financial risk for referral care costs. Such arrangements are typically used by HMOs rather than PPOs, but new hybrid forms of at-risk PPOs may be restricted by such a prohibition.

NORTH CAROLINA

North Carolina’s PPO enabling statute\(^{19}\) became effective October 1, 1985, and provides that insurers and health service corporations are authorized to enter into preferred provider contracts for the purpose of reducing the cost of providing health care services, provided that the PPO agreement not restrict the provider’s right to enter into PPO arrangements with other parties (which is not a significant restriction, particularly since the U.S. Federal Trade Commission has interpreted federal antitrust laws to much the same effect).\(^{20}\) The statute also provides that any entity that proposes to offer preferred provider plans must provide the insurance department with summary data regarding the financial reimbursement offered to providers.

The statute overrides all of the provisions to the contrary that may limit the formation of PPOs and appears to be one of the more favorable PPO enabling laws in the country. The statute does, however, prohibit EPOs.

OHIO

Ohio is unique among the 50 states in that its insurance code does not include either freedom-of-choice or antidiscrimination provisions, and there is no other restriction against PPOs sponsored by insurance companies, but its hospital service association law effectively prohibits those entities from offering PPOs by imposing restrictive freedom-of-choice requirements.\(^{21}\) An amendment to the hospital service association law that would expressly authorize hospital service associations to offer PPOs is currently before the legislature.\(^{22}\)

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\(^{21}\) Ohio Rev. Code, Section 1738.06.

\(^{22}\) H.B. No. 886 (Striziano), amending Sections 1739.01, 1739.02, and 1739.06 of the Ohio Revised Code to give hospital service associations broad latitude in implementing PPO arrangements.
OREGON

In Oregon, House Bill 2031,23 which became effective July 1, 1985, authorizes PPOs. Like California's PPO enabling law, the statute provides that an insurer may negotiate and enter into contracts for “alternative rates of payment” with providers and may offer the benefits of such alternative rates to insureds who select such providers.

The Oregon PPO enabling act thus is as favorable as any in the country, including such relatively liberal statutes as those in California, Iowa, Nebraska, North Carolina, Pennsylvania, and Wyoming.

PENNSYLVANIA

The Pennsylvania Legislature has recently enacted a broad PPO enabling act under which insured PPOs are expressly exempted from the existing freedom of choice and antidiscrimination provisions under the Pennsylvania insurance code.24 This act includes few significant restrictions on PPOs and also authorizes EPOs.

The most interesting provisions concern PPOs that assume financial risk. The Insurance Commissioner must determine for each PPO that it is licensed as an insurer in the state, has adequate working capital and reserves, or is covered by ERISA. In addition, the Insurance Commissioner and the Secretary of Health jointly must ensure that if a PPO assumes financial risk that may lead to undertreatment or other poor-quality care, the PPO has adequate quality and utilization controls and a formal grievance system. Risk-bearing PPOs cannot operate without first filing certain information with the state, and the Insurance Commissioner and Secretary of Health may stop any of these PPOs at any time if deficiencies are found.

Although the provisions of this PPO enabling act appear broad, they do not expressly authorize insured PPOs to be selective in their choice of provider. Therefore, it is conceivable that regulations issued under this statute could include an any-willing-provider requirement, though such a regulatory requirement would appear to be inconsistent with the legislative intent in exempting PPOs from Pennsylvania's freedom-of-choice requirements.

24Senate Bill No. 935 (11-13), amending Pennsylvania Insurance Code § 621.2 (C) and 626 and adding § 630 (1986).
TEXAS

The Texas Board of Insurance has published regulations authorizing insured PPOs, effective July 1, 1986. The regulations, while authorizing PPOs, contain a number of restrictions, including some unusual provisions that give physicians a role in monitoring the PPOs to which they belong. PPOs are required to establish one or more panels with at least three physicians chosen from "a list of those physicians contracting with the insurer, which list is to be provided by those physicians contracting with the insurer in the applicable service area." Such a panel must be available to review and advise on all instances of a provider not being accepted as a preferred provider. In addition, all actions taken by an insurer to "correct a suspected deviation" or to deny payment in the course of the utilization review process must be approved by a physician or a physician panel. Finally, if the PPO has a quality assessment program, it must be conducted by such a panel.

Other provisions provide that the benefit differential between preferred and nonpreferred providers cannot exceed 30 percent. Although any such limit may be adverse to PPO effectiveness, the proposed percentage differential is relatively liberal and, depending upon how it is interpreted in practice, should not significantly hamper insured PPOs.

In addition, the regulations include provisions that conceivably might be interpreted to require that PPOs contract with any-willing-provider. All classes of practitioners and institutional providers licensed to treat illnesses or injuries or to provide services covered by the policy must be afforded a "fair, reasonable, and equivalent opportunity" to become preferred providers. The terms and conditions of the PPO arrangement must be "reasonable" and based solely on economic, quality, and accessibility considerations. Further, although the regulations specifically permit PPOs to limit their physician panels to physicians with staff privileges at selected hospitals, PPOs may not exclude nonphysician practitioners because they lack such privileges. Finally, any term or condition that limits participation on the basis of quality must be consistent with established standards of care in the profession.

Among other provisions, the regulations require that the insurer cooperate with the insurance department in the collection of data on, for example, quality of care, access to services, and costs. Payments to preferred and nonpreferred providers must be equally prompt. The insurer must attempt to include a mix of nonprofit, for-profit, and publicly supported institutional providers, and must give special considera-

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Texas Admin. Code tit. 28, § 3.3701 et seq. (1986).
tion to those that have teaching programs or provide indigent care. Practitioners may share in PPO profits as a group, but not as individuals, and the PPO may not require that providers pay for unnecessary services or referrals to specialists.

Since these regulations have just been published, it is difficult to evaluate their restrictiveness. The physician panels conceivably may limit PPO activities, even in areas in which the panels have only advisory roles. The large number of restrictive provisions also may deter some insurers from organizing PPOs, as well as limit those insurers who elect to proceed with PPOs.

UTAH

Utah's new insurance code, which became effective July 1, 1986, expressly authorizes PPOs. The statute provides that any insurer or third party administrator may enter into contracts with health care providers at prices specified in the contracts. The contract may require the health care providers to accept the specified payment as payment in full, relinquishing the rights to collect additional amounts from the insured person, and may reward the insured for the selection of preferred health care providers by reducing premium rates, deductibles, coinsurance, or other copayments, or in any other reasonable manner.

However, the statute also provides that when an insured receives services from a nonpreferred provider, the insurer shall reimburse the insured for at least 75 percent of the average amount paid by the insurer for comparable services from preferred providers. Further, the Utah statute includes an unusual provision that limits the PPO plan annual deductible level to $100 per enrollee and $300 per family. Finally, any health care provider willing and able to meet the terms and conditions of the contract, as established by the insurer, must be allowed to participate as a preferred provider. Also, an insurer is prohibited from discriminating between classes of health care providers when selecting health care providers with whom to contract. Thus, Utah's PPO enabling statute is one of the more restrictive and may well significantly limit the development of insured PPOs in that state.

Certain amendments to Utah Senate Bill No. 91 (1986) were proposed before its enactment to avoid this result. In particular, the proposed amendments would have changed the permissible benefit differential provision to the greater of at least 75 percent of the average

amount paid by the insurer for comparable services, or at least 50 percent of the usual, customary, and reasonable fee for comparable services. In addition, the amendments would have deleted both the any-willing-provider provision and the prohibition against discrimination between classes of health care providers. Finally, the amendments would have added a provision to the effect that any employer group that offers a PPO arrangement to its employees also must offer simultaneously a traditional health insurance plan. However, according to a representative of the Utah Department of Insurance with whom we spoke on March 17, 1986, these amendments were deleted in their entirety when Senate Bill No. 91 was approved by the legislature in March of 1986.

VIRGINIA

Virginia's PPO enabling statute\(^{27}\) provides that insurers and health service corporations may offer or administer a preferred provider health benefit program under which the policies or contracts limit the numbers and types of providers of health care services eligible for payment as preferred providers under the contract. The statute states that the terms and conditions of the contract may not discriminate unreasonably against or among health care providers. However, like Indiana's PPO enabling statutes, the Virginia statute specifically provides that differences in price among hospitals or other institutional providers because of individual negotiations, or among other providers because of different geographical areas, shall not be deemed unreasonable discrimination.

However, the statute includes a restrictive any-willing-provider provision mandating that any hospital, physician, or other provider willing to meet the terms and conditions established by the PPO cannot be excluded from entering into a PPO agreement. Further, the statute prohibits EPOs.

WISCONSIN

Wisconsin's PPO enabling statute\(^{28}\) defines a "preferred provider plan" as a health insurance contract that provides coverage for health care services (excluding vision-related services) and limits participation in the contract to providers selected by the health care plan. The


statute specifically overrides the state's antidiscrimination provisions insofar as they might otherwise apply to a preferred provider plan.

However, the Wisconsin statute limits the maximum copayment for services provided by nonparticipating hospitals to 20 percent of the applicable charge. Therefore, the maximum benefit differential is 20 percent, and in practice is likely to be less because PPOs increasingly have moved away from eliminating copayments for preferred provider services because of the resulting incentive for overutilization. Accordingly, the 20 percent payment differential limit is likely to significantly limit the ability of Wisconsin PPOs to channel patients to the preferred providers. However, Wisconsin permits insurers to penalize the use of nonparticipating providers by surcharging enrollees up to $2500 per enrollee or $5000 per family, subject to the Insurance Commissioner's approval. The statute also requires that an insured who is offered coverage in a PPO arrangement also must be offered a traditional health insurance plan and an annual opportunity to choose between the plans.30 Finally, the Wisconsin Commissioner of Insurance has issued regulations requiring that preferred provider plans ensure that patients are not forced to travel excessive distances to receive services (the regulations state that preferred providers for primary care and emergency services must be available within 30 minutes travel time of the person's place of residence) and that continuity of patient care not be disrupted.30

WYOMING

Wyoming's PPO enabling statute31 provides that an insurance company or health service corporation (Blue Cross/Blue Shield) may enter into agreements with any provider relating to health care services that may be rendered to insureds of the group, including amounts to be charged the insureds for services rendered. The agreements may include incentives for an insured to choose the preferred providers and may limit the amount of reimbursement for health care services provided by nonpreferred providers. The statute does, however, prohibit "gatekeeper" agreements.

Wyoming's PPO statute overrides any other Wyoming statutes to the contrary, and is one of the most favorable in the country.

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30The ERISA preemption of this state regulation for self-insured employee benefit plans has been upheld by the courts in, e.g., Port Howard Paper Co. v. Fox, No. 83-c-1907 (E.D. Wis. 1984).


However, Wyoming's relatively sparse population makes it unlikely that PPOs will proliferate in that state for reasons of provider accessibility, because discounts are less likely to be generated on the basis of anticipated additional patient volume.
Appendix B

COMPILATION OF APPLICABLE LEGAL AUTHORITIES

ALABAMA

PPO Legislation

Currently there is no PPO legislation in Alabama.

Commercial Insurers

Ala. Code § 27-1-10 (1975). The insured or other person entitled to benefits for health services shall have the exclusive right to choose or select any member of the healing arts.

Ala. Code § 27-20-7 (1979). Any blanket disability policy may not require that the service be rendered by a particular hospital or person.

Ala. Code § 27-12-11 (1971). No person shall make or permit any unfair discrimination between the amount of premium, policy fees, or rates charged for any policy or contract of disability insurance hereinafter cited as the unfair discrimination provision.

Ala. Code § 27-19A-1 et seq. This law effectively prevents formation of PPOs for dental care by permitting the insured to have free choice in the selection of any dentist and by prohibiting the denial of a dentist’s participation as a provider in any health policy or plan.

Health Service Corporations

Ala. Code § 10-4-100 et seq. Health Care Service Plans.


Health Maintenance Organizations

Ala. Code § 22-21-260(5) (1984). Defines “health care facilities” to include HMOs and they are licensed by the State Board of Health.

Chapter 420-5-6 et seq., Rules of the Alabama State Board of Health, Bureau of Licensure and Identification. These rules define
HMOs as entities that provide health care services on a prepaid per capita or a prepaid fixed sum basis.

**Professional Licensure**


*Lee Optical Company of Alabama v. State of Board of Optometry,* 261 So.2d 17 (1972). The Alabama Supreme Court held that an optical company did not engage the practice of optometry by employing registered optometrists.


Ala. Code § 34-24-360 (1983). It is unprofessional conduct to agree to split or divide fees for professional services with any person for bringing or referring a patient.


Ala. Code § 34-9-18 (1981). A dentist may have his license suspended or revoked for agreeing to divide any fee received for dental services with any person for bringing or referring a patient.


Ala. Code § 22-21-20 *et seq.* Hospital licensing provisions.

**Peer Review**

Ala. Code § 6-5-333 (1982). Any dentist, chiropractor, or physician licensed to practice medicine in Alabama who serves on a peer review or utilization or quality control committee shall not be liable to any person for damages as a result of any action taken or recommendation made by him in the scope of his function as a member of or employee or consultant of any such review committee.

**ALASKA**

**PPO Legislation**

There is currently no PPO legislation in Alaska.
Commercial Insurers

Alaska Stat. § 21.54.020 (1966). A group disability policy may not require that the service be rendered by a particular hospital or person.

Health Service Corporations

Alaska Stat. § 21.87.010 et seq. Hospital and Medical Service Corporations.
Alaska Stat. § 21.87.160 (1981). A Hospital or Medical Service Plan may not restrict the subscriber's right to free choice of provider or hospital, but it shall restrict benefits to be provided on a service basis to services rendered by participant providers and participant hospitals.

HMO Legislation

There are no HMO statutes in Alaska.

Professional Licensure

Alaska Stat. § 08.64.170 et seq. Physician Practice Act. See also 12 Alaska Admin. Code 40.790 et seq.
Alaska Stat. § 08.64.200 (1974). The statute provides the qualifications for physician applicants including good moral character and educational requirements.
Alaska Stat. § 08.72.110 et seq. Optometry licensing and registration. See also 12 Alaska Admin. Code 48.970 et seq.
Alaska Stat. § 08.86.110 et seq. Psychology Practice Act. See also 12 Alaska Admin. Code 60.150. et seq.

Peer Review

Alaska Stat. § 18.23.010 et seq. No person who is a member or employee of or acts in an advisory capacity to, or furnishes information
to a review organization is liable for damages by reason of his performance of that duty, function, or activity on the review organization.

ARIZONA

PPO Legislation

There is currently no PPO legislation in Arizona.

Commercial Insurers

Ariz. Rev. Stat. § 20-1403 (1954). Any group disability policy may not require that the service be rendered by a particular hospital or person.

Ariz. Rev. Stat. § 20-1406 (1983). If any group disability or blanket disability contract provides or offers eye care services, the subscriber shall have freedom of choice to select either an optometrist or physician.

Ariz. Rev. Stat. § 20-1406.01 (1983). If any group disability or blanket disability insurance contract provides for reimbursement for any service which is within the lawful scope of the practice of a psychologist, a subscriber coverage under such contract may select either a physician or psychologist to provide the services.


