

---

January 1988

## Cost v. Quality in the Regulation of Preferred Provider Arrangements: A Green Light To The Gold Rush

Lori A. Tobias

---

### Recommended Citation

Lori A. Tobias, Comment, *Cost v. Quality in the Regulation of Preferred Provider Arrangements: A Green Light To The Gold Rush*, 41 Sw L.J. 1155 (1988)  
<https://scholar.smu.edu/smulr/vol41/iss5/5>

This Comment is brought to you for free and open access by the Law Journals at SMU Scholar. It has been accepted for inclusion in SMU Law Review by an authorized administrator of SMU Scholar. For more information, please visit <http://digitalrepository.smu.edu>.

## COMMENTS

# COST V. QUALITY IN THE REGULATION OF PREFERRED PROVIDER ARRANGEMENTS: A "GREEN LIGHT TO THE GOLD RUSH"?

by *Lori A. Tobias*

**T**HE Texas State Board of Insurance recently adopted rules that permit commercial insurance companies to market preferred provider health insurance plans.<sup>1</sup> The Texas Preferred Provider Plan Rules authorize commercial insurers to develop preferred provider arrangements and to offer a different level of coverage to insureds who obtain health care services from preferred providers.<sup>2</sup> Drafted to address the conflicting public policy objectives of cost containment and quality assurance in health care delivery, the rules set forth minimum standards derived from the Texas Insurance Code for establishing preferred provider arrangements<sup>3</sup> and preferred provider health insurance plans.<sup>4</sup> Principal actors in the Texas Preferred Provider Plan rulemaking process included commercial insurers, insurance regulators, and representatives of the provider community. The final version of the Texas Preferred Provider Plan Rules represents the product of a two-year process marked by legislative, administrative, and judicial action.<sup>5</sup>

---

1. State Bd. Ins., 28 TEX. ADMIN. CODE §§ 3.3701-.3705 (Nov. 1, 1986) (Preferred Provider Plan Rules).

2. *Id.* § 3.3701.

3. Hereinafter referred to in the text and notes alternatively as preferred provider arrangements or PPAs.

4. For a summary of the specific Texas Insurance Code provisions impacting the issuance of preferred provider health insurance plans, see State Bd. Ins., 11 Tex. Reg. 2810, 2811-12 (June 17, 1986).

5. For a comprehensive chronology of the proceedings attendant to the Texas Preferred Provider Plan rulemaking process, see TEXAS MED. ASS'N, PPO POLICY DEVELOPMENT FOR TMA AND THE STATE OF TEXAS (June 17, 1986) [hereinafter TMA CHRONOLOGY]; see also Wilcox, *Preferred Provider Plans and Contracts with Physicians*, TEX. MED., Sept. 1986, at 65, 65-67. In 1984 Commercial State Life Insurance Company (Commercial Life), an affiliate of Humana Insurance Co., Inc., submitted a health insurance policy form to the State Board of Insurance (the Board) for approval pursuant to article 3.42 of the Texas Insurance Code. TMA CHRONOLOGY, *supra*, at 1; see TEX. INS. CODE ANN. art. 3.42(c) (Vernon 1981 & Supp. 1988) (insurers required to file policy forms with Board sixty days prior to issuance); *id.* art. 3.42(a) (issuance, delivery, and use of group accident or health insurance policy prohibited

This Comment analyzes the regulatory framework that impacts the for-

---

prior to Board approval). The proposed policy provided for an alternate level of benefits for insureds who elected to obtain treatment from a physician at a participating hospital. See Supplemental Amicus Brief in Opposition to Commercial State Life Insurance Company's Application for Review of Commission's Order No. 85-0677 at 4, *In re Appeal of Commercial State Life Insurance Company*, No. 1456 State Board of Insurance (Apr. 15, 1985) [hereinafter TMA Supplemental Amicus Brief]. On April 15, 1985, the Commissioner disapproved the policy. Order No. 85-0677, Disapproving Commercial State Life Insurance Company Proposed Policy Forms (Apr. 15, 1985). Commercial Life appealed the Commissioner's disapproval of its policy form to the full Board. TMA CHRONOLOGY, *supra*, at 1. The Board reversed the Commissioner's decision and approved the proposed Commercial Life policy form. *Id.* at 1.

During the course of these administrative proceedings, representatives from the insurance industry lobbied for the enactment of legislation that would amend the Insurance Code to eliminate statutory barriers to the issuance of preferred provider health insurance plans. See Tex. S.B. 413, 69th Leg. (1985); Tex. H.B. 1129, 69th Leg. (1985). On April 8, 1985, the Texas Medical Association (TMA) Emergency Policy Board voted to defeat insurance industry legislation and seek an interim legislative study addressing preferred provider health insurance policies. TMA CHRONOLOGY, *supra*, at 1. Due to strong TMA opposition, legislative initiatives were defeated in both houses of the Texas Legislature. *Id.*; see Memorandum from A. Gilchrist to TMA Task Force on Contract Provider Organizations (CPOs) (Sept. 30, 1985) [hereinafter TMA Task Force Memo] (outlines formulation of TMA position on CPOs and TMA lobbying efforts to defeat insurance industry-sponsored preferred provider legislation prior to and during 1985 Regular Session of Texas Legislature); Memorandum from D. Wilcox to TMA Task Force on CPOs (Jan. 3, 1986) [hereinafter TMA Safeguard Memo] (outlines TMA legislative counterproposals relating to freedom of physician choice, access to medical care, quality of care, and other provisions designed to guarantee appropriate decision-making and prevent unfair terms); see also Tex. S.B. 1206, 68th Leg. (1983) (defeated) (providing for removal of statutory restrictions on insurers' ability to contract with selected physicians to provide medical services). For a discussion of the statutory barriers to the issuance of preferred provider plans, see *supra* notes 173-79 and accompanying text.

On October 23, 1985, TMA requested that the Board reconsider its approval of the Commercial Life policy. TMA CHRONOLOGY, *supra*, at 2. Two days later, TMA filed suit in the District Court of Travis County seeking a declaratory judgment that approval of the Commercial Life policy was outside the scope of the Board's statutory authority. *Id.*; see TEX. INS. CODE ANN. art. 3.42(i) (Vernon 1981 & Supp. 1988) (parties may file appeals from any order of the Board issued pursuant to its policy approval process pursuant to art. 21.80 of the Insurance Code); *id.* art. 21.80 (Vernon 1981 & Supp. 1988) (insurance company or any other party in interest dissatisfied with any decision, regulation, order, or ruling adopted by Board may file petition in District Court of Travis County, Texas, against Board as defendant). On November 7, 1985, Commercial Life requested that the Board rule on TMA's standing to challenge the action taken by the Board. TMA CHRONOLOGY, *supra*, at 2. On December 19, 1985, the Board acknowledged TMA's standing to challenge approval of the Commercial Life policy, granted TMA's motion to reconsider approval of the policy form, and remanded the Commercial Life application to the Commissioner with instructions that he delay findings until the Board adopted final rules regarding preferred provider health insurance policies. *Id.* At the same time, the Board issued proposed rules governing preferred provider plans and solicited public comment. State Bd. Ins., 10 Tex. Reg. 4729 (Dec. 10, 1985) (proposed to be codified at 28 TEX. ADMIN. CODE §§ 3.3701-.3705). In comments submitted to the Board, Donald P. Wilcox, TMA General Counsel, urged the Board to consider the impact that the proposed rules would have on public policy issues. Mr. Wilcox commented, "Surely the Board does not wish to irresponsibly give the green light to the gold rush which will follow just to see what will happen with respect to insurance and health care under this drastic new scheme." D. Wilcox, Comments of Texas Medical Association on Texas Proposed Preferred Provider Plan Rules, 28 TEX. ADMIN. CODE §§ 3.3701-.3705 (1986) (Jan. 15, 1985) [hereinafter TMA Comments].

On January 17, 1986, the Board conducted a hearing at which it received testimony on the proposed preferred provider plan rules and appointed an advisory committee to recommend changes to the rules. TMA CHRONOLOGY, *supra*, at 3. The advisory committee included five representatives nominated by TMA, three representatives of the insurance industry, a proprie-

mation and operation of insurer-sponsored preferred provider arrangements. Section one charts the trend toward competitive solutions to rising health care costs and identifies the factors that have prompted the development of preferred provider arrangements as an alternative health care finance and delivery system. By analyzing the six principal components of the preferred provider health care finance and delivery system, section two provides an outline of the structure and operation of preferred provider arrangements. Section three describes four distinct applications of the basic PPA model. To facilitate an evaluation of the regulatory scheme adopted by the Texas State Board of Insurance, section four identifies the scope and outlines specific provisions of the Texas Preferred Provider Plan Rules, model preferred provider plan legislation, and the statutes and regulations enacted in other states that govern preferred provider health benefit plans. The discussion focuses on the provisions relating to provider contracting, preferred provider health care benefits, provider referral, utilization and quality management procedures, and consumer protection. Finally, section five critically analyzes specific provisions of the Texas Preferred Provider Plan Rules.

### I. HEALTH CARE COST CONTAINMENT

The Texas State Health Care Plan<sup>6</sup> identifies health care service reimbursement as the primary contributing factor to health care cost escalation.<sup>7</sup> According to the report, approximately seventy percent of all health care

---

tary hospital spokesperson, a third party administrator, and a former Board chairman. *Id.* On March 18, 1986, the advisory committee submitted amended proposed rules to the Board for approval. *Id.* A majority and minority report accompanied the advisory committee's proposals. See STATE BD. INS. ADVISORY COMM. ON RULES ON PREFERRED PROVIDER ORGS., MAJORITY REPORT (Mar. 14, 1986); STATE BD. INS. ADVISORY COMM. ON RULES ON PREFERRED PROVIDER ORGS., MINORITY REPORT (Mar. 14, 1986) [hereinafter MINORITY REPORT]. Reflecting TMA's determination to safeguard physician and patient interests, the minority report called for physician control of provider selection, utilization review, and quality assurance. *Id.* at 2, 6 & attachment 3; see also TMA TASK FORCE ON CPOs, REPORT OF TMA TASK FORCE ON CONTRACT PROVIDER ORGANIZATIONS TO THE [TMA] EXECUTIVE BOARD (Mar. 23, 1986) [hereinafter TMA TASK FORCE REPORT]. After continued negotiations, the Board further revised the amended proposed rules to incorporate certain safeguards recommended by TMA. See TMA Safeguard Memo, *supra*, at 1-5. The Board approved the revised rules, which became effective on July 1, 1986. State Bd. Ins., 11 Tex. Reg. 2810 (June 17, 1986) (codified at 28 TEX. ADMIN. CODE §§ 3.3701-.3705).

6. TEXAS DEP'T OF HEALTH, TEXAS STATE HEALTH CARE PLAN FOR 1987-88 (1986) [hereinafter TDH HEALTH CARE PLAN].

7. *Id.* § XVII. For analyses of health care expenditures on the national and state level, see Arnett, McKusick, Sonnefeld & Cowell, *Projections of Health Care Spending to 1990*, HEALTH CARE FIN. REV., Spring, 1986, at 1 [hereinafter Arnett & McKusick]; Begley & Mains, *Health Care Spending in Texas, 1975-1984*, TEX. MED., Sept. 1987, at 30. A recent national study predicted that: (1) national health expenditures from 1984 to 1990 would increase at an 8.7% average annual rate, two-thirds of the 12.6% rate measured over the previous eight-year period; (2) health care sector's share of GNP will gradually increase from 10.6% in 1984 to 11.3% in 1990; and (3) government financing and private sector cost containment mechanisms will constitute a source of downward pressure on health care spending. Arnett & McKusick, *supra*, at 5-9. According to an analysis of Texas health care expenditures: (1) the annual growth rate of health care expenditures is higher in Texas than the national average; (2) the most rapidly growing item of expenditure is prepayment and administration for the operation of private third-party insurance programs, Medicaid, and the state portion of Medicare; and (3) 78% of prepayment and administrative expenditures go to

purchases are financed via third-party payors, typically on the basis of cost reimbursement.<sup>8</sup> Cost-based reimbursement mechanisms promote the phenomenon of "moral hazard," wherein insurance itself fuels increases in the cost of health care.<sup>9</sup> In response to rising health care costs, purchasers and providers have attempted to promote a more direct interest in cost containment on the part of participants in the health care marketplace.<sup>10</sup> Alternative health care finance and delivery systems<sup>11</sup> seek to reduce aggregate health care costs while maintaining access to quality health care by restructuring health care reimbursement to provide incentives for cost-effective service delivery.<sup>12</sup>

## II. STRUCTURE AND OPERATION OF PREFERRED PROVIDER ARRANGEMENTS

Preferred provider arrangements<sup>13</sup> represent an emerging form of alternative health care finance and delivery system.<sup>14</sup> Based on a series of contracts

private health insurance companies, representing the difference between premiums received and claims incurred. Begley & Mains, *supra*, at 33.

8. TDH HEALTH CARE PLAN, *supra* note 6, § XVII.

9. See Thurow, *Medicine v. Economics*, 313 NEW ENG. J. MED. 611, 612 (1985).

10. See B.N.A., HEALTH CARE COSTS: WHERE'S THE BOTTOM LINE? 1 (1986) [hereinafter B.N.A., BOTTOM LINE?] (outlines series of initiatives undertaken by purchasers and providers of health care services to contain costs); Levey & Hesse, *Bottom-Line Health Care?* 312 NEW ENG. J. MED. 644 (1985) (analyzes trend towards business-like health care management style); Thurow, *supra* note 9, at 612 (advocates prospective reimbursement system to promote payor and provider interest in cost containment).

11. See V. FUCHS, THE HEALTH ECONOMY 340-41 (1986). Fuchs observes that new reimbursement methods tend to lower costs for specific payors, replace payments for individual units of service with a single global payment, set reimbursement rates on a prospective basis, and require consumers to make more choices and accept increased financial responsibility. *Id.* For an analysis of selected alternative health care finance and delivery systems, see AMERICAN MED. ASS'N, AN INTRODUCTION TO ALTERNATIVE SYSTEMS OF HEALTH CARE DELIVERY (1983); MACDONALD, MEYER & ESSIG, HEALTH CARE LAW: A PRACTICAL GUIDE § 7.03[5] (1987) [hereinafter MACDONALD & MEYER]; Lemkin, *Alternative Delivery Systems: HMOs, PPOs, and CMPs*, 371 PRACT. L. INST. 231, 231-91 (1985).

12. For a definition of cost-effective health care service delivery, see Doubilet, Weinstein & McNeil, *Use and Misuse of the Term Cost-Effective in Medicine*, 314 NEW ENG. J. MED. 253, 253-56 (cost-effective means producing additional benefit worth additional cost).

13. Preferred provider arrangements are commonly referred to as preferred provider organizations (PPOs). The reference to an organization may constitute a misnomer. Commentators have proposed a variety of PPO definitions. "The PPO is not so much an organization as a technique for packaging or integrating health care services to be sold to bulk purchasers." Holmquest & James, *Preferred Provider Organizations—An Emerging Health Care Delivery System*, TEX. MED., Apr. 1985, at 57, 57.

In point of fact, most Preferred Provider Organizations are not organizations at all, from the physician's perspective. They are, instead, a contractual arrangement between health care providers (professional and/or institutional) and employers, insurance carriers or third-party administrators, to provide health care services to a defined population at established fees which may or may not be a discount from usual and customary or reasonable charges . . . .

AMERICAN MED. ASS'N, A PHYSICIAN'S GUIDE TO PREFERRED PROVIDER ORGANIZATIONS 3 (1983) [hereinafter AMA PHYSICIAN'S GUIDE].

14. The American Association of Preferred Provider Organizations (AAPPO) directory lists 674 operational preferred provider arrangements. *American Ass'n of Preferred Provider Orgs., Directory of Operational PPOs* (1987). Current statistics represent the consistent increase in PPA activity in recent years. The AAPPO directory reported 143 operational PPAs

between group purchasers of health care, health care providers, and underwriters of health care benefits,<sup>15</sup> preferred provider arrangements are designed to contain costs by promoting competition in the health care marketplace.<sup>16</sup> Six principal components comprise the preferred provider health care finance and delivery system: (1) a select panel of providers; (2) a negotiated fee-for-services reimbursement schedule; (3) an open panel service delivery system; (4) an incentive driven benefits package; (5) an aggressive program of utilization management; and (6) a quality assurance scheme.<sup>17</sup> By monitoring the price and effectiveness of services delivered, the components of the preferred provider health care finance and delivery system function to reduce the group purchaser's health care costs while maintaining quality health care service delivery.<sup>18</sup>

#### A. Component One: Select Provider Panel

The dynamics of the preferred provider contracting process enable purchasers to actively select efficient providers for participation in the system.<sup>19</sup> Selection criteria for professional providers may include price, effective practice management, proficient diagnosis and treatment skills, and a conserva-

---

in December, 1984, 325 PPAs in October, 1985, and 369 PPAs in October, 1986. See DiBlase, *Preferred Provider Organizations Evolve as Market Impact Expands*, BUS. INS., Feb. 16, 1987, at 3, 4.

15. Commentators regard the use of direct contracting for health care services as representative of a fundamental change in the way health care services are bought and sold. Boland, *The Role of Preferred Provider Contracting in the Healthcare Market*, in THE NEW HEALTHCARE MARKET: A GUIDE TO PPOs FOR PURCHASERS, PAYORS AND PROVIDERS 3 (P. Boland ed. 1985). [hereinafter NEW HEALTHCARE MARKET]. The prediction is that the contracting process will impact the way purchasers regard health care and the way providers regard business. *Id.* Specifically, the preferred provider contracting process will educate purchasers to the economics of health care delivery, enabling them to buy health care services with the same appreciation for efficiency and quality that they apply to the purchase of other goods and services. *Id.* The contracting process will produce a corresponding effect on health care providers by conditioning them to apply commercial priorities such as cost control and performance to the delivery of health care services. *Id.* at 4.

16. See *infra* note 18.

17. Analysts from the health care research firm InterStudy first outlined the defining characteristics of a preferred provider arrangement. See L. ELLWEIN & D. GREGG, AN INTRODUCTION TO PREFERRED PROVIDER ORGANIZATIONS (1982).

18. For empirical analyses of the operation and cost-effectiveness of PPA health care finance and delivery systems, see Billet & Cantor, *Employer's Experience With Preferred Provider Organizations*, COMPENSATION & BENEFITS MGMT., Autumn, 1985, at 21, 21-26 (survey of 140 employees' experiences with PPOs); Gabel, Ermann, Rice & de Lissovoy, *The Emergence and Future of PPOs*, 11 J. HEALTH POL. POL'Y & L. 305 (1986) [hereinafter Gabel & Ermann] (national telephone survey of 140 PPOs examines PPO activity in selected market segments as indicators of future trends in PPO organization and operation including cost containment devices); Hosek & Marquis, *Preferred Provider Organization Project* (study in progress 1984-1988 by Rand Corporation for Department of Health and Human Services) (documenting employer health care cost containment experience under preferred provider arrangements); Hester, Wouters & Wright, *Evaluation of a Preferred Provider Organization*, 65 MILBANK Q. 575-613 (1987) [hereinafter Hester & Wouters] (prepared for Robert Wood Johnson Foundation, Program for Research and Development on Health Costs) (case study evaluation of employer-sponsored PPA cost-effectiveness).

19. See AMA PHYSICIAN'S GUIDE, *supra* note 13, at 14-15; Enthoven, *An Economic Analysis of the "Preferred Provider Organization" Concept*, in NEW HEALTHCARE MARKET, *supra* note 15, at 94, 100-103.

tive pattern of resource utilization and referral.<sup>20</sup> Institutional provider selection factors may include price, optimum average lengths of stay, conservative medical staff utilization and referral patterns, and efficient administration.<sup>21</sup> As a fundamental element of the preferred provider health care system, the formation of an economical provider panel allows providers to promote health care cost containment prior to service delivery.

### B. Component Two: Negotiated Reimbursement

Comprising the second component of the preferred provider health care finance system, discounted provider reimbursement schedules complement panel composition as a mechanism for cost containment.<sup>22</sup> Negotiated provider price reductions constitute consideration for the potential increase in patient volume that accompanies PPA participation.<sup>23</sup> Moreover, provider discounts create the potential for purchaser cost savings by reducing the per-unit price of health care services delivered pursuant to preferred provider arrangements.<sup>24</sup>

### C. Component Three: Preferred Provider Benefits

The aggregate level of cost savings under a preferred provider arrangement depends on enrollee participation.<sup>25</sup> Accordingly, this component of the preferred provider health care finance system supplies enrollees with a financial incentive to obtain services from preferred providers. Financial incentives may include levels of coverage,<sup>26</sup> decreased cost sharing,<sup>27</sup> or guar-

20. See Enthoven, *supra* note 19, at 102-03.

21. See *id.* at 101-02.

22. See AMA PHYSICIAN'S GUIDE, *supra* note 13, at 16; Arnett & McKusick, *supra* note 7, at 7, 10.

23. PPA sponsors may set per-unit prices for physician services on the basis of usual, customary, and reasonable (UCR) charges or a relative value system. Rothenberg, *Healthcare Buyers' Approach to Selective Contracting*, in NEW HEALTHCARE MARKET, *supra* note 15, at 390, 399-400. UCR charges are literally the fee that an individual provider customarily charges for a particular service. *Id.* at 398. PPA organizers may negotiate for a straightforward discount from each UCR charge. *Id.* Alternatively, PPAs may set a single conversion factor that, when multiplied by a standard relative value unit assigned to each physician service, establishes the fee for each procedure. *Id.* at 399-400. Capitation constitutes a third option for physician service pricing. Boland, *Evaluation Criteria for Assessing Negotiated Provider Agreements: A Guide for Healthcare Purchasers*, in NEW HEALTHCARE MARKET, *supra* note 15, at 250, 268. PPA sponsors may set prices for hospital services on the basis of: (1) per patient day or per diem rates; (2) across the board or service-specific negotiated discounts from established hospital charges; (3) per case prices based on a prospectively determined rate; or (4) per capitation based on a predetermined rate for each covered beneficiary. *Id.* at 265-66; see also Leal, *Payor's Perspective on Reimbursement Methods Under a Preferred Provider Arrangement*, in NEW HEALTHCARE MARKET, *supra* note 15, at 459, 461-65. For an analysis of alternative methods of health care reimbursement, see MACDONALD & MEYER, *supra* note 11, § 7.02[2].

