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REGULATION OF PREFERRED PROVIDER ORGANIZATIONS (PPOs) AND OTHER ALTERNATE DELIVERY SYSTEMS

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- Status of state and federal regulations regarding the development of PPOs and other alternate delivery systems
- Anti-trust laws affecting PPO development

MR. JAY BOEKHOFF: It should come as no surprise to know that Preferred Provider options are becoming more popular with both employer and labor groups. Employers see this type of care delivery as a method of managing the care provided to their employees. Labor groups are becoming more satisfied with the increased benefits at the expense of only a minor loss of freedom among their members. According to data from the Health Insurance Association of America, PPO enrollment has increased 350% over the first six months of 1985. It is estimated that the current enrollment exceeds 6,000,000 workers. These numbers are difficult to quantify, however, because of the varying reporting relationships among PPO sponsors.

For our purpose we will think of PPOs as being one of three types. The first type is payor sponsored PPOs, such as one sponsored by a Blue Cross plan or an

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insurer. These comprise about 40% of the PPOs we see today. The second type is a provider sponsored PPO, and this comprises about 40% of the total also. And finally, are the entrepreneurial ventures which bring the payors and providers together, which comprise about 20%.

There is wide diversity in the methods of operations of the PPOs from the standpoint of administration, risk sharing and provider reimbursement. For thisreason, efforts by the regulators to monitor and control PPO development and the provision of PPO services have been a patchwork among the states, impacted by federal regulations and court decisions. Aside from the first step of allowing a PPO through enabling legislation, you will see that regulatory interest is of the same nature as those affecting other insurance products, namely, to maintain a free market for competition by both the providers and the buyers of the care and also to substitute for a fully informed consumer. Since a fully informed buyer rarely exists, much of the regulators' activity is centered around protecting the consumer interest through insuring proper disclosure, access to providers, quality of care, solvency of the providers, continuity of coverage, and other activities which would be unnecessary if we all had the knowledge and inclination to investigate our buying decisions.

Our speakers this afternoon have unique perspectives with regard to development of regulation for PPOs. Jim Clements is an Assistant General Counsel with Allstate Life Insurance Company and has been a member of the Health Insurance Association PPO Task Force since its inception. Jim will be primarily discussing federal court cases and regulatory interest with regard to PPOs. Sandy Anderson is a Planning Analyst with the Wisconsin Insurance Department. As you may be aware Wisconsin is one of the states leading in the development of PPO regulations. Sandy has been actively involved in this movement and also in assisting the NAIC Task Force on PPO regulations. Sandy will be addressing the state role in regulations of PPOs.

MR. JAMES D. CLEMENTS: I have been asked to discuss the question of federal government involvement with Preferred Provider Arrangement and Organizations (PPO). Up to this point I could summarize that involvement with just a very short phrase, which is: "Very little but that may change." But before we talk

about affirmative federal actions in that area, let me give you a brief rundown on the application of the anti-trust laws.

No discussion of anti-trust and insurance would be complete without mention of the McCarran-Ferguson Act. For those of you who have not read about it, the McCarran-Ferguson Act essentially, and in a very general way, exempts the business of insurance from the application of the federal anti-trust laws. The first thing I want to impress upon you is that Preferred Provider Arrangements (PPA) in my opinion, and that of most writers on the subject, and in the opinion of the courts which have an opportunity to deal with the issue, do not constitute the "business of insurance" and thus are not exempted from scrutiny under the federal anti-trust laws.

Now essentially any individual buyer of a "good or service" and any individual seller of a "good or service" can make any sort of arrangement they want to make without concern about federal anti-trust laws. It is only when individual competitors get together to decide what they are going to do or not do in a certain transaction or series of transactions that the anti-trust laws become involved. Thus, in a situation in California where a PPO was formed and it involved a majority of the physicians who would not contract with any other PPO, the Justice Department got very much interested, indicated that it was going to bring action against this PPO, and it was immediately disbanded. That's the type of activity that will get people in trouble. On the other hand, a single insurance company or a single employer which goes out and makes a "take it or leave it" deal with a specific hospital or a doctor or a dentist would have a problem. The other side of the coin is that any hospital or doctor who goes out and contacts insurers or employers and says, "Here is the sort of deal that I am willing to make with you," would likewise not create any problems. It is only when you have aggregations of organizations of either side, either buyers or sellers, that you are likely to have a difficult situation. Another situation of concern is when a buyer or seller is so large in a particular market that it becomes what is referred to as a "dominant influence." The best example that I can give you of a situation like that would be to take a city, of say, 20,000 individuals with an employer which employs 10,000 people. Obviously, that employer is a very dominant influence.

