THE REGULATION OF PREFERRED PROVIDER ARRANGEMENTS

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Prologue: *In a rapid fashion, preferred provider arrangements have become a new and central feature of medical care delivery reform. Nurtured largely by the private sector, these arrangements, also known by the derivative preferred provider organizations, represent a compromise between the freedom patients have enjoyed to seek treatment from any physician and the more restrictive practices of closed-panel plans that require their enrolled members to select a doctor who is employed by or contracts with the plan. One of the concerns among advocates of preferred provider arrangements, such as Rep. Ron Wyden (D-OR), has been whether state laws are impeding their implementation. In this report, three Rand Corporation researchers look specifically at this question. Their findings are a part of a large-scale study that Rand has under way involving preferred provider arrangements. The project is funded by the Department of Health and Human Services, with additional support from the Federal Trade Commission and the National Institute of Mental Health. Perhaps the most striking finding of the study is the vintage of state laws that are affecting the implementation of preferred provider arrangements. For the most part, they are not old statutes that are, unwittingly, impeding the proliferation of these new delivery arrangements. Rather, they are new laws that derived from recent deliberations of state legislatures. This finding raises questions about the appropriateness of federal intervention on behalf of preferred provider arrangements. Elizabeth Rolph, with a master's degree from the University of California, Berkeley, is a political scientist at Rand, where she has undertaken a variety of research projects designed to evaluate institutional effectiveness. Paul Ginsburg, a respected economist with a doctorate from Harvard University, left Rand last November to become executive director of the Physician Payment Review Commission. Susan Hosek, an economist at Rand with a master's degree from Northwestern University, has been involved in a range of health policy studies in the civilian and military health care systems.*

During the past three years, preferred provider arrangements (PPAs), also known as preferred provider organizations (PPOs), have become an important part of the landscape of health care financing. In a survey reported in this issue of *Health Affairs*, Gabel and colleagues indicate that 16.5 million persons were eligible to use PPAs in 1986.[1] Enrollment is undoubtedly much higher today. A reading of the trade press indicates that development of PPAs is one of the largest preoccupations of insurers and large employers.

While it is too early to assess the ultimate role of PPAs in the health care system, if only because they are rapidly evolving and their cost implications have not yet been carefully assessed, some have raised concerns that legal barriers could sharply limit PPA development. Long-standing state-level limitations on the activities of commercial health insurers and health service corporations (mostly Blue Cross and Blue Shield plans) may be interpreted to preclude some functions of PPAs that are essential to their effectiveness. Concerns about these barriers led Rep. Ron Wyden (D-OR) to introduce legislation in 1983 that would prohibit states from restricting the operations of PPAs.

This article assesses the degree to which state-level regulation of PPAs has affected or is likely to affect the operation of this health care financing and delivery arrangement. In addition to drawing on legal reviews of provisions that might facilitate or restrict the development or operations of PPAs, we conducted extensive interviews with state officials, commercial insurers, Blue Cross/Blue Shield plans, third-party administrators, multihospital chains, business coalitions, and PPAs to explore how these provisions were being applied.[2]

Preferred Provider Arrangements

A PPA is a fee-for-service alternative to traditional health insurance under which those covered are given financial incentives to choose from a panel of preferred providers with whom the payer has contracted. Rather than being a specific entity, a PPA is a series of contractual agreements among an insurance plan (or a self-insured payer), those covered by insurance, and the preferred providers, with a third-party administrator or other broker sometimes serving as an intermediary.

All three parties to a PPA—the payer, the insured persons, and the providers—hope to gain from this relationship. The payer hopes to contain health care outlays by obtaining discounts from preferred providers, choosing providers who have either lower-than-average fees or more economical practice patterns, or applying utilization controls with a panel of providers that have agreed to cooperate, making such controls more effective. Insured persons may benefit from the financial incentives to use the preferred providers. These incentives include reduced cost

sharing, broader coverage, and reduced premiums. Providers may benefit from an increase in market share that results from the incentives to consumers to favor them over providers that are not in the panel.

Channeling insured persons to preferred providers is often critical to the success of a PPA. Unless persons who have used providers from outside the panel are induced to change providers, the potential benefits of PPAs are limited. Only those insured persons already using preferred providers would receive the financial incentives; providers would not increase their market share and thus would be unwilling to continue any discounts; and payers would have few gains to offset the costs of financial incentives to those with no need to change their behavior.