24. See *supra* note 23.

25. Hester & Wouters, *supra* note 18 (if PPA costs are 30% lower than costs of competitor plan, but PPA directs only 10% of total health care expenditures to its provider panel, then it will only reduce overall expenses by 3%).

26. See C. VADAKIN & Z. LIPTON, THE HEALTH INSURANCE ANSWER BOOK 119 (1986) (discussing alternate coverage levels as one form of incentive to utilize preferred providers).

27. Preferred provider health benefit plans typically pay a larger amount of the insured's

antees against balanced billing.<sup>28</sup> By promoting the use of cost-efficient preferred providers, incentive driven benefits packages potentially multiply purchaser cost savings.<sup>29</sup>

#### D. Component Four: Open Panel Service Delivery

In contrast to the closed system, health care delivery, and referral adopted by health maintenance organizations,<sup>30</sup> the open panel preferred provider health care delivery system permits insureds to obtain covered services from either panel or nonpanel providers.<sup>31</sup> Because insureds receive a basic level of coverage irrespective of the panel membership of the health care service provider, the preferred provider health care delivery system promotes flexibility in provider selection and referral.<sup>32</sup> Characterized as a "soft lock in" system,<sup>33</sup> the PPA open panel delivery system permits insureds to exercise a consumer's prerogative in purchasing health care services<sup>34</sup> and providers to exercise professional judgment in delivery health care services.<sup>35</sup>

#### E. Component Five: Utilization Management

Preferred provider contracts generally reimburse providers at set fees for individual units of service.<sup>36</sup> Under a conventional, fee-for-service reimbursement calculus, the quantity of services rendered remains a function of provider discretion.<sup>37</sup> As a result, in an open panel PPA, provider discounts represent only a partial solution for reducing health care costs. To reinforce cost containment, the utilization management component of the preferred provider health care delivery system monitors the quantities of health care resources expended by panel providers.<sup>38</sup>

---

expenses when the insured obtains services from a preferred provider. *Id.* Preferred provider plans decrease an insured's expenses by varying deductible and coinsurance amounts. *Id.* Under an incentive plan, the third-party payor retains the standard deductible and coinsurance level for nonpreferred provider reimbursement, but decreases the level for preferred provider reimbursement. *Id.* Under a punitive plan, the third-party payor retains the deductible and coinsurance level for preferred provider reimbursement, but increases the level for nonpreferred provider reimbursement. *Id.*

28. See Maturi & Raichel, *Preferred Provider Arrangements: Market and Delivery System Perspectives*, in *NEW HEALTHCARE MARKET*, *supra* note 15, at 19, 25 (preferred providers may agree to accept per unit benefit program payment levels as payment in full for services delivered to enrollees).

29. Gabel & Ermann, *supra* note 18, at 307.

30. Hereinafter referred to in the text and notes alternatively as health maintenance organizations or HMOs. For discussion of the HMO health care service delivery system, see MACDONALD & MEYER, *supra* note 11, § 7.03[5]; Lemkin, *supra* note 11, at 1-27.

31. Enthoven, *supra* note 19, at 95-96.

32. See *supra* notes 26-29 and accompanying text.

33. Enthoven, *supra* note 19, at 96.

34. *Id.*

35. *Id.*

36. See *supra* note 23.

37. Fee-for-service medicine is regarded as a hallmark of professional autonomy. See P. STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 25 (1982).

38. Recent PPA studies indicate that utilization review constitutes the primary mechanism for cost control under preferred provider arrangements. See HEALTH RESEARCH INST., 1985 HEALTH CARE COST CONTAINMENT SURVEY 2 (1986); Gabel & Ermann, *supra* note 18, at 312; see also DiBlase, *Utilization Review Programs Paying Off*, *BUS. INS.*, Feb. 16, 1987, at



PPA utilization management programs may be administered on a delegated basis by the sponsoring entity,<sup>39</sup> or participating provider,<sup>40</sup> on a nondelegated basis by a peer review organization<sup>41</sup> or private review corporation.<sup>42</sup> In order to eliminate the incentive for maximizing reimbursement through over-utilization,<sup>43</sup> utilization review personnel screen treatment decisions during the course of service delivery to determine whether the treatment is medically necessary and, if so, whether the treatment is being properly administered.<sup>44</sup> Conducted at each stage in the delivery process, utilization review is designed to ensure that care is being delivered at an appropriate facility, by an appropriate health care professional, using appropriate resources, over an appropriate period of time.<sup>45</sup> A comprehensive utilization management program for an inpatient hospital stay, therefore, may include preadmission certification,<sup>46</sup> admission review,<sup>47</sup> concurrent treatment review,<sup>48</sup> continued stay review,<sup>49</sup> and discharge planning.<sup>50</sup>

---

32, 32-34 (prevalence and effectiveness of utilization review mechanisms as component of traditional and alternative health care delivery systems). Utilization review mechanisms may be prospective, concurrent, or retrospective. For empirical analyses of the effectiveness of various methods of utilization review, see Cleary & Jette, *The Validity of Self-Reported Physician Utilization Measures*, 22 MED. CARE 796 (1984); Eisenberg, *Physician Utilization—The State of Research About Physician's Practice Patterns*, 23 MED. CARE 461 (1985); Garg, Kleinberg, Schmitt & Baransky, *A New Methodology for Ancillary Services Review*, 23 MED. CARE 809 (1985); Jackson & Blank, *Utilization Reporting System Facilitates Physician Practice Analysis*, J. AMBULATORY CARE MGMT., Feb. 1986, at 16, 23-29; Mushlin, *Cost Containment Opportunities in Medicine*, 4 QUALITY REV. BULL. 378 (1985). For a further discussion of utilization review methods, see *infra* notes 39-50.

39. See Anthony, *PPOs: Will They Compromise Quality of Care?*, PHYSICIAN'S MGMT., Dec. 1985, at 76, 90; see also AMA PHYSICIAN'S GUIDE, *supra* note 13, at 19.

40. See Anthony, *supra* note 39, at 90; see also AMA PHYSICIAN'S GUIDE, *supra* note 13, at 19.

41. See Dans, Weiner & Otter, *Peer Review Organizations: Promises and Potential Pitfalls*, 313 NEW ENG. J. MED. 1131 (1985); cf. *Finding the Insurers: What's TMF All About?* TEX. MED., Feb. 1986, at 66, 66-69 (interview with chief executive officer of Texas Medical Foundation, designated state peer review organization).

42. See Anthony, *supra* note 39, at 87; see also AMA PHYSICIAN'S GUIDE, *supra* note 13, at 19.

43. See Oehm, *Utilization Review Methods and Incentives*, in NEW HEALTHCARE MARKET, *supra* note 15, at 298, 309 (exhibit presents provider incentives for overutilization as function of identified market characteristics).

44. See *id.* at 300.

45. See *id.* at 301-11.

46. To reduce unnecessary hospitalization, providers and patients subject to preadmission certification must submit diagnostic information or planned procedures to a review organization before entering the hospital or receiving any treatment. *Id.* at 301.

47. After the patient is admitted to the hospital under an arrangement requiring admission review, a representative conducts a patient record review to determine whether the admission is medically necessary and appropriate. *Id.* at 302.

48. Concurrent treatment review monitors the utilization of health care services during the course of treatment. *Id.* at 302-03; Masciantonio, *Business Requirements for Implementing PPOs*, in NEW HEALTHCARE MARKET, *supra* note 15, at 756, 761. Persons conducting concurrent treatment review may recommend an accelerated discharge schedule or transfer to an intermediate care facility. *Id.* at 761.

49. Designed to minimize the length of hospital stay, continued stay review assesses the patient's continued hospitalization for medical necessity and appropriateness. Oehm, *supra* note 43, at 302-03.

50. To facilitate timely discharge, allied health personnel may coordinate transfer to an intermediate care facility or the delivery of home health care services. *Id.* at 303.

### F. Component Six: Quality Assurance

Preferred provider arrangements purport to facilitate the cost-effective delivery of high quality health care services.<sup>51</sup> To delivery quality guarantees, the quality assurance component of the preferred provider health care delivery system is designed to ensure that health care services rendered by participating providers meet acceptable professional standards.<sup>52</sup> PPAs may perform quality assurance activities on a delegated or nondelegated basis. PPAs employing delegated quality assurance mechanisms use participating providers to assess the quality of health care services.<sup>53</sup> PPAs utilizing nondelegated quality assurance mechanisms conduct quality assurance activities through an independent peer review organization.<sup>54</sup>

## III. MODELS OF PREFERRED PROVIDER ARRANGEMENTS

Preferred provider contract negotiations provide participants with an opportunity to bargain for payment and delivery terms in advance of treatment. Because each participant brings a unique set of concerns to the health care bargaining table,<sup>55</sup> the resulting finance and delivery agreements take a variety of forms. Variations in the financing and delivery of health care services under certain preferred provider arrangements permit the articulation of four distinct PPA models.<sup>56</sup> Factors that contribute to the categorization of PPAs include: (1) the identity of the entity that initiates provider contracting; and (2) the extent to which that entity underwrites the financial risk of providing health care benefits.<sup>57</sup> Based on these factors, PPAs may be broadly classified as either preferred provider networks, entrepreneur-based

---

51. Larson, *The Jury Is Still Out: Do PPOs Practice Quality Medicine?*, PHYSICIAN'S MGMT., Feb. 1985, at 298, 308 (PPA movement is built on provision of quality health care services).

52. For an analysis of alternative methods for measuring quality of care, see Brook & Lohr, *Efficiency, Effectiveness, Variations, and Quality*, 23 MED. CARE 710 (1985); Donabedian, *The Definition of Quality and Approaches to its Assessment*, in 1 EXPLORATIONS IN QUALITY ASSESSMENT AND MONITORING (1980); Johnston, *Measuring the Quality of Care*, TEX. MED., Jan. 1988, at 38; Merry, *What Is Quality Care? A Model for Measuring Health Care Excellence*, 6 QUALITY REV. BULL. 298, 298-301 (1987); Reinhardt, *Quality of Care in Competitive Markets*, BUS. & HEALTH, July-Aug. 1986, at 7, 7-9.

53. Larson, *supra* note 51, at 308 (PPA evaluates physician performance on basis of American Medical Association (AMA) standards).

54. See *supra* note 41.

55. Purchaser incentives to participate in PPAs include (1) the potential for cost savings and (2) the ability to offer enhanced benefits to insureds such as lower out-of-pocket expenses, increased coverage, and access to high quality providers. Flachbart, *Organizing and Developing a PPO*, in NEW HEALTHCARE MARKET, *supra* note 15, at 529, 531. Provider incentives to participate in PPAs include: (1) maintenance or increase in market share; (2) retention of fee-for-service reimbursement structure; (3) efficient claims payment; and (4) development of a mechanism to foster other cooperative ventures among providers. *Id.* at 531.

56. To facilitate an evaluation of the laws and regulations governing one type of preferred provider arrangement, this Comment defines PPA models using both a functional and a structural approach. Accordingly, this Comment's definitional framework incorporates certain aspects of a functionally oriented PPA classification system designed by Peter N. Grant and a structurally oriented system designed by Peter Boland. See Boland, *supra* note 23, at 262-64; Grant, *Redefining Preferred Provider Contracting Models*, in NEW HEALTHCARE MARKET, *supra* note 15, at 38, 39-43.

57. Grant, *supra* note 56, at 38-43.

preferred provider arrangements, purchaser-based preferred provider arrangements, or preferred provider health benefit plans.

### A. Preferred Provider Networks

A preferred provider network consists of a group of professional and institutional health care providers that coordinate services to offer a system of care to group purchasers.<sup>58</sup> Members of a preferred provider network may incorporate to form an integrated service corporation<sup>59</sup> that offers a product that includes discounted health care services, comprehensive utilization and quality controls, and administrative and marketing services.<sup>60</sup> The service corporation may contract with an entrepreneur, a self-insured employer, or an insurance carrier to serve as the provider component of an entrepreneur or purchaser-based PPA or a preferred provider health benefit plan.<sup>61</sup>

#### 1. Physician-Sponsored Preferred Provider Networks

Physician-sponsored preferred provider networks purport to assemble health care professionals committed to the delivery of cost effective high quality medical care.<sup>62</sup> Network coordinators emphasize provider selection<sup>63</sup> and stringent utilization review<sup>64</sup> as mechanisms for cost control. Physician networks generally focus on the provision of ambulatory care services.<sup>65</sup> As a result, they often elect to use an intermediary to establish necessary hospital arrangements.<sup>66</sup> Physician networks traditionally finance service delivery by entering into contracts with self-insured employers or in-

---

58. *Id.* at 42.

59. Brook & Anthony, *Provider Inducement in Selective Contracting*, in *NEW HEALTHCARE MARKET*, *supra* note 15, at 543, 554.

60. *Id.*

61. *Id.* at 551; Adams-Ryan, Peddecord & Root, *Operational and Legal Implications of Preferred Provider Organizations*, *HOSP. & HEALTH SERVS. ADMIN.*, May-June, 1985, at 44, 47 [hereinafter Adams-Ryan & Peddecord]. Preferred provider network formation produces a cooperative business venture among potential competitors that raises substantive antitrust issues. For an analysis of the antitrust implications of preferred provider networking, see Classen, *Provider-Based Preferred Provider Organizations: A Viable Alternative Under Present Federal Antitrust Policies?* 66 *N.C.L. REV.* 253, 254-81 (1988); Elden & Hinden, *Legal Issues in Creating PPOs*, 1 *J.L. & HEALTH* 1, 2-22 (1987); Finke & Gary, *Physicians and PPOs: Antitrust Lessons From Maricopa*, *HOSP. MED. STAFF*, July, 1983, at 10, 10-15; Perkins, Mercer & McClary, *Monopolies, Maricopa, and Marketing: A Case Study*, *HOSP. & HEALTH SERVS. ADMIN.*, July-Aug. 1986, at 34, 34-44; J. McGrath, Remarks at the American Bar Association Antitrust Spring Meeting Concerning Preferred Provider Organizations and the Antitrust Laws (Mar. 22, 1985).

62. For a case study of the leading physician sponsored preferred provider network, see Zalta, *Case Study: CaPP CARE Fountain Valley, California*, in *NEW HEALTHCARE MARKET*, *supra* note 15, at 966, 966-74; see also *Physician Cost Cuts Spur PPO Success*, *HOSP.*, Mar. 16, 1985 at 65, 65 [hereinafter *PPO Success*].

63. See Anthony, *supra* note 39, at 83; Zalta, *supra* note 62, at 969.

64. See Zalta, *supra* note 62, at 969 (program of cost containment under which 1,300 surgical procedures must be performed on outpatient basis and 1,700 elective surgical procedures require pretreatment authorization); see also Frederick, *The Buck Stops With These Doctors—And They Like It*, *MED. ECON.*, Aug. 19, 1985, at 73, 74-82.

65. *PPO Success*, *supra* note 62, at 65.

66. *Id.*

insurance carriers.<sup>67</sup> The insurance carrier usually generates the appropriate reimbursement schedule and offers it to network physicians on an individual or network basis.<sup>68</sup>

## 2. Hospital-Sponsored Preferred Provider Networks

An individual hospital,<sup>69</sup> groups of hospitals within a particular market,<sup>70</sup> or constituents of multi-hospital chains<sup>71</sup> may organize preferred provider networks. Hospitals generally establish the networking body as a separate corporation.<sup>72</sup> The corporation first enters into contracts with the hospital and its medical staff to secure administrative and clinical services.<sup>73</sup> Based on these contracts, the corporation then negotiates with group purchasers to provide hospital and medical services to their enrollees.<sup>74</sup>

### B. Entrepreneur-Based Preferred Provider Arrangements

A third-party administrator<sup>75</sup> or an independent investor<sup>76</sup> may coordinate the formation and operation of an entrepreneur-based preferred provider arrangements. Entrepreneurs form PPAs by matching providers that agree to a reduced reimbursement schedule and utilization review with group purchasers that assume the financial risk of underwriting health care benefits and supply enrollees.<sup>77</sup> Under the direction of a PPA administrator, an entrepreneur-based PPA operates to offer providers and enrollees group-

---

67. See *infra* notes 74, 79.

68. *Id.*; see also Zalta, *supra* note 62, at 971 (chart delineates contractual relationships in physician-sponsored preferred provider arrangements).

69. See Travella, *Hospitals Turn to PPOs to Bolster Business*, BUS. INS., July 22, 1985, at 31, 31; Trauner & Hunt, *Hospitals That Contract With PPOs: Who Are They?*, BUS. & HEALTH, Mar. 1986, at 30, 30-33.

70. See *Hospital's Rising Admissions Linked to PPA Contracting*, HOSPS. June 1, 1985, at 45, 45 (discussing Long Beach, California based Memorial Health Services); Travella, *supra* note 69, at 31.

71. See Barkholz, *Investors-Owned Chains in Race to Introduce Insurance Products*, MOD. HEALTHCARE, Jan. 31, 1986, at 50, 50; Gabel & Ermann, *supra* note 18, at 316-18; Plant, *Risky Business: PPOs Present Greater Financial, Actuarial Risk for Sponsoring Multis*, MULTIS, Mar. 1, 1984, at 44, 44-50. But see DiBlase, *Competition Forces AMI to Shutter Fledging PPO*, BUS. INS., Sept. 1, 1986, at 2, 2 (multi discontinues preferred provider group health product).

72. See Roebel, Knowlton & Rosenberg, *Hospital Sponsored Preferred Provider Organizations*, 12 L. MED. & HEALTHCARE 204, 205 (1984) (outlines business and legal issues relating to formation of hospital-sponsored PPAs).

73. *Id.* See generally, AMERICAN HOSP. ASS'N, HMO/PPO SELECTIVE CONTRACTING: ISSUES FOR HOSPITALS (1985) (outlines hospital strategy for participation in PPOs, methods for evaluating PPO contract provisions); Blacker & Mickelson, *Negotiating Contracts with PPOs*, HEALTHCARE FIN. MGMT., Sept. 1983, at 48, 48-50 (outlines potential contract issues including rate arrangements, utilization review procedures, closed staff PPAs); Feller, *Contracting Guidelines for Hospitals*, HEALTHCARE FIN. MGMT., Feb. 1985, at 79, 79-80 (lists thirty suggested questions relating to negotiation of preferred provider contracts).

74. Richman, *Hospitals Should Mull Implications of HMO, PPO Contracts—Experts*, MOD. HEALTHCARE, July 5, 1985, at 38, 40.

75. DiBlase, *supra* note 14, at 6 (discusses PPA contracting activities of third-party administrator, Admar Corp.).

76. See Jasper, *Case Study: Benefit Panel Services, Los Angeles, CA*, in NEW HEALTHCARE MARKET, *supra* note 15, at 1035, 1035-43.

77. Boland, *supra* note 23, at 264.

specific utilization review, claims processing, actuarial reporting systems, financial and accounting services, and planning mechanisms.<sup>78</sup>

### C. Purchaser-Based Preferred Provider Arrangements

Large employers and labor organizations increasingly opt to insure employee health care expenditures from corporate earnings or trust fund contributions.<sup>79</sup> As group purchasers of health care that have elected to assume the financial risk of underwriting health care benefits, self-insured employers,<sup>80</sup> business coalitions,<sup>81</sup> and union trusts<sup>82</sup> may contract directly with individual providers or members of a provider network to form preferred provider arrangements. Self-insured employee benefit plans may purchase "stop loss" insurance coverage to fund claims that exceed the limit of its financial resources<sup>83</sup> or may retain an insurance company on an administrative services only basis.<sup>84</sup>

### D. Preferred Provider Health Benefit Plans

Selective provider contracting by an insurer offering a preferred provider health benefit plan constitutes an alternate model for structuring preferred provider arrangements. Commercial insurance companies, hospital and medical service corporations, or public entities may initiate provider contracting.

#### 1. Commercial Insurance Plans

A commercial insurance carrier may enlist institutional and professional health care providers on an individual basis or as members of existing preferred provider networks to render services to insureds at predetermined

---

78. Trombly, *Administrative Information Services*, in *NEW HEALTHCARE MARKET*, *supra* note 15, at 737, 740-41.

79. See TEXAS HOUSE OF REP. COMM. ON INS., *THE IMPACT OF ERISA ON GROUP HEALTH BENEFITS* 1, n.2 (1985) (traces trend toward self-insured employee health benefit plans).

80. See, e.g., B.N.A., *BOTTOM LINE?*, *supra* note 10, at 47 (case study of Humana Inc. modified PPA health care plan for employees); Flagg, *Case Study: The Stouffer Corp.*, in *NEW HEALTHCARE MARKET*, *supra* note 15, at 1070, 1072-76 (case study of Stouffer Corp. medical and dental PPA health care plan for employees); Hester & Wouters, *supra* note 18, at 575-613 (case study of Security Pacific Health Care Plan, PPA formed by Security Pacific National Bank); see also Bradford, *Anxious Employers Jump Feet First into PPOs*, *BUS. INS.* July 22, 1985, at 28, 28-30 (overview of employer-based PPAs).

