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# Preferred Provider Organization Structures and Agreements

*James C. Dechene\**

## INTRODUCTION

Despite the failure of the last Congress to enact any comprehensive health reform plan, and doubts about whether the new Republican-led Congress will focus on health care reform, the market is rapidly changing the face of our health care delivery system. Third-party payers are competing to form networks of providers that can provide cost-effective, quality medical services. Physicians and other providers are forming their own networks that can be offered to third-party payers.

The networks fill a void in the delivery system that developed after decades of indemnity insurance coverage for health care services. That void is the absence of mechanisms to ensure that the care provided by the delivery system is cost-effective and of a reasonable quality. In the basic indemnity model delivery system, patients had little incentive to utilize only cost-effective providers. Similarly, indemnity payers historically did not focus on the need for cost-effective care. Indeed, there was little that indemnity payers could do if patients chose less cost-effective providers.

The foregoing gaps in indemnity coverage led to the formation of various preferred provider organizations (PPOs). The basic feature of these organizations is a limited panel of providers selected in some manner that will control costs. Most early panels were selected simply on the basis of the providers' willingness to grant discounts. Providers willing to discount from their usual and customary fees were included in the network,

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while those who were not willing to discount were not included in the network.

Mere discounts from usual and customary charges, however, provide only a one-time savings. Indeed, in many cases, providers raised their usual prices by the amount of the discount, making any reduction illusory. Moreover, price discounts can be quickly eliminated through excess utilization. Thus, third-party payers discovered that real savings could be achieved only through selecting a network of cost-effective providers.

Unfortunately, limited networks created by payers pose a significant threat to providers. Providers may never be selected to participate in networks established by third-party payers. The costs for other payers of putting together their own network of providers may be prohibitive. Thus, the only way that many providers may have the opportunity to participate in a preferred provider network is to form their own PPO that then is offered to payers.

In large part, formation of provider networks is motivated by the fear that the networks created by third-party payers will not include many providers. Providers may find that their long-term viability is enhanced only if they form their own networks. In addition, many providers believe that the only way to control the selection process, credentialing process, and other aspects of the PPO is to form, own, and operate the PPO themselves.

This article addresses the two leading issues that providers need to consider in considering PPO options. First, what structure should be used to form a PPO that can be offered to payers? Second, what are the major issues that arise in the contracts between the PPO and payer, and between the PPO and individual participating providers.

## I. LEGAL STRUCTURE

There are six structures that are generally considered when forming a PPO. These are: (1) contractual arrangements between payers and providers; (2) a general partnership; (3) a limited partnership; (4) a limited liability company; (5) a taxable, for-profit corporation; and (6) a tax-exempt, not-for-profit corporation. While these structures are quite diverse, one of these structures should meet the needs of the particular group seeking to form a PPO.

The selection of the best legal structure generally involves considerations relating to (1) governance; (2) ownership; (3)

control; (4) limitation of liability; and (5) tax issues. Of course, the structure selected will not ipso facto create a successful PPO. The structure merely provides the vehicle for establishing the provider network. The effectiveness of any vehicle depends on the commitment of both the PPO sponsors and the providers to work together to reduce costs without reducing quality. The following issues and considerations relate to each of the possible PPO structures.

### A. *Contractual Arrangements*

Payers and managed care plans typically create their PPO networks solely through provider contracts. Of course, provider contracts are an important feature of all PPOs. In the case of payer PPO networks, the provider contracts essentially are all that is necessary to form the PPO. A PPO created solely by a payer is relatively simple to establish and easier to terminate than the other alternatives. Contractual arrangements eliminate the need to create a formal business entity. The contracting parties generally are independent of each other, so there is less likelihood of imputed liability for the actions of the other participating parties.

Providers seeking to form a PPO can attempt to do so solely on the basis of contracts. However, provider-sponsored PPOs that rely solely on contractual arrangements are limited in what they can accomplish since no single entity can hold itself out to payers as the platform for the PPO. Many issues arise.

