

State Laws and Regulations Governing Preferred Provider Organizations

Executive Summary

Elizabeth S. Rolph, J. Peter Rich, Paul B. Ginsburg,
Susan D. Hosek, Karen M. Keenan, Gary B. Gertler

Rand

The research described in this report was sponsored jointly by the U.S. Department of Health and Human Services under Contract No. 100-84-0073 and by the Federal Trade Commission.

ISBN: 0-8330-0754-8

The Rand Publication Series: The Report is the principal publication documenting and transmitting Rand's major research findings and final research results. The Rand Note reports other outputs of sponsored research for general distribution. Publications of The Rand Corporation do not necessarily reflect the opinions or policies of the sponsors of Rand research.

Published by The Rand Corporation

R-3442/1-HHS/FTC

State Laws and Regulations Governing Preferred Provider Organizations

Executive Summary

Elizabeth S. Rolph, Paul B. Ginsburg,
Susan D. Hosek
of The Rand Corporation

and

J. Peter Rich, Karen M. Keenan, Gary B. Gertler
of Memel, Jacobs, Pierno, Gersh, and Ellsworth

August 1986

Prepared for
The Department of Health and Human Services
The Federal Trade Commission



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 executive summary on state laws summarizes the findings of a more detailed companion volume. A third volume contains an annotated bibliography covering all aspects of preferred provider organizations.

E. S. Rolph, J. P. Rich, P. B. Ginsburg, S. D. Hosek, K. M. Keenan, and G. B. Gertler, *State Laws and Regulations Governing Preferred Provider Organizations*, R-3442/2-HHS/FTC, August 1986.

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:

P. B. Ginsburg, S. D. Hosek, N. Duan, H. S. Luft, M. S. Marquis, and J. B. Trauner, *Research Plan for the Preferred Provider Organization Study*, N-2298-HHS, January 1986.

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.

ACKNOWLEDGMENTS

This study has benefited greatly from the knowledge and encouragement of a number of individuals. In particular, David Narrow of the Federal Trade Commission has offered invaluable substantive assistance, patience, and support, as our work progressed. Barbara Mayers, with McDermott, Will, and Emery in Chicago, and Richard Rettig, a Rand colleague, generously shared their expertise, providing insightful suggestions, especially regarding the overall organization of the report. Cheryl Austein and Randy Teach of the Department of Health and Human Services also provided us with much appreciated support in the course of our work. Mary Vaiana enabled us to join the independent work of several authors into a single, readable volume. Patricia Bedrosian edited the final report with competence and dispatch, while Terri Albert most ably and cheerfully undertook the typing and other support functions essential to the completion of this project.

Woodrow Eno of the Health Insurance Association of America was exceptionally helpful 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
Section	
I. INTRODUCTION	1
II. WHAT IS A PPO?	3
Characteristics of PPOs	3
The Growth and Importance of PPOs	4
III. THE LEGAL ENVIRONMENT FOR PPOs	5
The Preexisting Legal Environment	5
State Responses to PPOs	6
IV. MAJOR PROVISIONS IN STATE LAW: EFFECTS ON PPO DEVELOPMENT	8
Any-Willing-Provider and Freedom-of-Choice Provisions	9
Antidiscrimination Provisions and Payment Differential Limits	10
Consumer Protection Measures	10
Incidence of Restrictions in PPO Laws and Regulations	11
Other Provisions of State Law	11
Antitrust Law	13
V. IMPLICATIONS	14

I. INTRODUCTION

In the past three years, preferred provider organizations (PPOs) have emerged as an important mechanism for reducing costs by promoting competition among health care providers.¹ Through a PPO, insurers and other purchasers of health care services contract with a select group of providers to deliver care to persons enrolled in health insurance or benefits plans. The contractual arrangements are intended to give the purchaser some control over costs. The cost control devices may include discounts on charges, vigorous utilization controls, and selection of low-cost providers. Enrollees are given economic incentives to use PPO providers, although the enrollees typically are able to use other providers if they so choose. If the PPO is successful, the purchaser will reduce his outlays, enrollees will receive better benefits without a reduction in satisfaction with care, and PPO providers will get more patients.