Similarly, the PPA's ability to contract selectively with a limited number of providers is essential to the success of the arrangement. The PPA must be able to winnow out high-cost and low-quality providers. If it is to offer increased patient volume to providers, it must also be able to limit the size of the panel.

PPAs can be either an extension of a traditional insurance plan or a separate plan. In the former case, the PPA is an alternative benefit structure that applies when services are obtained from preferred providers. Under a separate plan, the covered person enrolls in a PPA instead of the traditional plan, usually with a lower premium, and has provisions calling for increased cost sharing when providers outside the panel are used. In either case, services obtained from providers outside the panel are reimbursed, albeit less generously. Usually, the insured persons are not "locked in" to the preferred providers, as is the norm in health maintenance organizations (HMOs).[3]

PPAs have been developed by a variety of organizations, including providers, payers, and brokers. Provider-sponsored PPAs are usually formed by physicians, hospitals, or physician-hospital joint ventures. To obtain enrollees, these PPAs need to market their services to payers. These can be self-insured employers, payer-sponsored PPAs, or broker-sponsored PPAs that have contracts with payers.

Payer-sponsored PPAs have been organized by commercial insurers, Blue Cross/Blue Shield plans, multiple employer trusts, and employee welfare benefit plans. These can be insured or self-insured. If the plan is insured, the insurer bears the risk. In a self-insured plan, the employer, multiple employer trust, or union trust fund bears the risk directly. These plans commonly hire a third-party administrator to manage the plan. The third-party administrator may be a commercial insurer, a Blue Cross/Blue Shield plan, or simply an organization specializing in third-party administration. Thus, an insurer may offer the same preferred panel to its insurance clients and to the self-insured clients to whom it provides administrative services.

PPAs And The Regulation Of Third-Party Payers

The body of law that governs health benefits plans evolved during a period when different types of entities marketed distinct products. Thus, commercial insurers marketed indemnity coverage, Blue Cross/Blue Shield plans marketed service benefits, and HMOs marketed closed-panel plans. Regulations aimed at problems peculiar to a type of product could be directed at the organization responsible for it. Today, product lines overlap, but regulation by type of entity continues. Thus, PPAs are subject to regulation that differs according to the type of organization that is sponsoring them. The result is often inconsistent policy and the absence of a level playing field for competition.

ERISA preemption of state insurance law. Before discussing how state laws that govern health benefit plans apply specifically to PPAs, one should note the significant degree to which many plans are exempt from state regulation. Under the Employee Retirement Income Security Act of 1974 (ERISA), self-funded plans and Taft-Hartley trust funds are exempt from state regulation.[4] Instead, the U.S. Department of Labor establishes reporting, disclosure, and fiduciary standards. In contrast to most state regulations, the ERISA provisions are generally regarded as minimal.

While, initially, few health benefit plans were exempted from state regulation through the ERISA preemption, large numbers of employers have converted to self-funded status in recent years. Exemption from state regulation has been an important motivation. More than 50 percent of covered employees are now in plans exempt from state regulation.[5] This implies that state regulation of health benefits plans may affect the use of PPAs by at most 60 percent of employees.

The definition of a self-funded plan—one that is exempt from state regulation—has been the subject of litigation. At issue is how much stop-loss (coverage a self-insuring employer holds to protect reserves) or other reinsurance coverage can be carried by an employer before the plan no longer qualifies for the exemption. A few courts have concluded that the ERISA preemption does not apply if any indemnification whatsoever is present.[6] In the absence of definitive court rulings, state departments of insurance are interpreting the law in their own ways—most applying the ERISA preemption generously, a few attempting to retain state control whenever possible.

Limitations on PPAs in traditional insurance law. The regulation of insurance by the states has long been oriented toward consumer protection. For example, reserve requirements are established to protect consumers against the inability of insurers to pay claims. In HMOs, where restriction on choice of provider is substantial, states have adopted rules regarding access to care and assurance of its quality. Some provisions,

while appearing to protect consumers, also protect providers from competition, and have often been enacted at the behest of providers. Two of these types of provisions are particularly relevant to PPAs.