Initially, by not creating a single, integrated entity, provider PPOs face a number of antitrust concerns. Pricing issues become especially sensitive in contractual joint ventures. Participants remain independent economic agents. As such, they generally must determine prices independently. There may be limited exceptions, however, permitting agreement on the global price that will be charged for a joint service provided under the contract.

In addition, the formation and operation of a PPO generally is subject to state law regulation. These laws discourage providers from forming a PPO solely on a contractual basis. For example, many states now expressly regulate third-party administrators (TPAs). In many cases, TPAs are defined as persons or entities that administer insurance benefits for others.<sup>1</sup> Of course, many

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1. See, e.g., CAL. INS. CODE § 1759 (Deering 1995).

PPOs may not meet the definition of a TPA under state law, particularly where the PPO limits itself to making available a network and conducting various utilization and peer review activities. To the extent, however, that a PPO is involved in processing and paying claims, the PPO is likely to be covered by the TPA statute.

In most cases, TPA regulations require the administrator to obtain a license, post a fidelity bond, and use licensed individuals to process and pay claims. In some cases, state law may also limit the methods by which a TPA is compensated. For example, under California law, a TPA may not be compensated on the basis of claims experience.<sup>2</sup> The view is that claims experience compensation is analogous to assuming some of the risk of the plan—an insurance function.

Other states directly regulate the administrators of PPOs. For example, the Illinois Health Care Reimbursement Reform Act of 1985 requires that all PPO administrators register with the Department of Insurance.<sup>3</sup> A PPO administrator is defined as any person or entity “that arranges, contracts with, or administers contracts with a provider whereby beneficiaries are provided an incentive to use the services of such provider.”<sup>4</sup> Each administrator who handles money must establish a fiduciary account and post a fidelity bond.<sup>5</sup>

As a result of the foregoing laws, the person or entity desiring to form the PPO will generally need to register the PPO with the state insurance department. Thus, the application of these laws often makes it more desirable to operate the PPO from a platform that includes a separate legal structure. The exception is the PPO that is operated by a payer, for example, a PPO formed by a self-insured plan under the Employee Retirement Income Security Act of 1974 (ERISA), which is generally not subject to state insurance law. In some cases, the ERISA plan may then offer the PPO to other ERISA plans or payers, which typically subjects the offering plan to state regulation. However, the plan already offering the PPO may not find it necessary or desirable to form a separate legal entity to house the PPO function.

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2. *See id.* § 1759.8.

3. 215 ILCS 5/370k (Smith-Hurd 1994).

4. *Id.* at 5/370g(g) (Smith-Hurd Supp. 1994).

5. *Id.* at 5/370l (Smith-Hurd 1993).

For persons seeking to create a PPO through contractual arrangements, the contractual vehicle of choice is a single provider agreement. That agreement generally needs to include all of the terms that payers desire to include in their contracts with providers. Indeed, the central function of the PPO is to facilitate the contractual process under which providers become contractually bound to payers to deliver services in the cost-effective way desired by the payers.

In particular, a typical PPO/provider contract will need to include appropriate terms covering the following areas:

1. appointment of the PPO representative as attorney in fact for purposes of entering into PPO and/or health maintenance organization (HMO) contracts;
2. establishment of PPO pricing and payment, which terms could be on the basis of a fee schedule, a fixed discount from usual and customary charges, or a type of capitation or all-inclusive rate;
3. provision of medical services in accordance with usual standards in the area and in the specific PPO networks in which the provider participates;
4. agreement to refer to and utilize in-network providers where possible;
5. agreement to follow the treatment protocols of the PPO, including, where applicable, the use of drug formularies and other such requirements;
6. agreement to cooperate with the peer review and credentialing processes of the PPO;
7. agreement to comply with patient billing limitations of the PPO;
8. agreement to verify the PPO coverage of patients;
9. agreement to obtain pre-service authorization where appropriate;
10. agreement to cooperate in the utilization review and quality assessment processes of the PPO;
11. agreement to release medical records for the administration of the PPO;
12. participation in the outcome and performance data system of the PPO, including the use of provider "report cards" reflecting the utilization and cost effectiveness of providers;

13. agreement to maintain appropriate levels of professional liability insurance coverage;
14. possible indemnification of the PPO for claims made against it that relate to the services furnished by the provider;
15. provider representations and warranties relating to such issues as licensure, privileges, and accuracy of application information; and
16. length of term and termination provisions.