Health Service Corporations

Ariz. Rev. Stat. § 20-821 et seq. The Hospital, Medical and Dental Services Corporation Act.


Health Maintenance Organizations

Ariz. Rev. Stat. § 20-151 et seq. Arizona’s Health Care Services Organizations Act includes health maintenance organizations that pro-
vide for basic health care services on a prepaid basis. See also Ariz. Admin. Comp. Rule 9-12-101 et seq.

Professional Licensure

Ariz. Rev. Stat. § 36-2901 et seq. Arizona Health Care Cost Containment System. This system provides for prepayment capitation coverage for the providers of in-patient services for the covered recipients.
Ariz. Rev. Stat. § 32-1201 (1984). Dentists may have their license suspended or revoked for giving or receiving rebates, either directly or indirectly.
Ariz. Rev. Stat. § 32-1701 (1982). An optometrist may have his license suspended or revoked for giving or receiving rebates.
Ariz. Admin. Comp. Rule 4-21-04 (1980). No optometrist shall divide, share, split, either directly or indirectly, any fee for optometry services or materials with any lay person, firm, or corporation.
State of Board of Optometry v. Sears Roebuck & Co., 102 Ariz. 175, 427 P.2d 126 (1967). The Supreme Court of Arizona held that a corporation can neither practice optometry itself nor practice optometry through employing licensed optometrists.
Op. Att'y Gen. No. 181-32. It is the opinion of the Attorney General that now deleted § 32-854-01, which prohibited referral payments, did not prohibit the offering of discounted fees to patients.
Ariz. Rev. Stat. § 32-1927 (1984). A pharmacy or pharmacist may have his license suspended or revoked for paying rebates or entering into an agreement for the payment of rebates to a medical practitioner or any other person in the health field. See also Ariz. Admin. Comp. Rule 4-23-404, which makes rebates or discounts an unethical practice.
Op. Att’y Gen. I79-291. It is the opinion of the Attorney General that a discount given for prompt payment offered by a pharmacist to a nursing home would constitute the payment of a rebate in violation of § 32-1927.

Peer Review Privileges

Ariz. Rev. Stat. § 36-441 et seq. A person is not subject to liability for civil damage who without malice makes a decision or recommendation as a member, agent, or employee of a health care utilization committee.

Ariz. Rev. Stat. § 36-2401 et seq. A person who in good faith and without malice takes any action or makes any decision or recommendation as a member, agent, or employee of a health care peer review committee shall not be subject to civil damages.

ARKANSAS

PPO Legislation

Arkansas Insurance Department Bulletin 9-85 states that it is the Insurance Department’s official opinion that insurers may form and/or participate in preferred provider organizations.

Commercial Insurers

Ark. Stat. § 66-3703 (1959). Any group disability policy may not require that the service be rendered by a particular hospital or person.
Ark. Stat. § 66-3707 (1959). Any blanket disability policy may not require that the service be rendered by a particular hospital or person.
Ark. Stat. § 66-32-12 et seq. These statutes provide for the freedom of choice between a physician and other types of nonphysician providers as well as the equal payment/reimbursement between these physicians and nonphysician providers.

Health Service Corporations
Ark. Stat. § 66-4901 et seq. Hospital and Medical Corporations.
Ark. Stat. § 66-4914 (1959). A medical or hospital service plan may not influence a subscriber’s free choice of hospital or physician, other than to limit its benefits to participating hospital and physicians. In addition, no such hospital or medical corporation shall be deemed to be engaged in the corporate practice of medicine.

Health Maintenance Organizations
Ark. Stat. § 66-5201 et seq. Arkansas’s Health Maintenance Organization Act of 1975 defines an HMO as any arrangement whereby the cost of any health care services is reimbursed on a prepaid basis to insurance or otherwise.

Professional Licensure
Ark. Stat. § 72-605 (1977). This statute provides the qualifications for applicants for medical licensure.
Ark. Stat. § 72-559 (1955). It is unlawful for any corporation to practice dentistry or to hold itself out as entitled to engage therein.

Peer Review Privileges
Ark. Stat. § 82-3201 et seq. There shall be no monetary liability on the part of and no cause of action for damages shall arise against any member of a peer review committee for any act or proceeding under-
taken or performed within the scope of the functions of such committee.

CALIFORNIA

PPO Legislation


Commercial Insurers

Cal. Ins. Code § 10133 (1982). A disability insurer may not participate in or control the selection of doctors or physicians from whom the insured has secured services, except that any insurer may negotiate and enter into contracts for alternative rates of payment and offer the benefits of such alternative rates to insureds who select such providers.

Cal. Ins. Code § 10401 (1982). The unfair discrimination provision. The payment to insureds by an insurer of alternative rates of payment negotiated and contracted for with institutional providers will not constitute a violation of this section.

Cal. Ins. Code § 740 (1984). Any person who provides coverage in California for medical expenses, whether such coverage is by direct payment or reimbursement or otherwise, shall be presumed to be subject to the jurisdiction of the insurance department.

Health Service Corporations


Cal. Ins. Code § 11512 (1983). No hospital service contract shall in any way or manner restrict or interfere with the right of any individual to select the contracting hospital or to make a free choice of his or her attending physician, except that this provision does not apply when the plan has been negotiated and entered into for alternative rates of payment with institutional providers or physicians.
Health Maintenance Organizations

Cal. Health & Safety Code § 437.03 et seq. The Health Planning Act defines an HMO to mean a public or private organization that provides basic health care services to enrolled participants on a predetermined periodic rate basis.

Professional Licensure


Cal. Bus. & Prof. Code § 2400 (1980). Corporations and other artificial entities shall have no professional rights, privileges, or powers.

Cal. Bus. & Prof. Code § 650 et seq. The offer, delivery, receipt, or acceptance by any licensed professional person of any rebate, refund, commission, discount, or other consideration, as compensation or inducement for referring patients, is unlawful.

Cal. Health & Safety Code § 1401 (1973). A referral agency means a private, profit, or nonprofit agency that is engaged in referring persons for remuneration to any extended care, skilled nursing home, or immediate care facility.

Cal. Health & Safety Code § 449 (1974). No person or corporation shall for profit refer or recommend any person to a physician, hospital, or health-related facility.

People v. Pacific Health Corporation, Inc., 12 Cal.2d 156, 82 P.2d 429 (1939). The California Supreme Court held that a corporation may not engage in the practice of such professions as law, medicine, or dentistry.

65 Op. Att’y Gen. 223 (1982). It is the opinion of the Attorney General that a corporation may not lawfully engage licensed physicians to treat employees of another entity.


Cal. Bus. & Prof. Code § 2052 (1980). Any person who practices or attempts to practice any system or mode of treating the sick without having a valid unrevoked license is guilty of a misdemeanor.

1 Op. Att'y Gen. 381 (1941). It is the opinion of the Attorney General that a doctor is prohibited from operating under the name of a corporation.


*Masters v. Board of Dental Examiners*, 15 Cal. App. 2d 506 (1936). The California Court of Appeals held that a corporation cannot practice dentistry directly or indirectly, and it follows that it cannot obtain a license to practice dentistry and it is unlawful if it does practice dentistry.

Cal. Bus. & Prof. Code § 1680 (1984). It is unprofessional conduct for a dentist to accept or receive any commission or rebate in any form or manner.


Cal. Bus. & Prof. Code § 2960 (1984). Psychologists may have their license suspended or revoked for accepting commissions or rebates or other forms of remuneration for referring persons to other professionals.


**Peer Review Privileges**

Cal. Civ. Code § 43.7 et seq. There shall be no monetary liability against any person for the communication of information to any peer review committee when such communication is intended to aid in the evaluation of the qualifications, fitness, character, or insurability of a practitioner of the healing arts.

Cal. Evid. Code § 1157 (1983). Neither the proceedings nor the records of organized committees of the medical staffs of hospitals shall be subject to discovery.
COLORADO

PPO Legislation

There is currently no PPO legislation in Colorado. PPO legislation, which would have permitted insurance-based PPOs (Colorado HB 1330 (1983)), was proposed and defeated.

Commercial Insurers


Health Service Corporations

Colo. Rev. Stat. § 10-16-107 (1963). A nonprofit hospital or health service corporation may not influence or seek to influence any subscriber in the choice or selection of a contracting hospital or contracting physician.

Health Maintenance Organizations

Colo. Rev. Stat. § 10-17-101 et seq. Colorado’s Health Maintenance Organization Act. Defines HMOs to mean any person who arranges or provides for health care services to enrollees on a fixed prepayment basis.

Professional Licensure

Colo. Rev. Stat. § 12-36-125 (1979). A physician may be guilty of a misdemeanor for fee-splitting, or for either directly or indirectly paying or compensating another person for sending or referring any patient.
Colo. Rev. Stat. § 12-35-118 (1981). A dentist may have his license suspended or revoked for sharing any professional fees.
Colo. Rev. Stat. § 12-118(1) (1983). An optometrist may be guilty of unprofessional conduct for the sharing of any professional fees or for interfering with the free choice of selecting a physician or other health care practitioner. See also 4 CCR 23-1 (Regulations).
Colo. Rev. Stat. § 12-43-111 (1982). A psychologist may have his license suspended or revoked if he has accepted commissions or rebates or other forms of remuneration for referring clients to other professional persons.

Peer Review Privileges

Colo. Rev. Stat. § 12-43.5-101 et seq. A member of a review committee or a witness before a review committee shall be immune from suit in any civil action brought by a physician who is the subject of review by such committee.

CONNECTICUT

PPO Legislation

There is currently no PPO legislation in Connecticut.

Commercial Insurers

Conn. Gen. Stat. § 38-174 (1979). Nothing in Section 38-172 shall apply to or affect accident, health or accident, and health policies or certificates issued upon a group plan as defined by the commissioner.
Conn. Gen. Stat. § 38-262K (1983). An employer who offers dental benefits must make sure that the insured has the option of at least one dental plan which allows that subscriber the freedom to select any duly licensed dentist of his own choice.
Rate Setting


Health Service Corporations


Health Maintenance Organizations


Professional Licensure


28 Op. Att’y Gen. 248 (Dec. 3, 1954). The practice of medicine and surgery is restricted to individuals and does not include a corporation; however, nonprofit charitable hospitals are excepted.
Kronholz v. State Board of Optometry, 21 Conn. Supp. 332, 154 A.2d 619 (1959). The Superior Court held that the practice of optometry should be treated as a profession, but that it should not be construed as unprofessional conduct for an optometrist to practice his profession while employed by a store.
Conn. Gen. Stat. § 20-175 (1984). A pharmacist or pharmacy may have his license suspended or revoked for the splitting of fees for pro-
fessional services, including discounts or rebates with any physician, dentist, podiatrist, or hospital.


Peer Review Privileges

Conn. Gen. Stat. § 52-557e (1982). No action shall be taken against a physician serving as a member of a hospitalization review committee.
Conn. Gen. Stat. § 38-19a (1982). There shall be no monetary liability against any member of a medical review committee for any act or proceeding undertaken or performed within the scope of any such committee's functions.

DELAWARE

PPO Legislation

There is currently no PPO legislation in Delaware.

Commercial Insurers

Del. Code 18 § 3504 (1953). Any group health policy may not require that the service be rendered by a particular hospital or person.
Del. Code 18 § 3509 (1953). Any blanket health policy or contract may not require that the service be rendered by a particular hospital or hospital.

Health Service Corporations


Health Maintenance Organizations

Del. Code 16 § 9901 et seq. An HMO means any public or private organization that provides or otherwise makes available basic health care services to enrolled participants on a predetermined periodic rate basis.
Professional Licensure

Del. Code 16 § 9301 et seq. Equitable Health Planning and Review.
Del. Code 24 § 1702 (1962). No person shall practice medicine without a license and the qualifications for licensure are found at Section 1720.

Peer Review Privileges

Del. Code 24 § 1768 (1979). Members of review committees and witnesses testifying before them are immune from suit regarding the review proceedings.

DISTRICT OF COLUMBIA

PPO Legislation

There is currently no PPO legislation in the District of Columbia.

Commercial Insurers

D.C. Code § 35-517 (1953). All policies of health insurance may not require that the service be rendered by a particular hospital or person.
D.C. Code § 35-1533 (1973). Discrimination between individual risks of the same class or hazard is prohibited.
D.C. Code § 35-530 (1982). Any person shall be free to select and have direct access to any psychologist or optometrist without supervision or referral by a practitioner of the healing arts.

Health Service Corporations

There is currently no legislation pertaining to health service corporations in the District of Columbia.
Health Maintenance Organizations

There is no legislation pertaining to HMOs in the District of Columbia.

Professional Licensure


D.C. Code § 29-303 (1978). A corporation may be organized for any lawful purpose, except for the purpose of banking or life insurance.

*United States v. American Medical Association*, 72 App. D.C. 12 n.6, 110, F.2d, 703 n.6 (1940). The court held that a corporation is unlawfully engaged in the practice of medicine where the corporation operates a clinic or hospital, employs licensed physicians and surgeons to treat patients, and itself receives the fee.


D.C. Code § 2-1302 (1973). No person shall practice the healing arts who is not licensed to do so.


D.C. Code § 2-1326 (1981). A physician may have his license suspended or revoked for agreeing to split or divide fees received for professional services, or for accepting or giving compensation for the referral of patients to other health care providers.


*Silver v. Lansburgh and Brothers*, 111 F.2d 518 (D.C. Cir. 1940). The court held that a corporation may employ a licensed optometrist to perform optometrical services for the corporation's patrons, since optometry is not a learned profession and does not fall within the same rules as those preventing the practice of law and medicine through corporations.


Peer Review Privileges

D.C. Code § 32-501 et seq. No member of a peer review committee shall be liable to any other person for damages or equitable relief by reason of any action or recommendation made by the member or the committee to which the member belongs.
FLORIDA

PPO Legislation


Commercial Insurers

Fla. Stat. § 626.9541 (1985). The unfair discrimination provision. However, alternative rates of payment are expressly exempted from this section.
Fla. Stat. § 627.6577 (1984). An employer who offers dental benefits must make sure that the subscriber has the option of at least one dental plan that allows the insured the freedom to select any duly licensed dentist of his own choice.
Fla. Stat. § 624.33 (1984). Any person who, provides any type of health insurance coverage in this state, whether such coverage is by direct payment, reimbursement, or otherwise, shall, upon request, file certain forms with the Department of Insurance.

Health Service Corporations


Health Maintenance Organizations

Fla. Stat. § 641.17 et seq. The Health Maintenance Organization Act defines an HMO as a prepaid health care plans for enrolled participants.

Professional Licensure

Fla. Stat. § 641.01 et seq. Health Care Service Programs.
Fla. Stat. § 458.331 (1981). A physician may be subject to disciplinary action for paying or receiving any commission, kickback, or rebate, or engaging in any fee-splitting arrangement.
Fla. Stat. § 466.028 (1983). Dentists may be subject to disciplinary action for being employed by any corporation or other person other than a dentist or professional association composed of dentists.
Fla. Stat. § 461.013 (1979). Podiatrists may be subject to disciplinary action for paying or receiving any commission, kickback, or rebate, or engaging in any fee-splitting arrangement.
Fla. Stat. § 490.009 (1984). A psychologist may be subject to discipline for paying or receiving a kickback, rebate, or other remuneration for receiving or referring a patient or client to another provider.
Fla. Stat. § 483.245 (1979). It is unlawful for a clinical laboratory to pay or receive any commission, kickback, or rebate, or engage in any fee-splitting arrangement with any physician or other person.
Fla. Stat. § 395.001 et seq. Hospital Licensing provisions.
Fla. Stat. § 395.0185 (1982). It is unlawful for any person to pay or receive any kickback or rebate or engage in any split-fee arrangement for patients referred to a licensed facility.