If that employer has an employee benefit plan that is self insured, and if that employer goes to every doctor and dentist or every provider of health care services in the community and states that "you are either going to have to play ball on my terms, or else," then you may have an anti-trust problem simply because that employer is so dominant within that market that it tends to create a monopoly. But in any event, as a basic proposition a Preferred Provider Arrangement or Organization, if properly structured, should not have any trouble at all in dealing with the anti-trust laws. Most of the lawsuits that have arisen in connection with preferred provider activity have involved Blue Cross and Blue Shield organizations.

Most recently is the case of Ball Memorial Hospital in Indiana. A claim that the Blues Indiana PPO violated anti-trust laws was rejected when the federal court held that the Blues lack sufficient market power to effectively restrain trade in the health care financing industry. That is, even though as large and as important as the Blues may be in a particular state, they do not have sufficient market power to violate the anti-trust laws simply by going to each doctor who they deal with and saying, "Here is the arrangement we want to have with you," on a take it leave it basis. With respect to the federal government agencies, generally the federal enforcement authorities have been very supportive of the PPO concept. The Federal Trade Commission (FTC) has issued several "no action" letters, which in effect approve properly constructed PPAs. The Justice Department has likewise issued a number of "business review letters" to PPAs, and said that they may proceed, based on the proposition that they are not conspiracies in restraint of trade as they are not aggregations of doctors or hospitals or insurers, and also that the individuals comprising either one side or the other are not so dominant in the market as to effectively control that market.

Now what about legislation on the federal side? Well, there have been quasi PPA enabling legislative pieces introduced in Congress in the last several years. For example, Senator Spector's Joint Negotiations Bill, which was introduced in 1983 would have permitted insurers to band together in contracting with providers. Representative Wyden's Preferred Provider Health Care Act of 1983 would have preempted any state laws impacting formation and operation of PPAs. The Health Insurance Association of America has drafted a federal bill which would

preempt all state laws which would in any way impede the effective operation or creation of PPAs. That bill has not yet found a sponsor, and the reason for that is very simple. In 1984, Congress authorized a study of Preferred Provider Organizations and Arrangements to be conducted by the Rand Corporation. The Rand Corporation study is looking at PPAs in two distinct ways. One, way is the operational aspects of the PPAs; how many are there, who is involved, who are they covering, and what has been the impact economically in the marketplace. The other side of the study has been subcontracted to a Los Angeles law firm. That law firm is doing a survey of what the legal impediments are to the effective operation of PPAs. In particular, they are looking at impediments in state law that exist currently.

The Reagan Administration has indicated an interest in federal legislation which would preempt state laws respecting PPAs, but is not going to make a decision until the Rand Corporation study is presented. If the Rand Corporation study comes to a strong conclusion that state law, as it currently exists, is impeding the operation of PPAs, then there is a very good chance that the Reagan Administration would agree to sponsor and support preferred provider legislation. The reverse is also the case. If the Rand Corporation study indicates that there are currently no serious impediments to the proper creation and operation of PPAs, then there probably will not be any great push for federal legislation.

MS. SANDRA DREW ANDERSON: When I was preparing this session I discovered that PPOs are uniform in one way -- namely the lack of similarity from one jurisdiction to another as to what is considered a PPO and how it regulated. Rather than trying to capsulize all the various state PPO regulations, I will touch on what the National Association of Insurance Commissioners (NAIC) is currently considering, discuss in more detail the development of PPOs and other alternative health care plans in Wisconsin, and touch on what the future may hold in this area. This week the State and Federal Health Insurance Legislative Policy Task Force presented to the NAIC draft model legislation to regulate PPAs. The draft is for exposure only. NAIC members are expected to vote on it at the Winter 1986 Meeting.

The purpose of the proposed model legislation is basically twofold. It is to protect the public while at the same time allowing entities, operating within a state, to take advantage of their bargaining power by entering into contractual agreements with providers and also to enable all existing insurers to enter into the PPO contractual relationship. Reviewing the model, I noted that the definition of what is considered a health care insurer is extremely broad. It includes an insurance company, a hospital plan corporation, a health services plan corporation, an HMO, a fraternal, or other entity regulated by the insurance department.