Specific contracts may also contain other terms particular to the PPO. These may include noncompete clauses, network or provider exclusivity provisions, prohibitions on waivers of copayments and deductibles, or requirements for the payer to enforce its patient steering provisions.

In sum, the use of provider contracts is the typical way by which payers create their PPO networks. On the other hand, contractual arrangements for provider-sponsored PPOs are generally viewed as temporary, interim approaches. They are useful where speed in establishing a relationship is imperative. They should also be considered where the parties want to consider a trial arrangement before they commit to a more permanent venture.

A provider-sponsored PPO that is limited to contractual arrangements is more difficult to operate. There is no central management with the authority to bind participating parties, and decisions relating to proposals for third-party payers require separate decisions by each participant. Upon termination of the PPO for whatever reason, the participants may individually seek to appropriate the goodwill and existing business relations of the venture for themselves. These issues require careful consideration.

### *B. General Partnership*

As discussed above, it will generally make the most sense to form a legal structure to own and operate a PPO. One legal structure to consider is the general partnership, as it is usually the easiest and least expensive multiple-owner legal structure that can be established.

When establishing a general partnership, there is no need to secure a corporate charter or comply with the necessary formalities associated with a corporation. Generally, there are no regulatory filings or fees associated with the formation and operation

of a partnership. In addition, there is no separate tax incurred at the organizational level—all of the profits and losses of the partnership are attributed to the individual partners. This avoids the double taxation of distributed earnings associated with most corporations.

There are, however, some significant disadvantages associated with a general partnership. Initially, all of the partners have unlimited liability for any claims that may be brought against the partnership. Thus, the personal assets of individual partners are potentially exposed for the partnership's creditors or claimants. To some extent, the risk to individual partners can be managed through liability insurance and a strong financial base within the partnership. Nevertheless, there is greater potential exposure to a partner in a general partnership than for an investor in a limited partnership, corporation, or limited liability company.

Moreover, the profits and losses of the partnership are attributed to the partners whether or not any income is in fact distributed to the partners. Thus, a partner may incur a significant tax liability for partnership income without receiving any cash flow from the partnership. To the extent that the partnership requires additional capital to operate, the partners may be called upon to make mandatory capital contributions to the partnership.

As a result of these disadvantages, the general partnership form is rarely used for the formation and operation of a PPO. The only circumstances where the general partnership might be a viable alternative are (1) where the PPO will be owned and operated by existing corporate organizations, such as a joint venture among several self-insured ERISA plans; (2) where two or more relatively small insurers desire to pool their resources for the formation and operation of a PPO network that could be used by all of the partners; or (3) where the PPO will be operated by corporate providers such as hospitals, existing physician organizations, or physician-hospital organizations that desire to form a broader network of providers. The partners will be entities that already have limited liability through their existing corporate structures. For those existing entities, tax efficiency and the avoidance of yet another layer of tax make the general partnership form particularly attractive. The partnership form permits the partners to share the costs associated with the development of the PPO, share access to the network created,



and share revenues that may result from renting the network to other payers.

General partnerships, of course, are governed by state partnership statutes and the terms of the general partnership agreement. Virtually all states have adopted the Model Uniform Partnership Act,<sup>6</sup> with minor variations. However, the general partnership agreement can modify most of the fall-back positions that are provided for in the state statutes. While there is no legal requirement that the partnership be formed by a written agreement, it is, of course, advisable to ensure that all understandings are memorialized in a written agreement.