Peer Review Privileges

Fla. Stat. § 768.40 (1980). There shall be no monetary liability against any member of a duly appointed medical review committee.

GEORGIA

PPO Legislation

There is currently no PPO legislation in Georgia.

Commercial Insurers

shall not require that the service be rendered by a particular hospital or person.

Health Service Corporations

 Ga. Code § 33-18-17 (1973). Subscribers shall have the free choice to obtain the services of any licensed physician, dentist, or podiatrist.
 Ga. Code § 33-18-18 (1973). Every physician, dentist or podiatrist in good standing has the right to become a participating physician in the medical service corporation.
 Ga. Code § 33-19-13 (1960). The subscriber shall have the right to obtain the service of any licensed hospital.
 Ga. Code § 33-20-16 (1976). Every provider in good standing shall have the right to become a participating physician.
 Ga. Code § 33-20-18 (1976). The subscriber shall have the right to obtain the service of any licensed physician, dentist, or podiatrist.

Health Maintenance Organizations

Ga. Code § 33-21-1 et seq. The Health Maintenance Organization Act defines an HMO as a plan that arranges for basic health care services on a prepaid basis.

Professional Licensure

Ga. Code § 43-34-37 (1983). A physician may have his license suspended or revoked for fee-splitting or agreeing to divide fees received for professional services with any person, or for bringing or referring a patient. See also Ga. Admin. Comp., Chapter 360-2.


Op. Att’y Gen. 82-71 (Aug. 27, 1982). It is the Attorney General’s Opinion that prepaid dental plans may constitute the offering of insurance under certain conditions.


Ga. Code § 43-35-7 (1984). A podiatrist may have his license suspended or revoked for the division of fees for professional services or for bringing or referring a patient for remuneration.


Ga. Admin. Comp. Chapter 430-4-.01 (1984). It is unprofessional conduct for an optometrist to agree to divide or split fees with any person when referring or bringing a patient.

Pearle Optical of Monroeville, Inc. v. State Board of Optometry, 219 Ga. 364, 133 S.E.2d 374 (1963). The Supreme Court of Georgia held that the rules inhibiting employment of a licensed optometrist by an unlicensed person or corporation is in keeping with the public policy of this state.


Ga. Admin. Comp. Chapter 480-11-.01 (1985). It is unprofessional conduct for a pharmacist to enter into any agreement that denies the public the right of free choice of pharmacists.


Bradfield v. Hospital Authority of Muscogee County, 220 Ga. 575, 176 S.E. 2d 92 (1970). The Supreme Court of Georgia held that a suitable private corporation may properly operate a hospital either as lessee or as owner, so as to promote the public health functions of government.
Peer Review

Ga. Code § 31-7-130 et seq. No person providing information to any review organization shall be civilly libel under any law.
Ga. Code § 31-7-140 et seq. There shall be no monetary liability against any member of a duly appointed medical review committee for any act or proceeding taken or performed within the scope of the functions of such committee.

HAWAII

PPO Legislation

There is currently no PPO legislation in Hawaii.

Commercial Insurers

Hawaii Rev. Stat. § 431-473 (1955). The payment of claims provision may, at the option of the insurer, provide that it is not required that the service be rendered by a particular hospital or person.
Hawaii Rev. Stat. § 431-521 (1959). Any group or blanket disability policy may not require that the service be rendered by a particular hospital or person.

Health Service Corporations


Health Maintenance Organizations

There is currently no HMO legislation in Hawaii.

Professional Licensure

Hawaii Rev. Stat. § 453-4 (1984). This provision provides the qualifications to obtain a medical license.


Hawaii Rev. Stat. § 448-17 (1974). A dentist may have his license suspended or revoked for agreeing to split or divide the fees received for dental services with any person for bringing or referring a patient.


Hawaii Rev. Stat. § 459-9 (1979). An optometrist may have his license suspended or revoked for receiving, directly or indirectly, any price differential, rebate, discount, or kickback for referring or sending to the dispensing optician any patient.


Peer Review

Hawaii Rev. Stat. § 435E-34 (1977). No peer review committee, or any of its members shall be libel for any action taken by the committee in reviewing the qualifications of a physician and surgeon.

Hawaii Rev. Stat. § 624-25.5 (1982). Neither the proceedings nor the records of peer review committees in hospitals shall be subject to discovery.

Hawaii Rev. Stat. § 663-1.7 (1976). There shall be no civil liability for any member of a peer review committee for any acts done in furtherance of the purpose for which the committee was established.

IDAHO

PPO Legislation

There is currently no PPO legislation in Idaho.
Commercial Insurers

Idaho Code § 41-2204 (1961). Any group disability policy may not require that the service be rendered by a particular hospital or person.
Idaho Code § 41-2209 (1961). Any blanket disability policy may not require that the service be rendered by a particular hospital or person.

Health Service Corporations

Idaho Code § 41-3401 et seq. The Hospital and Professional Service Corporations Act.
Idaho Code § 41-3417 (1971). Subscribers shall have the free choice of any participating hospitals and physicians.

Health Maintenance Organizations


Professional Licensure

Idaho Code § 54-1814 (1979). A physician may have his license suspended or revoked for agreeing to split or divide fees received for professional services with any person in exchange for referrals, or for giving or receiving rebates, either directly or indirectly.
Idaho Code § 54-901 et seq. Dental Practice Act.
Idaho Code § 54-609 (1982). It is unprofessional conduct for a podiatrist to either accept or receive any rebates or commissions for recommending any footware, drug, medicine, or other article to his patients.
Idaho Code § 54-1501 et seq. Optometry Practice Act.
Idaho Code § 54-2301 et seq. Psychology Practice Act.
Peer Review

Idaho Code § 39-1392 et seq. The records of any in-hospital medical staff committee shall be confidential and privileged and any person providing information to such committee shall be immune from civil liability.

ILLINOIS

PPO Legislation

Ill. Admin. Reg. 50 6501.10 et seq. Emergency rules for the regulation of preferred provider plans and administrators.

Commercial Insurers

Ill. Stat. 73 § 979 (1984). Any group accident and health insurance policy may not require that the service be rendered by a particular hospital or person.
Ill. Stat. 73 § 979(a) (1984). Any blanket accident and health insurance policy may not require that the service be rendered by a particular hospital or person.
Ill. Stat. 73 § 976 (1985). Discrimination between individuals of the same class in the amount of premiums or rates charged is prohibited.
Senate Bill No. 669. Signed into law August 16, 1985. Creates the Employee’s Dental Freedom of Choice Act. Any employer that purchases dental insurance for its employees that requires such employees to obtain services from an approved list of dentists must provide an alternative plan whereby the employees or members may receive similar services from a dentist of their own choosing.

Health Service Corporations

Ill. Stat. 32 § 569 (1945). Every physician in good standing shall be eligible to become a participating physician in the medical service plan corporation.
Ill. Stat. 32 § 601 (1951). Subscribers shall have the free choice of any participating physician, dentist, or podiatrist.
Health Maintenance Organizations

Ill. Stat. 111-1/2 § 1402 et seq. The Health Maintenance Organization Act defines an HMO as any health care plan that arranges or provides for any basic health care services on a per capita prepaid basis.

Professional Licensure

Ill. Stat. 32 § 632 et seq. The Medical Corporation Act.
Ill. Stat. 111 § 4433 (1983). A physician or state hospital may have its license suspended or revoked for directly or indirectly giving to or receiving from any physician, any fee, rebate, or other form of compensation for any professional services not actually and personally rendered.
Ill. Stat. 111 § 4434(a) (1984). It is unlawful to advertise that a physician will accept as full payment from a third party the amount the third party covers as payment in full.
Ill. Stat. 111 § 4460 (1973). It is unlawful for any person to practice medicine without a license.
Ill. Stat. 111 § 4473 (1983). The practice of medicine without a valid license is declared to be inimical to the public welfare and constitutes a public nuisance.

Kerner v. United Medical Service, Inc., 362 Ill. 442, 200 N.E. 157 (1936). The Supreme Court of Illinois held that a corporation cannot obtain a license to engage in the practice of medicine, and the Business Corporation Act authorizing formation of a corporation for any lawful purpose does not authorize a corporation to engage in the practice of a learned profession such as medicine.
Ill. Stat. 111 § 2222 (1984). A dentist may have his license suspended or revoked for agreeing to split or divide the fees received for dental services with any person for bringing or referring a patient.

People v. United States Dental Institute, Inc., 57 Ill. App. 3d 1029, 373 N.E.2d 635 (1978). The court held that it was the illegal practice of dentistry by a corporation for a school’s instructors to give its student-dentists direct advice regarding the care of that student-dentist’s clients.

Dubin v. Department of Registration and Education, 396 Ill. 276, 71 N.E.2d 785 (1947). The court held that it was unlawful for a dentist to practice medicine under the name of “Madison Dental Laboratory”
because this manner of carrying on the practice of dentistry violated the strict provisions forbidding the practice of dentistry under the name of a corporation.

_Basford v. Department of Registration and Education_, 390 Ill. 601, 62 N.E.2d 482 (1945). The court held that a corporation was unlawfully engaged in the practice of dentistry when a dentist’s patients were not patients of the dentist, but rather patients of the corporation.

_Winberry v. Hallihan_, 361 Ill. 121, 197 N.E. 552 (1935). The court upheld the constitutionality of the Dental Practice Act which provides that no corporation shall practice dentistry or hold itself out as being entitled to practice dentistry.

_Dr. Allison, Dentist, Inc. v. Allison_, 360 Ill. 638, 196 N.E. 799 (1935). The court held that no corporation can qualify for the practice of a profession because professional requirements are spoken of generically as good moral character which is a prerequisite to the licensing of any professional person and no corporation can qualify as having good moral character.


Ill. Stat. 111 § 4922 (1980). A podiatrist may have his license suspended or revoked for directly or indirectly giving to or receiving from any person, any fee, rebate, or other form of compensation for any professional services not actually and personally rendered.


_Klein v. Rosen_, 327 Ill. App. 375, 64 N.E.2d 225 (1945). The court held that optometry is not one of the learned professions and therefore optometry could be practiced by a corporation.


Ill. Stat. 111 § 5316 (1983). A psychologist may have his license suspended or revoked for directly or indirectly giving or receiving from any person, any fee, rebate, or other form of compensation for any professional service not actually and personally rendered.

Ill. Stat. 111 § 621-103 et seq. Clinical Laboratory Licensure.


**Peer Review**

Ill. Stat. 111 § 4406 (1977). Any person serving upon any utilization committee or peer review committee shall not be liable for civil damages as the result of his acts, omissions, or decisions in connection with his duties on such committees.

Ill. Stat. 111-1/2 § 4141 et seq. Any person serving upon a peer review committee whose purpose is to evaluate the qualifications of
long-term care providers will not be liable for civil damages as a result of his or her acts, omissions, or decisions in connection with his or her duties on such a committee.

**INDIANA**

**PPO Legislation**

Ind. Code § 27-8-11-1 et seq. Indiana PPO Legislation.

**Commercial Insurers**

Ind. Code § 27-8-5-10 (1974). Any group accident and sickness insurance policy may not require that the services be rendered by a particular hospital or person.


**Health Service Corporations**

There is currently no legislation pertaining to health service corporations in Indiana.

**Health Maintenance Organizations**

Ind. Code § 27-8-7-1 et seq. The prepaid health care delivery plan act defines an HMO as any plan that provides for or arranges for health care services to individuals voluntarily enrolled with such an organization on a per capita or a predetermined, fixed prepayment basis.

**Professional Licensure**

Ind. Code § 23-1.5-1-1 et seq. The Professional Corporations Act.

Ind. Code § 27-8-10-1 et seq. The Comprehensive Health Insurance Act.


Ind. Code § 25-22.1-8-1 (1975). It is unlawful for any person to practice medicine without a license.

*Huber v. Protestant Deaconess Hospital Association of Evansville*, 127 Ind. App. 565, 133 N.E.2d 864 (1956). The court held that a corpora-
tion may neither practice medicine nor engage in the practice of medicine by employing one who is licensed to practice medicine.

*Itzman v. Baker, 214 Ind. 308, 15 N.E.2d 365 (1938).* The Supreme Court of Indiana held that a corporation or other unlicensed person may not engage in the practice of medicine by employing one who is licensed to so practice.

1931-32 Op. Att’y Gen. 669 (1932). It is the opinion of the Attorney General that a corporation is not authorized to practice medicine within the meaning of the Medical Registration Act because there is no method by which a corporation can qualify for a medical license.


*State Board of Dental Examiners v. Boston System Dentists, 125 Ind. 485, 19 N.E.2d 949 (1939).* The Supreme Court of Indiana held that a corporation that maintains an office for the practice of dentistry, owned equipment, paid operating expenses, and employed licensed dentists who carried on dental practices in the office is engaged in the practice of dentistry in violation of statutes requiring a license.

Ind. Code § 16-12-21-12 et seq. Public Hospital licensure Provisions.

**Peer Review**

Ind. Code § 34-4-12.6-1 et seq. The personnel of a peer review committee shall be immune from any civil action arising from any determination made in good faith in regard to the evaluation of patient care.

**IOWA**

**PPO Legislation**

House Bill No. 570 (1985). This bill, which became effective on July 1, 1985, amended sections 508.29 and 515.48(5)(a) of the Iowa Code to provide that an insurer may contract with health care service providers and offer different levels of benefits to policyholders based upon the provider contracts.
Commercial Insurers

Iowa Code § 544A.1 (1981). A policy of accident and sickness insurance may, at the option of the insurer, provide that it is not required that the service be rendered by a particular hospital or person.


Health Service Corporations

Iowa Code § 514.1 et seq. Mutual Hospital Service Corporations Act.

Health Maintenance Organizations

Iowa Code § 514B et seq. The Health Maintenance Organization Act defines an HMO as any person who provides or arranges for health care services to enrollees on a fixed prepayment basis.

Professional Licensure

Iowa Code § 496B.1 et seq. The Professional Corporations Act.


Iowa Code § 153.32 (1981). It is unprofessional conduct for any dentist to receive any rebate or other thing of value, directly or indirectly, from any dental laboratory or dental technician; or to divide fees or agree to split or divide the fees received for professional services with any person for bringing or referring a patient.

Iowa Admin. Code § 320-30.4(153) (1979). A dentist shall be subject to discipline by the board for splitting fees, accepting rebates, or accepting commissions from any source associated with the service rendered to the patient.

Iowa Code § 154.1 et seq. Optometry Practice Act.

Iowa Code § 149.1 et seq. Podiatry Practice Act.

Iowa Code § 154B.1 et seq. Psychology Practice Act.

Iowa Code § 155B.1 et seq. Licensure and Regulation of Hospitals.