81. See, e.g., B.N.A., *BOTTOM LINE?* *supra* note 10, at 9, 9 (nine case studies of health care coalition PPAs); Colasanto, *Coalition Perspective*, *GROUP PRAC.* J. May-June, 1984, at 16, 16-22 (case study of Community Care Network, PPA formed by San Diego Employers Health Care Coalition); Weiner, *The Politics of Building an Effective PPO Network*, *BUS. & HEALTH*, Mar. 1986, at 34, 34-37 (case study of South Florida Health Action Coalition PPA network development).

82. See B.N.A., *BOTTOM LINE?* *supra* note 10, at 69 (case study of Team Care, PPA formed by Teamsters Central States Southeast and Southwest Areas Health and Welfare Fund), 70 (case study of New Jersey Operating Engineers Local 825 PPA).

83. See Bradford, *supra* note 80, at 30.

84. See Maturi & Raichel, *supra* note 28, at 28 (discusses insurance product "unbundling").

rates.<sup>85</sup> In exchange for the payment of monthly premiums, commercial insurers indemnify insureds in the event that they require health care services.<sup>86</sup> Generally offered as an option to traditional fee-for-service indemnity plans, preferred provider plans are structured to establish an incentive for the use of preferred providers by featuring different benefit levels for services obtained from preferred and nonpreferred providers.<sup>87</sup> A commercial insurer may conduct its own utilization review.<sup>88</sup> Alternatively, an insurer may arrange for health care providers or third-party entities to conduct utilization review.<sup>89</sup>

## 2. *Blue Cross and Blue Shield Plans*

Hospital and medical service corporations are nonprofit entities that engage in direct contracting with health care providers for the provision of hospital and medical services to their subscribers.<sup>90</sup> Hospital and medical service corporations provide health care benefits to subscribers in exchange for periodic payments.<sup>91</sup> Under the resulting arrangement, termed a service benefit plan, providers obtain direct reimbursement from the third-party payor.<sup>92</sup> Blue Cross and Blue Shield plans represent notable examples of these direct coverage service benefit plans.<sup>93</sup> While Blue Cross and Blue Shield plans have engaged actively in non-selective provider contracting for over fifty years,<sup>94</sup> the Blues have also undertaken a substantial role in the development of selective provider contracting pursuant to preferred provider arrangements.<sup>95</sup>

---

85. See Greenberg, *Case Study: Massachusetts Mutual Life Insurance Company*, in *NEW HEALTHCARE MARKET*, *supra* note 15, at 1044, 1044-56 (case study of Preferred Plus, PPA formed by Massachusetts Mutual Life Insurance Company); Kastiel, *Insurers Forming PPOs to Meet Client's Demand*, *BUS. INS.*, July 22, 1985, at 24, 36 (comprehensive survey of Prudential, Metropolitan Life, Transamerican, and Aetna PPA activity).

86. See W. MEYER, *LIFE AND HEALTH INSURANCE LAW* §§ 2:3, :12 (1972 & Pam. Supp. 1987).

87. See C. VADAKIN & Z. LIPTON, *supra* note 26, at 119.

88. See Kastiel, *supra* note 85, at 40 (discusses Precert, Aetna's utilization review program).

89. *Id.* at 41 (discusses John Hancock utilization review program).

90. See 2 *COUCH ON INSURANCE* § 18:50 (rev. ed. 1984 & Supp. 1987) [hereinafter *COUCH*]. Hospital and medical service corporations operate subject to strict state regulation specifying acceptable benefits, provider contract terms, rate schedules, and corporate reserve requirements. See *Group Hospital Service Nonprofit Corporations Act*, *TEX. INS. CODE ANN.* arts. 20.01-.21 (Vernon 1981 & Supp. 1988).

91. See 2 *COUCH*, *supra* note 90, § 18:50.

92. *Id.*

93. See *BLUE CROSS & BLUE SHIELD ASS'N, QUESTIONS AND ANSWERS ABOUT THE BLUE CROSS & BLUE SHIELD ORGANIZATION* (1987) [hereinafter *BLUE CROSS & BLUE SHIELD Q&A*]. Blue Cross is comprised of 63 independent organizations that provide subscribers with prepaid hospital and other institutional services, outpatient care, and home care. *Id.* at 2. Blue Shield is comprised of 65 organizations that provide prepaid physician services and may provide dental and vision services. *Id.*

94. *Id.* at 1, 4; see P. STARR, *supra* note 37, at 295-310 (chronicles "the birth of Blues," 1929-1945).

95. See *BLUE CROSS & BLUE SHIELD Q&A*, *supra* note 93, at 8-9. Fifty-six Blue Cross and Blue Shield Plans, enrolling eight million persons, currently offer a preferred provider product. *Id.* at 9; see also Gabel & Ermann, *supra* note 18, at 308-10 (survey indicates increase in payor sponsored preferred provider arrangements due to accelerated PPA activity among

### 3. State-Sponsored Plans

In an effort to contain spiraling health care costs,<sup>96</sup> California enacted legislation<sup>97</sup> in 1982 that enabled Medi-Cal to negotiate contracts for the inpatient care of its beneficiaries<sup>98</sup> and allowed private insurers and Blue Cross to contract with hospitals and physicians for "alternate rates of pay."<sup>99</sup> Designed to promote competition in the market for health care services, the California system for state-sponsored selected provider arrangements legitimized the practice of direct contracting with health care providers by entities that assume the financial risk of underwriting health care benefits.<sup>100</sup>

---

Blues); Richman, *Blues Cooperation, Innovation Key to Retaining Industry Position*, MOD. HEALTHCARE, Jan. 31, 1986, at 40, 44-45 (analyzes Blues' competitive PPA development activity). For an analysis of selected Blue Cross & Blue Shield PPAs, see Kastiel, *supra* note 85, at 36 (discusses Preferred Care of Kansas City and Key Care of Virginia); Parcell, *Case Study: Blue Shield Preferred Plan—Blue Shield of California*, in NEW HEALTHCARE MARKET, *supra* note 15, at 1026, 1026-34 (case study of Blue Shield Preferred Plan).

96. Several factors contributed to the rise of selective contracting in response to the California health care crisis, including: (1) 20% inflation in hospital costs; (2) the issuance of health benefit policies by private insurers operating at losses; (3) requirements of the Omnibus Budget Reconciliation Act of 1981 that made waivers from Medicaid regulations requiring freedom of choice easier to obtain; and (4) a decreased Medi-Cal budget resulting from a reduction in state tax revenues due to economic recession. Johns, *Case Study: Selective Contracting In California*, in NEW HEALTHCARE MARKET, *supra* note 15, at 948-49.

97. For a discussion of the politics surrounding the enactment of the Medi-Cal reform package, see Bergthold, *Crabs in a Bucket: The Politics of Health Care Reform in California*, 9 J. HEALTH POL. POL'Y & L. 203, 206-15 (1984).

98. See Cal. A.B. 799, 1982 Leg. (codified as amended in scattered sections of CAL. HEALTH & SAFETY CODE) (establishing position of special negotiator appointed by governor authorized to contract with hospitals for inpatient care of Medi-Cal beneficiaries); Cal. S.B. 2012, 1982 Leg. (codified as amended in scattered sections of CAL. BUS. & PROF. CODE, CAL. GOV'T CODE, CAL. HEALTH & SAFETY CODE, CAL. INS. CODE, CAL. WELF. & INST. CODE) ("clean up" bill exempts special negotiator from disclosure required for all state proceedings). Assembly Bill 799 and Senate Bill 2012 called for the appointment of a special negotiator for the term of one year who was accorded maximum discretion and flexibility to contract with providers for inpatient care of Medi-Cal beneficiaries. For a chronology of the activities of the "Medi-Cal Czar" see Johns, *supra* note 96, at 951.

99. See Cal. A.B. 3480, 1982 Leg. (codified in scattered sections of CAL. HEALTH & SAFETY CODE, CAL. INS. CODE, CAL. WELF. & INST. CODE) (overriding freedom of choice provisions; insurers and Blue Cross authorized to negotiate and enter into contracts with hospitals and physicians for alternate rates of pay).

100. See Melia, *Competition in the Healthcare Marketplace: A Beginning in California*, 308 NEW ENG. J. MED. 788, 788-92 (1983). For a comprehensive analysis of the origin, impact, and policy implications of California's contracting legislation, refer to the series of reports compiled by the National Governors Association and the John A. Hartford Foundation. NATIONAL GOVERNORS ASS'N, SELECTIVE CONTRACTING FOR HEALTH SERVICES IN CALIFORNIA: FIRST REPORT (1984) (addresses enabling legislation, first year of implementation, and initial impact of legislation on hospitals and insurance companies); NATIONAL GOVERNOR'S ASS'N, SELECTIVE CONTRACTING FOR HEALTH SERVICES IN CALIFORNIA: AN UPDATE (1984) (addresses changes in Medi-Cal contracting, changes in legislation, and statistical trends in hospital utilization, costs, and revenue); NATIONAL GOVERNOR'S ASS'N, SELECTIVE CONTRACTING FOR HEALTH SERVICES IN CALIFORNIA: FINAL REPORT (1985) (addresses legislation, Round Two Medi-Cal Contracting, impact of contracting on hospital sector, health insurance marketplace, employee benefits, and statewide health care delivery).

#### IV. REGULATION OF PREFERRED PROVIDER HEALTH BENEFIT PLANS

The Texas Preferred Provider Plan Rules adopted by the State Board of Insurance authorize commercial insurers to form preferred provider arrangements and to offer insureds who obtain health care services from preferred providers an alternate level of coverage under preferred provider health benefit plans.<sup>101</sup> Presently, twenty-six states have enacted statutes or regulations that similarly enable insurers to issue preferred provider health benefit plans.<sup>102</sup> To assist states that have not yet pursued independent legislative or administrative action, the National Association of Insurance Commissioners recently adopted model legislation that provides a framework for the regulation of preferred provider arrangements and preferred provider health benefit plans.<sup>103</sup>

The Texas Preferred Provider Plan Rules attempt to facilitate the development of preferred provider arrangements as an alternative health care fi-

101. For a discussion of the Texas Preferred Provider Plan rulemaking process, see *supra* note 5.

102. Ark. Ins. Bull. 9-85 (May 10, 1985); Ark. Ins. Bull. 9-85A (July 18, 1985); CAL. INS. CODE §§ 10133-10133.6, 10402-10402.1, 11512-11512.05, 14165-14165.10 (West 1972 & Supp. 1988); CAL. ADMIN. CODE tit. 10, §§ 2240-2240.4 (1984); FLA. STAT. ANN. §§ 626.9541(2), 627.6375, 627.6695 (West 1984 & Supp. 1988); ILL. ANN. STAT. ch. 73, ¶¶ 982f-q (Smith-Hurd Pam. Supp. 1988); ILL. ADMIN. CODE tit. 50, §§ 6501.10-100 (1986); IND. CODE ANN. §§ 27-8-11-1 to -4 (Burns 1986 & Supp. 1987); IOWA CODE ANN. § 515.48(5)(a) (West 1988); KAN. STAT. ANN. § 40-231(a), (b)(3) (1986); KAN. INS. BULL. 1985-16 (June 24, 1985); 806 KY. ADMIN. REGS. 18:020 (1986); LA. REV. STAT. ANN. §§ 40:2201-:2204 (West Supp. 1988); ME. REV. STAT. ANN. tit. 24-A, §§ 2670-2679 (Supp. 1987); MD. ANN. CODE art. 48A, §§ 354EE, 477FF (1986 & Supp. 1987); MICH. COMP. LAWS ANN. §§ 550.51-63 (West Supp. 1988); MINN. STAT. ANN. § 72A.20, subd. 15(4) (West 1986 & Supp. 1988); MONT. CODE ANN. §§ 33-22-1701 to 33-22-1707 (1987); NEB. REV. STAT. §§ 44-4101 to -4113 (1984); N.H. REV. STAT. ANN. §§ 420-C:1 to :7 (Supp. 1987); N.C. GEN. STAT. §§ 57-16.1, 58-260.6 (Supp. & Pam. Supp. 1987); N.D. CENT. CODE §§ 26.1-47-01 to 26.1-47-07 (Supp. 1987); OR. REV. STAT. § 743.531(3) (Supp. 1987); PA. STAT. ANN. tit. 40, § 764a (Purdon Pam. Supp. 1988); 31 PA. CODE §§ 152.1-.25 (1987); S.D. CODIFIED LAWS ANN. §§ 36-5-14.3, 36-26-17.1, 36-27A-23.1, 58-41-15.1 (Supp. 1988); 28 TEX. ADMIN. CODE §§ 3.3701-3705 (1986); UTAH CODE ANN. § 31A-22-617 (1986); VA. CODE ANN. § 38.2-3407 (1986); WIS. STAT. ANN. §§ 609.20, 628.36(2)(a) (West Supp. 1987); WIS. ADMIN. CODE § Ins. 3.48(1)-(5) (1986); WYO. STAT. §§ 26-22-501 to 26-22-503 (Supp. 1987); see also Act effective July 1, 1988, 1988 Ga. Laws 1483 (to be codified at GA. CODE ANN. §§ 33-30-20 to -27) (applies to health benefit plans issued, delivered, or renewed on or after Jan. 1, 1989).

For recent compilations of state laws and regulations relating to preferred provider arrangements, see AMERICAN ASS'N OF PREFERRED PROVIDER ORGS., STATE BY STATE LEGISLATIVE OVERVIEW (1986); DEPT. OF STATE LEGIS., AMERICAN MED. ASS'N, SELECTED PPO STATUTES (1985); R. HINDER & K. LEPAK, SUMMARY OF PPO LEGISLATION ON A STATE LEVEL (1987) (prepared for AAPPO); OFFICE OF GEN. COUNSEL, AMERICAN HOSP. ASS'N, LEGAL MEMORANDUM NO. 8, REGULATION OF PREFERRED PROVIDER ORGANIZATIONS: A LEGAL GUIDE FOR HOSPITAL EXECUTIVES (1986); E. ROLPH, J. RICH, P. GINSBURG, S. HOSEK, K. KEENAN, & G. GERTLER, STATE LAWS AND REGULATIONS GOVERNING PREFERRED PROVIDER ORGANIZATIONS (1986) [hereinafter *FTC STUDY*] (prepared by Rand Corporation for Department of Health and Human Services and Federal Trade Commission).

103. See Preferred Provider Arrangements Model Act (National Ass'n Ins. Comm'rs 1987) [hereinafter referred to in text and notes as *NAIC Model Act*]; see also H.R. 733, 99th Cong., 1st Sess., 131 CONG. REC. H167 (1985) (proposed federal legislation would have permitted group health care payors to negotiate and contract for alternate rates of payment with health care providers and to offer alternate rates to beneficiaries electing to receive services from participating providers; legislation would have expressly overridden any conflicting state law or regulation).



nance and delivery system while protecting the interests of both providers and consumers of health care services.<sup>104</sup> To ensure broad provider participation, the Texas rules require insurers to offer all health care providers an opportunity to participate in a preferred provider panel<sup>105</sup> and prescribe acceptable preferred provider contract terms and conditions.<sup>106</sup> To protect insureds from discrimination and to guarantee freedom of provider choice, the rules limit the differential in benefits applicable to health care services rendered by preferred and nonpreferred providers<sup>107</sup> and regulate provider referral<sup>108</sup> and emergency service delivery protocol.<sup>109</sup> Furthermore, the rules require that preferred provider arrangements set forth specific complaint resolution procedures<sup>110</sup> and incorporate a series of other consumer protection measures.<sup>111</sup> Finally, in a direct effort to promote the delivery of high quality, cost-effective health care services for the benefit of both providers and consumers, the rules set forth guidelines for provider participation in utilization review<sup>112</sup> and quality assurance procedures.<sup>113</sup>

#### A. Scope of the Regulation

The State Board of Insurance limited the scope of the Texas Preferred Provider Plan Rules to preferred provider health benefit plans based on contracts between commercial insurers<sup>114</sup> and health care providers.<sup>115</sup> Preferred provider networks that contract with certain health care purchasers, preferred provider arrangements sponsored by third-party entities and self-insured labor organizations or employers, and preferred provider health benefit plans sponsored by health care service corporations and public entities fall outside the scope of the Texas rules.<sup>116</sup> The rules apply only to group health insurance policies<sup>117</sup> that permit insureds to receive a higher level of coverage for health care services obtained from preferred professional and institutional providers.<sup>118</sup>

---

104. See 28 TEX. ADMIN. CODE §§ 3.3701-.3705 (1986). For an analysis of the final version of the Texas Preferred Provider Plan Rules prepared immediately prior to their publication in the Texas Register, see Wood, Luksinger & Epstein, *Texas State Board of Insurance Adopts New Rules Governing Insured Preferred Provider Plans*, TEXAS ALERT (June 16, 1986) [hereinafter WLE TEXAS ALERT].

105. 28 TEX. ADMIN. CODE §§ 3.3703(1), (3), 3.3704(8) (1986).

106. *Id.* § 3.3703(2).

107. *Id.* § 3.3704(1).

108. *Id.* §§ 3.3703(3), 3.3704(4).

109. *Id.* § 3.3704(4).

110. *Id.* § 3.3705(2).

111. *Id.* § 3.3704(5), (6).

112. *Id.* § 3.3705(4).

113. *Id.* § 3.3705(3).

114. See *id.* § 3.3702 (insurer includes any life, health, accident, or health and accident insurance company authorized to issue or deliver health insurance policies approved under art. 3.422 of Insurance Code).

115. See *id.* (preferred provider includes physician, nonphysician practitioner, hospital or other institutional provider, or organization of physicians or health care providers). The rules specifically prohibit the formation of dental care PPAs. See *id.* § 3.3701.

116. *Id.* § 3.3701.

117. See *id.* § 3.3702.

118. *Id.* § 3.3701.

Preferred provider statutes and regulations adopted by other states vary in scope. PPA enabling provisions in five other states similarly apply only to insurance.<sup>119</sup> Provisions in certain other states apply to insurers and either third-party administrators,<sup>120</sup> health service corporations,<sup>121</sup> or both third-party administrators and health service corporations.<sup>122</sup> In addition to these PPAs, preferred provider statutes in eight states also regulate preferred provider arrangements sponsored by fraternal benefit societies<sup>123</sup> and HMOs.<sup>124</sup> Health care purchaser-sponsored preferred provider arrangements are regulated in a nonuniform manner. Several states expressly subject PPAs sponsored by employers and labor organizations to regulation.<sup>125</sup> Certain other states' PPA statutes expressly exclude employers and organizations exempt from state insurance regulation under the terms of the Employee Retirement Income Securities Act of 1974 (ERISA).<sup>126</sup> Sponsoring entities that fall within the scope of the *NAIC Model Act* include insurers, health care service

---

119. Ark. Ins. Bull. 9-85 (May 10, 1985); IND. CODE ANN. § 27-8-11-3 (Burns 1986 & Supp. 1987); IOWA CODE ANN. § 515.48(5)(a) (West Supp. 1988); MINN. STAT. ANN. § 72A.20, subd. 15(4) (West 1986 & Supp. 1988); OR. REV. STAT. § 743.531(3) (Supp. 1987).

120. KAN. STAT. ANN. § 40-231 (Supp. 1988); UTAH CODE ANN. § 31A-22-617 (1986).

121. CAL. INS. CODE § 10133 (West 1972 & Supp. 1988) (commercial insurance companies); 806 KY. ADMIN. REGS. 18:020 § 1(3) (1986); MD. ANN. CODE art. 48A, § 477FF (1986 & Supp. 1987) (insurer); *id.* § 354EE (nonprofit health service plans); N.H. REV. STAT. ANN. § 420-C:1(IV) (Supp. 1987); N.C. GEN. STAT. § 58-260.6 (Pam. Supp. 1987) (insurers); *id.* § 57-16.1 (Supp. 1987) (hospital, medical and dental service corporations); VA. CODE ANN. § 38.2-3407 (1986) (insurer); *id.* § 38.2-4209 (nonstock corporation); WYO. STAT. § 26-22-502 (Supp. 1987).

122. ILL. ANN. STAT. ch. 73, para. 982i (Smith-Hurd Pam. Supp. 1988); ME. REV. STAT. ANN. tit. 24-A, § 2672 (Supp. 1987) (insurers and administrators); *id.* tit. 24, § 2335 (nonprofit service organizations); MICH. COMP. LAWS ANN. § 550.52(j) (West Supp. 1988).

123. See MONT. CODE ANN. § 33-22-1703(5) (1987); NEB. REV. STAT. § 44-4103 (1984); N.D. CENT. CODE § 26.1-47-01(4) (Supp. 1987); WIS. STAT. ANN. § 609.01(4) (West Supp. 1987); see also Act effective July 1, 1988, 1988 Ga. Laws 1483, 1484 (to be codified at GA. CODE ANN. § 33-30-22(3)) (applies to health benefit plans issued, delivered, or renewed on or after Jan. 1, 1989).

124. See MONT. CODE ANN. § 33-22-1703(5) (1987); NEB. REV. STAT. § 44-4103 (1984); N.D. CENT. CODE § 26.1-47-01(4) (Supp. 1987); see also Act effective July 1, 1988, 1988 Ga. Laws 1483, 1484 (to be codified at GA. CODE ANN. § 33-30-22(3)) (applies to health benefit plans issued, delivered, or renewed on or after Jan. 1, 1989).

125. See FLA. STAT. ANN. § 627.6695 (Supp. 1988) (insurers, including any self-insurer); LA. REV. STAT. ANN. § 40:2202(3) (West Supp. 1988) (group purchasers, including insurers, self-funded organizations, Taft-Hartley trusts, employers, health care financiers, third-party administrators, providers, or other intermediaries); NEB. REV. STAT. § 44-4105 (1984) (participants in an insurance arrangement, including any employer, union, or other organization providing health care services or benefits to its employees or members through an insurance arrangement).