First, freedom-of-choice provisions prohibit commercial insurers and/or Blue Cross/Blue Shield plans from restricting an insured person's freedom to choose a health care provider. The most common form of limitation states that the policy "may not require that the health service be rendered by a *particular* hospital or person."[7] While PPAs do not require that a particular provider render services, some insurance departments have interpreted such provisions to preclude financial arrangements that penalize an insured person's use of nonpreferred providers. About 65 percent of states have freedom-of-choice provisions applicable to commercial insurers, and about 55 percent have such provisions applicable to Blue Cross/Blue Shield plans.

Second, antidiscrimination provisions prohibit health plans from discriminating between individuals of the same class of risk in the amount charged for insurance. Many PPA sponsors fear that such provisions, existing in almost all states, could interfere with financial incentives to channel patients to preferred providers. However, in all but two of the states with antidiscrimination provisions, the statutory language is qualified in that it prohibits "unfair" discrimination. Therefore, states may take the position that payment differentials between preferred and nonpreferred providers and benefit differentials between insured persons' use of preferred and nonpreferred providers are not unfairly discriminatory because agreements behind the differentials are voluntary. Also, there is arguably a relationship between the reduction of costs in the context of a PPA and the increase in subscriber benefits.

Application of insurance statutes to PPAs. Having freedom-of-choice and antidiscrimination provisions on the books does not necessarily imply an obstacle to selective contracting and channeling activities by PPAs. States have been active in deciding whether these provisions prevent PPAs from operating. As shown in Exhibit 1, twenty states have adopted legislation beneficial to PPAs by expressly permitting channeling and selective contracting. In two more states, insurance commissioners have formally ruled that such provisions do not preclude PPA activities. At the other extreme, three states have interpreted their statutes as precluding PPAs sponsored by one of the categories of insurers. In seven states, departments of insurance have made no formal ruling on the application of existing statutes to PPA activities but have clearly indicated that they are acceptable. However, in states without enabling statutes, permissive interpretations may be challenged in the courts. The last column in Exhibit 1 identifies those states that do not now have a certain policy. In many of them, PPA activity has not been extensive enough for pressure to build to establish a policy. Officials in

Exhibit 1
State Legal Environments For PPOs: Application Of Preexisting Provisions, June 1986

Prior restrictions[a]	PPOs not permitted	PPOs permitted	Undetermined
Enabling statutes:	Georgia[b]	Informal interpretation:	Appears positive:
California	Montana	Arizona	Alabama
Florida	Ohio[c]	Colorado	Alaska
Illinois		Massachusetts	Connecticut
Iowa		Missouri	Delaware
Kansas		New Jersey	Oklahoma
Louisiana		New York	Rhode Island
Maine		Tennessee	South Carolina
Maryland			West Virginia
Michigan		Other legislation:	
Minnesota		Nevada	Possible conflict:
Nebraska			Mississippi
New Hampshire			New Mexico
North Carolina			North Dakota
Oregon			Vermont
Pennsylvania			
Utah			No opinion:
Virginia			Hawaii
Wisconsin			Idaho
Wyoming			South Dakota
			Washington, D.C.
Formal regulation:			
Arkansas			
Texas			
(Kentucky[d])			

[a] Statutes in these states had been interpreted or perceived to prohibit certain essential features of a PPO. These states have now adopted enabling statutes or regulations to overcome the obstacles.
[b] Commercial insurers only.
[c] Health service corporations only.
[d] Kentucky is in the process of adopting regulations.

seven of these states informally suggested that their statutes should not interfere with PPA activities, while those in four other states indicated that their statutes might pose a problem to PPAs. Four had no opinion.[8]

There appears to be a pattern of steps through which states go in developing their policies toward PPAs. Until serious interest in PPAs develops, there is no need to resolve any potential statutory conflict with their activities. Once interest in PPAs develops, sponsors decide whether to test the acceptability of PPAs by organizing them or to press for clear authorization through enabling statutes or regulations. In states where sponsors have pressed seriously for an enabling measure, they have most often been successful within a year or two.

If sponsors, instead, test the applicability of state laws, a few PPAs may be approved before the department of insurance reviews its policies. Once policies are established, sponsors will continue to develop PPAs if the policies are favorable or will move to the legislative arena if they are unfavorable. Early signs suggest that a last step in the process may be the

imposition of additional regulatory restrictions on the activities of PPAs once the state has gained some familiarity with their operation and the problems they might cause.

