Health Care Provider Networks:
Regulatory Issues for State Policy Makers

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Executive Summary

Health care provider networks are emerging in many states as physicians and hospitals seek to regain control over medical care from insurers and health maintenance organizations (HMOs) and as public and private sector purchasers seek to contain spending by contracting directly with providers. Networks gain the attention of state policy makers if they bear risk or aggregate market power. Many states have begun to examine the policy issues surrounding newly emerging provider networks. Because few states have much experience with these new forms of health care delivery, this paper highlights current trends in state policy, recent innovations in several states, and implications for provider network regulation of federal pension law (ERISA).

• What is a health care provider network?
  A provider network is a joint venture among health care providers. For example, a hospital may join with its medical staff to create a “physician-hospital organization” (PHO) or a physician group practice or state medical society may form a separate organization. Provider networks may go by many names, such as provider-sponsored networks, integrated delivery systems, or organized delivery systems. Their purpose is to contract with health care purchasers such as HMOs, public agencies, or employers.

• How do provider networks differ from HMOs?
  Provider networks are similar to some types of health maintenance organizations. While the first HMOs were composed of physician group practices, most current HMOs are operated by insurance companies or other organizations that hire or contract with providers. Provider networks represent a return to the earlier model of provider-centered organizations.

• Why might provider networks pose problems of interest to policy makers?
  Networks can pose problems for health care consumers if they bear risk by accepting a payment for the promise to provide all services a consumer may need over a given period of time. Spreading the risk that need for services will exceed a projected budget is the function of insurance. When providers accept such a risk they are undertaking an insurance activity. State governments traditionally regulate insurance companies and HMOs that bear such risk to protect consumers against insolvency and unfair marketing and claims practices. Because HMOs promise not only to pay for services but also to provide them, state governments regulate not only HMO finances and marketing but also quality of care, access to promised services, and fair resolution of grievances. If provider networks accept risk similar to HMOs, they may pose the same kinds of financial, quality, information, and access problems.

  Even networks that do not bear risk may raise some consumer protection concerns because they involve a limited number of physicians and other providers that consumers can use. Consequently, some states regulate provider networks to
assure they provide adequate choice and meet consumer needs. As provider networks are emerging, state policy makers may want to consider whether they want to regulate risk-bearing and/or non-risk-bearing networks to protect consumers.

- **Why are provider networks currently emerging as a policy issue?**
  Provider networks are a popular and apparently growing phenomenon. Managed care plans have grown in response to employer demand to control medical care spending. Physicians often form networks to regain control over their practices and save administrative costs by “cutting out the middle man” (the insurance company or HMO) and contracting directly with health care buyers, such as employers. It is not yet clear how much direct contracting actually will occur, but it is important for policy makers to understand and monitor these developments.

- **How do issues of provider networks come to the attention of state policy makers?**
  Networks have become a political and policy issue in many states because many state regulators take the position that, particularly if networks bear risk like insurers, they should be licensed as insurers. This sometimes leads to physician and hospital complaints that they do not want to meet insurance or HMO licensing standards. Sometimes business representatives support reducing licensure standards as a cost control measure. On the other hand, HMOs and insurance companies object to allowing networks to accept risk without complying with licensure laws. Consumers sometimes raise concerns about access and quality of managed care plans especially when plans deny requested services. Consumers might, therefore, support tighter regulation of provider networks and other managed care plans.

- **What are ERISA implications for provider network regulation?**
  States are prohibited by federal law (“ERISA”) from regulating “self-insured” employee plans. The only way a state can protect consumers in these plans is by regulating provider networks that contract with them.

- **What are states doing about provider networks?**
  Most states are just beginning to examine the phenomenon of provider networks. Early surveys suggest that the majority of states would license a physician-hospital organization that assumes full risk by accepting a fixed per capita fee (capitation) to provide all needed health care to an enrolled population. State policy is more varied on issues of whether accepting other types of risk, such as partial risk, require licensure or whether a network must be licensed if it contracts only with another licensed entity like an HMO. The paper outlines examples from states that are taking various approaches to regulating provider networks.

- **What should states do about provider networks?**
  Because state experience with the new generation of provider networks is so new, it is premature to try to identify the most appropriate kinds of policies to address potential consumer concerns. Policy makers should examine the experience
in their states and identify resource people from the legislative and executive branches as well as representatives of providers, consumers, insurers and HMOs who can help explain how the health care market is evolving and problems that may warrant policy responses. To defuse the often highly-charged environment these issues raise, a broad-based task force might be created to analyze issues and propose policy options.

- **What happens if a state does nothing about provider networks?**
  Depending on the amount of risk that provider networks actually accept, unregulated provider networks can pose several problems. Without public oversight of provider networks, consumers may be denied choice of and access to services, lose coverage due to provider insolvency, lack a process to resolve grievances, and experience poor quality of care.

- **What issues should policy makers consider in analyzing whether and how to regulate provider networks?**
  Among the policy and technical issues for policy makers examined in this report are: 1) how to define “risk” and the “business of insurance,” 2) Is having one licensed entity sufficient consumer protection? 3) How should provider networks be defined? 4) Are any existing insurance or HMO licensure requirements are unduly burdensome? 5) Under what agency’s jurisdiction should networks be regulated? 6) Are insurance laws applied even-handedly? 7) What impacts does provider network regulation have on public entities? 8) Should regulatory standards be flexible? 9) What are the appropriate standards for managed care plans? 10) How can policy makers obtain timely and accurate data about health plan performance? 11) how can states balance competing policy objectives of consumer protection and innovation to control costs.