126. Pub. L. No. 93-406, 88 Stat. 829 (codified as amended at 5, 18, 26, 29, 31, 42 U.S.C.) ILL. ANN. STAT. ch. 73, ¶ 982j (Smith-Hurd Pam. Supp. 1988) (self-insured employers, employee benefit trust funds, other ERISA exempt organizations, and State of Illinois exempt from any provisions related to preferred provider arrangement); MD. ANN. CODE tit. 48-A, § 477FF(d) (1986) (employee benefit plans regulated by federal law or ERISA not subject to provisions related to preferred provider arrangements); PA. STAT. ANN. tit. 40, § 764a (Purdon Pam. Supp. 1988) (preferred provider organizations that assume financial risk and regulated under ERISA required to file certificate acknowledging ERISA governance with Insurance Commissioner); see also Act effective July 1, 1988, 1988 Ga. Laws 1483, 1487 (to be codified at GA. CODE ANN. § 33-30-23(d)) (applies to health benefit plans issued, delivered, or renewed after Jan. 1, 1989).

corporations, HMOs, and fraternal benefit societies.<sup>127</sup> An optional provision contained in the *NAIC Model Act* facilitating verification of the PPA activities of noninsurance entities exempts employer PPA sponsors from filing requirements.<sup>128</sup>

### B. *Terms and Conditions of Provider Participation*

Provisions contained in the Texas Preferred Provider Plan Rules relating to the assembly of preferred provider panels and the criteria for panel membership attempt to ensure that the preferred provider contracting process promotes broad provider participation. The Texas Preferred Provider Plan Rules require insurers to offer all physicians and health care providers that comply with the terms and conditions of provider participation a fair and reasonable opportunity to become members of a preferred provider panel.<sup>129</sup> Preferred provider plan rules in certain other states similarly guarantee preferred status to any professional or institutional provider that agrees to comply with the provider participation requirements.<sup>130</sup> Rules adopted by two states protect only the participation of professional providers.<sup>131</sup> Moreover, rules adopted in certain other states protect the providers' rights to apply for preferred provider panel membership, but do not guarantee participation.<sup>132</sup>

The provider participation provisions set forth in the Texas Preferred Provider Plan Rules encompass both physicians and nonphysician practitioners.<sup>133</sup> The Texas Insurance Code specifically prohibits discrimination against certain classes of health care practitioners.<sup>134</sup> Accordingly, the

127. *NAIC Model Act* § 3(E) (National Ass'n Ins. Comm'rs 1987).

128. *Id.* § 4(C) & drafting note.

129. 28 TEX. ADMIN. CODE § 3.3703(1) (1986).

130. Ark. Ins. Bull. 9-85 (May 10, 1985), as amended by Ark. Ins. Bull. 9-85A (July 18, 1985) (membership on provider panels must be open to all practitioners willing and able to meet terms and conditions of organization); IND. CODE ANN. § 27-8-11-3(c) (Burns 1986) (no hospital, physician, pharmacist, or other designated provider may be denied right to enter preferred provider agreement); UTAH CODE ANN. § 31A-22-617 (1986) (any health care provider who is willing to meet terms and conditions established by insurer for designation as preferred health care provider shall be eligible to apply for and receive preferred provider status); VA. CODE ANN. § 38.2-3407B (1986) (no physician, hospital, or nonphysical practitioner willing to meet terms and conditions of preferred provider contract shall be excluded); *see also* Act effective July 1, 1988, 1988 Ga. Laws 1483, 1487-88 (to be codified at GA. CODE ANN. § 33-30-25) (applies to health benefit plans issued, delivered, or renewed on or after Jan. 1, 1989) (all health care providers within defined service area who satisfy standards set forth by insurer must be given opportunity to apply and to become preferred provider).

131. ILL. ANN. STAT. ch. 73, ¶ 982h (Smith-Hurd Pam. Supp. 1988) (insurer shall not refuse to contract with any noninstitutional provider who meets terms and conditions established by insurer or administrator); LA. REV. STAT. ANN. § 40:2202(5)(c) (West Supp. 1988) (no licensed provider, other than hospital, who meets terms and conditions of preferred provider contract may be denied right to preferred provider status).

132. MICH. COMP. LAWS ANN. § 550.53(2) (West Supp. 1988) (organizations shall grant interested health care providers located in geographic area served by organization opportunity to apply for membership on panel); N.C. GEN. STAT. § 58-260.6(c) (Pam. Supp. 1987) (any professional or institutional provider shall be allowed opportunity to submit proposal for participation in preferred provider plan; providers may be permitted to participate at discretion of preferred provider plan).

133. 28 TEX. ADMIN. CODE § 3.3703(1) (1986).

134. *See* TEX. INS. CODE ANN. arts. 3.70-2(B), 21.35A, 21.52 (Vernon 1981 & Supp. 1988).

Texas rules compel insurers offering preferred provider plans that cover services delivered by certain nonphysician practitioners to afford both physicians and nonphysician practitioners an equivalent opportunity to participate as preferred providers.<sup>135</sup> Preferred provider plan rules in seven other states also protect the panel membership interests of nonphysician practitioners.<sup>136</sup> In contrast, preferred provider plan rules in two states stipulate that although insurers must open panel membership application to nonphysician practitioners, insurers may selectively contract with providers who apply.<sup>137</sup> To facilitate professional provider application and participation, the Texas rules require insurers to notify all practitioners in the geographic area covered by the plan of the opportunity to participate in the preferred provider panel.<sup>138</sup>

To promote the participation of a broad range of institutional health care providers,<sup>139</sup> the Texas Preferred Provider Plan Rules require that insurers offering preferred provider plans make a good faith effort to recruit a mix of for-profit, nonprofit, and tax-supported facilities.<sup>140</sup> Furthermore, the rules mandate that insurers give special consideration to teaching hospitals and hospitals that treat a large number of indigent or uninsured patients.<sup>141</sup> The rules fail, however, to require insurers to notify institutional providers of panel formation.

---

135. 28 TEX. ADMIN. CODE § 3.703(3) (1986).

136. See Ark. Ins. Bull. 9-85A (July 18, 1985) (amends Ark. Ins. Bull. 9-85 (May 10, 1985) to comply with ARK. STAT. ANN. § 66-3212 (1980)) (preferred provider panel membership must be open not only to professionals licensed under Medical Practice Act, but also to licensed optometrists, podiatrists, psychologists, and dentists); IND. CODE ANN. § 27-8-11-3 (Burns 1986) (providers designated as mandated providers may not be denied right to enter into agreement); N.H. REV. STAT. ANN. § 420-C:2(V) (Supp. 1987) (insurers may contract with providers licensed to deliver health care services, including medical, surgical, pharmaceutical, podiatric, psychological, and nursing services); S.D. CODIFIED LAWS § 36-5-14.3 (Supp. 1988) (chiropractors may organize or contract for services with corporation organized by licensed practitioners of healing acts for purpose of negotiating group health care contracts and providing services with alternative health care delivery systems, including preferred provider organizations); *id.* § 36-26-17.1 (social workers); *id.* § 36-26-23.1 (psychologists); UTAH CODE ANN. § 31A-22-617(7) (1986) (any health care provider licensed to treat any illness or inquiry within scope of his practice who is willing and able to meet terms and conditions of provider participation shall be eligible to receive preferred provider designation); VA. CODE ANN. § 38.2-3407(C) (1986) (podiatrists, chiropractors, optometrists, opticians, psychologists, clinical social workers, and chiropractors shall possess same opportunity to qualify for payment as preferred providers as doctors of medicine); WIS. STAT. ANN. § 632.87(1) (West 1980 & Supp. 1988) (insurers may not refuse to provide or pay for benefits for health care services provided by licensed health care professional because services not rendered by physician). *But see* MONT. CODE ANN. § 33-22-1704 (1987) (insurers not required to negotiate or enter into agreements with any specific provider or class of providers).

137. MICH. COMP. LAWS ANN. §§ 550.53(6), (1) (West Supp. 1988); NEB. REV. STAT. §§ 44-4110, 44-4112 (1984).

138. 28 TEX. ADMIN. CODE § 3.3703(1) (1986) (requires publication or written notice of preferred provider panel formation); accord MICH. COMP. LAWS ANN. § 550.53(4) (West Supp. 1988) (organization agrees to notify health care providers of panel formation); see also 28 TEX. ADMIN. CODE § 3.3703(1) (1986) (insurer must provide noncontracting practitioners notice and opportunity to participate on annual basis).

139. 28 TEX. ADMIN. CODE § 3.3702 (1986) (institutional provider definition includes hospital, nursing home, and any other medical or health-related service facility).

140. *Id.* § 3.3704(8).

141. *Id.*

Permissible terms and conditions for preferred provider participation under the Texas rules include economic, quality, and accessibility considerations.<sup>142</sup> Practice privileges at preferred hospitals or institutions also constitute a valid condition of participation for professional providers, unless no preferred hospital or facility extends privileges to a particular provider class.<sup>143</sup> Preferred provider plan rules in other states recognize negotiated price differences,<sup>144</sup> price differences based on geographical area,<sup>145</sup> market conditions, method of payment or patient mix,<sup>146</sup> and specialty<sup>147</sup> and non-price related considerations including quality of care,<sup>148</sup> availability of services,<sup>149</sup> location,<sup>150</sup> profession,<sup>151</sup> specialization,<sup>152</sup> professional privileges,<sup>153</sup> and projected utilization,<sup>154</sup> as valid provider selection criteria. The *NAIC Model Act* similarly recognizes negotiated price differences, quality of care, and availability of services as valid bases for provider participation decisions.<sup>155</sup> Certain other states' provisions set forth less specific selection guidelines including compliance with reasonable terms and conditions established by the insurer independently or as a product of PPA contract negotiations.<sup>156</sup>

The Texas Preferred Provider Plan Rules also identify certain participation criteria for institutional providers. Under the rules, an insurer may condition its decision to extend preferred institutional provider status on economic, quality, and accessibility considerations.<sup>157</sup> For certain types of facilities, insurers may also consider geographic, economic, or operational

142. *Id.* § 3.3703(2).

143. *Id.*

144. ILL. ANN. STAT. ch. 73, ¶ 982h (Smith-Hurd Pam. Supp. 1988); ME. REV. STAT. ANN. tit. 24-A, § 2672 (Supp. 1987).

145. ILL. ANN. STAT. ch. 73, ¶ 982h (Smith-Hurd Pam. Supp. 1988); IND. CODE ANN. § 27-8-11-3 (Burns 1986); ME. REV. STAT. ANN. tit. 24-A, § 2672 (Supp. 1987); NEB. REV. STAT. § 44-4111 (1984); VA. CODE ANN. § 38.2-3407(B) (1986).

146. NEB. REV. STAT. § 44-4111 (1984).

147. ILL. ANN. STAT. ch. 73, ¶ 982h (Smith-Hurd Pam. Supp. 1988); IND. CODE ANN. § 27-8-11-3 (Burns 1986); ME. REV. STAT. ANN. tit. 24-A, § 2672 (Supp. 1987); NEB. REV. STAT. § 44-4111 (1984).

148. N.D. CENT. CODE § 26.1-47-04 (Supp. 1987); WIS. STAT. ANN. § 628.36(2)(b) (Supp. 1987).

149. CAL. ADMIN. CODE tit. 10, § 2240.1 (1984).

150. *Id.*; ME. REV. STAT. ANN. tit. 24-A, § 2672 (Supp. 1987); MICH. COMP. LAWS ANN. § 550.53(9) (West Supp. 1988); N.H. REV. STAT. ANN. § 420-C:5 (Supp. 1987).

151. NEB. REV. STAT. § 44-4110 (1984).

152. CAL. ADMIN. CODE tit. 10, § 2240.1 (1984); ME. REV. STAT. ANN. tit. 24-A, § 2672 (Supp. 1987); NEB. REV. STAT. § 44-4110 (1984).

153. N.H. REV. STAT. ANN. § 420-C:5 (Supp. 1987). *Contra* MONT. CODE ANN. § 33-22-1705(b)(2) (1987) (insurers may not require hospital staff privileges as criteria for preferred provider designation).

154. CAL. ADMIN. CODE tit. 10, § 2240.1 (1984); ME. REV. STAT. ANN. tit. 24-A, § 2672 (Supp. 1987); MICH. COMP. LAWS ANN. § 550.53(1) (West Supp. 1988); NEB. REV. STAT. § 44-4110 (1984).

155. *NAIC Model Act* § 6 (National Ass'n Ins. Commr's 1987).

156. MD. ANN. CODE art. 48A, § 477FF(b)(2) (1986); MICH. COMP. LAWS ANN. § 550.53(1) (West Supp. 1988); UTAH CODE ANN. § 31A-22-167 (1986); WIS. STAT. ANN. § 609.20 (West Supp. 1987).

157. 28 TEX. ADMIN. CODE § 3.3703(2) (1986).

factors.<sup>158</sup> PPA provisions in other states permit insurers to condition preferred institutional provider status on negotiated price differences,<sup>159</sup> price differences based on geographic area,<sup>160</sup> market condition,<sup>161</sup> method of payment, and patient mix<sup>162</sup> and non-price related factors such as quality of care,<sup>163</sup> location,<sup>164</sup> and projected utilization.<sup>165</sup> Under the *NAIC Model Act*, insureds may condition preferred institutional provider status on negotiated price differences, quality of care, and availability of services.<sup>166</sup>

Pursuant to the Texas rules, insurers may neither unreasonably withhold preferred provider status from physicians or health care providers willing to comply with the terms and conditions of participation<sup>167</sup> nor prevent professional or institutional providers from participating in other preferred provider plans, health maintenance organizations, or other types of insurance plans.<sup>168</sup> For physicians denied preferred provider status, the rules require that insurers provide an appeal mechanism.<sup>169</sup> Specifically, the rules make an insurer's decision to withhold preferred provider status from a physician subject to review by a three-member physician panel selected by the insurer from a list of contracting physicians supplied by preferred physician providers.<sup>170</sup> For nonphysician practitioners denied preferred provider status, no specific course of appeal exists under the rules. Furthermore, although the rules permit insurers to deny preferred provider status to hospital and other institutional providers that reserve staff privileges only for practitioners under contract with a preferred provider panel,<sup>171</sup> the rules fail to provide a review mechanism for hospital and other institutional providers denied preferred status.<sup>172</sup>

158. *Id.* § 3.3704(8).

159. IND. CODE ANN. § 27-8-11-3 (Burns 1986); ME. REV. STAT. ANN. tit. 24-A, § 2172 (Supp. 1987); MD. ANN. CODE art. 48A, § 477FF(cc) (1986); VA. CODE ANN. § 38.2-3407(B) (1986).

160. IND. CODE ANN. § 27-8-11-3 (Burns 1986); ME. REV. STAT. ANN. tit. 24-A, § 2672 (Supp. 1987); MD. ANN. CODE art. 48A, § 477FF(c) (1986); NEB. REV. STAT. § 44-4111 (1984); VA. CODE ANN. § 38.2-3407(B) (1986).

161. MD. ANN. CODE art. 48A, § 477FF(c) (1986); NEB. REV. STAT. § 44-4111 (1984); VA. CODE ANN. § 38.2-3407(B) (1986).

162. NEB. REV. STAT. § 44-4111 (1984).

163. N.D. CENT. CODE § 26.1-47-04 (Supp. 1987); WIS. STAT. ANN. § 628.36(2)(b) (Supp. 1987).

164. CAL. ADMIN. CODE tit. 10, § 2240.1 (1984); ME. REV. STAT. ANN. tit. 24-A, § 2672 (Supp. 1987); MICH. COMP. LAWS ANN. § 550.53(9) (West Supp. 1988); N.H. REV. STAT. ANN. § 420-C:5 (Supp. 1987).

165. CAL. ADMIN. CODE tit. 10, § 2240.1 (1984); ME. REV. STAT. ANN. tit. 24-A, § 2672 (Supp. 1987); MICH. COMP. LAWS ANN. § 550.53(1) (West Supp. 1988); NEB. REV. STAT. § 44-4110 (1984).

166. *NAIC Model Act* § 6 (National Ass'n Ins. Commr's 1987).

167. 28 TEX. ADMIN. CODE § 3.3703(1) (1986).

168. *Id.* § 3.3704(2); accord MICH. COMP. LAWS ANN. § 550.53(8) (West Supp. 1988); N.C. GEN. STAT. § 58-260.6(f) (Pam. Supp. 1987); WIS. STAT. ANN. § 628.36(2)(b)(2) (West Supp. 1987).

169. 28 TEX. ADMIN. CODE § 3.3703(1) (1986).

170. *Id.*

171. *Id.* § 3.3703(2).

172. See WLE TEXAS ALERT, *supra* note 104, at 4.

### C. Preferred Provider Health Care Benefits

The Texas Preferred Provider Plan Rules regulate the amount of leverage that insurers may exercise in implementing health care finance and delivery systems designed to channel insureds to preferred providers. Certain provisions contained in the Texas Insurance Code that safeguard insureds from discrimination and guarantee freedom of provider selection form the statutory basis for these protective regulations. First, the Texas Insurance Code categorically prohibits commercial insurers from discriminating among insureds in the amount of health insurance premium, the level of health insurance benefits payable under a policy, and the terms and conditions of the insurance contract.<sup>173</sup> Statutory prohibitions against unfair discrimination among insureds are derived from the principle that premium and benefit levels constitute a function of the degree of risk associated with a particular class of individuals.<sup>174</sup> Based on this premise, individuals that represent the same degree of risk to the insurer belong to the same class of insureds.<sup>175</sup> To ensure compliance with these fundamental principles, unfair discrimination statutes require insurers to assess uniform premium payments and policy benefits to members of the same class of insureds.<sup>176</sup> Second, the Texas Insurance Code enjoins commercial insurers from restricting an insured's right to obtain treatment from the health care provider of his choice by making benefits payable for health care services under any insurance plan contingent upon obtaining services from a particular professional or institutional provider.<sup>177</sup> Freedom of provider choice provisions protect the interests of in-

---

173. TEX. INS. CODE ANN. art. 21.21, § 4(7)(b) (Vernon 1981 & Supp. 1988).

174. See 5 COUCH, *supra* note 90, §§ 30:3, 30:11, 30:15.

175. See TEX. INS. CODE ANN. art. 21.21, § 4(7)(b) (Vernon 1981 & Supp. 1988); *Reeves v. New York Life Ins. Co.*, 421 S.W.2d 686 (Tex. Civ. App.—Waco 1986, writ ref'd n.r.e.) (variation in benefits under insurance policy for different classes of individuals not unfair discrimination).

176. TEX. INS. CODE ANN. art. 21.21, § 4(7)(b) (Vernon 1981 & Supp. 1988). For an analysis of the purpose and operation of unfair discrimination statutes, see 5 COUCH, *supra* note 90, §§ 30:48-51, 30:55.

177. See TEX. INS. CODE ANN. art. 3.51-6, § 3 (Vernon 1981 & Supp. 1988) (accident and sickness insurance policy may not require that service be rendered by particular hospital or person); *id.* art. 3.70-2(B) (health insurance benefits may not be contingent upon treatment by particular practitioner, unless the policy designates practitioners whom insurer will recognize and those whom insurer will not recognize); *id.* art. 21.35A (health insurance benefit plan that covers services within scope of practice of licensed psychologist must provide reimbursement for services whether performed by licensed doctor of medicine or licensed psychologist); *id.* art. 21.52, § 3 (insured may select licensed doctor of podiatric medicine, doctor of chiropractic, or doctor of optometry to perform medical or surgical services covered by health insurance benefit plan or audiologist or speech-language pathologist to perform hearing and speech related health services covered by health insurance plan; health insurance benefit plan that covers such health care services may not classify, differentiate, or otherwise discriminate in payment for such services when performed by such practitioners). For an analysis of the purpose and operation of freedom of choice statutes, see W. MEYER, *supra* note 86, § 18:1-3.

In 1985 at the request of the Chairman of the State Board of Insurance, the Texas Attorney General reviewed several proposed insurance policy provisions that excluded certain types of practitioners from coverage based on express provisions and "place and manner" restrictions. Op. Tex. Att'y Gen. No. JM-301, at 1359 (1985). Based on an analysis of the statutes and legislative history, the Attorney General determined that the Texas Insurance Code freedom of choice provisions applied to health care services (1) rendered by podiatrists, dentists, chiropractors, optometrists, audiologists, speech-language pathologists and psychologists, (2) cov-

insureds in obtaining reimbursement for health care services rendered by physicians and other types of health care professionals in a variety of treatment settings.<sup>178</sup> Freedom of choice provisions also protect the interests of health care providers in delivering services to insured patients.<sup>179</sup>

In apparent conflict with unfair discrimination and freedom of choice provisions, preferred provider insurance contracts classify and reimburse insureds on the basis of provider selection, rather than level of risk.<sup>180</sup> The Texas Preferred Provider Plan Rules explicitly state that the Commissioner of Insurance shall not consider health insurance policy terms that conform with the rules to constitute unfair discrimination among insureds<sup>181</sup> or an unlawful restriction on the insured's freedom of choice in the selection of a professional or institutional provider.<sup>182</sup> To permit commercial insurers to issue preferred provider policies featuring differential benefit levels based on the insured's choice of provider, the rules contain certain other provisions drafted to reconcile preferred provider health care finance and delivery mechanisms with Insurance Code provisions relating to unfair discrimination and freedom of provider choice.<sup>183</sup>

Provisions contained in the Texas Preferred Provider Plan Rules that limit differential benefit levels offered under the PPA health care finance system attempt to eliminate both express and constructive interference with an insured's provider choice.<sup>184</sup> Specifically, rules stipulate that benefits for preferred provider services may not exceed an amount thirty percent higher than benefits for nonpreferred provider services.<sup>185</sup> The rules also stipulate that the deductible applicable to reimbursement for services obtained from nonpreferred providers be reasonable in comparison to the preferred provider deductible.<sup>186</sup>

The *NAIC Model Act*<sup>187</sup> and preferred provider plan rules in other

---

ered by the relevant policy, and (3) within the scope of the affected practitioner's license or certification. *Id.* at 1362. The Attorney General warned that interference with an insured's autonomy of provider choice may arise both from policy provisions that expressly discriminate against certain providers and from provisions that have a discriminatory purpose or effect. *Id.* at 1363. Accordingly, the Attorney General ruled that a health insurance policy provision that limited benefits to services rendered by a physician and a provision that limited the dollar amount of benefits and the number of covered treatments for services rendered by a chiropractor and a psychologist directly discriminated against one or more of the affected practitioners. *Id.* at 1362. The Attorney General further ruled that a policy provision restricting benefits for chiropractic services to those services performed in a hospital or while the insured is under general anesthesia indirectly discriminated against practitioners precluded by the scope of their licenses from performing services in the prescribed place and manner. *Id.* at 1363.