Iowa Code § 347.7 et seq. County Public Hospitals Provisions.

Iowa Code § 347.18 (1981). Each patient shall have the right to employ at the patient’s expense any physician of the patient’s choice at a county public hospital.
Peer Review

Iowa Code § 258A.8 (1981). A person shall not be liable for civil damages as a result of filing a report or complaint with a peer review committee.

KANSAS

PPO Legislation

Senate Bill No. 19 (1985). This bill amends Kansas Statute § 40-231 to allow insurance-company-sponsored PPOs.

Commercial Insurers


Health Service Corporations


Health Maintenance Organizations

Kan. Stat. § 40-3201 et seq. The Health Maintenance Organization Act defines an HMO as an organization that provides or otherwise makes available to enrollees, health care services on a predetermined periodic rate basis.

Professional Licensure

Kan. Stat. § 65-2804 (1983). This statute provides the qualifications an applicant needs to obtain a license in the healing arts.
Kan. Stat. § 65-1436 (1984). A dentist may have his license suspended or revoked if he is engaged in the division of fees or agrees to split or divide any fee received for dental services with any person for bringing or referring a patient.
State ex rel. Beck v. Goldman Jewelry Company, 142 K. 881, 51 P.2d 995 (1935). The Supreme Court of Kansas held that a corporation may not engage in the practice of optometry, either directly or indirectly, through the employment of duly registered optometrists.

Peer Review

KENTUCKY

PPO Legislation
There is currently no PPO legislation in Kentucky, although authorizing regulations are being developed.

Commercial Insurers
Ky. Rev. Stat. § 304.18-040 (1970). Any group health policy may not require that the service be rendered by a particular hospital or person.
Ky. Rev. Stat. § 304.18-090 (1970). Any blanket health policy may not require that the service be rendered by a particular hospital or person.
Health Service Corporations

Ky. Rev. Stat. § 304.32-010 et seq. The Hospital, Medical-Surgical and Dental Health Service Corporations Act.

Health Maintenance Organizations

Ky. Rev. Stat. § 304.38-010 et seq. The Health Maintenance Organization Act defines an HMO as any person who provides or arranges for health care services to individuals voluntarily enrolled with such an organization on a per capita or predetermined, fixed prepayment basis.

Professional Licensure

Ky. Rev. Stat. § 313.140 (1964). A physician may be guilty of unprofessional conduct for fee-splitting, or for giving or receiving, directly or indirectly, any fee, rebate, or other form of compensation for referring patients.

Johnson v. Stumbo, 277 Ky. 301 (1939). The Supreme Court of Kentucky stated that a majority of the previous decisions are to the effect that a corporation may not engage in the practice of medicine.
Kendall v. Beiling, 295 Ky. 782 (1943). The Supreme Court of Kentucky held that a corporation was aiding and abetting the unauthorized practice of optometry by employing an optometrist.
Ky. Rev. Stat. § 333.240 (1968). No person shall operate or maintain a medical laboratory and contract to perform medical laboratory examinations in a manner that implies an offer of a rebate to a person
or persons submitting specimens, or for any other fee-splitting inducements.


Peer Review

Ky. Rev. Stat. § 311.377 (1980). Any person granted staff privileges is deemed to have waived any claim for damages taken by any person who is a member of any committee designated to review and evaluate the health care acts of other health care personnel.

Ky. Rev. Stat. § 311.600 et seq. Members of the board shall be immune from suit in any action, civil or criminal, which is based upon any official act or acts performed by the board in good faith.

LOUISIANA

PPO Legislation


Commercial Insurers


Health Service Corporations


Health Maintenance Organizations

There is currently no HMO legislation in Louisiana.
Professional Licensure

La. Rev. Stat. § 37:1285 (1977). A physician may have his license suspended or revoked for paying or presenting to any person money or anything of value for the purpose of securing patients.
1948-50 Op. Att’y Gen. 60 (1948). Corporations may not engage in the practice of medicine because they cannot meet the qualification requirements enumerated in the statute.
La. Rev. Stat. § 37:776 (1982). A dentist may have his license suspended or revoked for the division of fees, or the agreement to divide the fees received for dental services with any person for bringing or referring a patient.
La. Rev. Stat. § 37:624 (1970). A podiatrist may have his license suspended or revoked for paying or presenting to any person, money or anything of value for the purpose of securing patients.
Michell v. State Board of Optometry, 245 La. 1, 156, So.2d 457 (1963). The court held that since a corporation may not be licensed to practice optometry, any professional connection between a corporation and a licensed optometrist would violate the statute prohibiting any professional connection between a practitioner and a corporation.
La. Rev. Stat. § 37:1225 (1964). A pharmacy or pharmacist may have his license suspended or revoked for entering into any type of agreement with any physician for the payment or acceptance of compensation for the recommending of professional services of either party, or for entering into a rebate arrangement of any kind which in any way limits a patient’s free choice of a pharmacist or pharmacy.
La. Rev. Stat. § 37:2360 (1980). A psychologist may have his license suspended or revoked for accepting commissions or rebates or other forms of remuneration for referring clients to other professional persons.

1914-16 Op. Att’y Gen. 183 (1914). Licenses to practice medicine or dentistry cannot be issued to institutions, because institutions are not authorized to practice medicine or dentistry in Louisiana.

Peer Review

La. Rev. Stat. § 13:3715.3 (1983). No member of any hospital or dental peer review committee shall be liable for damages to any person for any action taken or recommendation made within the scope of the functions of such committee.

MAINE

PPO Legislation


Commercial Insurers

Me. Rev. Stat. § 24-A §2713 (1969). Payment of claims of any health insurance may, at the option of the insurer, provide that it is not required that the service be rendered by a particular hospital or person.


“Rate Setting”


Health Service Corporations


Me. Rev. Stat. 24 § 2303 (1983). Contracts issued under a health care plan shall provide that the patient shall have a free choice of any provider of health care able and willing to provide those services.
Health Maintenance Organizations

Me. Rev. Stat. 24-A § 4201 et seq. The Health Maintenance Organization Act defines an HMO as an organization that provides or arranges for health care services to enrolled participants solely on a predetermined periodic rate basis.

Professional Licensure


Me. Rev. Stat. 32 § 3271 (1974). This statute provides the qualifications to obtain a physician license.


Me. Rev. Stat. 32 § 2431-A (1983). An optometrist may have his license suspended or revoked for splitting or dividing any fee with any person, or for giving or accepting any rebate from an optician or ophthalmic dispenser.


Rules of the Maine Board of Optometry. An optometrist shall not split fees with any person or accept rebates from any optician or ophthalmic dispenser.

*Small v. State Board of Optometry*, 293 A.2d 786 (1972). The court found that an optometrist, whose registration and license was issued in his own name, violated the statutory prohibition against practicing under another name by carrying his practice under the name of “Maine Optical.”


Peer Review

Me. Rev. Stat. 32 § 3293 (1975). No physician shall be liable for damages as a result of his acts, omissions, or decisions in connection with his duties on a peer review committee.

MARYLAND

PPO Legislation


Commercial Insurers

Md. Code Art. 48A, § 473 (1963). Any group health policy may not require that the service be rendered by a particular hospital or person.

Rate Setting


Health Service Corporations


Health Maintenance Organizations

Md. Gen. Prov. Code § 19-701 et seq. The Health Maintenance Organization Act defines an HMO to include a profit or nonprofit organization that provides or makes available health care services to members on a predetermined periodic rate basis.
Professional Licensure


Md. Health Occ. Code § 14-305 (1981). This provision provides the qualifications to obtain a medical license.

Md. Health Occ. Code § 14-504 (1981). A physician may have his license suspended or revoked for paying or agreeing to pay any sum to any person for bringing or referring a patient.


Md. Health Occ. Code § 4-314 (1984). A dentist may have his license suspended or revoked for abrogating or forgiving the copayment provisions of any insurance policy by accepting the payment received from a third party as payment in full.

Backus v. County Board of Appeals for Montgomery County, 224 Md. 28, 166 A.2d 241 (1960). The court found that a proposed dental clinic was an “entity” within the statutory provision providing that no dental license shall be issued to any corporation, and was therefore forbidden.


Md. Health Occ. Code § 15-311 (1984). A podiatrist may have his license suspended or revoked for paying or agreeing to pay any sum to any person for bringing or referring a patient.


Md. Health Occ. Code § 10-312 (1984). An optometrist may have his license suspended or revoked for splitting or agreeing to split a fee for optometric services with any person for bringing or referring a patient.


Md. Health Occ. Code § 12-311 (1984). A pharmacy or pharmacist may have his license suspended or revoked for splitting or agreeing to split fees for professional services with another authorized prescriber.


Md. Gen. Prov. Code § 19-356 (1982). A hospital or related institution may not grant a discount to or receive a discount from any medical referral service or in any manner split fees with a medical referral service.
Peer Review

Md. Health Occ. Code § 14-601 et seq. A person on a medical review committee is not civilly liable for any action as a member for giving information to, participating in, or contributing to the function of the medical review committee.

Md. Health Occ. Code § 14-510 et seq. A person is not civilly liable for participating in a hearing or otherwise acting on an allegation requiring commission action.

MASSACHUSETTS

PPO Legislation

There is currently no PPO legislation in Massachusetts.

Commercial Insurers

Mass. Gen. Laws 175 § 108 (1973). Any policy of accident or sickness insurance may not require that the service be rendered by a particular hospital or person.

Mass. Gen. Laws 175 § 193K (1968). An insurance policy may not provide any unfair discrimination in reimbursement against individuals or persons licensed under the professional licensure provisions.


Rate Setting

Mass. Gen. Laws 6A § 1 et seq. The health services rate setting commission.

Mass. Gen. Laws 6A § 59 (1982). This statute allows commercial insurers, nonprofit hospital service plans, and HMOs to apply for a reduction in the charges it would otherwise be required to pay if it finds that the applicant has implemented an activity or program resulting in quantifiable savings to acute care hospitals.

Senate Bill No. 2397 (1985). Amends chapters 173 and 176G to require employers who offer dental benefits to offer at least one alternative dental plan whereby the insured has the freedom to select any duly licensed dentist.
Health Service Corporations

Mass. Gen. Laws 176B § 7 (1984). Every registered physician shall have the right to enter into a written agreement with a medical service corporation and a subscriber shall have the free choice of any participating physician or chiropractor.
Mass. Gen. Laws 176C § 7 (1941). A nonprofit medical service plan shall not influence or attempt to influence a subscriber in his choice of an associated physician and any physician in good standing shall have the right to become a participating physician.

Health Maintenance Organizations

Mass. Gen. Laws 176G § 1 et seq. The Health Maintenance Organization Act defines an HMO as an entity that provides or arranges for health care services to voluntarily enrolled members in exchange primarily for a prepaid per capita or aggregate fixed sum payment.

Professional Licensure

Mass. Admin. Code 249 § 5.03 (1984). A podiatrist may be guilty of unprofessional conduct for directly or indirectly offering, giving, receiving, or agreeing to receive any fee for the referral of a patient; or for permitting any person to share in the fees for professional services, other than a partner or associate.
Mass. Admin. Code 247 § 7 (1979). A pharmacist or pharmacy shall not, directly or indirectly, give any rebates or any gifts or benefits for the purpose of inducing that practitioner or employee to recommend or promote the use or patronage of a particular pharmacy.
Mass. Admin. Code 251 § 3.07 (1983). A psychologist may have his license suspended or revoked for giving or accepting commissions, rebates, or other forms of remuneration of a fee-splitting nature for professional referrals.
Mass. Gen. Laws 111D § 8 (1984). Under Section 11, a clinical laboratory may have its license suspended or revoked for accepting or offering any commission, rebate, or other fee, directly or indirectly, to any person as consideration for a referral of a specimen.

Peer Review
Mass. Gen. Laws 231 § 85N (1972). Any member of a duly appointed committee shall not be liable in any suit for damages as a result of his acts, omissions, or proceedings undertaken or performed within the scope of his duties as a committee member.

MICHIGAN

PPO Legislation

Commercial Insurers
Health Service Corporations


Health Maintenance Organizations

Mich. Comp. Laws § 333.21001 et seq. The Health Maintenance Organization Health Act defines an HMO as any health facility or agency that delivers designated health care services to enrollees in exchange for a fixed prepaid sum or per capita prepayment charge.

Professional Licensure


Mich. Comp. Laws § 750.298 (1931). No person shall practice medicine or advertise to practice medicine under any name other than his own.


Mich. Comp. Laws § 750.428 (1931). No physician or surgeon shall provide fees to or shall promise to pay a part of his fee to any other physician or surgeon or person who sends patients to him for treatment or operation.

Mich. Comp. Laws § 750.429 (1931). Any physician or surgeon who pays or presents to any person money or other valuable gift for bringing patients to him shall be guilty of a misdemeanor.


Mich. Comp. Laws § 333.16221 (1978). A dentist may have his license suspended or revoked for dividing fees for the referral of patients, or for accepting kickbacks for medical or surgical services.

Mich. Admin. Code R. 338.4201 (1978). A dentist shall not split, divide, or allocate, either directly or indirectly, with another dentist or a layperson a fee earned in the rendering of a dental service.

Toole v. State Board of Dentistry, 306 Mich. 527, 11 N.W.2d 229 (1943). The Supreme Court of Michigan held that the rule relating to fee-splitting was aimed at fee-splitting between dentists or between a dentist and a layperson, and does not prevent the practice of dentistry by partners.

Mich. Comp. Laws § 445.162 (1973). A person licensed to practice medicine shall not receive a fee or other remuneration from a clinical laboratory for submitting specimens from patients to that clinical laboratory.

1976-77 Op. Att’y Gen. (No. 5229) 234 (1977). It is the opinion of the Attorney General that there is no statutory prohibition against referring patients’ specimens to a clinical laboratory in which a physician has a financial interest. If the clinical laboratory enters into an agreement with the physician, however, whereby the physician will receive a remuneration intended to be a kickback, rebate, or other form of fee-splitting, the arrangement is illegal.


**Peer Review**

Mich. Comp. Laws § 333.21515 (1978). The records collected for or by individuals or committees assigned a review function are confidential.

Mich. Comp. Laws § 333.20175 (1978). The records collected for or by individuals or committees assigned a professional review function in a health facility are confidential.

**MINNESOTA**

**PPO Legislation**

Commercial Insurers

Minn. Stat. § 62A.04 (1971). Any standard health policy cannot require that the service be rendered by a particular hospital or person.

Health Service Corporations


Health Maintenance Organizations

Minn. Stat. § 62D.01 et seq. The Health Maintenance Act of 1973 defines an HMO as a nonprofit corporation that provides or arranges for comprehensive health care services to enrollees on a fixed prepaid sum.

Professional Licensure

Minn. Stat. § 147.01 et seq. Physician Practice Act.
Minn. Stat. § 147.10 (1971). Any person practicing medicine without a license is guilty of a gross misdemeanor.
Minn. Stat. § 147.11 (1927). It shall be unlawful for any physician or surgeon to divide fees or promise to pay a part of his fees to any other physician or surgeon or person who sends patients to him for treatment or operation.