Organizers of PPOs have pointed to state laws and regulations that might preclude them from incorporating into PPOs some of the incentives deemed critical to their success. Many of the provisions causing concern had been enacted long before current PPO models were developed and did not envision the arrangements that we are seeing today.

These preexisting state laws and regulations have prompted concern among those in the Congress that an attractive device to control health care costs through competition could be prohibited or severely limited. To learn more about the nature and dimensions of regulatory impediments to PPOs, the House Committee on Energy and Commerce asked the Federal Trade Commission to report to the Congress on how state laws and regulations have affected PPO development and whether they adequately protect consumers. This study was prepared in response to that request.

In conducting the study, we pursued two approaches. First, we compiled and analyzed the relevant laws and regulations in each of the 50 states. Second, we interviewed representatives of the major groups interested in PPOs: state officials, insurers, multihospital chains, business coalitions, provider associations, and PPOs themselves. In addition, we reviewed the literature on PPOs. These efforts are described in greater detail in separate volumes of this report.

¹As 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.

The states are moving rapidly to change their laws, regulations, and policies in response to PPOs. Consequently, the information in this report that describes the states' legal environment may rapidly be outdated. However, our conclusions about how *types* of laws affect PPOs remain valid.

The remainder of this summary is organized into four sections. Section II describes the major features of PPOs and their growth and role in the market for health services. Section III describes the preexisting state regulatory environments and the various ways in which the states have adapted their environments to PPOs. Section IV outlines the major provisions in state law that might limit PPO arrangements and the actual effects of these provisions on PPO development. The final section draws policy implications from our findings.

II. WHAT IS A PPO?

The term "preferred provider organization" covers a wide variety of arrangements. In this early stage of development, individual PPOs are exploring different approaches, although most of them share certain features, which are described in this section.

CHARACTERISTICS OF PPOs

Although PPOs differ, they all offer enrollees incentives to limit their care to a panel of "preferred" providers, including hospitals, physicians, and sometimes nonphysician practitioners. Typical incentives include lower deductibles and copayments, or coverage of more services when a PPO provider is used instead of a non-PPO provider. In a few cases, the benefit plan does not provide benefits for services obtained from non-PPO providers; this arrangement is called an exclusive provider organization (EPO).

Unlike a health maintenance organization (HMO), the insurance risk in PPO programs is borne by the insurance company or by the self-insured employer instead of by the providers.

Provider selection patterns vary a great deal. Some PPOs attempt to select providers that have demonstrated lower costs, whether through more efficient practice styles or lower fees. This approach is the norm for selecting hospitals but is not common for selecting physicians. Many PPOs offer membership to any physician willing to accept the program's contractual terms. Even without rigorous physician selection, PPOs can control costs through channeling patients to low-cost hospitals, discounts on charges from hospitals and/or physicians, and utilization controls. Once the PPO develops profiles on physicians, it may drop those with unacceptable practice patterns.

PPOs have been organized by groups of hospitals or physicians, by independent brokers, by self-insured employers, by commercial insurers, and by health service corporations (mostly Blue Cross or Blue Shield). Typically, provider-sponsored and broker-sponsored PPOs are marketed to self-insured employer plans. Insurer-sponsored PPOs may also be marketed to self-insured employers (through administrative services only contracts), but insurers also offer PPOs as part of an insurance contract to employers unwilling or unable to self-insure.

THE GROWTH AND IMPORTANCE OF PPOs

PPOs made their first appearance in California and Colorado in the 1970s but until recently were limited to a small share of the market in only a few areas. However, all of these areas were characterized by high costs for medical care and a disproportionately large supply of providers. In California, Colorado, and Ohio, hospitals hoping to gain or retain market share were active in setting up PPOs. Florida was the first state in which an employer coalition initiated the development of PPOs.

In the 1980s, the growth of PPOs has accelerated, with much of the growth occurring initially in the states pioneering the concept. This dramatic growth was documented in a national survey of PPOs, conducted in 1985 by Rice et al.¹ Of the almost six million persons enrolled in 1985 in plans including a PPO, 44 percent lived in California and 17 percent in Colorado and Florida. The proportion of physicians in all states having one or more PPO affiliations grew from 5 percent in early 1983 to 28 percent two years later.