178. Op. Tex. Att'y Gen. No. JM-301, at 1361.

179. *Id.*

180. See 28 TEX. ADMIN. CODE § 3.3701 (1986).

181. *Id.* § 3.3703.

182. *Id.* § 3.3704.

183. See *supra* note 177.

184. See Op. Tex. Att'y Gen. No. JM-301, at 1363.

185. 28 TEX. ADMIN. CODE § 3.3704(1) (1986).

186. *Id.*; accord N.H. REV. STAT. ANN. § 420-C:4(III) (Supp. 1987).

187. *NAIC Model Act* § 5(B) (National Ass'n Ins. Comm'rs 1987) (differences in benefit levels payable to preferred and nonpreferred providers may be no greater than necessary to provide reasonable incentive for insureds to use preferred provider).



states<sup>188</sup> protect the insured's freedom of choice by specifying a similar cap on the insurer's channeling leverage. The autonomy of the insured is less protected in the remaining states. Certain states allow the insurer to exercise discretionary leverage by requiring only that insurers provide insureds some coverage for services obtained from nonpreferred providers.<sup>189</sup> Certain other states fail to set forth minimum coverage levels for services rendered by nonpreferred providers.<sup>190</sup>

By authorizing insurers to issue exclusive provider plans, preferred prov-

---

188. Five states limit the difference in benefits payable to insureds who obtain services from preferred and nonpreferred providers. Ark. Ins. Bull. 9-85 (May 10, 1985) (25% benefit differential limit); 806 KY. ADMIN. REGS. 18:020, § 2 (1986) (same); ME. REV. STAT. ANN. tit. 24-A, § 2677 (Supp. 1987) (20% benefit differential limit); N.D. CENT. CODE § 26.1-47-03 (Supp. 1987) (differences in benefit levels payable to preferred and nonpreferred providers may be no greater than necessary to provide reasonable incentive for insured to use preferred provider); UTAH CODE ANN. § 31A-22-617(2)(d) (1986) (annual deductible applicable to reimbursement for services obtained from nonpanel provider limited to \$100 per person and \$300 per family); see also Act effective July 1, 1988, 1988 Ga. Laws 1483, 1485 (to be codified at GA. CODE ANN. § 33-30-23(b)(3)) (applies to health benefit plans issued, delivered, or renewed on or after Jan. 1, 1989) (20% coinsurance differential limit); *id.* at 1486 (to be codified at § 33-30-23(b)(4)) (applies to health benefit plans issued, delivered, or renewed on or after Jan. 1, 1989) (30% limit on differential between nonpreferred and basic benefit levels). PPA enabling provisions in four states limit the percentage by which insurers may reduce the amount of reimbursement payable to nonpreferred providers relative to that payable to preferred providers. MD. ANN. CODE art. 48A, § 477FF(b)(4) (1986) (payment for services rendered by nonpreferred providers may not be less than 85% of amount that would be paid to preferred providers for similar services in same geographic area, unless insurer demonstrates to Insurance Commissioner that alternate level and payment more appropriate under circumstances); MONT. CODE ANN. § 33-22-1706(1)(a) (1987) (payment difference for reimbursement of preferred provider may not exceed 25% of preferred provider reimbursement level); N.C. GEN. STAT. § 58-260.6(d) (Pam. Supp. 1987) (payment for services delivered by nonparticipating providers may not be reduced by more than 20% of payments applicable to participants providers); UTAH CODE ANN. § 31A-22-617(2)(b) (1986) (insurer shall reimburse insured for at least 75% of average amount paid for comparable services of preferred health care providers of same class); see Act effective July 1, 1988, 1988 Ga. Laws 1483, 1486 (to be codified at GA. CODE ANN. § 33-30-23(c)) (applies to health benefit plans issued, delivered, or renewed on or after Jan. 1, 1989) (payments or reimbursement for covered pharmaceutical or dental services must be same for preferred and nonpreferred providers, but not greater than provider's actual fee).

189. See NEB. REV. STAT. § 44-4113 (1984) (insurers shall provide for payment for services rendered by nonpreferred providers who have not negotiated contract with insurer; insured may be held financially responsible for charges of nonpreferred in excess of benefits available under preferred provider plan); VA. CODE ANN. § 38.2-3407(D) (1986) (preferred provider policies shall provide payment for services rendered by nonpreferred providers, but payments need not be same as for preferred providers).

190. FLA. STAT. ANN. § 626.9541(2) (West Supp. 1988) (insurers may limit payments under policies issued pursuant to agreements with insureds; insurers must offer benefits of alternate rates to insureds who select designated providers); ILL. ANN. STAT. ch. 73, ¶ 982i(b)(2) (Smith-Hurd Pam. Supp. 1988) (insurer may issue policies that include incentives for insured to utilize services of contract providers); IND. CODE ANN. § 27-8-11-3 (Burns 1986) (same); KAN. STAT. ANN. § 40-231(b) (1968) (insurers may offer alternate rates of payment to insureds who select contract providers); LA. REV. STAT. ANN. § 40:2202(5)(b) (West Supp. 1988) (preferred provider agreement may include incentives that encourage insured employee or member to utilize preferred provider); *id.* § 40:2203(C) (group purchaser members shall be guaranteed access to standard benefit under their policy whether they choose preferred or nonpreferred provider); PA. STAT. ANN. tit. 40, § 764a (Purdon Pam. Supp. 1988) (insurer may issue policies that include incentives for insured to use contract provider); WYO. STAT. § 26-22-503(a)(ii)(A), (B) (Supp. 1987) (policies issued pursuant to preferred provider agreements may include incentives for insured and limit reimbursement for health care services).

iders plan rules in six states allow the insurer to exercise absolute channeling leverage.<sup>191</sup> An optional provision set forth in the *NAIC Model Act* similarly authorizes insurers to issue preferred provider health benefit plans pursuant to exclusive provider arrangements.<sup>192</sup> Under an exclusive provider plan, insurers offer no coverage to insureds who obtain health care services from nonpreferred providers.<sup>193</sup> Preferred provider plan rules in certain states, including Texas, expressly proscribe exclusive provider plans.<sup>194</sup>

#### D. Open Panel Health Care Services Delivery

Four provisions contained in the Texas Preferred Provider Plan Rules relating to access to practitioners and referral protocol under the PPA health care delivery system seek to further prevent interference with the insured's freedom of provider choice. First, the rules require that preferred provider plans guarantee insureds direct and reasonable access to professional providers of all classes, specialty care services, and adequately staffed health care facilities.<sup>195</sup> Second, the rules provide that preferred provider plans may not require that an insured gain access to the system by referral from a practitioner of another class or by a subspecialist of the same class.<sup>196</sup> Consequently, the rules preclude insurers from using primary care physician gatekeepers to direct the delivery of health care services under preferred provider arrangements.<sup>197</sup> Third, the rules expressly guarantee each insured the right to the treatment and diagnostic techniques prescribed by the insured's practitioner.<sup>198</sup> If certain health care services are not available through preferred providers, the rules permit insureds to obtain services from an appropriate nonpreferred provider and require insurers to reimburse insureds for the services rendered by the nonpreferred provider at the preferred rate.<sup>199</sup>

---

191. See CAL. ADMIN. CODE tit. 10, §§ 2240(f), 2240.4 (1984) (exclusive provider includes any institution or health care professional rendering exclusive services to covered persons pursuant to contract with insurer to provide services at alternate rates); IND. CODE ANN. § 27-8-11-3(a)(3) (Burns 1986) (insurer may issue policies that provide reimbursement for expenses only if service is rendered by contract provider); MICH. COMP. LAWS ANN. § 550.3405(2) (West Supp. 1988) (insurer may offer policies that condition coverage on insured's election to obtain services from providers who have entered into purchase agreements, if insurer also offers insured option of enlisting in nonexclusive policy); N.H. REV. STAT. ANN. § 420-C:3(III) (Supp. 1987) (insurer may issue policies that provide benefit only if preferred provider renders health care services); PA. STAT. ANN. tit. 40, § 764a(c) (Purdon Pam. Supp. 1988) (insurer may issue policies that reimburse only if contract provider or physician renders health care services).

192. *NAIC Model Act* § 9 drafting note (National Ass'n Ins. Comm'rs 1987) (if state elects to permit exclusive provider arrangements and if arrangement satisfies standards for availability and adequacy of services, legislation may permit insurers to provide benefits only if preferred provider renders health care services).

193. See *supra* notes 191-92. Exclusive provider health benefit plans generally cover emergency services rendered by nonexclusive providers. FTC STUDY, *supra* note 102; see *infra* note 208.

194. 806 KY. ADMIN. REGS. 18:020 (1986); 28 TEX. ADMIN. CODE § 3.3703(2) (1986).

195. 28 TEX. ADMIN. CODE §§ 3.3703(3), 3.3705.

196. *Id.* § 3.3703(3).

197. See WLE TEXAS ALERT, *supra* note 104, at 4.

198. 28 TEX. ADMIN. CODE § 3.3705(1) (1986).

199. *Id.* § 3.3704(4).

Whether or not prescribed health care services are available through a preferred provider, the rules further specify that insurers offering preferred provider plans must allow participating providers to refer an insured to nonparticipating providers, if the participating provider informs the insured that a different schedule of benefits may apply.<sup>200</sup> Finally, the rules specifically address the contingency of emergency care delivery by a nonpreferred provider. Under the rules, if an insured requires emergency medical services<sup>201</sup> and is unable to obtain the necessary services from a preferred provider, the insured may seek care from a nonpreferred provider.<sup>202</sup> Moreover, the insurer must reimburse the insured at the preferred rate until the insured can be safely transferred to the care of a preferred provider.<sup>203</sup>

Preferred provider statutes and regulations enacted in other states facilitate open panel health care service delivery in varying degrees. PPA's provisions expressly guarantee an insured's access to preferred health care personnel and facilities.<sup>204</sup> Coordinated gatekeeper referral is authorized in two states<sup>205</sup> and proscribed in two states.<sup>206</sup> Provisions authorizing referral to nonpreferred providers in nonemergency cases constitute a part of only one other state's PPA health care service delivery scheme.<sup>207</sup> In contrast, several states' rules provide for the delivery of health care services in case of emergency.<sup>208</sup> The *NAIC Model Act* requires PPA sponsors to assure rea-

---

200. *Id.* § 3.3705(1).

201. The Texas Preferred Provider Plan Rules fail to include a specific definition of emergency medical services. *But cf.* CAL. ADMIN. CODE tit. 10, § 2240(e) (1984) (emergency health care services defined); ILL. ANN. STAT. ch. 73, ¶ 982g(h) (Smith-Hurd Pam. Supp. 1988) (emergency health care services defined). *See also* Act effective July 1, 1988, 1988 Ga. Laws 1483, 1484 (to be codified at GA. CODE ANN. § 33-30-22) (applies to health benefit plans issued, delivered, or renewed on or after Jan. 1, 1989) (emergency health care services defined). The *NAIC Model Act* proposes a comprehensive definition of emergency health care services. *See NAIC Model Act* § 3(D) (National Ass'n Ins. Commr's 1987) (emergency care defined to include covered services obtained by insured suffering accidental bodily injury or medical condition requiring immediate medical care under circumstances or at location which reasonably precludes insured from obtaining services from preferred provider).

202. 28 TEX. ADMIN. CODE § 3.3704(4) (1986).

203. *Id.*

204. CAL. ADMIN. CODE tit. 10, § 2240.1 (1984); ILL. ANN. STAT. ch. 73, ¶ 982i(a) (Smith-Hurd Pam. Supp. 1988); IND. CODE ANN. § 27-8-11-4 (Burns 1986); ME. REV. STAT. ANN. tit. 24-A, § 2673(1) (Supp. 1987); MICH. COMP. LAWS ANN. § 550.53(1) (West Supp. 1988); WIS. ADMIN. CODE § Ins. 3.48(5) (1986).

205. CAL. ADMIN. CODE tit. 10, § 2240(k) (1984) (primary care physician responsible for providing initial primary care, ensuring continuity of patient care, and initiating referral for specialist care); WIS. STAT. ANN. § 609.05(3) (West Supp. 1987) (preferred provider plan may require enrollee to obtain referral from designated primary provider to other select providers).

206. IND. CODE § 27-8-11-3(d) (1986) (insurer may not deny or limit reimbursement to insured because insured was not referred to preferred provider by person acting on behalf of or under agreement with insurer); WYO. STAT. § 26-22-503(b) (Supp. 1987) (same).

207. N.D. CENT. CODE § 26.1-47-03(1)(b) (Supp. 1987).

208. ILL. ANN. STAT. ch. 73, ¶ 982 (Smith-Hurd Pam. Supp. 1988); LA. REV. STAT. ANN. § 40:2203(E) (West Supp. 1988); MICH. COMP. LAWS ANN. § 550.53(11) (West Supp. 1988); MONT. CODE ANN. § 33-22-1705(a) (1987); N.D. CENT. CODE § 26.1-47-03(1)(a) (Supp. 1987); *see also* Act effective July 1, 1988, 1988 Ga. Laws 1483, 1487 (to be codified at GA. CODE ANN. § 33-30-24(1)) (applies to health benefit plans issued, delivered, or renewed on or after Jan. 1, 1989); *cf.* CAL. ADMIN. CODE tit. 10, § 2240.1(a)(5) (1984) (coverage on indemnity or provision of service basis for emergency services rendered outside service area pursuant to exclusive provider group benefit plan).

sonable access to services covered by a preferred provider health benefit plan.<sup>209</sup> The model legislation neither permits nor proscribes gatekeeper control mechanisms and addresses nonpreferred provider care only in the emergency context.<sup>210</sup>

### E. Utilization Review

The Texas Preferred Provider Plan Rules permit insurers to conduct utilization review designed to monitor the cost and appropriateness of expending health care resources and to correct any departure from professionally recognized levels of service delivery.<sup>211</sup> By dictating that an insurer may not require a physician to cover the costs of unnecessary procedures,<sup>212</sup> however, the rules prohibit insurers from employing utilization review mechanisms that establish a direct correlation between a physician's decision to treat and the assessment of a financial penalty or reward. Instead, the rules provide for physician-controlled utilization review.<sup>213</sup> Specifically, the rules require that a physician or physicians, selected by the insurer from a list of physicians supplied by the provider panel, approve all actions by an insurer to correct a deviation from prescribed utilization patterns or to deny payment for a physician's services in the course of utilization review.<sup>214</sup>

Provisions relating to the utilization of referral providers and the allocation of PPA cost savings similarly separate medical and economic considerations. First, the rules specifically prohibit insurers from rewarding a physician for not referring a patient to a specialist or for not treating a particular condition.<sup>215</sup> Second, the rules prohibit insurers from requiring the referring provider to bear the expense of specialty care referral into or out of the preferred provider panel.<sup>216</sup> Finally, the rules stipulate that preferred professional providers may only share savings from the cost-effective utilization of health care resources in the aggregate.<sup>217</sup>

PPA statutes in three other states permit, but do not require, insurers to conduct utilization review.<sup>218</sup> The *NAIC Model Act*<sup>219</sup> and certain other state statutes<sup>220</sup> require insurers to implement some form of cost contain-

209. *NAIC Model Act* § 4(A)(3) (National Ass'n Ins. Comm'rs 1987).

210. *Id.* § 5(A)(1).

211. 28 TEX. ADMIN. CODE §§ 3.3702, 3.3705(4) (1986).

212. *Id.* § 3.3703(2). *But see id.* (preferred provider may agree with insurer not to bill insured for care determined medically unnecessary by utilization review panel). For a discussion of guarantees against balanced billing as an incentive to use preferred providers, see *supra* note 47.

213. 28 TEX. ADMIN. CODE § 3.3705(4) (1986).

214. *Id.*

215. *Id.* § 3.3703(3). For further discussion of the open referral protocol advocated by the rules, see *supra* notes 184-86 and accompanying text.

216. 28 TEX. ADMIN. CODE § 3.3703(3) (1986).

217. *Id.*

218. IND. CODE ANN. § 27-8-11-3(a)(1) (1986); LA. REV. STAT. ANN. § 40:2202(e)(i) (West Supp. 1988); N.H. REV. STAT. ANN. §§ 420-C:3(b), (c) (Supp. 1987).

219. *NAIC Model Act* § 4(A)(2) (National Ass'n Ins. Comm'rs 1987).

220. N.D. CENT. CODE § 26.1-47-02(1)(b) (Supp. 1987); *see also* Act effective July 1, 1988, 1988 Ga. Laws 1483, 1486 (to be codified at GA. CODE ANN. § 33-30-23(a)(3)) (applied to health benefit plans issued, delivered, or renewed on or after Jan. 1, 1989).

ment system that may include utilization review. PPA statutes in five states advocate mandatory utilization review.<sup>221</sup>

### F. Quality Assurance Procedures

The Texas Preferred Provider Plan Rules permit, but do not require, insurers to conduct a periodic assessment of the quality of the health care services delivered under preferred provider plans.<sup>222</sup> Accordingly, the Texas rules identify quality assessment as an optional mechanism that an insurer may utilize to evaluate, monitor, or improve the quality and effectiveness of medical care delivered by physicians pursuant to preferred provider health benefit plans.<sup>223</sup> If an insurer elects to conduct quality assessment, the Texas rules stipulate that the objective of the assessment should be to ensure that care delivered under the plan is consistent with that delivered by an ordinary, reasonable, and prudent physician under the same or similar circumstances.<sup>224</sup> To facilitate that objective, the rules require that insurers engage a three-member panel of physicians selected from a list of participating physicians supplied by the provider panel to conduct quality assessment procedures.<sup>225</sup>

In contrast to the Texas rules, statutes and regulations adopted in four states regard quality assurance activities as a mandatory component of an operational preferred provider arrangement.<sup>226</sup> Preferred provider statutes in three states set forth comprehensive guidelines regulating the structure and operation of acceptable quality assurance programs.<sup>227</sup> One PPA stat-

221. CAL. INS. CODE § 10133(d) (West Supp. 1988); ILL. ANN. STAT. ch. 73, ¶ 982n (Smith-Hurd Pam. Supp. 1988); ME. REV. STAT. ANN. § 2678 (Supp. 1987); MICH. COMP. LAWS ANN. § 550.53(5) (West Supp. 1988); PA. STAT. ANN. § 764a(e) (Purdon Pam. Supp. 1988).

222. 28 TEX. ADMIN. CODE §§ 3.3702, 3.3705(3) (1986).

223. *Id.* § 3.3702.

224. *Id.*

225. *Id.* § 3.3705(3).

226. See CAL. INS. CODE § 10133(d) (West Supp. 1988); MICH. COMP. LAWS ANN. § 550.53(5) (West Supp. 1988); N.D. CENT. CODE § 26.1-47-04 (Supp. 1987); PA. STAT. ANN. tit. 40, § 764a(e) (Purdon Pam. Supp. 1988); UTAH CODE ANN. § 31A-22-617(4) (1986).

227. CAL. INS. CODE § 10133(d) (West Supp. 1988) (preferred provider contracts must provide for continuous review of quality of care by independent professionally recognized third party utilizing similarly licensed professionals to review each medical, dental, or psychological service covered by plan); MICH. COMP. LAWS ANN. § 550.53(5) (West Supp. 1988) (requires organization to conduct professional review of quality of health care delivery and performance of health care personnel; organization must employ professionally recognized independent third party to evaluate performance review program on biannual basis); *id.* § 550.53(3) (organization must submit proposed written standards for monitoring quality health care to Insurance Commissioner before formation of initial provider panel); UTAH CODE ANN. § 31A-22-617(4)(a) (1986) (insurers required to institute quality assurance program designed to ensure that care delivered by contract providers is consistent with prevailing Utah standards); *id.* § 31A-22-617(4)(b) (Insurance Commissioner and Department of Health may designate qualified persons to conduct annual audit of PPA quality assurance program); *cf.* WIS. STAT. ANN. § 628.36(2)(b)(4) (West Supp. 1987) (any health care plan may exclude provider from participation for cause related to professional practice); *id.* § 609.17 (preferred provider plan required to notify medical examining board of any disciplinary action taken against licensed select provider).

ute advocates nondelegated quality assurance review.<sup>228</sup> Two statutes permit delegated quality assurance review, but require a periodic independent evaluation of the quality assurance program.<sup>229</sup>

### G. Administrative and Marketing Provisions

The Texas Preferred Provider Plan Rules compel insurers marketing preferred provider health benefit plans to comply with a series of provisions designed to protect the interests of insureds and providers. Specifically, the rules require insurers to implement a protocol for the resolution of complaints initiated by insureds and providers.<sup>230</sup> According to the rules, the complaint resolution procedure must provide for reasonable due process which includes advisory review by a physician panel selected from a list of participating physicians supplied by the provider panel.<sup>231</sup>

In addition to complaint resolution procedures, the Texas Preferred Provider Plan Rules' consumer protection scheme stipulates that preferred provider health insurance policies and promotional materials clearly describe the distinction between preferred and nonpreferred providers.<sup>232</sup> The rules require that any description of preferred provider benefits appear in close proximity to an equally prominent description of nonpreferred provider benefits.<sup>233</sup> The rules also require insurers to supply prospective insureds with an annually updated list of participating providers.<sup>234</sup>

Statutes and regulations enacted in certain other states contain comparable administrative and marketing provisions. Preferred provider plan administration provisions in four states incorporate complaint resolution procedures.<sup>235</sup> Certain states impose comprehensive marketing restrictions including annual mandatory disclosures to insureds,<sup>236</sup> annual distribution

228. CAL. INS. CODE § 10133(d) (Supp. 1988).

229. MICH. COMP. LAWS ANN. § 550.53(5) (West Supp. 1988); UTAH CODE ANN. § 31A-22-617(4)(b) (1986).

230. 28 TEX. ADMIN. CODE § 3.3705(2) (1986).