The partnership agreement generally specifies how the partners shall make business decisions regarding the enterprise, capital contributions, and divisions of profits and losses. There may be special provisions regarding extraordinary decisions, noncompete provisions, and procedures for termination of the partnership. The partnership agreement can be revised or amended at any time through the agreement of the partners.

### *C. Limited Partnership*

The limited partnership form is frequently considered for either (1) the creation of a PPO by a group of providers, or (2) the creation of a PPO by one or more payers where there are significant concerns relating to limiting liability. This structure for a PPO has two principal advantages: (1) the liability of each of the limited partners is limited to their capital contributions, and (2) the income of the partnership is taxed once as the income of the partners. However, as discussed at section I(D), the comparatively new option of the limited liability company (LLC) has reduced the usefulness of the limited partnership option.

A limited partnership is established in much the same way as a general partnership. Each state has a limited partnership statute that generally is patterned on the Model Limited Partnership Act.<sup>7</sup> The fall-back provisions contained in the statutes can generally be modified by the terms of a written limited partnership agreement. In order to satisfy Internal Revenue Service (IRS) requirements for partnership taxation, the document must provide for the allocation of losses to limited partners in a manner that reduces the capital accounts of the limited partners. In

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6. See UNIF. PARTNERSHIP ACT (1993).

7. See UNIF. LIMITED PARTNERSHIP ACT (1985).

some cases, this means that the capital accounts of the limited partners may become negative. The limited partners are not required to make up the deficiencies in their capital accounts. However, any subsequent earnings of the limited partnership will need to be credited against accumulated deficits before there is any distribution of subsequent profits.

In many cases, the general partner is designated as a corporate entity. This has the effect of limiting the total exposure of the limited partnership to the assets of the limited partnership plus the assets of the corporation that serves as the general partner. Of course, the corporate general partner must have sufficient assets of its own. Otherwise, the IRS may tax the enterprise as a corporation, and creditors and claimants may successfully pierce the corporate veil.

The limited partnership form does not eliminate the tax liability of partners' undistributed profits. If the partnership retains profits to build up the business, individual partners will still have to include their portion of the profits in their income. In some cases, the limited partnership agreement requires the partnership to distribute to the partners a sufficient portion of the profits (for example, 35%) so that partners will at least have sufficient cash flow to cover their tax liability.

#### D. *Limited Liability Company*

The limited liability company (LLC) is a relatively attractive option for the formation of a PPO by a group of providers. It can be used both for the formation of a physician-sponsored PPO or for the formation of a physician-hospital organization (PHO). The LLC can provide useful solutions to governance issues through the flexibility permitted in its organizational documents. At the same time, it provides the limited liability that providers usually insist upon when forming a PPO.

A comparatively new structure, the LLC is an unincorporated organization whose owners' liability is limited to their investment in the organization.<sup>8</sup> The form has been expressly adopted by statute in most states.<sup>9</sup>

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8. See Robert Keatinge et al., *The Limited Liability Company: A Study of the Emerging Entity*, 47 BUS. LAW. 375, 378-381 (1992).

9. LLC statutes have been adopted by the following states: ALA. CODE §§ 10-12-1 to -61 (Supp. 1994); ARIZ. REV. STAT. ANN. §§ 29-601 to -857 (Supp. 1994); ARK. CODE ANN. §§ 4-32-101 to -1316 (Michie Supp. 1994); COLO. REV. STAT. §§ 7-80-101 to -1101 (1994); 1993 Conn. Acts 93-267 (Reg. Sess.), amended by 1994 Conn. Acts 94-217 (Reg. Sess.); DEL. CODE. ANN. tit. 6, §§ 18-101 to -1107 (Supp. 1994); FLA.