PPA enabling statutes. States have enacted legislation specifically authorizing PPA activities either to resolve ambiguities in the statutes governing insurers or health services corporations or specifically to override provisions that have been interpreted as obstacles to PPAs. Support for such legislation has come from commercial insurers and Blue Cross/Blue Shield plans, business coalitions, large employers, and unions. Physicians and other practitioners have often opposed it, arguing that restricting the enrollee's choice of provider potentially threatens the quality of care. In addition, practitioners may fear the effects of a more competitive market that PPAs may bring about. Hospitals, in contrast, have often been divided, with some welcoming the opportunity to increase market share and others fearing the increased competition.

Not all attempts to pass enabling legislation have been successful. Practitioners have successfully blocked legislation in a number of states. Conversely, in at least one state, practitioners supported an enabling statute with a very strong freedom-of-choice provision, but third-party payers blocked its passage. Again, in a few states, certain practitioner groups, pharmacists for example, have removed themselves from the purview of the enabling statute. In four states, dentists successfully sponsored legislation that effectively precludes PPAs for dental services.

Of the twenty-two states that have adopted enabling legislation or regulations, only a handful have completely permissive policies toward PPAs (see Exhibit 2). Three types of provisions that limit PPA activities have appeared in enabling statutes or regulations: "any willing provider" requirements, payment or benefit differential limits, and consumer protection measures.

First, "any willing provider" provisions require that all providers meeting predetermined criteria be entitled to membership on the panel of preferred providers. These restrictions, which resemble the freedom-of-choice limitations of previous laws, may restrict PPAs in a number of ways. In the absence of objective criteria, PPAs may not be able to exclude those physicians that appear to practice in a costly manner or even those whose quality of care may be questionable. They also may not be able to exclude providers who do not conform to the market niche that the PPA may be attempting to establish. The inability to exclude other providers is likely to prompt a provider or group of providers to abandon plans to increase market share by sponsoring a PPA. It may also handicap a PPA in its negotiations with providers over discounts. Without control over the size and composition of the preferred panel, the PPA could have difficulty making credible assurances of increased market share to those agreeing to discount charges. Finally, should "any

Exhibit 2
Characteristics Of State Enabling Statutes And Regulations, June 1986

State	Year of adoption	Contains "any willing provider" provision	Limits differentials (%)	Contains consumer protection policy	Has policy on EPOs[a]
By statute					
California	1982				OK
Florida	1983			X	No
Illinois	1985	X[b]		X	
Indiana	1984	X			OK
Iowa	1985				
Kansas	1985			X	
Louisiana	1984	X[b]		X	
Maine	1986		20%	X	No
Maryland	1985		20		
Michigan	1984		15	X	OK
Minnesota	1984			X	
Nebraska	1984				
New Hampshire	1985	X		X	
North 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[c]	1986		10–20		
Texas	1986	X	30	X	No

[a] Exclusive provider organizations.
[b] Applies only to physicians.
[c] Informal regulation.

willing provider" requirements result in larger panels, difficulties in conducting utilization review could be compounded.

Of the twenty-two states with enabling legislation or regulations, eight have "any willing provider" requirements (see Exhibit 2). Two of these do not apply to hospitals. Four of the states with "any willing provider" restrictions also prohibit the use of "gatekeeper" requirements, which deny reimbursement for services of specialists that have not been authorized by primary care physicians included in the preferred panel. Six of the states with "any willing provider" provisions require that panel membership be opened to certain categories of nonphysician practitioners, but they do not require equal reimbursement. The prevalence of "any willing provider" requirements may change over time, both as

additional states pass enabling laws and as practitioners attempt to add the provisions to existing PPA laws.

Since these provisions are quite new, it is difficult to assess their effect on PPAs. None of the states have yet adopted regulations necessary to implement the provisions. Furthermore, with PPAs in their infancy, we do not yet know the eventual importance of practices that might be precluded by these provisions. For example, PPAs have tended thus far not to be very selective in choosing physicians for preferred panels, but, with more experience and data, they might seek to become selective in the future—if not prevented from doing so by "any willing provider" provisions.