- **Do provider networks raise anti-trust law concerns?**
  Many areas of the U.S. have relatively few hospitals and physicians. Consequently, when these providers form joint ventures they may dominate a market and raise prices above a competitive level. Anti-trust officials use federal and state anti-trust laws to protect consumers against anti-competitive behavior.

- **What issues should policy makers consider in examining provider network anti-trust concerns?**
  Among the issues in the complicated and technical field of health care provider network anti-trust enforcement examined briefly in this report are: 1) how much concentration of power is too much? 2) has anti-trust enforcement actually deterred beneficial network formation? 3) How can states foster integration in medically underserved areas? 4) How much anti-trust oversight states want to undertake to monitor provider network activity?
I. Introduction

Among the many developments in the fast-changing world of health care is the appearance of provider networks designed to contract not only with HMOs and insurers but also directly with employers or buying co-operatives. While groups of physicians and hospitals have always formed the core of health care delivery systems, they raise new policy issues when they decide to accept insurance risk, through capitation and other payment arrangements, rather than merely offer a structure through which care can be delivered. Many of these issues arose during congressional debates over the 1995 budget bill, which would have exempted "provider-sponsored organizations" contracting with Medicare from state licensing laws and certain anti-trust restrictions. State policy makers need to be familiar with these developments for several reasons. For example, states have a traditional interest (expressed through insurance and HMO licensure laws) in protecting health care consumers by assuring that networks have financial and provider capacity to meet their promise to render care, include mechanisms to resolve consumer complaints, employ quality assurance systems, and meet fair market conduct standards. Health policy makers also need to understand how provider networks fit into the state's health care delivery system and whether they create concentrations of market power that may lead to higher prices. Furthermore, Medicaid agencies need to be aware of these issues in order to assess the potential impact of network regulation and network market power on their ability to contract with managed care plans to enroll low income people.

This issue brief is intended to alert state policy makers about reasons that provider networks are developing, policy issues they present, and options to address them. The paper focuses on whether and how provider networks should be regulated. It also touches briefly on anti-trust concerns that networks may raise. Because most states have only recently begun to explore issues of provider network regulation, it is premature to evaluate state experience. This paper draws from interviews with legislators and insurance and HMO regulators in twelve states to discuss policy issues that states are beginning to face and strategies in place or under consideration to address them.

II. The Emergence of Provider Networks

Groups of physicians and hospitals have long existed to contract with insurers and employers. The earliest forms of HMOs, dating back to the 1920s, were nonprofit prepaid group practices organized by physicians, such as Group Health Cooperative of Puget Sound, Kaiser Health Plan, and Ross-Loos, which accepted fixed monthly payments (capitation) to provide a defined set of benefits to an enrolled population. In some respects, new organizations appear to be returning to that model, which had been overtaken by other forms of prepaid managed care over the past 20 years. Spurred by the adoption of the federal HMO Act of 1973, many HMOs developed as contracts between group or individual physician practices and traditional insurance carriers, such as Aetna and Prudential, or organizations created to be the insuring
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entity. Although some HMOs remain organized and controlled by physicians, many are operated by large, often multi-state for-profit firms. Increasingly, physicians complain that they have little choice but to contract with these HMOs and other managed care plans. Some physicians express concern that in order to satisfy Wall Street investors, they are being asked to accept financial risk (through capitation payments). They also object to medical decisions being made by distant bureaucrats.³

The renewed interest in provider networks appears to have several causes. Integrated delivery systems encompassing broader provider networks than traditional HMOs to improve quality while controlling costs were the basis of many state health reform discussions in recent years. Furthermore, purchasers, including employers and state governments, are contracting with managed care plans to control costs and seek the most efficient organizations. To survive in this competitive market, respond to purchaser demands, and regain control of their practices, some physicians contend that “cutting out the middle man” (insurer) can permit them to deliver the high quality, lower cost care purchasers desire while overcoming frustration with reimbursement limits and regaining control over their medical authority.

The prevalence of provider networks is unclear. Because they have existed for years without generally needing a state license, there is no reliable source of information on the numbers of new networks or how many are contracting to bear risk. One source estimates that 3000 physician-hospital organizations have been formed since the early 1980s.⁴ It has been estimated that 15 to 20 percent of managed care entities are operated by providers.⁵ It appears that new networks are forming in states with more mature managed care markets as physicians become interested in regaining control over their practice.⁶ And while providers have expressed interest in forming networks to contract directly with purchasers such as employers, it appears that few provider networks (other than those licensed as HMOs) are currently contracting to bear risk directly. A recent analysis by the Minnesota Department of Health suggested that direct contracting could encourage competition, facilitate choice, and enhance provider accountability, but analysts raised concerns about consumer access, quality, and financial security under such arrangements.⁷

Provider networks raise at least two types of regulatory issues. First, should they be licensed and, if so, under what standards? And second, do they result in aggregation of market power, particularly in rural areas, which might permit them to raise prices or engage in other types of anti-competitive conduct. Section III of this paper outlines issues regarding provider network regulation. Section IV briefly discusses anti-trust concerns that will be more fully developed in a National Academy for State Health Policy briefing paper later this spring.
III. Regulation of Risk-Bearing Provider Networks

States have been most interested in regulating provider networks that bear risk in order to protect consumers from insolvency and other problems. As discussed below, however, some state policy makers recognize that any limited provider network raises issues of access and quality. Furthermore, unless states can regulate provider networks, ERISA limits their authority to protect consumers in employee health plans.