John Granger v. A. W. Adson and Others, 190 Minn. 23, 250 N.W. 722 (1933). The Supreme Court of Minnesota held that it is improper and contrary to statute and public policy for a corporation or layperson to practice medicine by hiring a licensed physician to practice medicine for others.

Op. Att’y Gen. (July 15, 1930). It is the opinion of the Assistant Attorney General that while a corporation may not practice medicine in this state, several physicians may become associated and practice their provision together.


Minn. Code Agency R. § 3100.6200. It is conduct unbecoming of a person licensed to practice dentistry to accept rebates or split fees or commissions from any source associated with the service rendered to a patient.
Minn. Stat. § 153.01 et seq. Podiatry Practice Act.
Minn. Stat. § 151.01 et seq. Pharmacy Practice Act.
Minn. Stat. § 151.061 (1973). Any person engaged in the distribution of prescription drugs who shall discriminate between purchasers by selling prescription drugs at a lower price or rate to one purchaser than offered to another purchaser shall be guilty of unfair discrimination.
Minn. Code Agency R. § 6800.6600. No pharmacist shall participate in any agreement or plan that infringes on any patient’s right to freedom of choice as to the provider of prescription service.
Minn. Code Agency R. § 7200.5200. A psychologist shall not accept any commission, rebate, or other form of remuneration for the referral of clients for psychological services, and a psychologist may not divide fees with another professional.
Minn. Stat. § 144.12 et seq. Clinical Laboratory Licensure.

Peer Review

Minn. Stat. § 145.61 et seq. No person who is a member of or furnishes information to a review organization shall be liable for damages or other relief in any action brought by a person or persons whose activities have been, or are being, scrutinized or reviewed by the review organization.

MISSISSIPPI

PPO Legislation

There is currently no PPO legislation in Mississippi.

Commercial Insurers

Miss. Code § 83-9-5 (1956). The payment of claims provision may, at the option of the insurer, provide that it is not required that the service be rendered by a particular hospital or person.
Miss. Code § 83-41-203 et seq. These provisions provide for a beneficiary’s freedom of choice of licensed practitioner and for the reimbursement of a licensed optometrist, dentist, psychologist, or chiropractor instead of a physician.
Senate Bill No. 2649 (1985). The anti-PPO dental legislation permits the beneficiary to select his own dentist and prohibits the denial of a dentist’s participation as a provider in such policies or plans that provide for dental services.

Health Service Corporations
Miss. Code § 83-41-101 et seq. The Nonprofit Hospital, Medical and Surgical Service Corporations Act.

Health Maintenance Organizations
Miss. Code § 41-7-173 et seq. The health care commission law of 1979 defines an HMO as a public or private organization that provides or arranges for health care services to enrolled participants on a predetermined periodic basis.

Professional Licensure
Miss. Code § 97-23-43 (1942). If any person shall practice as a physician or surgeon, or as a pharmacist, or as a dentist, without first obtaining a license, he shall be punished by a fine.
Miss. Code § 73-25-1 (1980). Every person who desires to practice medicine must first obtain a license to do so.
Sears Roebuck v. State Board of Optometry, 213 Miss. 710, 57 So.2d 726 (1952). The Supreme Court of Mississippi held that a corporation may not engage in the practice of optometry either directly or indirectly through the employment of a duly registered optometrist.
Miss. Code § 73-31-21 (1966). A psychologist may have his license suspended or revoked for accepting commissions or rebates or other forms of remuneration for referring clients to other professionals.

Peer Review

Miss. Code § 41-63-1 et seq. No member of any medical or dental review committee shall be liable in damages to any person for any action taken or recommendation made within the scope of the functions of such a committee.

MISSOURI

PPO Legislation

There is currently no PPO legislation in Missouri.

Commercial Insurers


Health Service Corporations


Health Maintenance Organizations

Mo. Rev. Stat. § 354.400 et seq. The health maintenance organization provisions define an HMO as any person who undertakes to provide or arrange for basic and supplemental health care services to enrollees on a prepaid basis.

Professional Licensure

Mo. Rev. Stat. § 334.031 (1981). This provision provides the qualifications that must be obtained for physician applicants.


Mo. Rev. Stat. § 332.321 (1981). A dentist may have his license suspended or revoked for accepting or tendering rebates to or splitting fees with any other person; or for increasing charges when a patient utilizes a third-party payment program; or for reputed irregularities in billing a third-party for services rendered to a patient such as abrogating the copayment or deductible provisions of a third-party payment contract.

Op. Att’y Gen. No. 79 (July 31, 1979). A corporation organized for the purpose of engaging in the practice of dentistry cannot be lawfully established for such purposes, even if the dentist is a sole shareholder of the corporation.


Op. Att’y Gen. No. 133 (Mar. 6, 1970). The general business corporation laws of Missouri, which permit corporations to be organized for any lawful purpose, do not authorize the organization of the corporation to engage in the practice of podiatry where the statute regulating such practice contemplates only the licensing of individuals.


Peer Review

Mo. Rev. Stat. § 537.035 (1977). No member of a utilization review or peer review committee functioning for the sole purpose of maintaining the professional standards of those who are engaged in the professional practice shall be liable in damages to any person subject to the actions of the committee or board for any action taken or recommendation made by the committee or board.
MONTANA

PPO Legislation

There is currently no PPO legislation in Montana.

Commercial Insurers

Mont. Code § 33-22-505 (1947). Any group disability policy may not require that the service be rendered by a particular hospital or person.

Mont. Code § 33-22-111 (1983). All policies of disability insurance shall provide that the insured shall have full freedom of choice in the selection of any duly licensed physician, dentist, osteopath, chiropractor, optometrist, podiatrist, or psychologist for any illness or injury within the scope and limitations of his practice.


Health Service Corporations


Mont. Code § 33-30-306 (1975). No person may make any unreasonable discrimination between individuals of the same classification that may be established by a health service corporation.


Health Maintenance Organizations

There is currently no HMO legislation in Montana.

Professional Licensure


Mont. Admin. R. 8.16.709 (1981). Dentists shall not accept or tender rebates or split fees.


Mont. Code § 37-10-311 (1981). An optometrist may have his license suspended or revoked for accepting employment to practice optometry from or for a company or corporation.
Mont. Code § 40-1-201 et seq. Clinical Laboratory Licensure.

Peer Review
Mont. Code § 37-2-201 (1979). No member of the utilization review committee or peer review committee shall be liable in damages to any person for any action taken or recommendation made within a scope of the functions of the committee.
Mont. Code § 50-16-301 et seq. Confidential health care information is not subject to compulsory legal process in any type of proceeding.
Mont. Code § 27-6-701 et seq. The records of all proceedings made by a panel may not be made public and are not subject to subpoena, and no panel member may be called to testify in any proceeding concerning deliberations, discussions, decisions, and internal proceedings of any medical review panel.

NEBRASKA

PPO Legislation

Commercial Insurers
Neb. Rev. Stat. § 44-710.03 (1957). Any sickness and accident insurance may not require that the service be rendered by a particular hospital or person.

Health Service Corporations
Health Maintenance Organizations

Neb. Rev. Stat. § 44-3201 et seq. Nebraska’s Health Maintenance Organization Act defines an HMO as any arrangement that arranges or provides for health care services on a prepaid basis.

Professional Licensure


Neb. Rev. Stat. § 71-102 (1980). No person shall engage in the practice of medicine and surgery, osteopathy, dentistry, pharmacy, podiatry, or optometry unless such person has obtained a license for that purpose.

Neb. Rev. Stat. § 71-148 (1981). A license to practice any licensed profession may be suspended or revoked for the division of fees, or agreeing to split or divide the fees received for professional services, with any person for bringing or referring a patient.


Neb. Rev. Stat. § 71-1147.10 (1977). A pharmacy may have its license suspended or revoked for violating § 71-148 which prohibits the splitting of fees for the referral of patients.


Peer Review

Neb. Rev. Stat. § 71-147.01 (1976). No member of a peer review committee shall be liable in damages to any person for slander, libel, or defamation for any action taken or recommendation made within the scope of the function of such a committee.

Neb. Rev. Stat. § 71-2046 et seq. Any person making a report or providing information to a hospital medical staff committee or utilization review committee of a hospital upon request of such committee has a privilege to refuse to disclose and to prevent any other person from disclosing the reported information.
NEVADA

PPO Legislation

Senate Bill No. 286 (1985) provides that an insurer shall include provisions in a policy of health insurance encouraging an insured's use of services and facilities that are most efficient and that tend to control or reduce the cost of health care.

Commercial Insurers

Nev. Rev. Stat. § 689A.130 (1971). The payment of claims provision may, at the option of the insurer, provide that it is not required that the service be rendered by a particular hospital or person.

Nev. Rev. Stat. § 689A.380 (1977). No policy of health insurance may prevent an insured from selecting any duly licensed dentist, osteopath, podiatrist, or optometrist to perform any medical or surgical services covered by a policy of insurance if the services are within the scope of his license.

Nev. Rev. Stat. § 450.410 (1931). Any person admitted to a County Hospital and required to pay charges and fees shall have the right to the services of a physician or surgeon of his own choice.

Nev. Rev. Stat. § 679B.152 (1983). Any health insurance policy issued by a nonprofit hospital, medical, or dental service corporation that limits an insured's choice of dentist, must offer to its insureds the option of selecting a benefit plan that does not restrict a choice of a dentist.


Health Service Corporations


Health Maintenance Organizations

Nev. Rev. Stat. § 695C.010 et seq. The Nevada Health Maintenance Organization Act defines an HMO as any person that provides or arranges for health care services to its enrollees on a periodic prepaid basis.
Professional Licensure


Nev. Rev. Stat. § 630.305 (1983). A physician may be subject to discipline for unprofessional conduct for directly or indirectly giving to or receiving from any person, any rebate, commission, or other form of compensation for referring a patient.


Op. Att’y Gen. No. 245 (Sept. 1, 1961). It is the opinion of the Attorney General that a corporation may not be formed, nor licensed, to practice medicine. In addition, although individually licensed to practice medicine, a physician may not be a stockholder, officer, agent, or independent contractor of a corporate medical practice plan that may not lawfully practice medicine in Nevada.


Nev. Rev. Stat. § 631.13465 (1983). It is unprofessional conduct for dentists to divide fees or agree to divide any fees received for services rendered with any person for bringing or referring a patient.

Nev. Rev. Stat. § 631.347 (1983). Any plan that provides that patients are required to select a dentist from a preselected group constitutes unprofessional conduct unless those patients are also offered a plan that provides them with a reasonable opportunity to select their own dentist.


Nev. Rev. Stat. § 636.300 (1981). An optometrist may be guilty of unprofessional conduct for dividing fees under any arrangement with any person that is not an optometrist.


Nev. Rev. Stat. § 639.264 (1979). No pharmacist or pharmacy may offer, deliver, or pay any rebate, refund, discount, or other unearned consideration to any person as compensation or inducement to such person for referring prescriptions, patients, or customers to such pharmacist or pharmacy.


Nev. Rev. Stat. § 641.230 (1963). A psychologist may have his license suspended or revoked for accepting commissions, rebates, or other forms of remuneration for referring patients to other professional persons.
Nev. Rev. Stat. § 450.005 et seq. County Hospital and County Hospital District Licensing Provisions.

Peer Review
Nev. Rev. Stat. § 49.265 (1981). Physicians participating in hospital and medical review committees are not required to testify concerning the proceedings and the records of such committees are not subject to discovery proceedings.

NEW HAMPSHIRE

PPO Legislation
House Bill No. 80 (1985). This act concerns health insurance reimbursement agreements including preferred provider agreements.

Commercial Insurers
N.H. Rev. Stat. § 415:6 (1951). Any accident and sickness policy may, at the option of the insurer, provide that it is not required that the service be rendered by a particular hospital or person.
N.H. Rev. Stat. § 415:23 (1983). Notwithstanding any other law, any person or entity that provides coverage for medical or hospital expenses, whether said coverage is by direct payment, reimbursement, or otherwise, shall be presumed to be subject to the jurisdiction of the insurance department.

Health Service Corporations

Health Maintenance Organizations

N.H. Rev. Stat. § 420-B:1 et seq. The Health Maintenance Organization Act defines an HMO as any public or private organization that provides or makes available to enrolled participants health care services primarily on a predetermined periodic rate basis.

Professional Licensure

N.H. Rev. Stat. § 327:27 (1951). No corporation shall engage in the practice of optometry, nor shall any optometrist share, directly or indirectly, in any fees received in connection with such practice of optometry.

Peer Review


NEW JERSEY

PPO Legislation

There is currently no PPO legislation in New Jersey.
Commercial Insurers

N.J. Stat. § 17B:26-12 (1951). The payment of claims provisions may, at the option of the insurer, provide that it is not required that the service be rendered by a particular hospital or person.


N.J. Stat. § 17B:26-44.1 et seq. Any health insurance contract that provides for dental services shall allow the insured his free choice of any duly licensed physician or dentist, and equal reimbursement rates shall be paid for services performed, regardless of the discipline of the provider of the service.

N.J. Stat. § 26:17B-1 (1983). Dental plans that are offered by an employer must offer at least one plan that allows the subscriber to select his own duly licensed dentist.

N.J. Stat. § 27:17B-1 (1983). Dental plans that are offered by an employer must offer at least one plan that allows the subscriber to select his own duly licensed dentist.

N.J. Stat. § 17:48D-1 (1983). Dental plans that are offered by an employer must offer at least one plan that allows the subscriber to select his own duly licensed dentist.

N.J. Stat. § 17:48C-1 (1983). Dental plans that are offered by an employer must offer at least one plan that allows the subscriber to select his own duly licensed dentist.

Rate Setting

N.J. Stat. § 26:2H-4.1 et seq. The Hospital Rate-Setting Commission.


Health Service Corporations


Health Maintenance Organizations

N.J. Stat. § 26:2J-1 et seq. The Health Maintenance Organization Act defines an HMO as any person who directly or through contracts
with providers provides basic comprehensive health care services on a prepaid basis to enrollees.

**Professional Licensure**

N.J. Stat. § 45:9-6 (1968). This provision provides the qualifications for anyone applying for a license to practice medicine or surgery.
N.J. Admin. Code § 13:38-1.7 (1970). Any optometrist who offers or provides services at a fee less than his usual fee in consideration of the patient being associated with any person or company shall be considered as soliciting for the purpose of selling optometric services.
N.J. Stat. § 45:14-12 (1977). A pharmacist or pharmacy may have his license suspended or revoked for paying rebates or for entering into an agreement for the payment of rebates to any physician, dentist, or other person for the recommending of the services to any person.

**Peer Review**

N.J. Stat. § 2A:84A-22.10 (1979). Any person who serves as a member of a peer review committee shall not be liable in damages to any person for any action taken or recommendation made by him within the scope of his functions as a member of such committee.

**NEW MEXICO**

**PPO Legislation**

There is currently no PPO legislation in New Mexico.
Commercial Insurers


1977 Op. Att’y Gen. No. 77-13. An insurer or health care plan may not so limit the benefits to be paid for the services rendered by a particular profession of health care providers so as to effectively limit the freedom of choice of the insured or subscriber, and thus defeat the legislative mandate of § 59A-22-32.