231. *Id.* As a further mechanism for complaint resolution, the rules specifically recognize the authority of the State Board of Insurance to investigate complaints of rules violations, to conduct hearings and issue cease and desist orders and to enforce the rules governing preferred provider health benefit plans in the same manner as other health insurance policies. *Id.* § 3.3703(4) (citing TEX. INS. CODE ANN. art. 21.21-2 (Vernon 1981 & Supp. 1988)).

232. *Id.* § 3.3704(5).

233. *Id.*

234. *Id.*

235. ILL. ANN. STAT., ch. 73, ¶ 982m (Smith-Hurd Pam. Supp. 1988) (enrollee complaints only); PA. STAT. ANN. tit. 40, § 764a(e) (Purdon Pam. Supp. 1988) (enrollee complaints only); UTAH CODE ANN. § 31A-22-617(5) (1986) (enrollee and provider complaints); WIS. STAT. ANN. § 609.15 (West Supp. 1987) (enrollee complaints only).

236. *Cf.* CAL. ADMIN. CODE tit. 10, § 2240.3(a)-(f) (1984) (emergency service coverage, coverage for insured's dependents, limitations of exclusive provider arrangement, service area, and identity of principal institutional and professional providers); ME. REV. STAT. ANN. § 2675(2) (Supp. 1987) (identity of contract providers, extent of coverage, limitations or exclusions of health care services, availability of reimbursement for insured unable to obtain preferred provider services, complaint process, preferred provider deductibles and coinsurance, and rates of payment for services obtained from nonpreferred providers); MICH. COMP. LAWS ANN. § 550.53(10) (West Supp. 1988) (identity of organization contracting with provider panel and identity of party sponsoring coverage); N.D. CENT. CODE § 26.1-47-03(1)(c) (Supp.

of a provider roster,<sup>237</sup> registration with insurance authorities prior to offering preferred provider plans,<sup>238</sup> and annual reporting requirements.<sup>239</sup> The *NAIC Model Act* administration and marketing scheme does not require insurers to institute compliant resolution procedures, but does require insurers to disclose plan reimbursement terms to insureds<sup>240</sup> and noninsurer preferred provider plan sponsors to register with insurance authorities before issuing preferred provider plans.<sup>241</sup>

---

1987) (differences in benefit levels for health care services obtained from preferred and nonpreferred providers); UTAH CODE ANN. § 31A-22-617(3) (1986) (identity, location and specialty of contract providers, description of insured benefits, including deductibles, coinsurance or copayments, and description of quality assurance program and grievance procedures); WIS. ADMIN. CODE § Ins. 3.48(5) (1986) (services covered, definition of emergency services, location of providers for covered services, cost of plan, enrollment procedures, limits on benefits, and limits on choice of providers); *see also* Act effective July 1, 1988, 1988 Ga. Laws 1483, 1487 (to be codified at GA. CODE ANN. § 33-30-24(2)) (applies to health benefit plans issued, delivered, or renewed on or after Jan. 1, 1989) (differences in benefit levels for services obtained from preferred and nonpreferred providers).

237. CAL. INS. CODE § 10133.1 (West Supp. 1988); CAL. ADMIN. CODE tit. 10, §§ 2240.3(e), (f) (1984); ME. REV. STAT. ANN. tit. 24-A, § 2675(2)(A) (Supp. 1987); N.C. GEN. STAT. § 58.260.6(c)(3) (Pam. Supp. 1987).

238. Kan. Ins. Bull. 1985-16 (June 24, 1985) (insurer shall file with Commissioner of Insurance: copy of contract between insurer and health care providers; if PPO involved, copy of contract between PPO and health care providers; list of health care services covered by alternate rates of payment; and if PPO involved, statement certifying PPO capable of providing covered services); ME. REV. STAT. ANN. tit. 24-A, § 2675(1) (Supp. 1987) (insurer shall file registration statement with Insurance Commissioner containing: name which PPA intends to use and its business address; name, address, and nature of any separate organization which administers PPA for insurers; and names and addresses of all preferred providers and terms of preferred provider agreement); MINN. STAT. ANN. § 72A.20, subd. 15(4) (Supp. 1988) (same); N.C. GEN. STAT. § 58.260.6(c) (Pam. Supp. 1987) (same); PA. STAT. ANN. tit. 40, § 764a(f) (Purdon Pam. Supp. 1988) (preferred provider organization that assumes financial risk must provide requested information to Secretary of Health and Insurance Commissioner prior to commencing operation). Certain registration requirements contained in PPA statutes and regulations apply only to third-party administrators. *See* ILL. ANN. STAT. § 982k (Smith-Hurd Pam. Supp. 1988); ILL. ADMIN. CODE tit. 50, §§ 6501.10-100 (1986); ME. REV. STAT. ANN. tit. 24-A, § 2674 (Supp. 1987).

239. ME. REV. STAT. ANN. tit. 24-A, § 2679 (Supp. 1987) (administrator or insurer who issues or administers plan incorporating utilization review must file annual report with Superintendent of Insurance documenting: number and types of evaluations performed; result of each evaluation; number and result of any provider or patient appeals; complaints filed that state cause of action against administrator of insurer based on damages incurred as result of prospective evaluations); MICH. COMP. LAWS ANN. § 550.56 (West Supp. 1988) (organization shall file report documenting number of persons receiving health benefits; number of group and individual contracts providing health care services; and dollar volume of business conducted under prudent purchase agreements); MINN. STAT. ANN. § 72A.20, subd. 15(4) (Supp. 1988) (annual report shall contain summary data relating to financial reimbursement offered to preferred providers); N.C. GEN. STAT. § 58-260.6(c) (Pam. Supp. 1987) (same).

240. *See NAIC Model Act* § 5(A)(2) (National Ass'n Ins. Comm'rs 1987).

241. *See id.* § 4(C) (entity that enters into contract with health care provider, but not engaged in activities that require it to obtain license as health care insurer, must file with Commissioner of Insurance information describing its activities and terms of provider contract; employers that contract for exclusive benefit of employees exempt from registration requirements); *see also* Act effective July 1, 1988, 1988 Ga. Laws 1483, 1487 (to be codified at GA. CODE ANN. § 33-30-23(d)) (applies to health benefit plans issued, delivered, or renewed on or after Jan. 1, 1989) (same).

## V. EVALUATION OF THE TEXAS PREFERRED PROVIDER PLAN RULES

The current trend toward facilitating PPA development through legislative and administrative action<sup>242</sup> indicates a national recognition of the validity of preferred provider arrangements as a procompetitive mechanism for financing and delivering high quality, cost-effective health care services.<sup>243</sup> By regulating the formation and operation of insurer-sponsored preferred provider arrangements and the issuance of preferred provider health benefit plans, the Texas Preferred Provider Plan Rules represent an attempt to reconcile the competing state health care policy objectives of cost containment and quality assurance.<sup>244</sup> Accordingly, while the rules give commercial insurers the green light to contain costs by engaging in provider contracting and monitoring the utilization of health care resources, certain provisions in the rules designed to enhance the quality of health care services delivered pursuant to preferred provider arrangements require insurers to proceed with appropriate caution. Certain other provisions in the rules that fail to promote qualities of care adequately or that unduly impair cost containment under the preferred provider health care finance and delivery system, however, warrant critical analysis.

### A. Red Light to Regulation of PPAs Sponsored by Noninsurer Entities

State regulation of the structure and operation of preferred provider health benefit plans under the Texas Preferred Provider Plan Rules focuses exclusively on health care finance and delivery systems implemented by commercial insurers.<sup>245</sup> Despite the narrow scope of the rules, however, a

---

242. For a list of state laws and regulations enacted to facilitate the development of preferred provider arrangements, see *supra* note 102.

243. See CAL. INS. CODE § 10133.6 (West Supp. 1988) (legislature intends to ensure citizens receive high quality health care coverage in most efficient, cost effective manner possible by permitting formation of professional and institutional provider groups and purchasing groups as efficient-sized contracting units and negotiation for alternate rates of pay); LA. REV. STAT. ANN. § 40:2201 (West Supp. 1988) (legislature acknowledges that health care costs must be contained without jeopardizing quality, that health care purchasers and providers require some incentive to strive for most cost-effective methods of delivering quality patient care, and that state can assist in reducing health care costs by authorizing the formation of preferred provider organizations); NEB. REV. STAT. § 44-4108 (1984) (in connection with PPA provisions, legislature finds that it should promote competition for health care services while preserving quality of care); N.H. REV. STAT. ANN. § 420-C:1 (Supp. 1987) (purpose of PPA legislation is to ensure that contracts between insurers and preferred providers are fair and in the public interest and to establish reasonable regulations to contain health care costs while preserving quality of care); N.C. GEN. STAT. § 558.260.5 editor's note (Supp. 1987) (purpose of PPA legislation is to enable insurers and persons coordinating provision of health care benefits on fee for service basis to seek, experiment with, and implement innovative means of reducing costs of health care services); see *NAIC Model Act* § 2 (National Ass'n Ins. Comm'rs 1987) (purpose of legislation is to encourage health care cost containment while preserving quality of care); see also Act effective July 1, 1988, 1988 Ga. Laws 1483, 1484 (to be codified at GA. CODE ANN. § 30-30-21) (applies to health benefit plans issued, delivered, or renewed on or after Jan. 1, 1989) (legislature intends to encourage health care cost containment while preserving quality of care by permitting insurers to form PPAs and by preserving minimum standards to PPAs and preferred provider health benefit plans).

244. See TEXAS SENATE COMM. ON INS., INTERIM REPORT ON PREFERRED PROVIDER PLANS, 70th Leg. 1, 3-4 (1986) [hereinafter INSURANCE COMMITTEE REPORT].

245. 28 TEX. ADMIN. CODE § 3.3701 (1986).



variety of entities in Texas currently engage in provider contracting.<sup>246</sup> Under the present regulations' framework, insured, self-insured, and noninsured preferred provider arrangements operate without specific guidelines for providers' panel assembly, health care benefits, and service delivery.

The State Board of Insurance has statutory jurisdiction to adopt rules governing the health benefit plans offered by commercial insurers,<sup>247</sup> group hospital service corporations,<sup>248</sup> and HMOs.<sup>249</sup> As presently drafted, however, the Texas Preferred Provider Plan Rules only contain guidelines for plans issued by commercial insurance companies.<sup>250</sup> The Texas Insurance Code permits group hospital service corporations to contract with institutional and professional health care providers, other than physicians.<sup>251</sup> As a prerequisite to provider contracting under the code, the corporation must obtain approval of form provider agreements from the Commissioner of Insurance.<sup>252</sup> In a recent order the Commissioner approved a form agreement submitted by a corporation for use in contracting with physician providers.<sup>253</sup> By permitting group hospital service corporations on a case by case basis to contract with the same range of providers covered by the Texas Preferred Provider Plan Rules, the Commissioner is effectively permitting the corporations to circumvent provider participation and service delivery requirements imposed on commercial insurers. To eliminate this regulatory dichotomy, the State Board of Insurance should amend the rules to apply specifically to group hospital service corporations. The Board may also consider expanding the scope of the rules to permit an HMO to assemble preferred provider panels consisting of HMO panel members<sup>254</sup> or advocating selective contracting by public entities.<sup>255</sup>

Self-insured and certain other noninsured preferred provider arrangements remain outside the statutory jurisdiction of the State Board of Insurance and therefore outside the scope of the rules as presently drafted or amended. ERISA regulations impose reporting, disclosure, and fiduciary obligations on employers that administer qualified employee welfare benefit plans.<sup>256</sup> The preemption of state law by ERISA in the context of employee welfare benefit plans that include purchaser-based preferred provider ar-

---

246. INSURANCE COMMITTEE REPORT, *supra* note 244, at 7-8; TMA TASK FORCE REPORT, *supra* note 5, at 5.

247. TEX. INS. CODE ANN. art. 3.42 (Vernon 1981 & Supp. 1988).

248. *Id.* art. 20.02.

249. *Id.* art. 20A.04.

250. 28 TEX. ADMIN. CODE § 3.3701 (1986).

251. TEX. INS. CODE ANN. art. 20.11 (Vernon 1981).

252. *Id.* art. 20.02(e).

253. Order No. 87-0176, Approving Blue Cross and Blue Shield of Texas Proposed Provider Agreement Form (Feb. 23, 1987).

254. W. Darling, Comments of Wood, Lucksinger & Epstein on Texas Proposed Preferred Provider Plan Rules, 28 TEX. ADMIN. CODE §§ 3.3701-3.3705 (1986) 1-2 (Jan. 6, 1986) [hereinafter WLE Comments].

255. For an analysis of state-sponsored selective contracting, see *supra* notes 96-100 and accompanying text.

256. See ERISA § 3(1), 29 U.S.C. § 1002(1) (1982) (employee welfare benefit plan includes any program that provides medical, surgical, or hospital care, or benefits in the event of sickness, accident, disability, death, or unemployment).

rangements depends on the manner in which self-insured employers elect to finance and administer purchaser-based PPAs.<sup>257</sup> Regulatory grey areas arise when employees contract with insurance companies to administer the plan and process claims<sup>258</sup> and when employers purchase "stop loss" coverage from insurance companies.<sup>259</sup> Because these arrangements combine aspects of self-funding and indemnity insurance, the ERISA state law preemption may not apply. Indeed, two recent federal cases indicated that "mixed plans" may be subject to state insurance regulation.<sup>260</sup> Noninsured preferred provider arrangements not presently regulated by ERISA guidelines or the State Board of Insurance include PPAs sponsored by providers and third-party entities. Because the Board has no legal authority to control the activities of PPA sponsors not engaged in the business of insurance, however, noninsured PPAs may continue to function independently.<sup>261</sup>

### B. *Red Light to Selective Provider Contracting*

The Texas Preferred Provider Plan Rules mandate that insurers form open panel preferred provider arrangements.<sup>262</sup> The permissible terms and conditions of provider participation under the Texas rules, however, prevent insurers from engaging in selective contracting as a method of cost containment and quality control. Provider participation requirements also prevent insurers from establishing specialty or limited service provider panels.

The provisions regulating panel assembly contained in the Texas Preferred Provider Plan Rules require insurers to extend panel membership to any professional or institutional provider willing to meet the terms and conditions of provider participation.<sup>263</sup> The rules' provider participation provisions appropriately guarantee individual providers the right to participate in a preferred provider panel<sup>264</sup> and prevent discrimination among various provider classes.<sup>265</sup> The "any willing provider" requirement<sup>266</sup> may, however, substantially inhibit the insurer's ability to evaluate the professional qualifications of prospective panel members and realize maximum cost savings. Under the rules as presently drafted, general quality considerations constitute a valid condition of preferred provider participation.<sup>267</sup> The nonselective approach to provider contracting advocated by the rules, however, may prevent insurers from conducting a comprehensive quality appraisal of pro-

---

257. See *id.* § 1144(a); Kilberg & Inman, *Preemption of State Laws Relating to Employee Benefit Plans: An Analysis of ERISA Section 514*, 62 TEX. L. REV. 1313 (1984).

258. See FTC STUDY, *supra* note 102, at 14-16; Grant *supra* note 56, at 41.

259. See FTC STUDY, *supra* note 102, at 14-15.

260. See *Michigan United Food v. Baerwaldt*, 767 F.2d 308 (6th Cir. 1985), *cert. denied*, 106 S. Ct. 801 (1986) (self-funded employee benefit plan that purchased stop-loss coverage subject to mandated benefits provisions of Massachusetts insurance law).

261. INSURANCE COMMITTEE REPORT, *supra* note 244, at 8.

262. 28 TEX. ADMIN. CODE § 3.3703(1), (2) (1986); see FTC STUDY, *supra* note 102, at 42.

263. 28 TEX. ADMIN. CODE § 3.3703(1) (1986).

264. See *supra* notes 129-38.

265. See *supra* note 177.

266. See FTC STUDY, *supra* note 102, at 42-44 (analyzes incidence, rationale, and impact on PPAs of any willing provider provisions).

267. 28 TEX. ADMIN. CODE § 3.3703(1) (1986).

spective preferred providers. In comments submitted to the State Board of Insurance during the preferred provider plan rulemaking process, insurance industry spokespersons emphasized the important role of quality screening in the formation of preferred provider panels.<sup>268</sup> One commentator associated with the provider community proposed that the rules set forth a nonexclusive list of objective factors for evaluating potential provider participants.<sup>269</sup> According to the commentator, possible objective factors relating to provider quality include the number of complaints submitted to state licensing agencies concerning provider performance, the number of administrative or private sanctions imposed on a provider, and the number of civil suits against a provider successfully alleging professional or institutional liability.<sup>270</sup>

Comments submitted to the State Board of Insurance by representatives of the insurance industry in connection with the Texas Preferred Provider Plan Rules' rulemaking process indicate that the any willing provider requirement also creates a threefold negative impact on PPA cost containment initiatives.<sup>271</sup> First, the any willing provider requirement removes the competitive incentive for providers to grant discounts.<sup>272</sup> Selective provider contracting creates an incentive on the part of providers seeking to obtain panel membership to offer discounts in consideration for receiving preferred provider status.<sup>273</sup> Under the nonselective system contemplated by the rules, however, insurers automatically guarantee preferred status to providers that agree to comply with the terms and conditions of panel participation. As a result, providers need not offer competitive discounts in bargaining for panel membership.

Second, even if the any willing provider requirement does not inhibit provider discounts, certain comments predicted that the rules' failure to authorize selective provider contracting will promote the development of discount-

---

268. See D. Erenerman, Comments of Union Mutual Life Ins. Co. on Texas Proposed Preferred Provider Plan Rules, 28 TEX. ADMIN. CODE §§ 3.3701-3.3705 (1986) 2 (Jan. 16, 1986) [hereinafter Union Mutual Comments]; J. Cross, Comments of John Hancock Life Ins. Co. on Texas Proposed Preferred Provider Plan Rules, 28 TEX. ADMIN. CODE §§ 3.3701-3.3705 (1986) 4 (Jan. 17, 1986) [hereinafter John Hancock Comments]; A. Simpson, Comments of Pacific Mutual Life Ins. Co. on Texas Proposed Preferred Provider Plan Rules, 28 TEX. ADMIN. CODE §§ 3.3701-3.3705 (1986) 1 (Jan. 8, 1986).

269. WLE Comments, *supra* note 254, at 3 (objective factors proposed for institutional providers only).

270. See *id.*; John Hancock Comments, *supra* note 268, at 4. But see T. Campbell, Comments of Aetna Life Ins. Co. on Texas Proposed Preferred Provider Plan Rules, 28 TEX. ADMIN. CODE §§ 3.3701-3.3705 (1986) 2 (Jan. 6, 1986) [hereinafter Aetna Comments] (discusses difficulty of applying specific quality criteria to prospective preferred providers).

271. See Aetna Comments, *supra* note 270, at 2; Letter from Timothy R. Campbell, Asst. Vice Pres., Aetna Life Ins. Co. to Woody Pogue, Deputy Ins. Comm'r 2 (Jan. 7, 1986) [hereinafter Aetna Letter].

272. Aetna Letter, *supra* note 271, at 2.

273. *Id.*; S. Bleikoff, Comments of American General Group Ins. Co. on Texas Proposed Preferred Provider Plan Rules, 28 TEX. ADMIN. CODE §§ 3.3701-3.3703 (1986) 1 (Jan. 10, 1986) [hereinafter American General Comments]. For a discussion of provider discounts as a form of consideration for increases in patient volume, associated with participation in preferred provider arrangements, see *supra* note 23.

only PPAs.<sup>274</sup> Selective provider contracting enables PPA sponsors to assemble panels consisting of cost-efficient professionals and institutions.<sup>275</sup> The preferred provider health care delivery system operates to contain costs by enabling these proven low cost providers, practicing pursuant to the PPA utilization management protocol, to deliver a significant proportion of the covered health care services.<sup>276</sup> Analysts regard preferred provider arrangements that rely on provider discounts as the exclusive method of cost containment as economically unstable and conducive to cost shifting.<sup>277</sup>

Finally, the any willing provider requirement effectively eliminates preferred provider plan competition.<sup>278</sup> Several bases for competition exist among preferred provider health benefit plans. In addition to premium rates and benefit levels, the composition of the preferred provider panel has been identified as the most significant procompetitive plan variable.<sup>279</sup> The commentator noted that the types of providers represented on the panel and the reputation of particular panel members constitute extremely valuable sources of insurance product differentiation.<sup>280</sup> Representatives of the provider community generally regard competition among providers on the basis of fees, quality of service, skill, experience, and access as a positive characteristic of the market for health care services.<sup>281</sup> The nonselective provider contracting process advocated by the Texas rules, however, prevents insurers from utilizing this market characteristic to design a competitive preferred provider health benefit plan that features a cost-efficient, skilled and accessible provider panel. To enable insurers to adequately assess the professional qualifications of potential preferred providers and to eliminate the potential adverse effect of nonselective provider contracting on cost containment under the preferred provider health care finance and delivery system, the State Board of Insurance should amend the Texas Preferred Provider Plan Rules to permit insurers to contract with prospective providers on a selective basis.