A. Insurance Risk

The purpose of insurance is to pool, and therefore spread, the risk of costly but rare events among people who face a chance but not a certainty that the event will occur. In undertaking this function, insurers face several types of risk, for example, the possibility of enrollment of people needing more than average amounts of health care, investment risks due to market fluctuations, and business risks involving health plan design and management or negotiated discounts. While many businesses face some of these risks, a unique feature of insurance is insurance risk -- uncertainty concerning loss. An insurer's risk is exposure to differences between actual and projected costs. Health plans pose the insurance risk of an unexpectedly high need for service, for example, a large volume of claims or higher than expected claims. It can result from random variation in the incidence of illness as well as epidemics, poor health status of the enrolled population, and rapid technological change that increases demand for services. In voluntary markets, health insurance may be subject to adverse selection by people who know more about their health status than the insurer. Actuarial science, based on probability theory, establishes that the degree of risk declines as an insurance pool grows. Consequently, it is easier to predict and plan for risk in large groups.

Whereas indemnity insurance pools risk against the cost of accidents and illness, HMOs and other managed care entities not only promise to pay for (indemnify against) costs of unpredictable events, they also offer to furnish primary and preventive as well as acute services through a network of physicians, hospitals and ancillary providers. This commitment involves insurance risk, because a managed care plan may have demands for service that exceed its financial ability to pay or its providers' capability to deliver. The promise to provide or arrange for routine as well as less frequently needed care, rather than just to pay a claim, justifies government regulation of not only financial solvency but also network capacity and other consumer access standards, including grievance mechanisms to resolve enrollee disputes over denials of claims, quality standards, and systems to guard against under-service.

B. How Providers Assume Risk

Health care providers can assume insurance risk by contracts with a licensed insurer or HMO, employers or state Medicaid agencies, or other providers. Risk is assumed through payment arrangements. Capitation, whereby health plans pay providers or provider groups a fixed periodic fee for agreeing to provide a set of
services if needed by an enrolled population, most clearly involves insurance risk. If
a physician group is capitated and enrollee health care use exceeds projections,
physicians must render more services themselves and, if they are at risk for
ancillary care, specialty referrals, or hospitalization, pay for these services. Providers
may limit their risk by purchasing "stop-loss" insurance to cover costs above a
threshold (for example, if a case costs more than $20,000).

While capitation imposes the most open-ended risk, other payment
arrangements can involve insurance risk as well. For example, some HMOs pay
physicians on the basis of a fee for each service but set aside part of the payment into
a pool that will be distributed at the end of a budget period depending on the extent
to which the budget has been met. Other HMOs do not explicitly withhold part of
the payment but pay bonuses for meeting budgets. Another payment arrangement
uses "risk corridors." For example, physicians are held responsible for costs up to 110
percent of a budget and the plan covers costs above that amount. Because these
approaches limit the amount of risk that is imposed on providers, they raise the
legal issue of what constitutes insurance risk that justifies various types of
government regulation.

Providers sometimes assert that when they accept capitation for their own
services they are not bearing risk. While the risk they bear may be limited,
insurance regulators take the position that it is insurance risk because there is no
way to be certain that patient need will not exceed expectations. For example, a flu
epidemic may require much more service than in an average year. Medical break-
throughs may increase patient demand. Physicians may assert that they can provide
all needed primary care for an enrolled population. Yet they may underestimate
demand if needs increase or if the same physicians serve other networks or non-
capitated patients. And physicians obviously have less control over costs for which
they must pay, such as lab tests and supplies or collectively bargained wages,
included in the capitation payment. Even an institution like a hospital that accepts
capitation for its services may face a problem of under-capacity or a disaster like a
flood, fire, or earthquake that destroys its infrastructure and limits its ability to
provide promised services.

Providers object to various HMO licensure requirements. Some debate the need
for financial reserves; others dislike network adequacy standards, grievance systems,
or quality requirements. Some are willing to meet licensure standards but do not
want to be labeled as HMOs, which have a negative connotation in some
communities. While provider groups, particularly physicians and hospitals, have
been urging looser regulatory standards for networks, traditional insurers, Blue
Cross organizations, and HMOs seek parity in regulation. They assert that without a
level playing field for all risk-bearing organizations provider networks will gain a
competitive advantage by avoiding the cost of meeting state standards.
C. State Approaches to Regulating Provider Networks

1. Why regulate provider networks?

Health care organizations that do not bear risk raise fewer consumer protection issues than those that do. But about half the states license “preferred provider organizations” (PPOs) because even though PPOs do not bear risk, by limiting the network of providers that consumers can use, they raise issues of access and quality. Most states do not regulate provider networks if they share risk with a licensed insurer or HMO, although some states want to be sure that networks can manage such risk. Pennsylvania, for example, has proposed guidelines to assure that contracts between provider networks and HMOs assure accountability for access and quality and that providers agree not to seek payment from enrollees (so-called “hold harmless” clauses).

Because the federal pension reform law (ERISA, the Employee Retirement Income Security Act of 1974) prohibits state regulation of self-funded employee health plans, as discussed below, when providers assume risk from or share risk with these employee plans, there is no licensed entity such as an HMO that is ultimately responsible to meet state consumer protection standards. Consequently, states are particularly interested in whether and how to regulate risk-bearing provider networks contracting with non-licensed employee health plans.

The purposes of regulating insurance are to: 1) provide security that promised benefits will be provided when needed, 2) insure that information is furnished so that people understand what they are buying, and 3) assure fairness in marketing and claims and benefits disputes. Potential problems from unlicensed risk-bearing provider networks include financial insolvency, unfair or misleading marketing and information, lack of grievance mechanisms, and access and quality deficiencies. State experience with unregulated self-funded Multiple Employer Welfare Arrangements (organizations developed to offer health coverage to groups of employers) that have become insolvent justifies concerns about provider networks. In some states even HMOs have failed when their contracting provider group has become insolvent. And some physician-hospital organizations have had difficulty managing utilization, putting them in financial jeopardy. To protect consumers against health plan insolvency, states typically provide guarantee funds (that authorize insurance regulators to assess other insurers or HMOs to cover unpaid bills of insolvent plans) and/or hold harmless clauses. Without such other statutory protections consumers can be left with unpaid claims, incomplete treatment, and difficulty obtaining other health coverage.