Our interviews indicate divergent opinions among PPA sponsors. Physician-sponsored PPAs have tended not to see such provisions as particularly restrictive, although some hospital networks, more concerned with market share, report that "any willing provider" provisions might prevent them from developing PPAs, at least for the insured market. Most PPA sponsors report that these provisions have not yet affected them but fear that the provisions will ultimately force them to adopt rigid contracting standards, limiting their ability to select quality providers and to otherwise respond flexibly to market conditions. Most sponsors consider "any willing provider" provisions to be the most serious of the regulatory threats to effective operation.

A second type of restrictive legislation, resulting from concerns that insured persons not be restricted in their ability to choose providers, limits benefit or payment differentials. Such limits constrain the size of the financial incentive that may be given to insured persons to use preferred providers. A benefit differential limit restricts differences in deductibles and coinsurance rates that are applicable to preferred versus nonpreferred providers. Most limits are in the 20–25 percent range.[9] Such limits effectively prohibit exclusive provider organizations. A few additional states do not have benefit differential limits, but nevertheless prohibit exclusive provider organizations by requiring some reimbursement for nonpanel providers, without specifying how much.

A payment differential limit constrains how much less the PPA may pay nonpanel providers than it pays panel providers. Since the patient is likely to be required to pay the difference between the nonpanel provider's charge and the PPA reimbursement, limits on payment differentials, in effect, cap the cost sharing of insured persons and thus are similar to limits on benefit differentials.

Seven of the twenty-two states with PPA enabling legislation have differential limits of one sort or another. In some, the rationale is to give providers outside the panel at least some transitional protection against the effects of strong channeling incentives. In others, the motivation is consumer protection. If differentials are so large that the PPA is in effect

a closed panel, like an HMO, then the state may want to regulate PPAs in the same manner in which it regulates HMOs—paying more attention to access and quality of care.

Differential limits appear to be a less serious constraint to PPAs than "any willing provider" provisions are. Although no research has been undertaken to determine what constitutes an effective differential, the current consensus is that a 20 percent differential offers an adequate incentive to enrollees to choose preferred providers. Some sponsors, however, are concerned that larger differentials might be needed and that cumbersome reporting might be required to implement differential limits, especially when a PPA offers broader coverage of services as a channeling incentive.

PPAs are subject to a third type of regulation in the form of additional consumer protection provisions. The existing body of consumer protection regulation that governs all health insurance plans applies equally to PPAs. In addition, most PPA enabling statutes and regulations contain further provisions applicable to PPAs. Most states regard existing financial solvency regulations that apply to insurers and to Blue Cross/Blue Shield plans as adequate for PPAs sponsored by these organizations. But some have concerns about accessibility and quality of care, since enrollees' freedom of choice is somewhat restricted. Nevertheless, provisions applicable to PPAs have thus far been much less stringent than those applicable to HMOs, reflecting a reluctance to regulate in anticipation of problems rather than in response to them.

The most common consumer protection provisions concern the adequacy of information and access to care. Seven states require that PPAs make available to enrollees certain information on panel members and other plan characteristics. Although most states with consumer protection measures require PPAs to offer enrollees adequate access to care, especially emergency care, few have promulgated regulations specifying what PPAs must do to meet these requirements. A few states require PPAs to conduct quality assurance programs.

Whether consumer protection provisions will become a serious constraint for PPAs in the future is not clear. The course of this regulation will depend largely on the extent to which abuses do arise.

In summary, state enabling legislation and regulation cannot be described as a new wave of regulation. The generally cautious interventions that states have pursued mirror traditional regulatory patterns and interests. "Any willing provider" provisions and limits on fee differentials attempt to perpetuate longstanding policies that insulate providers from competitive pressures and preserve provider choice for enrollees. Consumer protection regulation in these measures is firmly rooted in earlier insurance regulation. Provider protection measures have been clearer and more immediately articulated than have consumer protection pro-

visions, because they are sponsored by well-organized, experienced interest groups and because they address immediate concerns.

Other Provisions Of State Law

Provisions of state law other than those governing insurance and other third-party payment may also affect PPAs. We reviewed these provisions and found that most of them are not likely to pose major problems for PPAs.[10] A few provisions, however, may affect the growth of PPAs.