By preventing insurers from engaging in selective provider contracting, the Texas rules' any willing provider requirement necessarily prohibits the formation of specialty or limited service provider panels. In comments on the proposed preferred provider plan rules, a proponent of single class provider panels convincingly argued that open panel plans force insurers to incur higher costs.<sup>282</sup> For example, a requirement that insurers providing

---

274. See Aetna Comments, *supra* note 270, at 2.

275. See *supra* notes 19-21 and accompanying text.

276. See Hester & Wouters, *supra* note 18.

277. See INSURANCE COMMITTEE REPORT, *supra* note 244, at 4; TMA TASK FORCE REPORT, *supra* note 5, at 4; Gabel & Ermann, *supra* note 18, at 307; Aetna Comments, *supra* note 270, at 2.

278. Aetna Letter, *supra* note 271, at 2.

279. *Id.*

280. *Id.*

281. AMERICAN MED. ASS'N, CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS § 6.11 (1986) [hereinafter AMA JUDICIAL OPINIONS]; see *id.* § 9.06 (free competition among physicians and alternative systems of care constitute prerequisites to optimal patient care).

282. Aetna Comments, *supra* note 270, at 2.

coverage for inpatient hospital care extend preferred provider status to nonhospital practitioners forces the insurer to establish two separate systems for application review, contract negotiation, billing and claims, and performance evaluation.<sup>283</sup> Preferred provider plan rules in certain other states provide a more flexible framework for panel composition by permitting insurers to limit panel membership based on types of services,<sup>284</sup> provider specialty,<sup>285</sup> and the anticipated needs of the insured population.<sup>286</sup> To enable insurers to tailor health benefit plans to the needs of the insured population and to enhance cost savings by facilitating competition on the basis of panel composition, the State Board of Insurance should amend the Texas Preferred Provider Plan Rules to permit insurers to make use of selective provider contracting to offer preferred provider health benefit plans that feature specialty or limited service provider panels.

### C. Differential Benefit Limit Requires Insurers to Proceed with Caution

An insurer's ability to promote the use of preferred providers by offering insureds an incentive to obtain health care services from contract providers constitutes an important component of the PPA cost containment equation.<sup>287</sup> Certain provisions of the Texas Insurance Code, however, prohibit insurers from drafting policy provisions that discriminate among insureds on non-risk grounds or that directly or indirectly dictate the insureds' choice of health care provider.<sup>288</sup> Furthermore, representatives of the provider community view freedom of provider choice as a fundamental prerequisite to the delivery of optimal patient care.<sup>289</sup> To accommodate the interests of insurers, insureds, and providers, the Texas Preferred Provider Plan Rules authorize insurers to issue health benefit plans featuring nondiscriminatory, potentially cost saving differential benefit levels that preserve the insureds' autonomy in provider selection.<sup>290</sup> Specifically, the rules permit insurers to institute a health care finance system that reimburses insureds who obtain services from preferred providers at a rate thirty percent higher than the basic level of coverage.<sup>291</sup> Consistent with provider community recommen-

---

283. *Id.*

284. WIS. STAT. ANN. § 609.01(4) (West Supp. 1987).

285. CAL. ADMIN. CODE tit. 10, § 2240.1 (1984); ME. REV. STAT. ANN. tit. 24-A, § 2672 (Supp. 1987); NEB. REV. STAT. § 44-4110 (1984).

286. CAL. ADMIN. CODE tit. 10, § 2240.1 (1984); ME. REV. STAT. ANN. tit. 24-A, § 2672 (Supp. 1987); MICH. COMP. LAWS ANN. §§ 550.53(1), (9) (West Supp. 1988); NEB. REV. STAT. § 44-4110 (1984).

287. *See supra* notes 25-29 and accompanying text.

288. *See supra* notes 173-79 and accompanying text.

289. *See* AMA JUDICIAL OPINIONS, *supra* note 281, at § 9.06 (every individual has right to select his physician); *see also* TMA Comments, *supra* note 5, at 4-7, 8-11. TMA contended that because preferred provider insurance plans require insureds to obtain services from a particular provider in order to receive a higher level of coverage, the plans violated the freedom of choice provisions of the Texas Insurance Code. *Id.* at 5. TMA disputed insurance industry arguments that an insured's provider and benefit schedule selection represented an exercise of voluntary choice. *Id.* at 6-8. Specifically, TMA maintained that preferred provider plans constituted an intrinsically coercive form of health care reimbursement system. *Id.* at 8.

290. *See* 28 TEX. ADMIN. CODE § 3.3704(1) (1986).

291. *Id.*

ditions, the State Board of Insurance appropriately reinforced the rules' moderate differential benefit scheme by banning the issuance of exclusive provider health benefit plans.<sup>292</sup>

Analysts assert that a twenty percent marginal increase in benefits offered for services obtained from preferred providers constitutes an adequate positive incentive for insureds to elect to obtain health care services from preferred rather than nonpreferred providers.<sup>293</sup> The thirty percent benefit differential authorized by the rules, therefore, is large enough to encourage the use of preferred providers, but not so large as to require insureds to obtain services from a particular provider.<sup>294</sup> Moreover, the rules' prohibition on health benefit plans based on exclusive provider arrangements further protects the insured's ability to select freely a health care provider by guaranteeing a basic level of coverage for services obtained from nonpreferred providers.<sup>295</sup> The Texas Preferred Provider Plan Rules, therefore, successfully resolve the conflict between the Insurance Code policy against imposing restrictions on freedom of provider choice and the economic policy in favor of containing health care costs by preserving the insured's autonomy in provider choice without nullifying the effect of differential benefit levels as a mechanism for patient channelling.

*D. Access and Referral Provisions Require Insurers  
to Proceed with Caution*

The provider access and referral regulations set forth in the Texas Preferred Provider Plan Rules distinctively impact four variables in the health care service delivery component of the PPA cost containment equation. First, the Texas Preferred Provider Plan Rules expressly guarantee insureds direct and reasonable access to all classes of professional providers licensed to deliver covered services.<sup>296</sup> Access guarantees impliedly dictate the number, type, and availability of health care providers under contract with an insurer, the first variable in the PPA cost containment equation. Provisions protecting an insured's right to access health care providers, therefore, compromise the insurer's ability to exercise complete discretion in provider panel assembly.<sup>297</sup> Moreover, adequate access requirements compel insurers to institute PPA operation procedures that guarantee the availability of appropriate health care personnel and facilities.

Based on the specific characteristics, medical needs, and projected demand for health care services of the insured population, adequate access constitutes a fundamental prerequisite to quality health care service delivery under a preferred provider arrangement. To deliver the guarantee of adequate access to preferred provider health care services, the State Board of Insurance

---

292. *Id.* § 3.3703(2); see TMA Safeguard Memo, *supra* note 5, at 3.

293. See FTC STUDY, *supra* note 102, at 48.

294. See Aetna Letter, *supra* note 271, at 2.

295. 28 TEX. ADMIN. CODE § 3.3703(2) (1986).

296. *Id.* § 3.3705(1).

297. For a discussion of preferred provider panel assembly, see *supra* notes 19-21 and accompanying text.

should amend the Texas Preferred Provider Plan Rules to require insurers to satisfy specific access standards similar to those adopted by other states.<sup>298</sup> Specifically, the Board should amend the rules to require insurers to form preferred provider panels that consist of the number of professional and institutional providers, including administrative and support personnel, necessary to enable the PPA to satisfy a minimum insured to provider ratio.<sup>299</sup> The Board should further amend the rules to require insurers to provide insureds adequate access to specialty care through contracting or referral and to contract with institutional providers located within a reasonable geographic proximity to insureds.<sup>300</sup>

Second, the Texas Preferred Provider Plan Rules prevent an insurer from requiring that a certain class of practitioner refer a patient into the preferred provider system.<sup>301</sup> Accordingly, the rules impact a second variable in the PPA cost containment equation by regulating initial preferred provider referral.<sup>302</sup> Specifically, the rules prevent insurers from designating a primary care physician to act as a health care resource gatekeeper.<sup>303</sup> Primary care gatekeepers function within health care delivery systems to promote the efficient use of medical resources by coordinating the care rendered by participating providers.<sup>304</sup> In comments on the proposed rules, representatives of the provider community characterized the primary care gatekeeper as an access limitation mechanism that prevents insureds from obtaining treatment from the practitioner or specialist of his choice.<sup>305</sup> The complete ban on gatekeeper mechanisms imposed by the Texas Preferred Provider Plan Rules, however, denies insurers an important cost-saving tool and evidences a disregard for variations in the design of certain gatekeeping mechanisms.

Preferred provider plans need not necessarily make gatekeeper referral an absolute prerequisite for access to the preferred provider system. To achieve the cost savings associated with coordinated utilization without violating policy concerns relating to restricted access to health care services, preferred provider plans could treat gatekeeper referral as an optional route for entry into the preferred provider system.<sup>306</sup> Under this alternate framework, preferred provider plans could offer a higher level of coverage or financial incentives to insureds who elect to access the system by seeking an initial referral from a preferred provider trained to make appropriate referral determinations.<sup>307</sup>

By providing insureds continuity of care and ease of access to providers

---

298. See *supra* note 204.

299. See CAL. ADMIN. CODE tit. 10, § 2240.2(b) (1984).

300. See *id.* § 2240.2(3); WIS. ADMIN. CODE § Ins. 3.48(2) (1986).

301. 28 TEX. ADMIN. CODE § 3.3703(3) (1986).

302. For a discussion of provider referral in the context of PPA open panel health care delivery system, see *supra* notes 31-35 and accompanying text.

303. WLE TEXAS ALERT, *supra* note 104, at 4.

304. See Trapnell, *Actuarial Problems in PPOs*, in NEW HEALTHCARE MARKET, *supra* note 15, at 285, 293 (outlines gatekeeper utilization control device).

305. See TMA Safeguard Memo, *supra* note 5, at 2.

306. See WLE Comments, *supra* note 254, at 4.

307. *Id.*

while managing the delivery of necessary health care services, preferred provider plans that employ primary care gatekeepers promote both quality of care and cost containment. In recognition of the valuable function of gatekeepers, the State Board of Insurance should amend the Texas Preferred Provider Plan Rules to permit insurer-sponsored PPAs to utilize primary care gatekeepers and offer insureds an incentive to use the primary care gatekeeper whether the gatekeeper refers the insured to a preferred or nonpreferred provider.

Third, consistent with provider community recommendations,<sup>308</sup> the Texas Preferred Provider Plan Rules guarantee each insured the right to the treatment and testing procedures prescribed by the insured's practitioner.<sup>309</sup> By regulating intra and extra system referral, a third variable in the PPA cost containment equation,<sup>310</sup> the rules appropriately assure flexible referral among preferred and nonpreferred providers.<sup>311</sup> Moreover, the pre-referral disclosure requirements imposed by the rules<sup>312</sup> comply with the referral procedures advocated by the provider community in the context of alternative health care delivery systems.<sup>313</sup> Open referral permits providers to direct insureds to the most appropriate medical care without regard to the providers' contractual relationship with the insurer.<sup>314</sup> Accordingly, the open referral system mandated by the rules promotes quality in health care service delivery by allowing the provider to function as an advocate for the health care needs of each insured patient.

Finally, specific provisions contained in the Texas Preferred Provider Plan Rules address the delivery of emergency care services, a fourth variable in the PPA cost containment equation. At the expense of payor cost containment, the rules specifically require insurers to reimburse insureds for emergency care services rendered by nonpreferred providers at the preferred rate until the insured can be safely transferred to the care of a preferred provider.<sup>315</sup> By facilitating the prompt delivery of emergency care services and eliminating financial incentives to transfer patients insured under preferred provider plans, the rules' emergency care provisions effectively promote quality in health care service delivery.<sup>316</sup>

---

308. See MINORITY REPORT, *supra* note 5, at 9.

309. 28 TEX. ADMIN. CODE § 3.3705(1) (1986).

310. See *supra* notes 31-35 and accompanying text.

311. See AMA JUDICIAL OPINIONS, *supra* note 281, § 3.04 (physician may refer patient for diagnosis or treatment to another physician, specialist, or health care provider if referral will benefit patient).

312. 28 TEX. ADMIN. CODE § 3.3705(1) (1986); see *supra* text accompanying note 200.

313. See AMA JUDICIAL OPINIONS, *supra* note 281, § 8.12 (if PPO or HMO limits referral to medical specialists or diagnostic or treatment facilities, when physician determines patient requires specialty care, the physician must inform patient of need for and consequences of referral).

314. TMA Safeguard Memo, *supra* note 5, at 2.

315. 28 TEX. ADMIN. CODE § 3.3705(1) (1986).

316. See G. Hooser, Comments of the American College of Emergency Physicians, Texas Chapter on Texas Preferred Provider Plan Rules, 28 TEX. ADMIN. CODE §§ 3.3701-3.3705 (1986) 1 (June 3, 1986).



*E. Green Light to Prospective Utilization Review*

Utilization review procedures implemented in connection with the preferred provider health care delivery system attempt to contain health care costs by monitoring the quantity of services delivered.<sup>317</sup> The Texas Preferred Provider Plan Rules authorize PPA sponsors to conduct both prospective and retrospective utilization review.<sup>318</sup> Certain prospective utilization review procedures require the physician to obtain pretreatment authorization for payment from the third-party health care payor.<sup>319</sup> To the extent that it subjects professional medical judgment to a cost-benefit analysis, prospective utilization review provides the setting for a direct confrontation between medical and economic decision making.<sup>320</sup> In practice, economic considerations may override professional judgment and the resulting payment denial may operate to preclude the delivery of needed patient care. By enabling insurers to require participating physicians to obtain pretreatment authorization for services delivered under a preferred provider health benefit plan, prospective utilization review conducted under the present Texas Preferred Provider Plan Rules may compromise the quality of care delivered pursuant to preferred provider arrangements. Moreover, prospective utilization review may expose insurers to liability for negligence in the design and implementation of prospective utilization review procedures, if care is denied as a result of a utilization review decision that overrides the medical judgment of the treating physician. Prospective utilization review may also expose insureds to contract and extracontract liability for bad faith. Finally, a system of prospective utilization review that directly incorporates financial considerations may expose providers to liability, if financial considerations cause providers to reduce the level of services delivered to insureds pursuant to a preferred provider health benefit plan below community standards.

A recent California state court decision indicates that an insurer may be legally responsible for harm resulting from the improper design and application of a prospective utilization review program. In *Wickline v. State of California*<sup>321</sup> a California court of appeals ruled that a patient who is harmed as

---

317. See *supra* notes 38-44 and accompanying text.

318. 28 TEX. ADMIN. CODE §§ 3.3702, 3.3705(4) (1986).

319. See *supra* notes 46-49.

320. In its amicus curiae brief submitted on behalf of the respondent to the California Court of Appeals in *Wickline v. California*, 183 Cal. App. 3d 1175, 228 Cal. Rptr. 661 (1986), counsel for the California Hospital Association noted that "hospitals and patients are caught in the crossfire of a major social conflict centered on reconciling the competing forces for health care cost containment and health care quality." Amicus Curiae Brief on Behalf of the California Hospital Association in Support of Respondent Lois J. Wickline at 7, *Wickline v. California*, 183 Cal. App. 3d 1175, 228 Cal. Rptr. 661 (1986) (2D Civ. B010156). Counsel characterized each decision regarding the utilization of inpatient care as a skirmish in the overall conflict. *Id.* For an analysis of the confrontation between medical and economic decision making in the PPA context, see Anthony, *supra* note 39, at 87-92; Entin, *DRGs, HMOs and PPOs: Introducing Economic Issues in the Medical Malpractice Case*, 20 FORUM 674, 681-84 (1985); Wilcox, *Pressure to Serve Two Masters*, TEX. MED., June 1986, at 67, 67-69.

321. 192 Cal. App. 3d 1630, 239 Cal. Rptr. 810 (1986). Wickline brought suit against the State of California as the administrator of the Medi-Cal utilization review program for dam-

a result of the denial of medical treatment may recover from all those responsible for the failure to treat, including, when appropriate, the third-party payor of health care services.<sup>322</sup> According to the court, the appropriate circumstances for holding a third-party payor liable exist when utilization review measures designed to contain health care costs unreasonably override a treating physician's medical judgment.<sup>323</sup>

In *Wickline* the appellate court identified the principal issue in the case to revolve around who bears the responsibility for a patient's hospital discharge, the patient's physician or Medi-Cal, the health care payor.<sup>324</sup> The *Wickline* court found that the decision to discharge is the responsibility of the patient's treating physician who is in a better position than a member of a utilization review panel to determine the medically necessary length of stay.<sup>325</sup> The court further found that physicians should appeal a denial of

---

ages associated with the amputation of her right leg. *Wickline v. California*, No. NWC 60672 (Cal. Civ. 1982) (no written opinion issued); see Butler, *Preferred Provider Organization Liability for Physician Malpractice*, 11 AM. J.L. & MED. 345, 364 n.154 (1986). The trial court found that the patient was injured as a result of a premature discharge ordered pursuant to continued stay review. See Butler, *supra*, at 364. Accordingly, the trial court held that the Medi-Cal patient presented a valid cause of action against the state utilization review consultant for denial of a request for an extension of hospital stay and awarded Wickline \$500,000.00 in damages. *Id.* On appeal, the second district court of appeals reversed the trial court and held in favor of the State. 183 Cal. App. 3d 1175, 228 Cal. Rptr 661 (1986). The Supreme Court of California dismissed the petition for review and remanded the case to the second district court of appeals. 43 Cal. 3d 1035, 741 P.2d 613, 239 Cal. Rptr. 805 (1987). Citations refer to the republished opinion of the second district court of appeals. 192 Cal. App. 3d at 1647, 239 Cal. Rptr. at 820.

322. 192 Cal. App. 3d at 1645, 239 Cal. Rptr. at 819.

323. *Id.*

324. *Id.* at 1644, 239 Cal. Rptr. at 819. The facts in *Wickline* parallel the typical scenario for a utilization monitored inpatient hospital stay. On January 6, 1977, after obtaining pre-treatment authorization from a Medi-Cal Consultant for surgery and hospitalization, Wickline was admitted to Van Nuys Community Hospital (the Hospital). See CAL. ADMIN. CODE tit. 22, § 51327(a)(2) (1977) (to obtain Medi-Cal coverage for nonemergency hospital care, a Medi-Cal Consultant shall authorize specified number of days for hospitalization prior to admission); see also CAL. WELF. INST. CODE § 14132 (West 1977) (prior authorization by Medi-Cal Consultant shall be based on determination of medical necessity). The next day Wickline underwent a lumbar sympathectomy. Due to complications, the patient's surgeon determined that Wickline's condition required hospitalization beyond the ten days allocated by Medi-Cal. Accordingly, he submitted a formal request for an extension of stay to the Medi-Cal on-site nurse. See CAL. ADMIN. CODE tit. 22, § 51327(a)(2) (1977) (necessary hospitalization beyond specified number of days shall be covered only upon approval of extension of hospital stay by Medi-Cal Consultant on or before last day of approved hospitalization period). Refusing to grant the requested extension of hospital stay, the on-site nurse referred Wickline's case to the Medi-Cal consulting physician for a final determination. *Id.* Based on a telephone conference with the on-site nurse, the Medi-Cal Consultant granted a four-day extension in lieu of the eight-day extension requested by Wickline's surgeon. In granting the four-day extension, the Medi-Cal Consultant elected not to review written information concerning Wickline's condition supplied by her surgeon. On January 21, 1977, in compliance with the limited extension of stay, Wickline's treating physicians processed her discharge from the Hospital. Subsequent to her discharge, the patient experienced increased pain and loss of circulation in her leg. On January 30, 1977, Wickline was readmitted to the Hospital as an emergency patient. Two weeks later, due to severe clotting and infection, Wickline's surgeon amputated her leg above the knee. Wickline elected not to sue her attending physician, since she regarded the physician as much a victim of the system as the patient. Butler, *supra* note 321, at 364 (citing S. TIBBITS & A. MANZANO, PPOS: AN EXECUTIVE'S GUIDE 142 (1984)).

325. 192 Cal. App. 3d at 1645, 239 Cal. Rptr. at 819.

extended hospital stay issued in connection with prospective utilization review if, in the physicians' professional judgment, a patient's condition warrants continued hospitalization.<sup>326</sup> Applying this rule to the *Wickline* facts, the court conceded that since Medi-Cal financed the patient's treatment, its input as to the extent of hospital care delivered may have influenced the treating physician's course of action.<sup>327</sup> Upon determining that Medi-Cal's influence in denying payment authorization for continued hospital stay was insufficient to override the professional judgment of Wickline's treating physician,<sup>328</sup> however, the court held that Medi-Cal was not liable for damages resulting from Wickline's premature discharge because Medi-Cal was not a party to her treating physician's medical discharge decision.<sup>329</sup>

The *Wickline* decision sets a significant precedent for insurer liability in the operation of utilization review pursuant to the Texas Preferred Provider Plan Rules. Notably, *Wickline* represents the first appellate court opinion to address the liability of a third-party payor for damages resulting from its prospective review of a medical decision.<sup>330</sup> Moreover, while the *Wickline* decision focuses on the liability of the State of California as sponsor of the Medi-Cal program, the holding should not be read as limited to its facts. Indeed, the opinion specifically recognizes that both public and private health care payors employ prospective utilization review as a method of cost containment.<sup>331</sup> As the *Wickline* court predicted, the decision to link health payors to the medical malpractice chain of causation by imposing liability for their participation in utilization review activities raises issues of great significance to the health care community and the insured public.<sup>332</sup> In particular, the *Wickline* decision provides useful guidance for third-party payors concerning the proper design and operation of utilization management programs.