In essence, LLCs combine the tax treatment of partnerships with the limited liability characteristics of corporations.<sup>10</sup> Unlike the limited partnership, there is no need for a general partner who has unlimited liability exposure since each of the participants in an LLC enjoy limited liability. Thus, unlike the limited partnership, each of the participants can actively engage in the management and operation of the enterprise.

LLCs may also be an option for parties seeking partnership tax treatment where there are numerous investors. This can be the case with PPOs that are owned by the providers that participate in the network. While Subchapter S<sup>11</sup> status is only available for corporations with 35 or fewer individual investors, LLCs can be formed with an unlimited number of investors.

LLCs must be established and operated in strict compliance with the requirements in the applicable state's authorizing statute. Participants in an LLC cannot freely transfer their interests in the same manner as shareholders or holders of limited partnership interests. Instead, to terminate an interest in the LLC, participants must withdraw from the LLC, receiving fair value from the LLC for their interest.

As a comparatively new form of enterprise, there are still a number of important questions regarding LLCs, depending on

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STAT. ch. 608.401-471 (1993); GA. CODE ANN. §§ 14-11-100 to -1109 (1994); IDAHO CODE §§ 53-601 to -672 (1994); 805 ILCS 180/1-1 to 180/60-1 (Smith-Hurd Supp. 1994); IND. CODE ANN. §§ 23-18-1-1 to -13-1 (Burns 1994); IOWA CODE §§ 490A.100-.1601 (Supp. 1993); KAN. STAT. ANN. §§ 17-7601 to -7657 (Supp. 1994); KY. REV. STAT. ANN. §§ 275.001-.455 (Baldwin Supp. 1994); LA. REV. STAT. ANN. §§ 12:1301-:1369 (West 1994); 1993 ME. LAWS 718; MD. CODE ANN. CORPS. & ASS'NS §§ 4A-101 to -1103 (1993 Repl. vol.); MICH. COMP. LAWS §§ 450-4101 to -5200 (Supp. 1994); MINN. STAT. §§ 322B.01-.960 (Supp. 1995); 1994 Miss. LAWS 402; MO. REV. STAT. §§ 347.010-.740 (1994); MONT. CODE ANN. §§ 35-8-101 to -1102 (Supp. 1994); NEB. REV. STAT. §§ 21-2601 to -2653 (Cumm. Supp. 1994); NEV. REV. STAT. ANN. §§ 86.010-.571 (Michie 1994 Repl. vol.); N.H. REV. STAT. ANN. §§ 304-c:1 to -c:85 (Cumm. Supp. 1994); N.J. STAT. ANN. §§ 42:2B-1 to :2B-70 (Supp. 1994); N.M. STAT. ANN. §§ 53-19-1 to -74 (Michie 1993 Repl. Pamphlet); N.C. GEN. STAT. §§ 57C-1-01 to -10-03 (1993); N.D. CENT. CODE §§ 10-32-01 to -155 (Cumm. Supp. 1993); 1994 Ohio LAWS 103 (S.B. 74); OKLA. STAT. tit. 18, §§ 2000-2060 (Supp. 1995); OR. REV. STAT. §§ 63.001-.990 (Cumm. Supp. 1994); R.I. GEN. LAWS §§ 7-16-1 to -75 (1992); 1994 S.C. Acts 448; S.D. CODIFIED LAWS ANN. §§ 47-34-1 to -59 (Supp. 1994); TENN. CODE ANN. §§ 48-248-101 to -606 (Supp. 1994); TEX. REV. CIV. STAT. ANN. art. 1528n (West Supp. 1995); UTAH CODE ANN. §§ 48-2b-102 to -157 (1994 Repl. Vol.); VA. CODE ANN. §§ 13.1-1000 to -1073 (Michie 1993 Repl. Vol.); 1994 Wash. Legis. Serv. 211 (West); W. VA. CODE §§ 31-1A-1 to -69 (Supp. 1994); WIS. STAT. §§ 183.0102-.1305 (Supp. 1994); WYO. STAT. §§ 17-15-101 to -136 (1989).