At the time of the PPO survey, provider-sponsored PPOs were more numerous than PPOs sponsored by other groups. Providers sponsored almost one-half of the PPOs, which had over 40 percent of the PPO enrollment. However, Blue Cross and Blue Shield plans are aggressively marketing PPOs and most commercial insurers already are offering, or soon will offer, PPOs. Insurer-sponsored PPOs are expected to overtake provider-sponsored PPOs in the near future.

¹Thomas Rice, Greg de Lissovoy, Jon Gabel, and Dan Ermann, "The State of PPOs: Results from a National Survey," *Health Affairs*, Vol. 4, No. 4, 1985.

III. THE LEGAL ENVIRONMENT FOR PPOs

The regulation to which a PPO is subject depends on the nature of the entity that underwrites the insurance risk and/or organizes the PPO. PPOs may be underwritten by commercial insurers or health service corporations (usually Blue Cross and Blue Shield plans), or they may be self-insured (underwritten by the employer). Some HMOs have expressed interest in developing PPOs from their panel of providers. In each case, a different set of rules applies.

This regulatory structure may have been understandable in the past, because the products offered by different kinds of insurers differed to some extent. This is no longer the case in today's health care market, where commercial insurers, Blue Cross/Blue Shield plans, and even HMOs market similar insurance products, PPOs, and HMOs, and the boundaries between these products have become increasingly blurred.

THE PREEXISTING LEGAL ENVIRONMENT

Historically, regulation of health benefits plans and providers was exclusively the responsibility of the states. Federal responsibility largely was limited to enforcement of federal antitrust laws. In many states, commercial insurers and health service plans faced essentially the same provisions, generally addressing fiduciary responsibility and consumer protection. However, in some states, the provisions governing health service plans differed from the provisions for insurers.

Most states enacted new statutes to govern the activities of HMOs because HMOs limit enrollees' choice of provider and pose additional risks to consumers. Therefore, HMO regulation focuses more attention on issues of access to care and quality of care.

In 1974, the federal government enacted the Employee Retirement Income Security Act (ERISA), which included a provision exempting self-insured employee benefit plans from state regulation. ERISA required certain minimal fiduciary, disclosure, and reporting requirements on employee benefit plans. However, it did not include most of the provisions commonly found in state laws governing "the business of insurance" as undertaken by insurance companies, health service corporations, and HMOs. Many employers have changed their health plans from insured to self-insured to take advantage of this exemption from state regulation. Today, roughly 40 percent of covered employees are in plans subject only to federal regulations.

STATE RESPONSES TO PPOs

The states have reacted differently to the emergence of PPOs. In some states, existing insurance and/or health service corporation laws have been interpreted either by state officials or by underwriters as precluding PPOs. Conversely, other states have interpreted similar laws as permitting PPOs. Some states have not yet taken a formal position regarding the legality of PPOs under these preexisting laws. To eliminate any uncertainty, 22 states have enacted legislation or adopted new regulations authorizing and regulating PPOs. These laws and regulations override the major preexisting provisions that might have limited PPO development, but some include additional provisions that PPOs regard as restrictive.

Table 1 categorizes the states according to their legal environments for PPOs. The categorization, which is based on information received at the time this report is issued, may rapidly become out of date as states adopt new guidelines for applying existing legislation or enact new legislation.

Recently, there has been a trend toward adoption of legislation or regulations specifically authorizing PPOs (see column one of Table 1). California adopted the first enabling act in 1982. In 1983, three states passed enabling acts, followed by five states in 1984, nine in 1985, and two in the first half of 1986. In the past year, three states have adopted new regulations under existing law that authorize PPOs. In at least seven states, PPO bills have failed to pass.

State PPO enabling acts and regulations vary considerably in their provisions. In addition to specifically authorizing PPOs, some restrict their activities to protect consumers or providers. These restrictions could limit a PPO's ability to select panel members, negotiate favorable contracts, or design incentives to channel enrollees to preferred providers. Other states have chosen to place very few restrictions on PPO activities. In each state, the provisions reflect, among other things, the balance among competing interests at the time the enabling act passed or the regulation was adopted. When the acts and regulations are viewed in chronological order, they show no discernible trend toward either more or less restrictive provisions.