2. Current state policy

A 1995 survey of state insurance and HMO regulators revealed that the vast majority of states (41) would license a physician-hospital joint venture (PHO) that assumed full risk (prepaid capitation) and would not license such activities assuming no risk. State policy varied on regulation of partial risk and whether to license networks contracting with a licensed insurer or HMO. Half the states would
require a license if a PHO contracts directly with employers to provide care under a budget if it is liable for expenses up to 110 percent of the budget; the other states had no clear licensure policy on this type of “risk corridor” arrangement. Only two states would require a PHO to be licensed if it contracts with a licensed health plan and the PHO is paid on a capitated basis. Over half would not license the PHO in this situation, but policy is unclear in 22 states.

Under a bill introduced in Ohio, provider networks that do not accept risk need not be licensed but must register with the Insurance Commissioner. Proposed Colorado regulations require networks not engaged in the business of insurance to so certify to the commissioner. A few states, such as Florida, and Texas allow individual practitioners, such as physicians, to accept risk for the services they are authorized to provide under their professional license but require licensure of risk-bearing provider networks. Pennsylvania permits HMOs to transfer risk to provider networks only for services that have signed provider agreements with the network and not, for example, out-of-network specialty referrals or out-of-area emergency services.

The National Academy for State Health Policy is currently conducting a survey (available later this spring) to learn more about how states regulate and oversee HMOs as well as what types of prepaid managed care entities come under state regulatory authority. The survey responses should indicate whether states regulate or license PHOs and other types of provider networks and, if so, whether they are regulated as HMOs.

Except for Iowa and Minnesota, which enacted laws directed at integrated delivery networks, state regulation of provider networks would fall under HMO licensing laws. While state laws differ, over half are drawn from the 1990 Model HMO Act of the National Association of Insurance Commissioners (NAIC). The NAIC model includes disclosure, rating standards, grievance procedures, hold harmless clauses, and insolvency protections (reserves, deposits, contributions to insolvency funds, and allocation of enrollees to other plans in the event of insolvency). It also requires that HMOs have a quality assurance program to ensure availability, accessibility, continuity, and quality of care and that they inform enrollees how to obtain care and provide notice if their primary care provider is terminated from the plan.

To address the function of managed care, rather than its organizational form, NAIC is currently developing a set of model managed care laws, called CLEAR (“consolidated licensure of entities at risk”). Designed to set uniform standards for all risk-bearing organizations regardless of their structure or name, these models include requirements for health plan quality improvement systems, standards for health care provider contracting by plans with limited networks, and provider credentialing, utilization review, grievance systems, data reporting, and confidentiality. Also under development at NAIC is a “risk-based capital” model law, under which states could vary financial capital, reserve, and/or deposit
requirements according to the amount of risk that an organization retained. This model, which is expected to be available in spring 1996, might be especially useful to states considering regulating risk-bearing provider networks.

3. **ERISA implications for provider networks**

NAIC and most states have taken the position that providers bearing risk, via full or partial capitation payment if not other reimbursement approaches, are engaging in the business of insurance and must be licensed unless they contract with a licensed entity such as an HMO. A few states have expressed concern, however, that although they can regulate networks contracting with insurers, ERISA prohibits state regulation of risk-bearing contracts between a provider network and a self-funded employee health plan.

ERISA pre-empts state laws that “relate to” employee health plans, but permits states to regulate the business of insurance. Courts have interpreted this provision to invalidate state regulation of employee health plan administration. Consequently, it is likely that state regulation of provider networks contracting with employee health plans would be held to “relate to” plans. Courts have not yet determined whether provider networks would constitute the business of insurance so as to come within the exception from pre-emption. The U.S. Supreme Court has held that an activity must meet three tests to constitute the business of insurance: spread risk, integrally involve the relationship between the insurer and insured, and be conducted by traditional insurance entities. If networks accept and spread risk, they would seem to be engaging in the business of insurance (despite the argument by some employers that they are contracting with providers not to transfer risk but to create more appropriate efficiency incentives). Furthermore, by defining services and the delivery system, the activity involves the terms of the relationship between the risk-bearing providers and enrollees. Finally, to the extent that risk-bearing networks function like HMOs, they would seem to meet the test of “traditional” insurance entities, although two courts have held that HMOs are not insurers whose regulation comes within ERISA’s savings clause. Until the Supreme Court provides clearer guidance on the meaning of the business of insurance under the savings clause, the authority for states to regulate provider networks as insurers will remain uncertain.

4. **Recent State Innovations**

Several states have adopted or are considering new policy to regulate provider networks. For example, Ohio is developing a new HMO licensure law, which would require risk-bearing networks to be licensed but permit other networks merely to register. Texas has proposed regulations to enforce a new law licensing non-profit risk-bearing provider networks. Florida and Pennsylvania are developing provider network regulations through which they hope to avoid “cascading capitation” where successively smaller groups of contracting providers pass risk down to another set of providers. A broad-based task force in Colorado recommended that networks contracting directly with purchasers be licensed but not those subcontracting with licensed insurance organizations and that the state develop...
capital requirements that take into account varying amounts of risk.²⁸ The state has proposed licensure standards for networks providing limited services such as mental health or pharmaceuticals directly to purchasers.