Hospital rate-setting laws. Laws governing hospital rate setting may inhibit PPAs in negotiating discounts with hospitals. While those laws that simply place ceilings on hospital rates would not prevent PPAs from negotiating discounts, the trend in rate setting has been to regulate discounts as well. In efforts to limit cost shifting among payers, many rate-setting programs limit discounts to those that can be justified by cost savings to hospitals—for example, prompt payment. Such limitations preclude PPAs from negotiating substantial discounts on the basis of their ability to channel patients to hospitals.

Whether this inability to obtain discounts prevents PPAs from operating successfully is subject to debate. In contrast to Medicare's prospective payment system, which tends toward uniform rates, most state rate-setting systems have hospital-specific rates based on each hospital's historical costs. Thus, PPAs can still save money by channeling patients to lower-cost hospitals, as well as through utilization review and other tools. But including only the lowest-cost hospitals may not be attractive from a marketing standpoint. Furthermore, choosing hospitals on the basis of nondiscountable charges could make adequate geographic coverage difficult to obtain and could risk an image of low quality.[11]

Peer review immunity and malpractice liability. Liability considerations have not yet affected PPAs, but they could in the future. Many of the laws granting immunity to peer reviewers do not apply to PPA review. The absence of immunity could dissuade some physicians from serving as peer reviewers. With regard to medical malpractice, PPAs could be sued for a panel member's malpractice on the grounds of insufficient care given to screening providers and monitoring the quality of care. PPAs also could be held liable for the results of a utilization review determination. In practice, however, only one malpractice insurer has tried to charge higher premiums to physicians participating in PPAs, but it was blocked by the state insurance department.

State antitrust laws. Antitrust legislation in states tends to follow federal law. Both the Federal Trade Commission and the U.S. Department of Justice have issued opinions that particular PPAs do not appear to violate the antitrust laws and, in fact, may be procompetitive. Nevertheless, PPAs, in some circumstances, may run some risk of antitrust

liability. Provider-sponsored PPAs, 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 *Maricopa* ruling and the dissolution of a physician-sponsored PPA in California under the threat of an antitrust action by the Department of Justice. Despite these actions, as PPAs gain experience, they report less concern about the antitrust laws' posing a barrier to their formation or operation.

Implications For Policy

When concern about state restrictions on PPAs first surfaced in 1983, it was a common perception that state policies reflected inattention to the possible effects of old laws on a new financing agreement. While that might have been the case in 1983, it is not today. The overwhelming majority of states have addressed the issue of regulating PPAs. Many have decided to clear the way for PPAs; some have subjected them only to traditional types of insurance regulation, such as financial responsibility, mandated benefits, and premium taxes. Others have further constrained PPAs by subjecting them to "any willing provider" provisions, by limiting the incentives they may use to encourage use of their panel of providers, and by applying new consumer protection requirements. States have applied these constraints either by interpreting how provisions in existing insurance law apply to PPAs or by including the restrictions in new laws that specifically enable PPAs.

It is impossible to determine how these restrictive provisions may affect the development and effective functioning of PPAs, because both the laws and the PPAs are still too new. It may be that these provisions will inhibit the ability of PPAs to attract market share and contain costs, causing sponsors to lose interest in the arrangements in which such restrictions do apply. On the other hand, these provisions may cause PPAs some limited problems but not impose a serious obstacle to their development or operation. Even in hostile regulatory environments, PPAs may find ample opportunities to serve self-insured health plans that are exempt from state insurance regulation.

In assessing the merits of existing PPA regulation and deciding what further steps state and federal policymakers might take to direct their development, two major concerns merit attention: the degree of regulatory control that is appropriate for PPAs and the discontinuity in the regulatory environment, especially between insured and self-insured health plans.

Appropriate regulatory control. A paramount consideration is the absence of sufficient information to determine the desirable level of regulation. Since PPAs are such a new phenomenon, it is not known how

much risk they present to consumers and providers and to what extent restrictions on their activities would reduce their effectiveness in containing costs. Although some restrictions may be warranted, regulatory protection generally comes with a price and ought to be used sparingly. Furthermore, because the status quo becomes hard to alter, policymakers should not plan on being able to roll back regulations that later prove unnecessary or to thwart cost-containment objectives. The limited experience with PPAs argues in favor of a cautious approach to regulation.