Health Service Corporations


Health Maintenance Organizations

N.M. Stat. § 59A-46-1 et seq. The Health Maintenance Organization Act defines an HMO as any person who provides or arranges for basic health care services to enrollees on a fixed prepayment basis.

Professional Licensure

N.M. Stat. § 53-6-1 et seq. The Professional Corporations Act.


N.M. Stat. § 61-6-14 (1979). A physician may have his license suspended or revoked for fee-splitting, which includes offering, delivering, or accepting unearned rebates, refunds, or discounts as compensation or inducement for referring patients.


N.M. Stat. § 61-5-17 (1971). It is unlawful for a corporation to practice dentistry.


N.M. Stat. § 61-2-16 (1985). No policy of insurance that provides for eye care services shall discriminate between ocular practitioners rendering similar services.


N.M. Stat. § 61-9-13 (1963). A psychologist may have his license suspended or revoked for accepting commissions or rebates or other
forms of remuneration for referring clients to other professional persons.

Peer Review
N.M. Stat. § 41-9-1 et seq. No person who is a member or employee of, or who acts in an advisory capacity to a review organization shall be liable for damages brought by any person or persons whose activities have been or are being scrutinized or reviewed by such review organization.

NEW YORK

PPO Legislation
There is currently no PPO legislation in New York.

Commercial Insurers

Rate Setting

Health Service Corporations
N.Y. Ins. Law § 4301 et seq. The Nonprofit Hospital, Medical and Dental Corporations Act.
N.Y. Ins. Law § 4301 (1982). Every medical corporation shall be open to any provider without any discrimination against any provider type and subscribers shall have the free choice of any physician or optometrist for visionary care services.
Health Maintenance Organizations

N.Y. Pub. Health Law § 4400 et seq. The Health Maintenance Organization Act defines an HMO as any organization that arranges for or provides comprehensive health care services to an enrolled population in consideration for a basic advance or periodic charge.

Professional Licensure


1963 Op. Att'y Gen. 50. The New York Attorney General opined that a corporation may not be formed for the purpose of bringing together physicians and patients and that such a purpose is contrary to the public policy of the state.

N.Y. Educ. Law § 6909-a (1977). It is unprofessional conduct for any professional person to directly or indirectly receive or participate in a division, rebate, splitting, or refunding of any fee in connection with the furnishing of professional care.


N.Y. Pub. Health Law § 4501 (1972). No person or corporation shall engage in any business or service for profit that in whole or in part includes the referral or recommendation of persons to a physician or hospital.


Peer Review

N.Y. Educ. Law § 6527 (1977). No individual who serves as a member of a utilization review committee or medical review committee shall be liable in damages to any person for any action taken or
recommendation made by him within the scope of his functions on such committee.

NORTH CAROLINA

PPO Legislation

House Bill No. 1037 (1985). An act to provide for health care cost containment activities including preferred provider contracts.

Commercial Insurers

N.C. Gen. Stat. § 58-251.1 (1979). Any accident and health policy may, at the option of the insurer, provide that it is not required that the service be rendered by a particular hospital or person.

N.C. Gen. Stat. § 58-260 (1977). Whenever any policy of insurance provides for the payment of or reimbursement for any service within the scope of practice of a duly licensed optometrist, podiatrist, dentist, chiropractor, or psychologist, the policyholder shall have the right to choose the services of any such duly licensed provider of such services.


Senate Bill No. 234 (1985). Notwithstanding any other provision of law, any person who provides coverage for medical or hospital expenses, whether such coverage is by direct payment, reimbursement, or otherwise, such entity shall be presumed to be subject to the jurisdiction of the insurance commissioner.

Health Service Corporations

N.C. Gen. Stat. § 57-1 et seq. The Hospital, Medical and Dental Service Corporations Act.


Health Maintenance Organizations

N.C. Gen. Stat. § 57B-1 et seq. The Health Maintenance Organization Act of 1979 defines an HMO as any person who undertakes to provide or arrange for the cost of any health care services on a prepaid basis.
Professional Licensure

N.C. Gen. Stat. § 90-48.1 (1965). No person shall deny the recipient of dental services the freedom to choose his own duly licensed dentist as the provider of care or services that are within the scope of practice of the profession of dentistry.
N.C. Gen. Stat. § 90-127.1 (1973). No person shall deny to a recipient or beneficiary the freedom to choose a duly licensed optometrist of his own choice.

Peer Review

N.C. Gen. Stat. § 131E-95 (1983). A member of a duly appointed medical review committee shall not be subject to liability for damages in any civil action on account of any act, statement, or proceeding undertaken, made, or performed within the scope of the functions of the Committee.

NORTH DAKOTA

PPO Legislation

There is currently no PPO legislation in North Dakota.

Commercial Insurers

N.D. Cent. Code § 26-03-39.1 (1957). A sickness or accident insurance policy may not deny the insured the right to choose any licensed physician, or to enter into any hospital he may select.
N.D. Cent. Code § 43-13-30 (1967). There shall be no discrimination between licensed practitioners of optometry and physicians and an
insured shall have the right to freely choose any ocular practitioner.


**Health Service Corporations**


N.D. Cent. Code § 26-27-08 (1973). Every physician and oral surgeon shall have the right to contract with any corporation and subscribers shall have the free choice of any participating provider.


N.D. Cent. Code § 26-27.1-09 (1963). Every dentist shall have the right to contract with any dental corporation and subscribers shall have the free choice of any participating provider.

**Health Maintenance Organizations**

N.D. Cent. Code § 26.1-18-01 et seq. The Health Maintenance Organization Act defines an HMO as any person who undertakes to provide or arrange for health care services on a prepaid basis.

**Professional Licensure**


N.D. Cent. Code § 43-28-18 (1981). A dentist may have his license suspended or revoked for sharing any professional fee with anyone or paying anyone for sending or referring patients to him.


N.D. Admin. Code § 56-02-03-01. It is unlawful for an optometrist to split fees for the purpose of obtaining patients.


Peer Review

N.D. Cent. Code § 23-01-02.1 (1983). No member of a hospital committee for quality assurance shall be liable in damages to any person for any action taken or recommendation made within the scope of the functions of the committee.

N.D. Cent. Code § 43-17.1-09 et seq. Any member of the commission on medical competency shall be immune from any liability for any acts or omissions made in the course of the performance or responsibilities as a member of the commission.

OHIO

PPO Legislation

There is currently no PPO legislation in Ohio, although proposed legislation would expressly authorize hospital service associations to offer PPO plans.

1983 Op. Att’y Gen. (Nov. 17, 1983). It is the opinion of the Assistant Attorney General that PPOs do not violate the antitrust laws as to price fixing or group boycotts.

Commercial Insurers

Ohio Rev. Code § 3923.04 (1953). The payment of claims provision may, at the option of the insurer, provide that it is not required that the services be rendered by a particular hospital or person.


Health Service Corporations

Ohio Rev. Code § 1737.01 et seq. The Medical Care Corporations Act.

Ohio Rev. Code § 1737.06 (1953). All physicians and surgeons shall be eligible to render professional services to the corporation and subscribers shall have the free choice of any participating physician or surgeon.


Ohio Rev. Code § 1739.06 (1980). Subscribers shall have the free choice of any hospital in Ohio.


Health Maintenance Organizations

Ohio Rev. Code § 1742.01 et seq. The Health Maintenance Organization Act defines an HMO as a public or private organization that provides or makes available to enrolled participants health care services primarily on a predetermined periodic rate basis.

Professional Licensure

Ohio Rev. Code § 1785.01 et seq. The Professional Associations Act.

Ohio Rev. Code § 1701.03 (1955). A corporation may be formed for any purpose or purposes, other than for carrying on the practice of any profession.

Ohio Rev. Code § 3702.51 et seq. Certificates of Need.


Ohio Rev. Code § 4731.22 (1983). A physician may have his license suspended or revoked for engaging in the division of fees for the referral of patients, or for fee-splitting with any person.


1952 Op. Att’y Gen. (1751) 608 (1952). A corporation may not lawfully engage in the practice of medicine in Ohio, whether or not the corporation is organized for profit.

Cleveland Clinic v. Sombrio, 6 Ohio Misc. 48, 215 N.E.2d 740 (1966). The corporate practice of medicine is solely within the legislative
branch which has the authority to authorize one or more licensed physicians to engage in the practice of medicine as a corporation.

*Kraus v. City of Cleveland*, 55 Ohio Op. 6 (1953). The addition to the water supply of inorganic chemicals and fluoride by the City of Cleveland, as a therapeutic agent for the prevention of caries, does not constitute the practice of medicine, dentistry, or pharmacy within the meaning or spirit of the provisions prohibiting such practice by persons or corporations unless qualified under the statutes.

Ohio Rev. Code § 4725.01 *et seq.* Optometry Practice Act.
Ohio Admin. Code § 4725.5-06 (1965). An optometrist may be guilty of unprofessional conduct for the splitting or dividing of any fee with any person.

Ohio Rev. Code § 4729.01 *et seq.* Pharmacy Practice Act.
Ohio Rev. Code § 4729.16 (1984). A pharmacy or pharmacist may have his license suspended or revoked before dividing or agreeing to divide any fee made in the practice of pharmacy.

Ohio Rev. Code § 4732.17 (1978). A psychologist may have his license suspended or revoked for accepting commissions or rebates or other forms of remuneration for referring patients to other professionals.

Ohio Admin. Code § 4732-17-01 (1981). A psychologist may not make any arrangements to share or divide fees with any other person.

Ohio Rev. Code § 3701.22 *et seq.* Clinical Laboratory Licensure.
Ohio Rev. Code § 140.01 *et seq.* Hospital Licensure Provisions.
Ohio Rev. Code § 749.01 *et seq.* Hospital Licensure Provisions.
Ohio Rev. Code § 339.01 *et seq.* Hospital Licensure Provisions.


1952 Op. Att’y Gen. (No. 1961) 750 (1952). A hospital is not engaged in the practice of medicine where graduate physicians are employed as interns or residents by the hospital.

**Peer Review**

Ohio Rev. Code § 2305.24 *et seq.* No member of the utilization review committee or peer review committee shall be deemed liable in damages to any person for any action taken or recommendation made within the scope of the functions of such committee.
OKLAHOMA

PPO Legislation

There is currently no PPO legislation in Oklahoma.

Commercial Insurers

Okla. Stat. 63 § 1-109 (1963). Nothing in the insurance code shall prevent citizens of this state from freely choosing any practitioner of the healing arts who is licensed to practice his profession in the state of Oklahoma.

Okla. Stat. 36 § 6055 (1984). Any policy providing accident or health benefits shall allow the insured to select any practitioner licensed under the healing arts to perform any necessary services and procedures.

Op. Att'y Gen. No. 80-245 (Apr. 16, 1981). It is the opinion of the Attorney General that an issuer of policies of medical or hospital insurance may exclude from coverage services and procedures so long as the policies do not discriminate between medical services provided by the various branches of the healing arts.

Okla. Stat. 36 § 6057 (1971). Any provision that denies an insured the free choice of any licensed practitioner of the healing arts in Oklahoma or use of any hospital is void.

Okla. Stat. 36 § 4503 (1957). Any group accident and health policy may not require that the service be rendered by a particular hospital or person.

Okla. Stat. 36 § 4504 (1957). Any blanket accident and health insurance policy may not require that the services be rendered by any particular hospital or person.

Okla. Stat. 36 § 6051 (1967). Under any policy that provides for reimbursement for any optometric service, the beneficiary shall be entitled to the free choice of any practitioner, and such practitioner shall be entitled to reimbursement on an equal basis for such service, whether the said service is performed by a physician or optometrist.


House Bill No. 1604 (1985). Unless otherwise provided, any person or other entity that provides coverage for medical or hospital expenses, whether coverage is by direct payment, reimbursement, or other means, shall be presumed to be subject to the jurisdiction of the Oklahoma Insurance Commissioner.
Senate Bill No. 284 (1985). Revises rules for prompt payment or prepayment discounts.

**Health Service Corporations**

Oklahoma Statutes, Title 36, § 2601 *et seq.* Hospital Service and Medical Indemnity Corporations Act.

Oklahoma Statutes, Title 36, § 2613 (1957). Subscribers shall have the free choice of any participating hospital or physician.

Oklahoma Statutes, Title 36, § 2671 *et seq.* Dental Service Corporations.

**Health Maintenance Organizations**

Oklahoma Statutes, Title 52, § 2501 *et seq.* The Health Maintenance Organization Act defines an HMO as any organization that provides or arranges for health maintenance services to enrolled members on a fixed prepayment basis.

**Professional Licensure**

Oklahoma Statutes, Title 18, § 800 *et seq.* The Professional Corporations Act.

Oklahoma Statutes, Title 59, § 491 *et seq.* Medical Practice Act.

Oklahoma Statutes, Title 59, § 510 (1923). It is the duty of any corporation engaged in the practice of medicine to report to the county clerk the names and addresses of all physicians who propose to practice medicine under such a name.

Oklahoma Statutes, Title 59, § 328.21 *etseq.* Dental Practice Act.

Oklahoma Statutes, Title 59, § 328.32 (1981). It shall be unlawful for any dentist to pay or accept any commissions, in any form or manner, as compensation for another’s referring dental patients to any dentist for professional services.

Oklahoma Statutes, Title 59, § 142 *et seq.* Podiatry Practice Act.

Oklahoma Statutes, Title 59, § 148 (1955). A podiatrist may have his license suspended or revoked for dividing any fee with any other person, except another licensed podiatrist.

Oklahoma Statutes, Title 59, § 581 *et seq.* Optometry Practice Act.

Oklahoma Statutes, Title 59, § 944 (1953). It shall be unlawful for any optometrist to receive or accept any rebate, kickback, or other premium from any optical company.

Oklahoma Statutes, Title 59, § 353.9 *et seq.* Pharmacy Practice Act.

Oklahoma Statutes, Title 59, § 1351 *et seq.* Psychology Practice Act.

Oklahoma Statutes, Title 63, § 1-702 *et seq.* Hospital Licensure Provisions.
Peer Review

Okla. Stat. 63 § 1-1709 (1968). No liability for damages shall arise or be enforced against any person appointed to a hospital utilization review committee.

OREGON

PPO Legislation

House Bill 2031(71) (1985). This legislation amends section 743.531 to provide for insurer-sponsored alternative rates of payment.

Commercial Insurers

Or. Rev. Stat. § 743.531 (1967). Any group health insurance policy may not require that the service be rendered by a particular hospital or person (however, this provision has been subsequently amended, see above).

Or. Rev. Stat. § 743.543 (1967). Any blanket health insurance policy may not require that the service be rendered by a particular hospital or person.

Or. Rev. Stat. § 743.123 (1975). Whenever a policy provides for reimbursement for any service that is within the lawful scope of a psychologist, the insured shall be free to choose any psychologist or physician.


Health Service Corporations


Health Maintenance Organizations

Or. Rev. Stat. § 442.015 (1983). The Health Maintenance Organization Act defines an HMO as either a public or private organization that provides or makes available to enrolled participants health care services on a predetermined periodic rate basis.
Professional Licensure

Or. Admin. R. 818-11-020 (1984). The dentist may be guilty of unprofessional conduct for accepting rebates or splitting fees or other commissions from any source associated with the service rendered to a patient.