States can use regulatory authority to foster health care delivery innovations. For instance, as part of broader health care reform initiatives, Iowa and Minnesota adopted standards for integrated delivery networks that provide more flexible standards than the states’ HMO licensure laws in order to encourage the development of integrated delivery systems, especially in rural areas. Iowa’s regulations²⁹ authorize licensure of risk-bearing “organized delivery systems” (ODS) meeting standards for financial solvency, geographic access, grievance resolution, and reporting on quality, utilization, and satisfaction. These regulations differ from the state’s HMO law primarily in their emphasis on reporting outcome measures of quality. Organized delivery systems are required to have higher capital ($1 million) than HMOs. Since the regulations were adopted in October 1994, one plan has become licensed. Insurance and Health Department regulators report that they have heard that provider networks are uncertain whether the state law applies to them, particularly if they do not provide the full scope of services in a “standard benefit plan” under state law. Physicians and hospitals have expressed reluctance to seek licensure under either HMO or ODS requirements, feeling that when they take risk for their own services they are not really acting as insurers.

Minnesota statutes permit the formation of a “community integrated service network” (CISN) that may enroll up to 50,000 people.³⁰ To encourage local control, CISNs must have a majority of local residents on the governing body. They are exempt from HMO requirements to conduct focused quality studies, file written quality assurance plans, maintain statistics, file provider contract forms, promptly report network provider changes, and file a marketing plan. CISNs may satisfy part of the net worth requirement by reinsuring and by sharing risk with providers under capitation contracts with provider networks that meet state standards for financial and operational capacity. Although several CISNs have been created, state regulators hear that providers want to form networks outside state regulation. Like their counterparts in Iowa, some providers claim that they are not insurers if they take risk for their own services. State regulators feel that providers object to meeting state mandated benefit requirements (including service standards for managed care) rather than standards for solvency, grievance, or access standards.

IV. Policy Issues in Provider Network Regulation

States are just beginning to examine the development of provider networks, identify possible policy problems, and devise solutions. Policy makers will have to balance the importance of consumer protection regulation to assure financial solvency, adequate provider capacity, grievance resolution, and quality assurance mechanisms against the potential that some types of regulation may discourage innovation and competition through the creation of provider networks. States are particularly interested in protecting consumers in self-funded employee health
plans that contract directly with provider networks, because ERISA preempts state regulation of self-funded employee health plans themselves while providing very limited consumer protections under federal law.

Among the issues identified by state health policy makers as they consider whether and how to regulate risk-bearing provider networks are:

- **How should states define “risk” and the “business of insurance?”** Insurance risk occurs due to an unknown level of service demand but may include a spectrum of possible risk. Full capitation for one’s own services (and certainly for the services of other providers) imposes risk, while receiving a fee for each service performed does not. Other forms of reimbursement, such as withholding part of each fee-for-service payment to be used to meet budget shortfalls or using risk corridors (defined above), impose some risk on providers. State policy makers need to consider at what point the risk assumed requires consumer protections and whether different regulatory standards might apply to accepting of different levels of risk.

States have taken different positions on which types of payment impose insurance risk. For example, Colorado and Louisiana consider networks paid using withholds and risk corridors to be bearing insurance risk, while Florida and Texas would limit the definition of insurance risk to capitation. A business coalition in Minnesota is seeking to contract with provider networks paying a fee for each service but reducing fee levels each quarter in order to meet a budget. 31 The Minnesota Department of Health has thus far taken the position that this is not a sufficient risk transfer to require the provider network to be licensed but is monitoring these types of arrangements.

Providers often allege that they are different from insurers if they accept risk for only their own services. Consequently, policy makers will need to explain how the type of risk assumed can raise consumer protection issues, for example if a network commits to serving too many enrollees, if actuarial projections are incorrect and use exceeds expectations, or if supplies and other costs exceed estimates. Another issue is what kind of risk providers can safely assume. Services under their own control may be manageable with less financial solvency protections than out-of-area emergency services.

- **Does having one entity licensed offer sufficient consumer protection?** One of the most challenging issues in provider network policy is whether having a single licensed organization with which networks contract protects consumers adequately. Some policy makers feel that the health care market is moving toward more of these arrangements rather than direct contracting with employers. The NAIC and most states have taken the position that provider networks need not be licensed if they contract with a licensed entity. Yet existing HMO licensure laws may not fully protect consumers at the end of a chain of “cascading contracts” where risk is transferred to multiple layers of provider
organizations, some of which may be very small. States may want to regulate such contracts, as Colorado, Pennsylvania, and Florida are proposing, to be sure that the licensee remains ultimately responsible to protect enrollees against insolvency, access, and quality problems. Such regulations would permit licensed entities to share financial risk with unlicensed networks but not to devolve to them all responsibilities for solvency, access, quality, and grievance resolution.

Exempting provider networks contracting with licensed entities may also raise an ERISA problem. An employee health plan might argue, for instance, that provider network licensing laws directed at self-funded plans not only “relate to” them but are not saved from pre-emption as laws regulating the business of insurance because they are essentially attempts to regulate the plan and ERISA prohibits self-funded plans from being “deemed” to be insurers.32

- **How might states define provider “networks?”** Although state HMO laws and Iowa’s and Minnesota’s integrated delivery system rules contemplate a comprehensive scope of benefits, some networks have developed to provide a limited scope of services, for example, dental care, mental health, or pharmacy services. Even when these organizations accept full capitation for their own services, the risk they assume may represent a relatively small part of the total plan benefits. Some states are considering whether limited service networks could be held to different standards for financial solvency, reporting, or accounting than broad service networks. Colorado has proposed regulations for “limited service provider networks” that would impose lower financial solvency standards, investment regulation, and filing requirements than for HMOs or indemnity carriers.