The proposed model is intended to establish standards to protect the public. A health insurer can define, by contract, the amount and manner of payment it will make to the provider; review or control utilization provided that costs are not passed on to subscribers for any post-utilization denial of payment; and issue policies which contain incentives for the subscriber to use the services of providers affiliated with the insurer. The insurer may include in the contract, and in policies which utilize that contract, items designed to contain health care costs and improve the quality of health care. These include a capitation payment to providers, a payment differential of not more than 25% between preferred and non-preferred providers, limitations on the number of providers with whom it will contract, and incentives for insureds to use the preferred providers. The proposed model allows other individuals, for example, providers or third party administrators, to make PPA arrangements with providers and then to make the arrangements available to insurers. The model permits this provided that the individual doing the contracting accepts no financial risk, is reimbursed for his work, and discloses his role and limited responsibilities. The proposal does not apply to any PPAs which are organized, established, and maintained by an employer solely for its employees and their dependents.

In Wisconsin the subject of PPOs actively surfaced in late 1982. At that time, Blue Cross and Blue Shield United of Wisconsin asked the commissioner to promulgate an administrative rule to authorize PPOs. At that time, Section 628.36 (2) of the Wisconsin Statutes stated in part that no professional could be required to participate exclusively in a health care plan as a condition of participation in the plan. Nor, and more importantly, could any provider be

denied the opportunity to participate in the plan under its term except for professional causes. The law, however, gave the commissioner the authority to promulgate a rule exempting that section for plans which provide innovative approaches to health care. Our office began promulgating such a rule. However, before it was completed, the Governor and state legislature included remedial legislation in the biennial budget for the development of health care plans. The legislation which became 1983 Wisconsin Act 27 included several innovative features. It authorized insurers to establish and operate preferred provider plans but specifically did not prevent a non-insurer from establishing and operating a PPO.

A Preferred Provider Plan (PPP) was defined as a health care plan which limits participation in it to providers selected by the health care plan. Insurers operating the PPPs were subject to all insurance laws except the previously sited Section 628.36 (2). However, non-insurers operating PPOs were not subject to any insurance laws. The law stated that the PPP could not prevent an enrollee from choosing any participating provider except by requiring the person to select a primary provider. An employer could not offer a PPP unless it also offered an open panel plan. An employer had to have an open enrollment period at least once yearly and was required to give complete and understandable information about the plans, with a sufficient notice, prior to the open enrollment. Copayments of up to 20% could be imposed if the person went to a provider not under the plan. The copayments could not exceed $2,500 per person or $5,000 per family. The commissioner was required to adopt rules which would assure that patients were not required to travel excessive distances to secure treatment, to insure that continuity of care was not disrupted, to define substantially equivalent benefits, and to assure adequate notice was given to all employees. You will note that the commissioner's office does not under this rule, or law, regulate utilization.

The 1985-86 biennial budget also contained amendments which effected PPPs. The definition was amended to specify that it is a discounted fee for service plan. In addition, all PPPs are required to have an internal grievance procedure and to advise insureds how to access it. The PPPs must file a yearly report with our office about all the grievances that are filed and how they are resolved. Today many of the major health writers in the state offer one or more PPPs.

However, since these companies do not have to file the census data with us, we really do not know how many individuals are actually covered by them. The alternative system which has had the greatest impact on the state is the HMO development. In 1982 there were 11 HMOs covering approximately 150,000 people in the state. At the end of 1985 there were 35 licensed HMOs covering approximately 850,000 people. All of the HMOs, by state statute, are considered insurers and are licensed either as for profit, not-for-profit or cooperative HMOs.

In addition to allowing the PPPs to exist, the 1983-84 budget included several provisions which allowed for, and actually fostered, the development of HMOs. The biggest boost to HMO development was the state initiative to change the way it paid for health insurance for its employees and the way it provided for medical care for Aid to Families with Dependent Children (AFDC) recipients. State employees as a result of that law change joined HMOs in droves when the state decided to pay up to 105% of the least expensive alternative plan or 90% of the standard plan, which is the state's self-funded plan. Today approximately 65% of all active and retired employees and their dependents in the state are in HMOs. The state also receives waivers from the federal government to place AFDC recipients in Milwaukee and Dane counties in HMOs. Today there are approximately 110,000 such individuals who receive their medical care from HMOs. As a result of those two initiatives the state has saved millions of dollars and plans to place more of the AFDC recipients in other counties in HMOs.