1932-36 Op. Att’y Gen. 570 (Nov. 15, 1935). It is the opinion of the Attorney General that a corporation cannot be licensed to practice dentistry.

1946-48 Op. Att’y Gen. 501 (Apr. 12, 1948). It is the opinion of the Attorney General that a corporation cannot hold a license to practice dentistry because it does not possess the qualifications of a licensee.


Or. Admin. R. 852-10-035 (1979). No optometrist shall enter into any agreement whereby he expressly or by implication agrees to give anything of value to a person in consideration for a referral.

Sisemore v. Standard Optical Company of Oregon, 188 P.2d 309 (1947). Permitting corporations to furnish optometrical services through salaried employees, who are licensed optometrists, could violate the statutory prohibition of the practice of optometry by unlicensed persons.


Peer Review

Or. Rev. Stat. § 41.675 (1981). A person serving on or communicating information to the medical staff committee or similar committee shall not be subject in any action for civil damages for affirmative actions taken or statements made in good faith by such committee.
PENNSYLVANIA

PPO Legislation

Senate Bill No. 935 (11-13). Amends Pa. Ins. Code § 621.2 (c) and 626, and adds § 630 (1986).

Commercial Insurers

Pa. Stat. 40 § 756.2 (1968). Any group accident and health policy may not require that the service be rendered by a particular hospital or person.


Health Service Corporations


Health Maintenance Organizations

Pa. Stat. 40 § 1551 et seq. The Health Maintenance Organization Act defines an HMO as an organized system that combines the delivery and financing of health care and that provides basic health care services to voluntarily enrolled subscribers on a fixed prepaid fee.

Professional Licensure


Pa. Stat. 63 § 421.6 (1974). This provision provides the qualifications needed by an applicant to obtain a medical license.


Commonwealth ex rel. Attorney General v. Alba Dentist Co., 13 Dist. Pa. District Reports 432 (Pa. Dist. 1904). The court held that a corporation was incapable of complying with the statutory licensure provisions relating to the practice of dentistry and hence is not a person within the meaning and intent of the act.
29 Pa. Admin. Code § 29.26 (1985). It shall be misconduct for licensed podiatrists to share a fee or enter into any agreement that calls for the splitting of fees with unlicensed individuals or entities.
Pa. Stat. 63 § 244.10 (1980). Any entity expending public money for any purpose involving eye care shall not deny the recipients or beneficiaries the freedom to choose an optometrist or physician and shall make the same reimbursement whether the service is provided by an optometrist or physician.
49 Pa. Admin. Code § 23.63 (1984). No optometrist shall divide, share, or split, either directly or indirectly, any fee for optometric services or materials with any layperson or corporation.
*Neill v. Chaby*, 86 D. & C. Pa. District and County Reports 457 (Phila. Cty. 1953). The court held that it was illegal for an unlicensed proprietor of an optical store to enter into referral agreements with a licensed optometrist.
Pa. Stat. 63 § 390-5 (1961). A pharmacy or pharmacist may have his license suspended or revoked for paying rebates to physicians or other persons for recommending the professional services of either party.
28 Pa. Admin. Code § 5.71 (1979). No clinical laboratory shall solicit for the referral of specimens to his or any other laboratory in any manner that offers or implies an offer of rebate to persons submitting specimens, or any other fee-splitting inducements.

**Peer Review**

Pa. Stat. 63 § 425.1 et seq. No individual who is a member of any review organization shall be held liable under any law by reason of his performance of any duty, function, or activity authorized or required by the review organization.
RHODE ISLAND

PPO Legislation

There is currently no PPO legislation in Rhode Island.

Commercial Insurers

R.I. Gen. Laws § 27-18-3 (1956). The payment of claims provision may, at the option of the insurer, provide that it is not required that the service be rendered by a particular hospital or person.


R.I. Gen. Laws § 27-42-1 et seq. Any person or entity providing coverage for hospital or medical expenses, whether by direct payment, reimbursement, or otherwise, shall be presumed to be subject to the jurisdiction of the director of business regulation.

Health Service Corporations


Health Maintenance Organizations

R.I. Gen. Laws § 27-41-1 et seq. The Health Maintenance Organization Act of 1983 defines an HMO as a public or private organization that provides or makes available to enrolled participants health care services on predetermined periodic rate basis.

Professional Licensure


R.I. Gen. Laws § 5-37.1-5 (1984). It shall be considered unprofessional conduct for a physician to divide fees or agree to split or divide the fees received for professional services with any person for bringing or referring a patient.
R.I. Gen. Laws § 5-37-21 (1975). No physician shall directly or indirectly receive payment, reimbursement, or a fee for a referral to any clinical laboratory.

R.I. Gen. Laws § 5-37-2 (1956). This provision provides the qualifications necessary for an applicant to obtain a medical license.

R.I. Gen. Laws § 23-16.2-5.1 (1979). A clinical laboratory shall not offer or give a commission, rebate, or other fee, directly or indirectly, to any person as consideration for the referral of a specimen to the clinical laboratory. Likewise, laboratory shall not solicit or accept such commission or rebate.


Peer Review

R.I. Gen. Laws § 5-37.1-1 et seq. There shall be no civil liability on the part of, and no cause of action of any nature shall arise against, the board of medical review for any statements made by them in any reports concerning the conduct or competence of any licensed physician.

SOUTH CAROLINA

PPO Legislation

There is currently no PPO legislation in South Carolina. House Bill No. 3594 and Senate Bill No. 834 would have given insurers the right to establish competitive health care plans; however, these bills died in committee two years ago and were not reintroduced the following year.

Commercial Insurers

S.C. Code § 38-35-440 (1980). The payment of claims provision may, at the option of the insurer, provide that it is not required that the service be rendered by a particular hospital or person.

S.C. Code § 38-35-90 (1980). Discrimination between individuals of the same class is prohibited; and whenever a policy reimburses for any service within the scope of the practice of a duly licensed podiatrist or
oral surgeon, the insured shall be entitled to reimbursement for such services whether such services are performed by a duly licensed physician or a duly licensed podiatrist or oral surgeon.


Health Service Corporations

S.C. Code § 38-35-10 (1972). Hospital and Medical Service Corporations shall be licensed as mutual insurance companies.

Health Maintenance Organizations

S.C. Code § 38-25-10 et seq. The Health Maintenance Organizations Act defines an HMO as an organization that provides general health services to persons enrolled with such organization on a per capita prepaid basis.

Professional Licensure

S.C. Code § 40-47-60 (1982). This provision provides the qualifications required to obtain a medical license.

Wadsworth v. McRae Drug Co., 28 S.E.2d 417 (1943). A corporation may not engage in the practice of medicine even through licensed employees.


Code of Regulations § 39-1 et seq. Dentists shall not accept or tender rebates or split fees.

Op. Att’y Gen. (Apr. 3, 1984). It is the opinion of the Attorney General that the Dental Practice Act, as it presently exists, does not authorize corporations to practice dentistry.


S.C. Code § 40-37-180 (1982). It shall be unlawful for an optometrist to offer or give eyeglasses as a premium or bonus with merchandise to induce the examination of the eye or sale of spectacles.

S.C. Code § 40-37-190 (1982). It shall be unlawful for an optometrist to offer eye examinations at a discount price or as a premium, the object of which is to induce the sale of ophthalmic services or materials.
Ezell v. Rital, 188 S.C. 39, 198 S.E. 419 (1938). The Supreme Court of South Carolina held that unlicensed persons employing practicing physicians to make eye examinations were guilty of illegally practicing optometry.

1933-34 Op. Att’y Gen. 244 (Mar. 13, 1934). It is the opinion of the Attorney General that a corporation cannot practice optometry, since licenses can be issued only to a qualified individual.

S.C. Code § 44-71-100 (1983). Hospices may not participate in or offer any rebate, kickbacks, or fee-splitting arrangements.

1957-58 Op. Att’y Ge. 187 (July 2, 1957). It is the opinion of the Attorney General that a hospital can hire salaried doctors to provide certain necessary services to patients incident to the business of the hospital without violating the corporate practice of medicine doctrine.

1958-59 Op. Att’y Gen. (No. 645) 147. It is the opinion of the Attorney General that a public hospital is not engaged in the illegal corporate practice of medicine by employing necessary technicians and doctors, and that no patient at a public hospital should lose his freedom to choose a doctor.

Peer Review

S.C. Code § 40-71-10 et seq. There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any member of a duly appointed committee that is formed to maintain professional standards.

SOUTH DAKOTA

PPO Legislation

There is currently no PPO legislation in South Dakota.

Commercial Insurers

not require that the service be rendered by a particular hospital or person.

S.D. Comp. Laws § 58-18-29 (1966). Any blanket health policy may not require that the service be rendered by a particular hospital or person.


Health Service Corporations

S.D. Comp. Laws § 58-38-1 et seq. Nonprofit Medical and Surgical Plans.

S.D. Comp. Laws § 58-38-9 (1966). Subscribers shall have the free choice of any professional provider.

S.D. Comp. Laws § 58-40-1 et seq. Nonprofit Hospital Service Plans.

S.D. Comp. Laws § 58-40-10 (1966). Subscribers shall have the free choice of any hospital.


Health Maintenance Organizations

S.D. Comp. Laws § 58-41-1 et seq. The Health Maintenance Organization Act defines an HMO as a corporation that provides or arranges for comprehensive health maintenance services to enrollees for a fixed prepaid sum.

Professional Licensure


S.D. Comp. Laws § 36-4-1 et seq. Physicians and Surgeons Practice Act.

S.D. Comp. Laws § 36-4-11 (1985). This provision provides the qualifications that are required to obtain a medical license.

S.D. Comp. Laws § 36-4-30 (1980). It is considered unprofessional conduct for a physician to split fees or give to any person furnishing a patient any portion of the fees received from such a patient; or for
paying or giving to any person any consideration whatsoever for furnishing any patient.

S.D. Comp. Laws § 36-6-1 et seq. Dental Practice Act.

S.D. Comp. Laws § 36-6-32 (1977). It is a misdemeanor for any dentist to divide fees with, or pay a commission to any dentist or any other person who sends patients to him for treatment or operation.

S.D. Comp. Laws § 36-8-1 et seq. Podiatry Practice Act.

S.D. Comp. Laws § 36-8-17 (1972). A podiatrist may have his license suspended or revoked for offering to any person any gift in return for the procurement of any patient or patients; or for accepting or receiving any rebates or commissions for prescribing or recommending any footwear, drugs, medicine, or any other article, to his patients.

S.D. Comp. Laws § 36-7-1 et seq. Optometry Practice Act.

S.D. Comp. Laws § 36-7-25 (1983). An optometrist may have his license suspended or revoked for splitting or dividing a fee or compensation with any person or corporation.

S.D. Comp. Laws § 36-11-1 et seq. Pharmacy Practice Act.


S.D. Comp. Laws § 34-12-1 et seq. Hospital Licensure Provisions.

**Peer Review**

S.D. Comp. Laws § 36-4-25 (1985). There shall be no monetary liability on the part of, and no cause of action for damages may arise against, any member of a duly appointed committee comprising physicians licensed to practice their profession in the state.

**TENNESSEE**

**PPO Legislation**

There is currently no PPO legislation in Tennessee.

**Commercial Insurers**

Tenn. Code § 56-7-1701 (1983). If a prepaid dental plan limits the subscribers to designated dentists or groups of designated dentists, the provider of such a plan shall also offer to such employees or members the option of selecting alternative coverage that permits such covered persons to obtain dental services from any licensed dentist of their choice.

Tenn. Code § 56-7-1010 (1983). Notwithstanding any other provision of law, any person who provides coverage for medical or hospital expenses, whether such coverage is by direct payment, reimbursement, or otherwise, shall be presumed to be subject to the jurisdiction of the Department of Commerce and Insurance.

Health Service Corporations

Tenn. Code § 56-27-108 (1950). A subscriber to any medical service plan shall at all times have free choice of any doctor of medicine who is a participating physician in the corporation and who agrees to accept a particular beneficiary as a patient.
Tenn. Code § 56-29-101 et seq. The Hospital and Medical Service Corporations Act.

Health Maintenance Organizations

Tenn. Code § 56-32-102 et seq. The Health Maintenance Organization Act defines an HMO as either a public or private organization that provides or arranges for health services to enrolled individuals on a per capita prepayment basis.

Professional Licensure

State ex. rel. Attorney General v. National Optical Stores Co., 189 Tenn. 433, 225 S.W.2d 263 (1949). The Supreme Court of Tennessee held that a corporation cannot practice one of the learned professions and a corporation cannot employ a licensed practitioner to practice it.
Tenn. Code § 63-6-214 (1980). A physician may have his license suspended or revoked for giving or receiving, or aiding or abetting the giving or receiving, of rebates, either directly or indirectly.
Tenn. Code § 39-6-1202 (1932). It shall be unlawful for any licensed physician or surgeon to divide or agree to divide any fee or compensation received in the practice of medicine or surgery with any other person.
Tenn. Code § 63-5-124 (1984). A dentist may have his license suspended or revoked for dividing fees, or agreeing to split or divide fees received for professional services, with any person for bringing or referring a patient.

Tenn. Code § 63-3-119 (1976). A podiatrist may have his license suspended or revoked for dividing fees, or the agreeing to split or divide fees received for professional services, with any person for bringing or referring a patient.

Tenn. Code § 63-8-120 (1979). An optometrist may have his license suspended or revoked for dividing fees, or agreeing to split or divide the fees received for professional services, with any person for bringing or referring a patient.

Tenn. Admin. Comp. § 1140-3-.03 (1983). A pharmacist should never agree to participate in any transaction with practitioners of other health professions or any other person under which fees are divided.

Tenn. Admin. Comp. § 1180-1-.06 (1978). It is unethical for a psychologist to receive any commission, rebate, or other form of remuneration for the referral of clients for professional services.


Peer Review
Tenn. Code § 63-6-219 (1983). Any individual appointed to any medical review committee shall be immune from liability for damages resulting from any decision rendered or action or proceeding taken by such committee.

TEXAS

PPO Legislation
Commercial Insurers

Tex. Stat. art. 3.51-6 (1982). Any group accident and health insurance policy may not require that the service be rendered by a particular hospital or person.

Tex. Stat. art. 3.70-2 (1985). No policy of accident and sickness insurance shall make benefits contingent upon treatment or examination by a particular practitioner or by particular practitioners of the healing arts.

Tex. Stat. art. 21.52 (1983). The payment or reimbursement of medical services or procedures shall not be denied because they were performed by a licensed podiatrist, optometrist, chiropractor, or dentist.

Op. Att’y Gen. No. JM-301 (Mar. 19, 1985). It is the opinion of the Attorney General that article 21.52 expressly prohibits an insurer from discriminating against an insured, with regard to payment or reimbursement, based on the type of practitioner the insured selects to provide medical care.


Tex. Stat. art. 21.53 (1983). No health insurance policy shall prevent any person from selecting his own dentist or interfere with the selection of any licensed dentist to furnish such dental care services. In addition, the reimbursement for a noncontracting provider dentist shall be the same as the payment or reimbursement for a contracting provider dentist in any dental service plan.