Table 1

STATE LEGAL ENVIRONMENTS FOR PPOs: APPLICATION
OF PREEXISTING PROVISIONS, AS OF JUNE 1986

Prior Restrictions ^a	PPOs Not Permitted	PPOs Permitted	Undetermined
Enabling Statutes:	Georgia ^b	Informal	Appears
California	Montana	Interpretation:	Positive:
Florida	Ohio ^c	Arizona	Alabama
Illinois		Colorado	Alaska
Indiana		Massachusetts	Connecticut
Iowa		Missouri	Delaware
Kansas		New Jersey	Oklahoma
Louisiana		New York	Rhode Island
Maine		Tennessee	South Carolina
Maryland			West Virginia
Michigan		Other	
Minnesota		Legislation:	Possible
Nebraska		Nevada	Conflict:
New Hampshire			Mississippi
North Carolina			New Mexico
Oregon			North Dakota
Pennsylvania			Vermont
Utah			
Virginia			No Opinion:
Wisconsin			Hawaii
Wyoming			Idaho
			South Dakota
Formal Regulation:			Washington, D.C.
Arkansas			
Texas			
(Kentucky ^d)			

^aStatutes 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.

^bCommercial insurers only.

^cHealth service corporations only.

^dKentucky is in the process of adopting regulations.

IV. MAJOR PROVISIONS IN STATE LAW: EFFECTS ON PPO DEVELOPMENT

In this section, we briefly describe the major provisions in state law that might affect PPOs and summarize the actual effect of each provision on PPO development. The discussion includes provisions found in preexisting law and in PPO enabling acts or regulations, which are more recent. ERISA exempts self-insured employee benefit plans from all of these provisions. However, many self-insured plans are guaranteed limits on benefit cost increases or bear risk only up to a certain level and purchase "stop-loss" coverage for amounts above that level. Whether ERISA is applicable to these partially self-insured plans is currently uncertain. Case law is proceeding to determine which types of self-insured plans are exempt from state regulation.

Some of the major provisions in the more restrictive PPO enabling acts are borrowed from the previously enacted laws governing commercial insurers and health service corporations. Both forms of law may restrict PPO activities. The provisions, described below, include: (1) "any willing provider" clauses, derived from the "freedom-of-choice" clauses in the insurance codes, (2) "payment differential limits" that resemble the old "anti-discrimination" provisions, and (3) an array of consumer protection provisions designed to assure quality and access standards, adequate consumer information, and plan financial stability.

A number of states, in their enabling acts or through regulatory action, have disallowed EPOs, the variant of PPO that does not reimburse for services from nonpreferred providers. A few states also have enacted provisions intended make participation in PPOs by some types of providers more difficult or impossible. Four states effectively prohibit the formation of PPOs for dental services. Three other states expressly exempt certain categories of nonphysician practitioners from the provisions of their enabling laws.

In addition to the insurance provisions and enabling acts, we surveyed various other areas of state law that might affect PPOs, including professional licensure acts, peer review provisions, and HMO statutes. Although the Congressional request specified a review of state law, we also briefly surveyed the application of federal antitrust law.

ANY-WILLING-PROVIDER AND FREEDOM-OF-CHOICE PROVISIONS

Freedom-of-choice provisions prohibit a health insurance plan or health service plan from dictating which providers an enrollee must use to be covered or to receive benefits. In their strictest interpretation, freedom-of-choice provisions may preclude plans that limit the choice of provider either directly or through financial incentives. Frequently, however, the interpretations given to freedom-of-choice provisions have not been so restrictive. In addition, many states, unsure about the application of freedom-of-choice laws to PPOs, have overridden them by passing PPO enabling laws.

Eight states with PPO enabling laws or regulations that generally exempt PPOs from preexisting laws' freedom-of-choice provisions have included "any-willing-provider" provisions in their new PPO enabling laws. These provisions require that PPOs accept any provider willing to accept the PPOs' conditions for membership.¹ A variant of the any willing provider clause, found in five states, requires that PPOs include nonphysicians on their provider panels. Finally, three states prohibit the use of primary care physicians as "gatekeepers" to regulate referrals to specialists, which limits the patient's freedom to choose when and from whom to get specialty care.