10. In particular, each participant is taxed on the participant's share of income without regard to whether there has been a distribution of income.

11. 26 U.S.C. § 1361(b) (1988).

the state. These include: (1) whether the LLC can be used for professional service organizations, and (2) the extent to which units in an LLC PPO offered only to providers actively involved in the governance and operation of the PPO are securities subject to registration under state or federal law. However, in a state that recognizes the LLC form, the LLC may be a viable option for the formation of a PPO as an alternative to a limited partnership.

### *E. Taxable, For-Profit Corporation*

The form that satisfies the objectives of most sponsors of PPOs is the taxable, for-profit corporation. In addition to limiting the liability of the owners, it can provide creative solutions to governance issues through the use of multiple classes of stock. The corporate form is, of course, subject to double taxation of any income that is distributed to its owners. However, the taxation issue is of lesser concern for provider-sponsored PPOs. The provider sponsors of the PPO are generally more interested in securing the additional patient volume that results from participation in managed care arrangements than in earning profits from the operation of the PPO network.

The principal advantage of the taxable, for-profit corporation is that it limits the liability of all investors to their initial investment. It is frequently viewed as an entity separate and distinct from its owners, unlike other business entities. Owners of a for-profit, corporate PPO may also have the opportunity to share in the appreciation in value that could accompany the creation of a successful PPO network. Although there are necessary formalities that must be followed in order to establish and operate a taxable, for-profit corporation, those formalities are not difficult. In particular, the charter or articles of incorporation must be filed with the secretary of state or other state agencies. The corporation must also pay applicable franchise taxes and must follow corporate governance requirements to ensure that the activities of the corporation are valid.

Unlike tax-exempt, not-for-profit enterprises, a for-profit corporation is not subject to regulatory oversight by the attorney general to ensure that the not-for-profit purposes are being fulfilled.<sup>12</sup> Thus, it is much easier to sell, transfer, liquidate, or restructure a for-profit corporation. In the event of a sale, the

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12. Not-for-profit corporations are generally monitored by the attorney general to ensure that the organization is fulfilling its purposes for the public trust.

shareholders of a for-profit corporation can share in the appreciation in the entity. Similarly, if the structure is not established to be a tax-exempt entity, there is no need to seek the approval of the IRS,<sup>13</sup> and less scrutiny is placed on arrangements between the organization and its shareholders, officers, and directors.

The principal disadvantage of the for-profit, taxable corporation is double taxation. Profits of the enterprise are taxed once at the corporate level, and again after they are distributed to shareholders. Unlike a partnership, however, shareholders are not taxed on undistributed profits of the corporation.

It is important to note that use of the for-profit, taxable structure does not necessarily mean that the management of the organization has to focus on profitability. A for-profit entity can seek to operate with near-zero profits over the long run. Following that strategy, a for-profit corporation can achieve many of the advantages of a tax-exempt entity without the regulatory scrutiny.

#### *F. Not-For-Profit, Tax-Exempt Corporation*

The not-for-profit corporate structure for PPOs generally is limited to PPOs that are sponsored in part by not-for-profit hospital systems. Not-for-profit hospital systems frequently are more comfortable using the not-for-profit corporate structure for all of the systems' ventures. Also, the not-for-profit corporate structure is often used for PHOs involving not-for-profit hospitals. There can be a number of advantages associated with the use of a not-for-profit structure. These may include: (1) the avoidance of securities registration requirements and other securities regulatory issues; (2) creative solutions to governance questions; (3) the reduction in concerns over the corporate practice of medicine in many states; and (4) the ability to generate a tax deduction for the participants' contributions of capital to the venture.

A not-for-profit, tax-exempt corporation combines two separate features: the structure of a not-for-profit corporation under

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13. Tax-exempt organizations must prove that the purposes, form, structure, and intended operations of the organization meet the rules and regulations for tax-exempt status as established by the IRS.

state law with a tax-exempt status conferred by the IRS under federal law.<sup>14</sup>

A not-for-profit corporation does not issue shares of stock *per se*. Indeed, the corporation is not owned by individuals. Rather, the not-for-profit corporation is a corporate structure that is impressed with a public trust.