A year ago the state legislature created yet another type alternative health care plan. This one is called a Limited Service Health Organization (LSHO). By statute an HMO could only provide comprehensive medical care. This precluded certain types of providers such as dentists and home health care agencies from forming their own HMO. To allow them the opportunity to take part in the competitive health care field, the legislature created the LSHO which can only provide a limited range of health services.

With all these changes, what can we expect to see in the future? It is the marketplace which we feel will likely demand more, not less, competitive choices. Insurers, HMOs, and PPOs in order to stay afloat will have to adapt

to these demands. One thing that may become commonplace in the market is the triple option. This is where a single entity offers an employer an indemnity plan, an HMO and a PPO as a package. We already have several insurers in our state which are able to do this. For example, Blue Cross has its traditional indemnity plans, it has PPPs and it has a for-profit HMO that is affiliated with it. Firemans Fund Employers has the same. We also have seen at least one joint venture between a cooperative federally qualified HMO and a standard indemnity insurer. They have joined together to market their products to small employers. It is our feeling that what we recognize today as an HMO or a PPO may not look the same a few years from now. But one thing is sure, the public is going to continue to demand quality health care at affordable prices.

MR. BOEKHOFF: Please clarify a couple of things regarding the NAIC model. You said that it would apply to any entity licensed by the insurance department, and it would be an insurance law. Is that correct? It would not be an employment law, so it would not apply to self-funded plans?

MS. ANDERSON: Yes.

MR. BOEKHOFF: What I would like to do is just supplement what Sandy said with a couple of examples of existing state variances regarding PPO regulations.

For starters, not all states have legislation. We see about 21 states with enabling legislation. At least one has taken the position that it does not need enabling legislation since PPOs have been allowable all along. There are other states which are clearly belligerent against PPOs and many more that are just sitting on the fence.

The states which have enacted other legislation in addition to enabling legislation have some interesting provisions. For example:

- Maryland has a provision that, in determining which hospitals are cost efficient, the sponsoring organization cannot include certain types of services, such as, medical education, uncompensated care and other aspects of hospital expenses which the state legislature thought were worthwhile and should be removed for consideration.

- North Carolina prohibits exclusive contracts by its providers with one PPO. This would help deal with the problem that Jim was discussing. North Carolina also prohibits any reference to the quality of care by either the PPO or its competitors in advertising.

- Utah currently contains a benefit differential restriction of 75%, which would be consistent with the NAIC Model.

- Kentucky is considering a likewise restriction.

- California has open regulations with regard to PPOs, but with regard to Exclusive Provider Organizations (EPOs), it has more restrictions. Specifically the following: the EPO must have a sufficient number of dually licensed providers. All the decisions that these providers make concerning medical care must be based on medical need, that is, not on economics. The facilities must be reasonably accessible to the work place or residence of the employees who would be affected. Facilities must be open at least 40 hours each week. The EPO must provide full time emergency services to all covered individuals. There must be a reasonable ratio of providers to covered members of at least one physician per 1,200 members and one primary care physician for each 2,000 members. We might be seeing more of these types of restrictions in the future. This is at least the first shot at guaranteeing accessibility of the care. Finally, the EPO must monitor the accessibility to care, and it must show that it is evaluating these monitors on a reasonable basis.

MR. CLAYTON A. CARDINAL: In New Jersey we do not have any PPO regulation. We are going to be adopting something, hopefully, in the future. HMOs are regulated in the Department of Health. The Department of Insurance collaborates on the appropriateness of the capitation rates. In New Jersey it has been deemed that the regulation of HMOs will consider the appropriateness and the quality of care with the regulation which is dually in the Department of Health. In Wisconsin do they get into that and how do they regulate that? Since you deemed the PPO to be regulated by the Department of Insurance, if you do get into that area of regulation, how will you affect that?

MS. ANDERSON: We do not get into that at all. We leave that to the marketplace for both the HMOs and PPOs as far as quality of care. So far we have been able to do this, because it is a very competitive market, and there is not a shortage of either HMOs or PPOs at this time.