It is too early to assess the effect of the any-willing-provider provisions on the rate and direction of PPO development. None of the states with these clauses has as yet issued implementing regulations. In addition, the relatively unsophisticated methods currently used by most PPOs to select providers, especially physicians and nonphysician practitioners, may be less likely to conflict with these provisions. The PPO sponsors we interviewed generally reported that they had not experienced problems with any-willing-provider provisions, but most are concerned that their selection and contracting processes may be limited in the future as their provider selection processes become more sophisticated. Of all the provisions we surveyed, these appear to have the greatest potential for restricting PPO activities.

¹A weak version of this type of restriction requires the PPOs to accept applications from any provider but not necessarily to contract with the provider.

ANTIDISCRIMINATION PROVISIONS AND PAYMENT DIFFERENTIAL LIMITS

Antidiscrimination clauses found in the insurance laws of almost every state provide that an insurer may not *unfairly* discriminate among covered individuals of the same risk classification in the level of premiums, fees, or benefits. Strictly interpreted, this type of provision might rule out the payment differentials used by PPOs as incentives to direct subscribers to PPO providers. However, in many states, the insurance departments have formally or informally concluded that PPOs do not discriminate *unfairly* because the different payment levels for preferred and nonpreferred providers reflect differences in charges and fees among these providers, and enrollees typically are able to use non-PPO providers if they choose.

Despite the common finding that antidiscrimination provisions do not prohibit PPOs, a major reason for passing PPO enabling legislation has been to remove any uncertainty regarding this issue. In the enabling statutes or regulations of several states, a “differential payment” or “differential benefit” limit serves some of the same purposes as the earlier antidiscrimination provisions. The typical provision limits the difference between payment or benefit levels for PPO and non-PPO providers to 10–30 percent, depending on the state.

Again, we cannot tell yet what practical effect the differential payment limits will have on PPOs. If PPOs can achieve their goal of redirecting patients to preferred providers with relatively small incentives, the payment differential limits should not pose a serious problem. If, on the other hand, large incentives are needed, the states will have to consider whether they want to limit differentials to lower, “noncoercive” levels or to give the PPOs greater freedom to channel patients to low-cost providers.

CONSUMER PROTECTION MEASURES

Many states have become concerned that PPOs, with their incentives for enrollees to choose particular providers and their utilization control procedures, may expose the patient to other or greater risks than are found in traditional arrangements for providing health care services. To protect consumers, various provisions have been adopted by 14 states, including requirements that the PPOs:

- Provide enrollees with lists of PPO providers, reimbursement rates, and other information.

- Offer panels that provide adequate access to care and/or a minimum range of services.
- Cover emergency services equally from PPO and non-PPO providers.
- Develop quality assurance programs and grievance procedures for enrollees and/or providers.

Most states are not applying their consumer protection provisions in a very restrictive manner at this early stage of PPO development. However, several state officials indicated that they were watching PPOs and intended to develop additional regulations if problems did indeed arise.

INCIDENCE OF RESTRICTIONS IN PPO LAWS AND REGULATIONS

Table 2 shows which types of provisions each of the states with PPO enabling laws or regulations has chosen to adopt. Most of the states have included at least some of the consumer protection measures listed above: Eight states include some form of any-willing-provider clause, and 11 limit payment or benefit differentials. Five states prohibit EPOs; four specifically authorize them. Generally, these measures are not viewed as being very restrictive.

OTHER PROVISIONS OF STATE LAW

We identified several other types of provisions in the state laws that may limit PPO activities. Nine states have enacted legislation that directly regulates the rates charged by hospitals to private (nongovernmental) purchasers. In eight of these nine states, PPOs have little or no ability to negotiate discounts. In one state, the rate schedule is applied as a ceiling, leaving PPOs free to negotiate discounts below the ceiling. In theory, neither rate-setting approach prevents PPOs from using other cost control mechanisms, such as selecting hospitals with lower rates or emphasizing utilization control. In practice, however, many sponsors of PPOs believe that they must be able to negotiate discounts to achieve their cost containment goals. Of the nine rate-setting states, only Massachusetts has a significant number of PPOs.