These definitions must be developed carefully. For example, if the rationale for lower standards for single service networks is to recognize their smaller role in a health benefits package, one would not want to treat networks of hospital services or physician services like those covering pharmacy or dental care. Colorado’s rules, for example, permit limited service networks to cover the services of only a single medical speciality or facility, not multiple services. Furthermore, but these plans may involve a greater risk due to less diversified business or more volatility in need for the service.

- **What existing licensure requirements are unduly burdensome?** Policy makers should determine what HMO or other licensure standards for risk-bearing entities are so burdensome that they discourage network formation. Physicians and hospitals complain that HMO licensure is onerous, often citing financial solvency standards and the time required for licensure approval. Policy makers should explore the situation in their own states in order to determine whether these concerns are justified. According to the NAIC, for instance, most states process HMO license applications within 60 days33 and most state HMO licensure laws require net worth of between $1 and $1.5 million, which should not
discourage larger provider networks from forming. States should consider risk-based capital standards, under development by the NAIC and part of Minnesota’s CISN law. If frequent reporting requirements or accounting standards are burdensome, it may be possible, as Minnesota has done, to modify them. Other standards such as grievance systems and quality assurance provisions, may be alleged to be onerous but may be needed to protect plan enrollees. Authority to complain to the state about provider network performance and quality may be especially important because ERISA limits appeal rights for self-funded employee health plan participants.

- **Are insurance laws applied even-handedly?** States should consider whether all organizations performing the same function, such as HMOs, insurers, Blue Cross plans, and provider networks that bear similar risk, are regulated in the same way. A potentially difficult issue is whether plans serving only Medicaid enrollees must be licensed and meet the same standards as commercial plans. Even-handed regulation is appropriate as a matter of fairness. Furthermore, a single definition of insurance risk that is applied consistently may help states overcome an ERISA challenge to their regulatory authority by employee plans.

- **How does network regulation affect public health care providers?** While even-handed application of licensure standards is a desirable policy goal, states must also consider the impact of HMO laws on networks of public providers, which might be interested in contracting with either Medicaid or commercial purchasers. For example, a public provider network might not be able to set aside required reserves but could establish financial solvency in some other way.

- **Under what jurisdiction should networks be regulated?** This issue involves not only which agency should regulate provider networks but also whether traditional insurance authority is sufficient to do so. While Insurance Commissioners are responsible to license HMOs in most states, Health Departments generally monitor quality and in some states are primarily responsible for licensing HMOs. A related issue, however, is whether, given ERISA uncertainties about state authority, network access and quality standards should be regulated through provider licensure (e.g., physician, hospital, or other such licensing authority). This approach may be more appropriate as regulation increasingly involves practice patterns and other care quality issues.

- **Should regulatory standards be flexible?** It may be difficult to draw a neat line between risk-bearing and non-risk bearing entities for purposes of insurance regulation. And early experience with provider networks suggests that no two arrangements are identical. Risk-based capital standards may enhance regulatory enforcement but not obviate the need for some regulatory flexibility. Furthermore, any “bright line” offers incentives to create organizations just outside the regulatory boundaries. Yet while providers may call for flexible application of licensing requirements, there are drawbacks to regulatory flexibility. For instance, it can take more time and more staff (leading to costs on
regulatory agencies and applicants). And it cedes a great deal of authority to regulators that may raise issues of how fairly the standards are applied.

- **What are the appropriate standards for managed care plans?** Questions about regulating provider networks present an opportunity to re-examine appropriate standards for all managed care plans, especially those bearing risk. The NAIC model laws on provider contracting, grievance systems, utilization review, capital, and other standards and the development of information on quality from organizations such as the National Committee on Quality Assurance (NCQA) offer the opportunity for state policy makers to review the regulatory standards for all managed care plans.

- **How can states balance competing policy objectives?** Because it is not possible to fully achieve all policy goals, policy makers must balance potentially conflicting objectives, such as cost containment, consumers' broad choice of provider, and health care delivery innovation. Policy makers need to identify both the benefits and the costs of policy options in order to make informed and rational decisions.

V. Antitrust Issues in Provider Networks

When a seller has a dominant market position, it can engage in anti-competitive activities like setting prices or limiting consumer choice. For example, a hospital with a monopoly in its market area can raise prices above a competitive level. The sole optometrist in an area could refuse to sell eyeglasses unless it had administered the eye exam that generated the prescription, forcing the consumer to buy both services. Anti-trust laws are designed to protect consumers by promoting competition through prohibiting anti-competitive agreements among sellers or the abuse of market power.

Federal and state governments have a policy to scrutinize health care provider activities such as mergers, price setting among competitors, and group refusals to contract with a third party, although few enforcement actions have been filed. Provider networks may raise anti-trust concerns if they engage in prohibited behaviors or if their market share is sufficiently large to control prices or reduce choice. Market power can be concentrated not only in rural communities but also in small metropolitan areas. For example, one analysis of the potential for competition among HMOs found that 29 percent of the U.S. population lives in health care market areas with under 180,000 people where competing health plans would need to share at least hospital services.

This section outlines briefly the approach and rationale of the federal anti-trust laws, their interpretation by government agencies with respect to provider networks, and policy issues raised by these anti-trust considerations. The National Academy for State Health Policy is preparing a briefing paper on anti-trust issues in provider networks that will be available this summer.
A. Anti-trust law

There are three statutory sources of federal anti-trust law. The Sherman Act prohibits monopolies and activities in restraint of trade. The Clayton Act prohibits price discrimination, exclusive dealing arrangements, and anti-competitive mergers. The Federal Trade Commission (FTC) Act prohibits unfair competition. The FTC and U.S. Department of Justice enforce federal anti-trust laws, and state Attorneys General enforce both state and federal anti-trust law. The McCarran-Ferguson Act exempts from federal anti-trust enforcement state-regulated business of insurance. This exception was created to permit insurers to collaborate on underwriting risks.