Health Service Corporations


Health Maintenance Organizations

Tex. Stat. art. 20A.01 et seq. The Health Maintenance Organization Act defines an HMO as any person who arranges or provides health care services to enrollees on a prepaid basis.

Professional Licensure


Garcia v. State Board of Medical Examiners, 384 F. Supp. 434, aff’d. 421 U.S. 995 (1975). Under Texas law, when a corporation employs a licensed physician to treat patients and itself receives the fee, the corporation is unlawfully engaged in the practice of medicine.
Woodson v. Scott and White Hospital, 186 S.W.2d 720 (1945). A corporation organized for profit cannot engage in the practice of medicine nor employ physicians to do so as its agents; and a license to practice medicine may be issued only to persons.


Tex. Stat. art. 4496b (1981). A physician or surgeon may not employ or pay any person any reward for securing or drumming up patients or patronage. In addition, a physician may have his license suspended or revoked for aiding or abetting, directly or indirectly, in the practice of medicine by a corporation.

Republic Reciprocal Insurance Association v. Colgin Hospital and Clinic, 123 Tex. 31 (1933). The Supreme Court of Texas held that a private corporation cannot legally practice medicine in this state, nor charge fees therefor.

Op. Att'y Gen. No. WW-278 (Oct. 16, 1957). It is the opinion of the Attorney General that whenever a corporation employs a licensed physician to treat patients and itself receives the fee, the corporation is unlawfully engaged in the practice of medicine.


Tex. Stat. art. 4552-5.13 (1981). No optometrist shall divide, share, or split, either directly or indirectly, any fee for optometric services with any person. (1985)

Kee v. Baber, 303 S.W.2d 376 (1957). The court held that the prohibition against the corporate practice of optometry does not prevent an optometrist from leasing office space from a business establishment as long as the optometrist does not place his license at the disposal of, or in the service of, any person not licensed to practice optometry.


Peer Review

Senate Bill No. 656 (1985). This Act amends Article 4447d, and provides that no member of any committee or joint committee of a hospital or medical organization shall be liable for damages to any person for any action taken or recommendation made within the scope of the functions of such committee.

Tex. Stat. art. 4495b-5.06 (1981). Any member or employee of any medical peer review committee shall be immune from civil liability for
assisting the board in carrying out its duties or functions provided by law.

UTAH

PPO Legislation


Commercial Insurers

Utah Code § 31-27-24 (1970). No insurer shall make any unfair discrimination in favor of particular individuals or between any duly licensed professional groups; and the right of any person to exercise full freedom of choice in the selection of any duly licensed hospital shall not be restricted under any policy of accident or sickness insurance.

Utah Code § 31-20-3 (1965). Any group disability policy may not require that the service be rendered by a particular hospital or person.


Utah Code § 31A-22-618 (1986). Except for PPO contracts, no insurer may refuse to reimburse covered services provided by a licensed optometrist, podiatrist, psychologist, or other practitioner of the healing arts.

Health Service Corporations

Utah Code § 31-37-1 et seq. The Nonprofit Hospital, Medical-Surgical, Dental and Health Service Corporations Act.

Utah Code § 31-37-8 (1973). Subscribers shall have the free choice of any participating hospital, physician, or dentist.


Health Maintenance Organizations

Utah Code § 31-42-1 et seq. The Health Maintenance Organization Act defines an HMO as any person who furnishes or arranges for health care to an enrolled member in return for periodic payment. See also § 31A-8-101 et seq. (1986).
Professional Licensure

Utah Code § 16-11-1 et seq. The Professional Corporation Act.
Utah Code § 26-20-4 (1981). Any person who offers or receives a kickback or bribe, or who receives a rebate or fee or charge for referring an individual to another person for the furnishing of goods or services is guilty of a second degree felony.
Utah Code § 58-12-26 et seq. Medical Practice Act.
Utah Code § 58-12-31 (1981). This provision provides the qualifications required to obtain a medical license.
Utah Code § 58-7-1 et seq. Dental Practice Act.
Utah Code § 58-7-9 (1979). A dentist may be guilty of unprofessional conduct for sharing professional fees with an unlicensed person or paying any person for sending or referring patients.
Utah Code § 58-16-1 et seq. Optometry Practice Act.
Utah Code § 58-17-1 et seq. Pharmacy Practice Act.
Utah Code § 58-17-9 (1965). A pharmacy or pharmacist may have his license suspended or revoked for giving or receiving rebates to practitioners or other health care providers for the recommending of the professional services of either party.

Peer Review

Utah Code § 58-12-25 (1969). Physicians appointed to serve upon utilization review committees shall be immune from liability with respect to such information or decisions furnished or made by such committees.

VERMONT

PPO Legislation

There is currently no PPO legislation in Vermont.

Commercial Insurers

Vt. Stat. 8 § 4065 (1953). The payment of claims provisions may, at the option of the insurer, provide that it is not required that the service be rendered by a particular hospital or person.

Health Service Corporations
Vt. Stat. 8 § 4585 (1947). Subscribers shall have the free choice of any participating physician.

Health Maintenance Organizations
Vt. Stat. 8 § 5101 et seq. The Health Maintenance Organization Act defines an HMO as any person who furnishes directly or arranges for comprehensive health care services to enrolled members in return for periodic payments.

Professional Licensure
Vt. Stat. 11 § 1851 (1971). Corporations may be organized in Vermont for carrying on any business or affecting any object not repugnant to the laws of this state except as limited by statute.
Vt. Stat. 26 § 1314 (1947). It is unlawful for a person to practice medicine without a license.
Vt. Stat. 26 § 1354 (1977). It is unprofessional conduct for a physician to divide or agree to split fees received for professional services with any person for bringing or referring a patient.
Vt. Stat. 26 § 809 (1977). A dentist may have his license suspended or revoked for the division of fees or agreeing to split or divide any fees received for professional services with any person for bringing or referring a patient.
Peer Review

Vt. Stat. 26 § 1441 et seq. There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any member of a peer review committee for any act or proceeding undertaken or performed within the scope of the functions of such committee.

VIRGINIA

PPO Legislation


Commercial Insurers


Health Service Corporations

Va. Code § 38.1-810 et seq. Hospital and Medical Service Plans.
Va. Code § 38.1-820 (1979). Any medical or surgical services plan must assure that the subscriber shall have free choice of any medical practitioners available and participating in the plan for medical services.

Health Maintenance Organizations

Va. Code § 38.1-864 et seq. The Health Maintenance Organization Act defines an HMO as any person who undertakes to provide or arrange for health care services on a prepaid basis.

Professional Licensure

Va. Code § 18.2-502 (1975). No person or corporation shall for profit engage in any business that includes the referral or recommendation of persons to a physician or hospital.
Va. Code § 54-274 (1982). It is unlawful to practice medicine without a license.

Va. Code § 54-278 (1956). No surgeon or physician shall directly or indirectly share any fee charged for medical services with any physician or person who sends or recommends a patient to that physician or surgeon.

1953-54 Op. Att'y Gen. 125 (1954). It is the opinion of the Attorney General that doctors may not form an association and share their fees because such a system would deter patients from making their free choice of providers.

1960-61 Op. Att'y Gen. 246 (1960). It is the opinion of the Attorney General that the Physician Practice Act does not prohibit the employment of one physician by another as long as a bona fide partnership is formed.


State Dentists, Inc. v. Gifford, 168 Va. 508 (1937). A corporation that has been chartered to practice dentistry in Virginia may have this valuable right withdrawn only by clear and unmistakable language on the part of the legislature.


Va. Code § 54-388 (1973). An optometrist may have his license suspended or revoked for the splitting or dividing of a fee with any person other than a duly registered optometrist who is a legal partner.


Peer Review

Va. Code § 8.01-581.13 et seq. Any physician or dentist shall be immune from civil liability for any act, decision, or omission made or done in the performance of his duties as a member of any committee.

WASHINGTON

PPO Legislation

There is currently no PPO legislation in Washington.
Commercial Insurers


Rate Setting


Health Service Corporations


Health Maintenance Organizations

Wash. Rev. Code § 48.46.010 et seq. The Health Maintenance Organization Act defines an HMO as any organization that provides comprehensive health care services to enrolled participants on a per capita prepayment basis or on a prepaid individual practice plan.

Professional Licensure

Standard Optical Company v. Superior Court, 17 Wash.2d 323, 135 P.2d 839 (1943). The Supreme Court of Washington held that a corporation cannot be licensed to carry on the practice of any learned profession, nor, as a general rule, can it engage in the practice of medicine, surgery, or dentistry through licensed employees. Further, the legislature did classify optometry as a learned profession and thus a corporation may not engage in the practice of optometry by employing licensed optometrists.
Wash. Rev. Code § 19.68.010 et seq. It shall be unlawful for any person, whether organized for profit or not for profit, to pay or offer to any person licensed to engage in the practice of medicine, dentistry, or pharmacy, directly or indirectly, a rebate, refund, discount, or other valuable consideration in connection with the referral of any patients.
Wash. Rev. Code § 18.71.050 (1909). This provision provides the qualifications required to obtain a medical license.
Wash. Rev. Code § 18.32.530 (1977). A dentist may be guilty of unprofessional conduct if he divides fees or agrees to split or divide the fees received for dental services with any person for bringing or referring a patient.
Wash. Rev. Code § 18.53.180 (1973). No state agency may enter into any agreement with any group or corporation which in any way, directly or indirectly, discriminates against licensed optometrists in performing and receiving compensation for services covered by their licenses.

Peer Review

Wash. Rev. Code § 4.24.240 et seq. No member of a professional review committee shall be liable in any civil action as a result of acts or omissions made in good faith on behalf of the committee.

WEST VIRGINIA

PPO Legislation

There is currently no PPO legislation in West Virginia.

Commercial Insurers

W. Va. Code § 33-15-4 (1957). The payment of claims provision may, at the option of the insurer, provide that it is not required that the service be rendered by a particular hospital or person.

Rate Setting

Health Service Corporations

W. Va. Code § 33-24-1 et seq. Hospital, Medical and Dental Service Corporations Act.


Health Maintenance Organizations


Professional Licensure


W. Va. Code § 30-3-10 (1980). It shall be unlawful to practice medicine without a license.

W. Va. Code § 30-3-14 (1980). A physician may be guilty of unprofessional conduct for receiving or paying, directly or indirectly, any rebate, refund, or other valuable consideration for the referral of patients to any person.


W. Va. Code § 30-4-4c (1985). No corporation shall practice dentistry or holds itself out as being capable of doing so.


W. Va. Code § 30-8-3b (1973). No corporation shall practice optometry or hold itself out as being capable as doing so.


Peer Review

W. Va. Code § 30-1-16 (1979). No member of a peer review committee shall be deemed liable to any person for any action taken or recommendation made within the scope of the functions of the committee.

W. Va. Code § 30-3C-2 et seq. Any member of a review organization shall be immune from liability for loss or injury to the person whose activities are being reviewed.

WISCONSIN

PPO Legislation


Commercial Insurers

Wis. Stat. § 146.17 (1969). Nothing in the statute shall interfere with an individual’s right to select his own physician or mode of treatment.

Wis. Stat. § 628.36(2) (1983). Except as exempted by preferred provider plans, no health care plan may prevent any person covered under the plan from choosing freely among providers who have agreed to participate in a plan.


Rate Setting

Wis. Stat. § 54.01 et seq. The Hospital Rate-Setting Provisions.

Health Service Corporations


Health Maintenance Organizations

Wis. Stat. § 628.36(2m) (1983). The Health Maintenance Organization Provision defines an HMO as an organization that makes available to enrolled participants comprehensive health care services in exchange for periodic fixed payments.
Professional Licensure

Wis. Stat. § 448.01 et seq. Physician Practice Act.
Wis. Stat. § 448.03 (1979). No person may practice medicine and surgery without a license.
Wis. Stat. § 448.08 (1977). No physician or podiatrist may give or receive, directly or indirectly, any fee, rebate, or other form of compensation for sending or referring any patient.
3 Op. Att’y Gen. 218 (1914). It is the opinion of the Attorney General that the splitting or dividing of fees by physicians and surgeons for the referral of patients is illegal.
21 Op. Att’y Gen. 489 (1932). It is the opinion of the Attorney General that a corporation may not operate a dental office unless all of its stockholders are licensed to practice dentistry.
Wis. Stat. § 449.01 et seq. Optometry Practice Act.
Wis. Stat. § 449.08 (1977). It is unprofessional conduct for an optometrist to split or divide any fee for optometric services with any person, except an associate licensed optometrist.
Harris v. Kindy Optical Co., 235 Wis. 498, 292 N.W. 283 (1940). The Supreme Court of Wisconsin held that a corporation, by employing licensed optometrists to assist in its business, did not violate any statute regulating the practice of optometry, even though the corporation itself is not licensed to practice optometry.
Wis. Stat. § 450.01 et seq. Pharmacy Practice Act.
Wis. Stat. § 455.01 et seq. Psychology Practice Act.
Wis. Stat. § 455.09 (1969). A psychologist may have his license suspended or revoked for accepting commissions or rebates or other forms of remuneration for referring persons to other professionals.
Wis. Stat. § 143.15 et seq. Clinical Laboratory Licensure.

Peer Review

Wis. Stat. § 146.37 et seq. No person who participates in the review or evaluation of the services of health care providers or facilities, or in the charges of improper utilization of such services, is liable for any
civil damages as a result of any act or omission by such person in the
course of such review or evaluation.

WYOMING

PPO Legislation


Commercial Insurers

Wyo. Stat. § 26-19-104 (1983). A group disability policy may not require that the service be rendered by a particular hospital or person.

Wyo. Stat. § 26-22-101 (1983). No insurance policy shall deny reimbursement for covered services as long as those services are rendered by a licensed provider within the state.


Health Service Corporations

Wyo. Stat. § 26-22-301 (1983). Hospital and Medical Service Plans are subject to regulation and taxation as an insurer.

Health Maintenance Organizations

Wyo. Stat. § 26-34-101 et seq. The Health Maintenance Organization Act of 1985 defines an HMO as any person who provides or arranges for basic health care services to enrollees on a prepaid basis.

Professional Licensure


Wyo. Stat. § 17-1-103 (1961). Corporations may be organized for any lawful purpose, except for the purpose of banking or insurance.

1977-80 Op. Att’y Gen. (No. 79-17) 287 (1979). It is the opinion of the Attorney General that historically doctors were precluded from incorporating under the state’s corporation statutes and that podiatrists, chiropractors, dentists, pharmacists, and any one engaged in the practice of medicine must comply with the professional corporation statutes to practice as a corporation.

Wyo. Stat. § 33-26-112 (1981). This provision provides the qualifications required for a medical license.

Wyo. Stat. § 33-23-110 (1957). An optometrist may have his license suspended or revoked for splitting or dividing any fee with any person or persons.

Wyo. Stat. § 33-27-109 (1965). A psychologist may have his license suspended or revoked for accepting commissions or rebates or other forms of remuneration for referring clients to other professional persons.


**Peer Review**

Wyo. Stat. § 35-2-601 et seq. No claim or action shall accrue against any hospital or medical staff member, by virtue of any suspension, expulsion, or any other restrictive or disciplinary action against any medical staff member, by reason of being on the medical staff committee.
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