MR. BOEKHOFF: The monitoring of quality of care is a tricky prospect no matter who does it, the Insurance Department or the Department of Health. Certainly from the hospital standpoint a starting place might be Joint Commission for Accreditation of Hospitals (JCAH). But beyond that, I noticed last week there was a quality indicator that is being promoted by a group of physicians in Orange County which incorporates some of the same things that the JCAH incorporates. It contains additional things such as the infection rates of the hospital or ratio of registered nurses to patients. What they are attempting to do in that case is come up with one composite indicator that potentially could be used for those types of purposes that show the hospitals at least are meeting certain quality standards. But certainly any efforts in compressing multi-dimensional factors into one indicator will be arbitrary at best. I guess we are all familiar with what the response was to the recent publication of mortality statistics by hospitals and the uproar the doctors had concerning that.

MR. A. KIRK TWISS: I have a question concerning the anti-trust aspects. How may these alternative delivery systems pay the providers? In particular with hospitals where there is a favored nation clause wherein the hospital agrees not to give a discount lower than a certain discount that it gives to one organization. If the hospital does give a lower discount, it would have to give it to everybody. With physicians, I have heard that some physicians, rather than establishing a maximum fee schedule with the organization, would set a schedule so that everyone would pay the same fee for a particular service. Could you comment on the anti-trust implications with respect to those?

MR. CLEMENTS: With respect to your first observation, there is nothing wrong under the anti-trust laws with you and I agreeing that I am going to sell you apples at a certain price and that they will always be at a price at least as low, or maybe lower, as I am going to charge anyone else. That may seem at first to be anti-competitive, but it is not -- at least according to anti-trust

theory. What you and I cannot agree is that I will sell you apples at price X but will sell them to the person sitting next to you at price Y. In other words, we cannot agree among the two of us as to what either of our actions are going to be with respect to a specific competitor or group of competitors. We can deal with competitors as a universe by saying that you will always get the lowest price. But we cannot single out competitors. Now the proviso is that in almost all of those situations, there is some economic rationale behind the agreement. So, for example, if I am coming up with a new product, and your distributor and you are going to invest a lot of time and effort in advertising and distribution channels, in training workers, or whatever, to handle my product, there is an economic justification for me to agree that you will always get the best price. Otherwise, I probably would not be able to get anyone to take a chance on it. In any event, that is the way it works. I am not telling you whether or not it makes any sense, but to understand the distinction.

As long as those arrangements are worked out on a one-on-one basis, there is no violation of the anti-trust laws. In other words, if I go to everyone in this room and say that I want to buy your actuarial services and I am willing to pay you $10 per hour and that is it, and I negotiate with every one of you individually and you all wind up accepting my deal, I haven't violated the anti-trust laws. If you all get together and say we agree that we are not going to sell our services for less than $12 per hour, then you have violated the anti-trust laws.

MR. BOEKHOFF: Jim, in a related issue I have noticed that some medical societies in certain areas will form a unit that will be capitated for purposes of providing a professional component for HMOs. The Society might work for more than one HMO but the medical society represents all of the physicians in that geographic area. Is that a problem with regard to anti-trust or what kind of things do they have to incorporate to avoid the problem?

MR. CLEMENTS: It has been and is a problem, for example, if all of the doctors in a county get together and through their medical society or medical association agree that they are going to set minimum fees, or even maximum fees, for certain services. One of the most famous anti-trust cases of recent

vintage is the Maricopa case, where the doctors in Maricopa County, Arizona, got together and said that they all would not charge more than X, and it was struck down as violating anti-trust laws. It is alright, if I understand how these things work, for a professional association, in an advisory capacity in the context of doing research, to make recommendations. By and large that is all right, but it is very difficult to tell when those associations cross the line from making recommendations as to what is an inappropriate level of charge for a particular type of care to the point of saying, "Okay boys and girls, let's everybody get together and agree that this is what it is going to be."

MR. CARDINAL: Sandy this is for you again. With regard to regulations of various sponsors and providers to the extent that regulation is not universal and to the extent that we have new and developing outlets for delivery, we have disparity in regulation across the different constituencies. One example might be in New Jersey where we have self-insured programs versus insured programs and pre-certification. Pre-certification would be an issue that would be regulated for insurance companies but self-insured programs are exempt. So among the citizens we have a disparity in regulation. What are you doing in Wisconsin and what else are you aware of that is happening?