Certain activities, such as price fixing, boycotts, and tying agreements, are considered so anti-competitive that they are per se (inherently) anti-trust violations and do not require proof of anti-competitive effects. The actual impact of other activities is evaluated under a "rule of reason" analysis to determine whether competitive effects outweigh anti-competitive ones in the relevant market.

B. Application of Anti-Trust Laws to Provider Networks

1. Federal Activities

Federal anti-trust officials have been particularly active in examining hospital mergers but have recently begun to monitor physician networks. The FTC has determined, for example, that provider networks that are financially and operationally integrated are not per se illegal but will be analyzed under the rule of reason approach. The agency looks for activities that offer a new service in the market, exist as a separate business organization, and involve providers pooling their capital and sharing a substantial risk of adverse financial results due to high health care use or cost. To avoid charges of price-fixing, non risk-bearing physician networks that negotiate with health care purchasers would have to use an independent agent ("messenger") to convey price information from individual sellers to the purchaser. This method is unwieldy, however, and apparently rarely used. Because most provider networks involve both some level of integration and some degree of risk-sharing, they fall in the middle of the spectrum (from an illegal price-setting PPO to a permissible single entity) so that anti-trust officials must examine actual market conduct and effects in order to decide whether networks pose a threat to competition.

The FTC and DOJ have issued policy statements ("safe harbors") indicating that they will not challenge non-exclusive physician network joint ventures comprising no more than 30 percent of physicians in a specialty in a geographic market who share substantial financial risk. These policy guidelines do not precisely define what constitutes the relevant market or how much risk sharing, short of full capitation, is "substantial."
2. State Activity

In recent years, several states have enforced anti-trust laws in health care markets, mostly in cases involving mergers and boycotts. Among the rare cases challenging provider network market power is a settlement between the Maine Attorney General and a physician-hospital organization in a rural area that organized to negotiate with purchasers. In the consent decree, the PHO agreed not to prohibit physicians from participating in other networks and also allowed the Attorney General to monitor its activity. If the Attorney General finds that the PHO is using its market dominance to raise prices or increase utilization inappropriately, compared to other managed care markets in the state, it can prohibit the PHO from negotiating with purchasers. The Assistant Attorney General in charge of this case observed that this approach would not be as useful for mergers, which cannot easily be dismantled, but should work for contracting arrangements.

C. Provider Network Anti-Trust Policy Issues

- How much market concentration is too much? Providers argue that they need to develop networks both to meet buyers' demands for efficiency and quality and to match the bargaining leverage of large public and private purchasers. Some providers have asked Congress for anti-trust law relief, asserting, for example, that the 30 percent "safe harbor" limits a network's ability to offer a sufficient choice of providers. One state anti-trust enforcement official agreed that this threshold has little practical regulatory significance in small markets where any network will exceed the limit. A related issue is whether policy makers should be concerned about networks without market power. In other words, should negotiations of discounts provider fees be per se illegal?

- Has anti-trust enforcement discouraged beneficial network formation? The Physician Payment Review Commission recently examined this question and concluded that while some physicians have faced difficulty organizing plans, the FTC and DOJ rarely challenge physician networks. The PPC observed, however, that little data are available on the extent to which anti-trust laws have discouraged the creation of efficient organizations or the effect on prices and quality of physician control of networks. As one state anti-trust enforcement official noted, underlying assumptions that physician integration and cooperation will reduce costs and increase quality are not proven. This official agreed with the PPC that, despite federal policy, the FTC and DOJ rarely challenge provider networks negotiating prices if they have no market power. But he also cautioned that federal policy such as the safe harbors may be an incentive for provider networks to accept more risk than they are able to manage in order to avoid anti-trust scrutiny.

- How can states foster integration in medically underserved areas? Eighteen states have procedures to exempt from anti-trust enforcement beneficial health care provider activities, such as joint purchases of capital equipment. This authority derives from the "state action exemption" to federal anti-trust laws set forth by
the U.S. Supreme Court in *Parker v. Brown* and subsequent cases. This doctrine requires "clearly articulated" state policy to displace competition with "active public supervision."

For example, Iowa's immunity law requires the Department of Public Health to determine whether the activity would be "in the best interests of the state" because it "is more likely to result in lower costs, increased access, or increased quality of care than would otherwise occur under existing or [future] market conditions." The agency bases its decision on factors such as supply of, demand for, and need for the services, potential cost savings to consumers, cost-shifting, costs of regulation, and effects on access and quality. Apparently only three states (Maine, Minnesota, and Washington) have granted immunity under their laws. Because such state health care provider antitrust exemptions have not been challenged in court, it is unclear whether they will meet the requirements of the *Parker v. Brown* decision. The state action exemption might be particularly useful in rural areas whose markets cannot support more than one or two health care networks. Yet as the PPRC has noted, it is difficult to document prospective efficiencies to establish that a network would benefit consumers.

- **How many resources can states devote to monitoring provider network activity?** Some states may prefer to leave this complex area of law to federal enforcement because of the need for skilled and experienced staff and the often time-consuming nature of these cases. And the Maine official who brought the PHO case cautioned that in states with many networks, the resources needed to monitor conduct after a successful prosecution or settlement would be considerable. Yet even small states like Maine have been able to protect consumers from potentially anti-competitive health care provider activities.