Some federal officials have been concerned that states have already gone too far in restricting cost-containment activities of PPAs. To satisfy such concerns, Congress could restrict the scope of state actions, for example, by prohibiting the application of "any willing provider" or antidiscrimination provisions to group health plans. States' high level of attention to PPA regulation to date would make federal restrictions particularly controversial, however.

Regulatory discontinuity. The issue of regulatory discontinuity has implications that extend far beyond the regulation of PPAs. Some discontinuities have arisen from the early regulation of third-party payment, under which similar PPAs sponsored by different categories of payers are sometimes subject to quite different regulations. Our research indicates that, with the possible exception of HMO-sponsored PPAs, states generally have been attuned to correcting the more obvious differences in regulatory restrictions.

A more far-reaching discontinuity comes from the increasingly important ERISA exemption for self-insured plans. At the moment, just under 60 percent of covered employees are subject to state regulation of health insurance, while over 40 percent are subject only to minimal federal regulations. Many employers have responded to this preferred treatment of self-insured plans by converting to self-insured status, although they then forgo some of the risk-spreading benefits of insurance. Those employers too small to self-insure find themselves at a disadvantage, as their premium costs increase relative to those of their larger competitors. Thus, inconsistent regulatory policy has broader economic implications.

To resolve this regulatory inconsistency, Congress will need to decide whether to return to its historical policy of leaving health insurance regulation to the states or to undertake a more active federal role. The first course would require cutting back or eliminating the ERISA preemption. Congress adopted this approach in 1982, when, rather than assuming a more active role, it returned control of multiple employer trusts to the states in response to the inability of some of them to pay employees' claims. The second course would require the creation of a new federal regulatory apparatus. Neither option yet enjoys sufficient political support to make it a viable policy option. Therefore, it is likely that the uneven regulatory environment will continue for some time.

NOTES

1. Jon Gabel et al., "The Commercial Health Insurance Industry in Transition," *Health Affairs* (Fall 1987): 46–60.
2. Elizabeth S. Rolph et al., *State Laws and Regulations Governing Preferred Provider Organizations*, The Rand Corporation, R-3442/2-HHS/FTC (August 1986); and American Hospital Association, *State Legal Initiatives* (AHA, 1984).
3. An "exclusive provider organization," a variant of PPAs, does not pay benefits when nonpanel providers are used. Exclusive provider organizations differ from HMOs in that providers do not assume capitation risk.
4. A 1983 amendment to ERISA ended the exemption for certain multiemployer plans.
5. Patricia McDonnell, Abbie Guttenberg, Leonard Greenberg, and Ross H. Arnett III, "Self-Insured Health Plans," *Health Care Financing Review* (Winter 1986): 1–16.
6. Citations for relevant court cases, laws, and regulations may be found in Rolph et al., *State Laws and Regulations Governing Preferred Provider Organizations*.
7. This language is taken from a model state developed many years ago by the National Association of Insurance Commissioners.
8. Our survey did not include health departments, which regulate HMOs in conjunction with insurance departments. We know of one state (Michigan) whose PPO enabling statute permits HMOs to offer a PPA option as an adjunct to its HMO coverage and another (Minnesota) that requires HMOs to offer PPA products through an insurance subsidiary or partner. The federal Office of HMOs currently requires federally qualified HMOs to offer any PPA product through an insurance company.
9. How a benefit differential limit would apply to differences in the range of covered services is not clear. For example, addition of a well-child care benefit would change the coinsurance for that service from 100 percent to, say, 20 percent.
10. The provisions of state law that were reviewed include medical practice act provisions prohibiting the corporate practice of medicine, referral fees, and fee splitting; peer review immunity statutes; malpractice liability; securities laws; franchise laws; certificate-of-need laws; and antitrust laws.
11. Some have noted that only one of the nine rate-setting states (Massachusetts) has substantial PPA activity, but such analyses are rarely convincing. For instance, only a small proportion of states without rate setting have substantial PPA activity either. Indeed, one can interpret the relationship between PPA activity and rate setting in an entirely different way. In states that have contained hospital costs through rate setting and have strictly limited cost shifting to those who pay hospital charges, there is less for PPAs to accomplish through selective contracting. Thus, while PPAs may have a more difficult time in the market when hospital discounts are precluded, there may be less of a need for them in those areas.