MS. ANDERSON: Here is our feeling toward the self-insured programs. We tried on two occasions to regulate self-insured plans. One was 1980 when the legislature adopted continuation conversion law which applied not only to insured plans but to all self-funded plans as well. That was struck down by the Federal court. Then we tried again in 1983 when the legislature enacted the various incentives for the alternative health care plans. At that time, they tried by the back door to make it applicable to the self-funded plans as well by tying it into deduction for state tax purposes. That also went by the board. To give insurers as much opportunity to compete with the self-funded plans as possible, regulations should contain minimum, yet adequate, restrictions. Again the marketplace will take care of several of these variances as long as there is adequate disclosure that the people know what they were getting into; that they have an opportunity to choose; and that there is the opportunity to choose a standard plan at the same time that employers are offering an HMO or a PPO.

OPEN FORUM

MR. CARDINAL: Did you say, in essence, that the attempts to regulate self-insured programs have failed?

MS. ANDERSON: That's right.

MR. CLEMENTS: Let me tail onto that. The development of PPOs, in one sense, has brought this basic issue into very sharp focus in a number of places. But it is, as I am sure you are aware, the basic problem for the health insurance industry and health insurers from a number of aspects. That is, the fact that state insurance departments, and to a great extent other organs of state government, cannot regulate, in any fashion, employee benefit plans sponsored by employers which are subject to Employer Retirement Income Security Act of 1974 (ERISA). This gives those employers, to a great extent, depending, of course, on whether or not they are negotiating with a union or whatever, a great latitude in flexibility in not only the design of the plans but in selecting who is going to provide the services in benefits. On the other hand, those employers which are funding those benefits through the insurance vehicle are subject to all of the various restrictions of state regulation, which I think is in great part why the last surveys I have seen indicate that, at least among employers of a certain size in terms of number of employees, the flight to self insurance is continuing and is getting more extreme.

MR. WILLARD WITHERSPOON JR.: I would like to know if you were aware of any regulation as to capitation rates in terms of adequacy and in terms of raising them from one year to the next. And, if there isn't any regulation like that, does there exist a level kind of playing field with respect to individual health insurance versus PPOs and HMOS, or is it unfair competition?

MS. ANDERSON: I will take the rate regulation question first. We do not regulate rates. We do have the authority to hold a hearing to see if rates are excessive or adequate. Again it has been our belief that the marketplace takes care of this. If the rates start becoming too excessive, there is a lot of competition there in the health field, and the employer is going to start looking somewhere else. We do not dictate what a capitation rate should be or whether there should be a differential as the NAIC Model does. Nor, do we put any controls as to what the rate increase can be from one year to the next. I

would imagine that in states where they have regulation and also regulate HMOs and PPOs, that the rate regulation would probably apply there. But I am just guessing on that part. Do you have rate regulation in New Jersey?

MR. CARDINAL: Yes, we regulate the rates in New Jersey. A number of years ago when the HMOs didn't have a large proportion of the market, not a lot of attention was given to it. Now that they have increasing proportion, we will begiving it more attention. It assumes that rate regulation, at least philosophically in New Jersey, is a form of cost containment. We neither want the rates too high nor too low in order to meet this expectation. We also agree to some of the abuses in the HMO area on market selection. These are areas of concern in the rates being charged. There is no published rate or rate standard on the subject of actuarial review.

MS. ANDERSON: Now one thing that we do watch and monitor very much is the financial solvency of the HMOs. They have less financial standards going in than insurance companies. They only have to provide $200,000 in surplus. But they have to file quarterly reports at least. They have additional reportings so that we can stay on top of it. If we start noticing problems we do not directly regulate the rates. We certainly would call the HMO and ask it how it plans to resolve this and take care of it that way.

MR. CARDINAL: We have rejected certificates of authority on dental plan organizations because we deemed the rates inadequate.

MR. BOEKHOFF: I think in general the capitation will not be the method used by PPOs to reimburse providers if the worker has other choices in providers that he can use.