**Conclusion**

Provider networks raise challenging issues for policy makers: the dilemma of balancing consumer protection against provider demands for regulatory relief to foster innovation and contain costs. It will be important for policy makers to examine provider network activity in their states, because creation of networks and the kinds of risks they assume appear to vary across the country. In states where networks are under development, it may be appropriate to establish policy to regulate them. Policy makers in states with less network activity may be able to draw on the experience of their counterparts to consider whether and how to regulate these organizations. Stakeholders concerned with these issues have often strong and divergent points of view. Consequently, it might be useful for policy makers to develop mechanisms, such as a task force of providers, health plans, regulators, employers, and consumer advocates, so that interest groups can achieve consensus or, at least, have their voices heard in the debate.
Provider networks are only part of the broad and growing landscape of managed care that faces legislators and executive branch officials. The issues discussed in this paper should be seen in the larger context of containing costs through managed care or other strategies. Policy makers contacted for this paper expressed both hope that managed care organizations can provide cost-effective health care and reservations about quality (such as under-service and access problems) and the impact of large managed care plans on public and teaching institutions and rural providers. They noted the potential for managed care’s focus on cost containment to limit private providers’ willingness and ability to render charity care, especially as traditional tax exempt institutions become for-profit organizations. And they expressed concern about the difficulty of measuring quality, the need for data on quality indicators such as consumer satisfaction and outcomes, and the difficulty of developing an accurate picture of managed care plan performance in view of the typical media focus on problem cases.

These policy makers suggested that, despite a political climate that frowns on government regulation and a trend to reverse recently enacted health care reforms, state governments can play a pivotal role in protecting health plan consumers. Increasing public suspicion about managed care could provide support for government oversight, including attention to newly emerging provider networks. Working in conjunction with private purchasers and accrediting agencies, states can develop standards for plan quality and information disclosure. Concerns about cost have driven public and private health care purchasers to managed care. The next step for policy makers is to balance concern for cost with attention to quality and access.
Endnotes


10. A true insurance risk is supposed to be outside the control of the insured and the insurer. Because some risks, such as those due to personal behavior or to physician practice style, are within the insured or insurer’s control, they might be seen as technically not insurance risks but another type of risk, such as business risk.

11. It is for this reason that insurers use “medical underwriting” to try to avoid subscribers with high medical needs.

13. This discussion focuses on the risks to an insurer. But HMOs and other prepaid risk-bearing managed care plans impose a risk on the consumer: in contrast to fee-for-service systems whose incentive is to provide more services, prepayment provides the incentive to under-serve in order to live within a limited budget or to make a profit. Consequently, enrollees face the risk that they will receive less care than they need.


16. Preferred Provider Organizations (PPOs), which encourage consumers to use limited provider networks by imposing higher cost sharing on out-of-network use, typically do not bear risk. If they do, they generally are licensed as HMOs or insurers (Pennsylvania licenses risk-assuming PPOs under a separate statute). About half the states license PPOs, many in order to assure that provider networks are adequate to meet consumer needs (Rolph et al. 1987. “Regulation of Preferred Provider Arrangements.” Health Affairs 6(3): 32-45). Other states might want to regulate network adequacy of even non-risk-bearing provider networks. To the extent that such provider networks contract with self-funded employer plans, however, ERISA may pre-empt state regulation, which would not be “saved” as regulating the business of insurance.

17. Insurance regulators call such an arrangement “downstream” risk because the licensed entity passes risk down to another organization, such as a provider network.

18. U.S. General Accounting Office. 1992. Employee Benefits: States Need Labor’s Help Regulating Multiple Employer Welfare Arrangements. (GAO/HRD-92-40). General Accounting Office, Washington, D.C. While some MEWAs were “Ponzi” schemes designed to collect premiums without an intention to pay claims, others failed due to mismanagement. The latter problem is probably a more serious concern for provider networks than the former. Since 1983 ERISA has allowed states to regulate non-insured MEWAs.


22. 29 U.S.C. 1144(a).

23. 29 U.S.C. 1144(b).

24. See, e.g., Arkansas Blue Cross & Blue Shield v. St. Mary's Hospital, 947 F.2d 1341 (8th Cir. 1991).

25. Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119 (1981). The Court explained that regulating the relationship between he insurer and insured includes standards for "the type of policy which could be issued, its reliability, interpretation, and enforcement..." 458 U.S. at 129.

26. It might be easier to argue that in contrast with provider networks, individual practitioners, such as physicians, who accept capitation for their own services only do not pool risk across their patients and therefore are not insurers.

27. The court in O'Reilly v. Ceuleers, 912 F./2d 1383 (11th Cir. 1990), so held, but the case involved the question of whether an HMO's severance pay plan became an insurance plan when the HMO was being liquidated by the Insurance Commissioner and may not apply to invalidate direct state regulation of HMOs. Similarly in New York State Health Maintenance Organization Conference v. Curiale (S.D. N.Y. 93 Civ.1298, Feb. 25, 1994, rev'd on other grds, 64 F. 3d 794 (2d Cir. 1995)(1994)), the court held HMOs not insurers at least in part because New York's HMO licensure statute (enforced by the state Department of Health rather than Insurance) explicitly said that HMOs are not insurers. The Supreme Court in Pireno noted that this latter "business of insurance" test need not necessarily be met, 458 U.S. at 133.


29. Iowa Administrative Code 641-201.1 et seq., 135.75 FA.ch158.


33. Of 29 states responding to a November 1995 NAIC survey, 38 percent reported they process applications within 30 days, 69 percent within 60 days, 83 percent within 90 days, and 90 percent within 120 days.


40. The safe harbor threshold for exclusive provider networks is 20 percent.


43. This case was filed under Maine’s anti-trust immunity statute because it authorizes state monitoring of health care provider activities, but the anti-trust official in the Attorney General’s office on the case believes states could use their general anti-trust laws.


46. 317 U.S. 341 (1943).