We also reviewed numerous other provisions of state law that could affect PPOs, including:

Table 2

CHARACTERISTICS OF STATE ENABLING STATUTES AND
REGULATIONS, AS OF JUNE 1986

State	Year of Adoption	Contains Any-Willing- Provider Provision	Limits Differ- entials	Contains Consumer Protection Policy	Has Policy on EPOs
By Statute					
California	1982				OK
Florida	1983			X	NO
Illinois	1985	X ^a		X	
Indiana	1984	X			OK
Iowa	1985				
Kansas	1985			X	
Louisiana	1984	X ^a		X	
Maine	1986		20%	X	NO
Maryland	1985		20%		
Michigan	1984		15%	X	OK
Minnesota	1984			X	
Nebraska	1984				
New Hampshire	1985	X		X	
No. Carolina	1985			X	NO
Pennsylvania	1986			X	OK
Oregon	1985			X	
Utah	1985	X	25%	X	
Virginia	1983	X		X	NO
Wisconsin	1983			X	
Wyoming	1985				
By Regulation					
Arkansas	1985	X	25%		
Florida ^b	1986		10-20%		
Texas	1986	X	30%	X	NO

^aApplies only to physicians.

^bInformal regulation.

- Professional licensure act provisions against the corporate practice of medicine, referral fees, and fee-splitting.
- Peer review immunity statutes, which generally do not cover PPO utilization review activities.
- Malpractice liability.
- Securities laws.
- Franchise laws.
- Certificate of need laws.

These provisions appear less likely to affect PPO activities, and we learned of no specific problems with them in our interviews. However, in some cases, a poorly designed PPO could violate these provisions. Considerations of peer review immunity and malpractice liability have not affected PPOs so far, but their utilization review programs conceivably could be hampered if the programs' records are not immune from public disclosure or if PPO providers face a higher risk of malpractice litigation.

ANTITRUST LAW

With regard to state antitrust laws, we found no provisions that differ significantly from federal law. A comprehensive review of the federal antitrust laws and their application to PPOs was beyond the scope of this study, but we note that both the Federal Trade Commission and the U.S. Department of Justice have issued opinions that particular PPO programs do not appear to violate the antitrust laws, and in fact may be procompetitive.

Nevertheless, PPOs in some circumstances may run some risk of antitrust liability. Provider-based PPOs in particular report that they have exercised caution in their activities to avoid even the appearance of anticompetitive activities, especially in light of the Supreme Court's ruling in *Arizona v. Maricopa County Medical Society*² and the dissolution of a physician-sponsored California PPO under the threat of an antitrust action by the Department of Justice. Despite these actions, as PPOs gain experience, they report less concern about the antitrust laws posing a barrier to their formation or operation.

²457 U.S. 332 (1982). The court held that a physician group engaged in illegal price-fixing when its members agreed on maximum fee levels for their charges under an insurer's program.

V. IMPLICATIONS

The overwhelming majority of states have addressed the issue of regulating PPOs by taking some form of action. Some states have decided to clear the way for PPOs, subjecting them only to regulations that traditional insurance is subject to, such as financial responsibility, mandated benefits, and premium taxes. Others have placed limits on the ability of PPOs to select a panel of preferred providers and to offer enrollees financial incentives to use the preferred providers. In only a few states do the laws preclude PPOs for all services or for the services of certain provider types.

Although most states appear to have endorsed a role for PPOs in the health care financing system, some have erected protections for providers and consumers against what they perceive as potential PPO excesses. Because PPOs are such a new phenomenon, we have only limited information concerning the degree of risk to consumers and providers posed by PPO arrangements in the absence of regulation. Likewise, it is too soon to know the degree to which such regulation will prevent PPOs from achieving success in cost containment. Without much experience with PPOs, the states are implicitly making major tradeoffs with little information about the relevant parameters.

The increasingly important ERISA exemption for self-insured plans generally relieves PPOs included in these plans of the restrictions contained in state laws and regulations. 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 involve a significant change in the division of responsibility between the state and federal governments. Although initial interest in federal overriding 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 involve the overriding of recent policy decisions on the part of the states.

RAND/R-3442/1-HHS/FTC