MR. CLEMENTS: I don't know of any situation currently. Of course, heaven knows what's out there. By and large the PPO arrangements I am familiar with are fee for service, with the agreement that the provider, with regard to the particular patient, is going to discount, or in some other fashion adjust, the charge that he or she will charge for the services rendered. The second part of your question I am not quite sure I understand. I gather what you are asking is, is it a fact that, for example, in many states HMOs and preferred

provider arrangements are pretty much free to let their prices go with the market, whereas under a lot of individual health plans, rates are regulated and whether or not that isn't unfair competition as regards to the individual health insurance product. I think it is very difficult competition. I am not quite sure it is unfair, because theoretically a company which is issuing individual health insurance products could do so and take advantage of a PPO. It would need a heavy concentration of insured in a given area, and I appreciate that you have insureds sprinkled all over the place. It might be very difficult to find providers in that wide span to compete. So again, I would say it is very difficult competition, but looking at it from the anti-trust standpoint, it is not unfair.

MR. DAVID J. BAHN: Our PPOs are reimbursing the hospitals on a DRG basis. The physicians are still on a discounted fee for service basis, although we are thinking of what is the "best" way to compensate those people. Also, we do market an individual PPO product. The way we do it is to tag along behind the networks once they are set up mainly for our group customers. Then we go in with a PPO product and are able to market that.

MR. CLEMENTS: I could see where that would be very effective for a state Blue Cross/Blue Shield operation, because you do have a heavy concentration and a restricted marketing area.

MR. CARDINAL: What do you do on the individual product with the person who utilizes the non-participanting provider?

MR. BAHN: There is a penalty in there of 25%. In other words, the coinsurance that we would pay drops from 80% to 60%. Emergency services, for instance on vacation, and needing emergency services are compensated at the full PPO level.

MR. CLEMENTS: May I ask what's the rationale for that? For providing emergency services on the basis as if it were provided by a preferred provider, when in fact it is not? What I am getting at is: the insurer is not getting the benefit of the better deal from the provider, so what's the rationale for the insurer then turning around and pretending, in a way, that the provider who did provide the services is doing so on a discounted or adjusted basis?

MR. BAHN: I think it is probably due to marketing more than anything else. One of the concerns that people always have is, will this pay if I am traveling? And if you have to say to them your product only pays 60% if you have an appendectomy while your at the meeting in Kansas City then I am not likely to buy it.

MR. CLEMENTS: I assume that you have a very careful definition of what constitutes an emergency service and when it stops.

MR. BAHN: Yes.

MR. JOHN D. BOHON: I have a problem with the rationale. I don't understand the rationale behind the definitions and therefore the restrictions based on PPOs on insured products. An employer can offer an HMO and direct the employees to certain providers entirely, no benefits will be paid if they go to any other providers except in qualified care or emergency situations. Insurance laws restrict, or attempt to, the benefit differentials like 25%. I do not understand all of the rationale behind that. I wonder if you could expand on that.

MS. ANDERSON: As to why the model has 25%?

MR. BOHON: Yes.

MS. ANDERSON: I believe it came out because you have a wide variance in state regulation and state attitudes towards regulation as the model was being developed.

MR. BOHON: What is the rationale behind any percentage? We have EPOs which are essentially HMOs. I don't know why they use different letters necessarily but they do. I think it is to distinguish between federally qualified and non- federally qualified.

MS. ANDERSON: I am not sure what the rationale is. Unless it is to try and keep it within the bounds of an insured plan, because it seems to me that those

organizations are defeating the purpose by competitiveness by putting the restriction on there.

MR. BOHON: It seems to me that, when they put more restrictions in anything with regard to insured plans, then more people will choose the self-insured route. Therefore, by regulating further they are regulating less.

MS. ANDERSON: I would suspect that there is going to be quite a bit of dis cussion on the model before action finally is taken one way or the other by the NAIC.

MR. CLEMENTS: I will second that. I am sure there is going to be a lot of discussion about it.

MS. ANDERSON: One of the other things addressed in the model is payment on a capitated basis. You may set the PPO up that way rather then the fee for service type.

MR. CLEMENTS: I cannot certify to this, but it is my understanding that, in some states where a differential limit has been placed, it is strictly a political compromise because the local medical associations want something in there so that the arrangement won't in effect make an Exclusive Provider Arrangement (EPA) out of a PPA. The medical association thinks that there is some point at which a patient's loyalty to good old Dr. Jones is going to evaporate if the difference in cost exceeds X, and maybe that X is 25%. I have heard that as being the rationale.