Pursuant to the *Wickline* standard, certain provisions contained in the Texas Preferred Provider Plan Rules governing utilization review may fail to facilitate the delivery of quality care adequately and, as a result, may expose

---

326. *Id.*; see CAL. ADMIN. CODE tit. 22, § 51000(g)(1)-(3) (1977). Under the Medi-Cal regulations, a provider must initiate an appeal of an extension of stay denial within thirty days of notification of the decision. *Id.* § 51003(g)(1). If the Medi-Cal Consultant finds no grounds for altering its decision, the consultant is directed to forward the appeal to the Field Services Regional Office and thereafter to the California Department of Health. *Id.* §§ 51003(g)(2), (3).

327. 192 Cal. App. 3d at 1646, 239 Cal. Rptr. at 819.

328. *Id.*

329. *Id.*; 239 Cal. Rptr. at 819-20.

330. Amicus Curiae Brief on Behalf of the California Medical Association in Support of Respondent Lois J. Wickline at 3, *Wickline v. California*, 183 Cal. App. 3d 1175, 228 Cal. Rptr. 661 (1986) (No. 2D Civ. 010156). Counsel for the California Medical Association stated:

The *Wickline* case has been noted in medical and legal publications throughout the country as an example of the concerns raised by prospective review programs. Moreover, this court's opinion may well be the first appellate court case in the nation to discuss the legal issues raised by the health care rationing process.

*Id.*; see also L. Snyder, Remarks at the AMCR Annual Conference (Sept. 26, 1986) (discussing significance of *Wickline* case for potential PPA liability).

331. 192 Cal. App. 3d at 1633, 239 Cal. Rptr. at 811.

332. *Id.*

insurers to liability. The Texas rules appropriately guarantee the insured patient's right to the treatment and diagnostic techniques prescribed by the insured's professional provider.<sup>333</sup> The Texas rules, however, also permit insurers to implement procedures for evaluating and correcting health care resource expenditures.<sup>334</sup> In an effort to ensure that resource utilization procedures do not compromise a provider's ability to exercise professional judgment in the decision of patient care, the rules authorize insurers to institute delegated, physician-controlled utilization review.<sup>335</sup> In a departure from the utilization review procedures advocated by *Wickline*, however, the Texas Preferred Provider Plan Rules fail to incorporate an appeal mechanism for providers who obtain utilization review determinations that conflict with a prescribed treatment program. To limit potential insurer liability in the operation of PPA utilization review mechanisms, therefore, the State Board of Insurance should amend the Texas Preferred Provider Plan Rules to require insurers to institute procedures for appealing treatment denials in connection with prospective utilization review.

In addition to liability for usurping professional treatment decisions, prospective utilization review mechanisms may constitute a source of insurer

---

333. 28 TEX. ADMIN. CODE § 3.3705(1) (1986). For a discussion of this patient safeguard in this context of provider referral, see *supra* notes 308-314 and accompanying text. TMA first recommended the provision as one of its counterproposals to PPO legislation sponsored by the insurance industry. See TMA Safeguard Memo, *supra* note 5, at 3. The provision is designed to prevent undue interference with a physician's discretion to treat his patient. *Id.* TMA proposed further language that would expressly prohibit interference by the insurer in patient care and preserve the traditional physician-patient relationship under the PPA system. *Id.* The TMA version read: "Each insured patient shall have the right to the treatment and diagnostic techniques as prescribed by the physician of the patient's choice without interference by the insurer. The insurer shall support continuity of care, and the development of a continuing relationship between physician and patient." *Id.*; see also CAL. ADMIN. CODE tit. 10, § 2240.1(a)(2) (1984) (insurers required to ensure decisions relating to health care services to be rendered to insureds based on the insureds' medical needs and made by or under supervision of licensed physicians or other health care professionals); *id.* § 2240.4 (contracts between exclusive providers and insurers shall provide that providers' primary consideration shall be quality of health care services rendered to insureds); LA. REV. STAT. ANN. § 40:2203 (West Supp. 1988) (agreement between group purchaser and provider to form preferred provider organization shall not authorize group purchaser to direct or control provision or selection of forms or types of medical services to group members); WIS. STAT. ANN. § 628.37 (West Supp. 1987) (no insurance plan related to or providing health care may alter direct relationship and responsibility of professional persons to their patients for the professional services rendered). But see Fox & Anderson, *Hybrid HMOs, PPOs: The New Focus*, BUS. & HEALTH, Mar. 1986, at 20, 21 (discussing merits of provider at risk PPA utilization schemes).

334. 28 TEX. ADMIN. CODE § 3.3702 (1986).

335. *Id.* § 3.3705(4); see TMA Comments, *supra* note 5, at 25. In a statement before the State Board of Insurance, D. Clifford Burross, M.D., TMA President, argued against insurer-controlled utilization review. D. Burross, Statement Before the State Board of Insurance on Preferred Provider Plan Proposed Regulations 1 (Jan. 17, 1986) [hereinafter TMA President Statement]. Dr. Burross asserted that physicians traditionally base medical treatment decisions on personal knowledge of the patient's condition and the patient's informed consent. *Id.* Accordingly, Dr. Burross objected to provisions contained in the proposed preferred provider plan rules that permitted nonphysician insurer employees to effectively veto the treating physician's medical judgment by denying reimbursement for prescribed care. *Id.*, see Wilcox, *supra* note 320, at 67 (proposed preferred provider plan rules' insurer veto power added to benefit-derived steering mechanisms would shift medical decision making from physician and patient to insurance company).

contract and extra-contract liability.<sup>336</sup> Based on an implied covenant of good faith and fair dealing that parties to an insurance contract are bound by duty to uphold,<sup>337</sup> certain recent state court decisions have addressed an insurer's potential liability for bad faith in denying reimbursement for certain medical treatment.<sup>338</sup> Possible sources of liability for bad faith in the health insurance context include intentional denial or failure to process and pay a claim for health care service reimbursement,<sup>339</sup> failure to disclose the medical basis for denial,<sup>340</sup> and failure to consult directly with an insured's treating physician prior to denying reimbursement.<sup>341</sup> To enhance the quality of health care services' delivery and reimbursement under preferred provider health insurance plans by reducing the incidence of insurer misconduct giving rise to bad faith claims, the State Board of Insurance should amend the Texas Preferred Provider Plan Rules to incorporate stringent standards for claim denials resulting from utilization review.

Cost-based prospective utilization review programs may directly incorporate financial considerations into the treatment review process.<sup>342</sup> Health care providers who participate in cost-base utilization review may be liable for damages resulting from inadequate treatment, if financial considerations compel providers to limit improperly the extent of health care services delivered to insureds.<sup>343</sup> The Texas Preferred Provider Plan Rules contain certain provisions, however, that effectively protect providers from liability for underservice in connection with cost-based prospective utilization procedures. Specifically, the Texas rules appropriately prohibit insurers from financially rewarding or penalizing physicians for treatment decisions.<sup>344</sup> Moreover, the rules also appropriately stipulate that preferred professional providers may only share savings from the cost-effective utilization of health care resources in the aggregate.<sup>345</sup>

---

336. See Carabillo, *Liability for Treatment Decisions: How Far Does It Extend?*, 393 PRACT. L. INST. 341, 381-89 (1986).

337. See Gruenberg v. Aetna Ins. Co., 9 Cal. 3d 566, 576, 510 P.2d 1032, 1038, 108 Cal. Rptr. 480, 486 (1973); Arnold v. National County Mut. Fire Ins. Co., 725 S.W.2d 165, 167 (Tex. 1987). For an analysis of the insurers' duty of good faith and fair dealing, see *Comment, Bad Faith: Limiting Insurers' Extra-Contractual Liability in Texas*, 41 Sw. L.J. 719 (1987).

338. Egan v. Mutual of Omaha Ins. Co., 24 Cal. 3d 809, 598 P.2d 452, 157 Cal. Rptr. 482 (1979); Linthicum v. Nationwide Life Ins. Co., 150 Ariz. 354, 723 P.2d 703 (Ariz. Ct. App. 1985), *rev'd in part, aff'd in part*, 150 Ariz. 326, 723 P.2d 675 (Ariz. 1986) (*en banc*); Blue Cross & Blue Shield, Inc. v. Whitaker, 687 S.W.2d 557 (Ky. Ct. App. 1985).

339. Noble v. National Am. Life Ins. Co., 128 Ariz. 188, 624 P.2d 866 (1981).

340. Delgado v. Heritage Life Ins. Co., 157 Cal. App. 3d 300, 203 Cal. Rptr. 672 (Cal. Ct. App. 1984).

341. McLaughlin v. Connecticut Gen. Life Ins. Co., 565 F. Supp. 434 (N.D. Cal. 1983).

342. See Chenen, *Hospitals that Use Dollar-Based Review Are Vulnerable to Charges of "Bad Faith"*, MOD. HEALTHCARE, Apr. 12, 1985, at 106, 106-09.

343. *Id.*

344. 28 TEX. ADMIN. CODE §§ 3.3703(2), (3) (1986); see TMA Safeguard Memo, *supra* note 5, at 2 (utilization derived penalty charges would destroy physician's ability to exercise good judgment on behalf of patient); accord AMA JUDICIAL OPINIONS, *supra* note 281, § 2.09 (although physicians should be conscious of costs and avoid prescribing unnecessary services, patient care should take precedence over other economic considerations).

345. 28 TEX. ADMIN. CODE § 3.3703(3) (1986).

*F. Green Light to Optional Quality Assurance Review*

Quality assurance procedures require insurers to evaluate the delivery of health care services on a retrospective basis pursuant to professional standards of care.<sup>346</sup> The Texas Preferred Provider Plan Rules establish minimal guidelines for implementing an optional delegated quality assessment program.<sup>347</sup> Moreover, the State Board of Insurance limited the scope of the Texas guidelines to address only quality assurance procedures for preferred physician providers.<sup>348</sup> The quality assurance guidelines provided by the Texas rules also fail to identify specifically the party responsible for assuring the quality of health care services. Finally, Texas quality assurance guidelines neither guarantee the confidentiality of quality assurance proceedings nor provide immunity from liability for participants in quality assurance activities.<sup>349</sup>

Quality assurance procedures constitute a direct mechanism for evaluating the quality of health care services delivered by professional providers pursuant to preferred provider arrangements. In contrast to the comprehensive provisions relating to mandatory quality assurance adopted by certain other states,<sup>350</sup> the Texas Preferred Provider Plan Rules neither require insurers to institute quality assurance programs nor provide adequate guidelines for establishing an optional program. To guarantee the delivery of quality PPA health care services, the State Board of Insurance should amend the Texas Preferred Provider Plan Rules to require insurers to implement a quality assurance program that monitors the performance of all professional providers as a mandatory component of an operational preferred provider arrangement.

Several insurers and providers who submitted comments in connection with the Texas Preferred Provider Plan rulemaking process requested the State Board of Insurance to clarify their respective roles with respect to quality assurance.<sup>351</sup> In response to the requests for clarification, the final rules define quality assessment as a mechanism for evaluating the level of care provided to insureds pursuant to preferred provider health benefit plans,<sup>352</sup> permit, but do not require, insurers to conduct quality assessment<sup>353</sup> and stipulate that insurers electing to conduct quality assessment act only through a physician panel.<sup>354</sup> As presently drafted, however, the rules still

---

346. See *supra* notes 52-54 and accompanying text.

347. 28 TEX. ADMIN. CODE §§ 3.3702, 3.3705(3) (1986); see WLE TEXAS ALERT, *supra* note 104, at 4.

348. See 28 TEX. ADMIN. CODE § 3.3702 (1986).

349. See WLE TEXAS ALERT, *supra* note 104, at 5.

350. See *supra* note 227.

351. See Aetna Comments, *supra* note 270, at 3; American General Comments, *supra* note 273, at 3; J. Ponder, Comments of Blue Cross and Blue Shield of Texas, Inc. on Texas Preferred Provider Plan Rules, 28 TEX. ADMIN. CODE §§ 3.3701-3.3705 (1986) 5 (Jan. 16, 1986); TMA Comments, *supra* note 5, at 25.

352. 28 TEX. ADMIN. CODE § 3.3702 (1986).

353. *Id.* § 3.3705(3).

354. *Id.*; see TMA Comments, *supra* note 5, at 25; TMA Safeguard Memo, *supra* note 5, at 4.

fail to clarify adequately the quality assurance roles of insurer and provider. Although the rules indicate that an insurer may initiate quality assessment efforts,<sup>355</sup> they also require the insurer to defer to a panel of contract physicians for the purpose of carrying out quality assessment activities.<sup>356</sup> As a result, the quality assessment scheme proposed by the rules fails to address explicitly whether the insurer or the provider is ultimately responsible for assuring that quality care is delivered under preferred provider plans.

A specific allocation of the responsibility for quality assurance takes on particular significance in light of the rules' appropriate proprovider ban on hold harmless clauses in preferred provider contracts.<sup>357</sup> By analogy to the duty imposed on hospitals to protect patients from recognizable malpractice,<sup>358</sup> preferred provider plan sponsors that facilitate the delivery of health care services by entering into contracts with providers of care may be held to possess a duty to evaluate the quality of care delivered by panel physicians. In comments on the proposed rules, one insurer argued, however, that the preferred provider insurance product is merely a mechanism for financing and not for providing health care services.<sup>359</sup> Under this rationale, the insurer whose role is limited to that of a reimbursement entity is removed from the process of delivering health care services, and, therefore, is justifiably exempt from liability.<sup>360</sup>

To eliminate the present ambiguity in the rules concerning the party responsible for quality assurance, the State Board of Insurance should amend the rules to allocate responsibility for quality assurance in a manner that preserves the traditional roles of the health care provider and insurer. Because the rules' open panel mandate prevents insurers from evaluating the

---

355. 28 TEX. ADMIN. CODE § 3.3702 (1986).

356. *Id.* § 3.3705(3).

357. *Id.* § 3.3705(5); see TMA Comments, *supra* note 5, at 26; TMA Safeguard Memo, *supra* note 5, at 5 (insurers and physicians should be responsible for their respective decisions; tort liability should not be disturbed by requiring physicians to insure insurance company). For a sample preferred provider contract hold-harmless clause, see CALIFORNIA MED. ASS'N, REVISED PHYSICIAN'S CONTRACTING HANDBOOK 3 (1985).

358. See Southwick, *The Hospital as an Institution—Expanding Responsibilities Change Its Relationship with the Staff Physician*, 9 CAL. W.L. REV. 429 (1973) (commentator observes that community hospitals have evolved into corporate institution responsible for supervising delivery of quality health care services); Tottenham, *Current Hospital Liability in Texas*, 28 SO. TEX. L. REV. 1, 10-17 (1987) (commentator asserts corporate liability theory supports cause of action for hospital negligence in selection of physicians, retention of incompetent physicians, failure to supervise physicians, and failure to formulate or enforce hospital policies set forth in bylaws and accreditation standards).

359. American General Comments, *supra* note 273, at 3; see also Butler, *supra* note 321, at 362 (unlike hospital, primary purpose of PPA is to provide alternative mechanism for financing health care services).

360. S. Robertson, Comments of Health Ins. Ass'n of America on Texas Proposed Preferred Provider Plan Rules, 28 TEX. ADMIN. CODE §§ 3.3701-3.3705 (1986) 2 (Jan. 15, 1986); R. Sampson, Comments of Mutual of Omaha on Texas Proposed Preferred Provider Plan Rules, 28 TEX. ADMIN. CODE §§ 3.3701-3.3705 (1986) 2 (Jan. 8, 1986) [hereinafter Mutual of Omaha Comments]. See Butler, *supra* note 321, at 362 (commentator argues that since services delivered pursuant to PPA are not provided in central location facilitating regular observation of medical practice and since PPAs have limited ability to impose sanctions on providers, PPAs should not be held to standard of care for supervising providers applicable to hospitals).

competency of providers as a prerequisite to panel membership,<sup>361</sup> insurers are neither sufficiently informed nor authorized to monitor the quality of health care service delivery. On the other hand, federal regulations,<sup>362</sup> state licensing statutes,<sup>363</sup> and guidelines established by independent professional organizations<sup>364</sup> already compel providers to engage in a periodic review of quality of care. As a result, pre-existing peer review mechanisms employed by the provider community represent the most effective vehicle for assuring the delivery of quality health care services pursuant to preferred provider arrangements. Mandatory quality assessment through peer review promotes the delivery of health care services that comply with professionally recognized standards of care and thereby serves as a mechanism for checking potential PPA liability for damages incurred in connection with the delivery of substandard care.

Finally, the Texas Preferred Provider Plan Rules neither specifically preserve the confidentiality of the records and proceedings of PPA quality assurance panels, nor insulate providers who serve on or offer information to the panels from liability associated with peer review.<sup>365</sup> As a codification of the "qualified privilege" doctrine,<sup>366</sup> article 4447d of the Texas Revised Civil

---

361. See *supra* notes 267, 269 and accompanying text.

362. See Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660, 100 Stat. 3743 (1986); Diosegy & Stravitz, *Peer Review and the Health Care Quality Improvement Act of 1986*, TEX. HEALTH L. REP., Aug. 1987, 1, 1-33; Dunn, *Federally Sponsored Medical Peer Review*, TEX. HEALTH L. REP., June 1987, 13, 13-19.

363. See TEX. REV. CIV. STAT. ANN. art. 4495b, § 3.08 (Vernon 1982 & Supp. 1988) (identifies conduct or omissions that may result in disciplinary sanctions, including nontherapeutic prescription or treatment, recurring gross overcharging or overtreatment, recurring meritorious health care liability claims); *id.* art. 4495b, § 5.06(b) (physicians and peer review committees required to report to Texas State Board of Medical Examiners (TSBME) any physicians or medical students who exhibit real and present danger to patient health through lack of competence, impaired status, or failure to adequately care for patients); *id.* art. 4495b, § 5.06(b) (health facilities and peer review committees required to file written report to TSBME concerning any professional review action adversely affecting physician clinical privileges for more than 30 days, or suspension of clinical privileges during or in lieu of investigation by professional review committee relating to possible incompetence or improper professional conduct; medical societies required to report possible incompetence or improper professional conduct; medical societies required to file written report when professional review action adversely affects association membership).

364. The American Medical Association (AMA) regards peer review of professional conduct as a necessary and recognized compromise of a physician's absolute professional freedom. AMA JUDICIAL OPINIONS, *supra* note 281, § 9.10. According to the AMA, peer review balances a physician's freedom to exercise professional judgment against his obligation to do so competently. *Id.* The Joint Commission on Accreditation of Hospitals (JCAH), a private credentialing organization, requires hospitals to institute a continuing quality assurance program designed "to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems." JOINT COMM'N ON ACCREDITATION OF HOSPS., ACCREDITATION MANUAL FOR HOSPITALS, QA.1 (1987); see Div. of Educ. & Div. of Accreditation, Joint Comm'n on Accreditation of Hosps., *Monitoring and Evaluation of the Quality and Appropriateness of Care: A Hospital Example*, 5 QUALITY REV. BULL. 326-30; see also TEXAS MED. ASS'N, CONSTITUTION AND BYLAWS ch. 15, § 15.471 (rev. 1985) (each county medical society required to establish public grievance committee to field complaints concerning ethical and professional conduct of society members).

365. See WLE TEXAS ALERT, *supra* note 104, at 5.

366. See Wilcox, *New Legislative Protections and Challenges in Peer Review*, TEX. MED., Mar. 1986, at 68, 68.



Statutes<sup>367</sup> protects the records and proceedings of any hospital or medical organization review committee from discovery and immunizes both persons who furnish information to medical peer review committees and the committee members, employees and agents from liability resulting from performance review.<sup>368</sup> Insurer-sponsored PPA quality assurance activities may fall within the scope of article 4447d, if the PPA physician review panel qualifies as a medical organization committee under the statute.<sup>369</sup> To ensure confidentiality and immunity in quality assurance review, the State Board of Insurance should amend the Texas Preferred Provider Plan Rules to specifically incorporate the provisions of article 4447d.

To facilitate the comprehensive review of the quality of health care services delivered under preferred provider arrangements, the State Board of Insurance should further amend the Texas Preferred Provider Plan Rules to expressly incorporate the provisions of article 4447d to protect the confidentiality of all quality assurance proceedings and to provide immunity from liability for participants in quality assurance review.

---

367. See TEX. REV. CIV. STAT. ANN. art. 4447d, § 3 (Vernon 1976 & Supp. 1988).

368. *Id.* For an analysis of the Texas statutory provisions relating to discovery of the records of peer review proceedings and immunity from civil liability for participants in peer review in Texas, see Butler, *Records and Proceedings of Hospital Committees Privileged Against Discovery*, 28 S. TEX. L. REV. 97 (1987); Davis, *Committee's Records 'Privileged'*, TEX. HOSP., Jan. 1986, at 10, 10-11; Southwick & Slee, *Quality Assurances in Health Care: Confidentiality of Information and Immunity for Participants*, 5 J. LEGAL MED. 343, 358, 374-75 (1984); Wilcox, *supra* note 366, at 68-71.

369. See WLE TEXAS ALERT, *supra* note 104, at 5.