State law governs the formation of the not-for-profit corporation. Generally, the organizers must file with the secretary of state articles of incorporation, which set forth the not-for-profit purposes of the organization as well as the manner of choosing the board of trustees/directors, the governing body of the organization. This governance structure, a key feature of the not-for-profit corporation, provides a great deal of flexibility. A not-for-profit corporation may be established with one or more corporate "members" who elect some or all of the members of the board. The corporate members' rights are limited to governing the organization as they have no claim to any of the assets, earnings, or underlying business value of the enterprise. Other not-for-profit corporations have a self-perpetuating board, the members of which are elected by existing board members.

Both the initial capital and all of the earnings of the not-for-profit corporation must be used to support the charitable purposes of the organization. Capital is raised from contributions (rather than the sale of shares), loans, and operating profits. If the operations of the not-for-profit become very profitable and an outside investor wishes to purchase the assets, the proceeds of the sale become impressed with a public trust. The not-for-profit cannot pay dividends to initial investors or otherwise convert the proceeds of the not-for-profit to private uses.

The mere fact that a corporation is not-for-profit does not guarantee that the corporation will also be exempt from tax. To qualify for tax-exempt status, the organization must be formed

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14. It is important to note that the requirements for achieving tax-exempt status under federal tax laws are different from the requirements for creating a not-for-profit corporation under state law. For example, the IRS has indicated that it will not grant tax-exempt status to an integrated delivery system in which physicians have more than 20% of the governance of the organization. EXEMPT ORGS. TECHNICAL DIV., INTERNAL REVENUE SERV., EXEMPT ORGANIZATIONS CONTINUING PROFESSIONAL EDUCATION TECHNICAL INSTRUCTION PROGRAM 212, 227-28 (1993). Because the foregoing IRS position is recent, it is not clear the extent to which states may impose a similar requirement to obtain an exemption from state taxes. States that look to the IRS' position for guidance are likely to impose a similar requirement. For most purposes, of course, federal tax-exempt status is a much greater concern than state tax-exempt status.

and operated principally for one or more of the charitable purposes that are recognized under section 501(c)(3)<sup>15</sup> of the Internal Revenue Code. Any income earned from activities that are unrelated to the tax-exempt purposes of the organization will be taxed as unrelated business income. The organization must be operated in a manner that ensures that its income and assets do not inure to the benefit of private parties.

To secure tax-exempt status, the corporation must file an application with the IRS and demonstrate that it meets one of the qualifications for exemption set forth in section 501. If the corporation also desires to be exempt from state taxation, it must file an appropriate application with the state department of revenue. It is possible for not-for-profit corporations to be (1) taxable under both state and federal law; (2) taxable under federal law, but exempt from tax under state law; or (3) exempt from tax under federal law, but taxable under state law.

There are some significant advantages associated with utilizing a tax-exempt, not-for-profit entity. Initially, of course, any earnings of the organization in fulfillment of its charitable purposes will not be subject to taxation. This includes earnings that may be necessary to pay back loans used to help capitalize the initial operation. In addition, the organization can raise capital through tax-deductible contributions. The formation of the organization does not usually implicate either federal or state securities laws. The structure also provides considerable flexibility regarding the governance of the organization.

The disadvantages of the tax-exempt structure relate to the regulatory requirements that the organization must continue to satisfy. All arrangements involving a tax-exempt corporation are subject to close scrutiny to ensure that they do not benefit private individuals. In addition, if the activities of the organization become profitable or there is a desire to sell the organization, none of the value of the organization may be appropriated by private individuals. Instead, all of the proceeds must be used to continue supporting the charitable purposes for which the organization was initially formed.

In some circumstances it makes sense to utilize the not-for-profit, taxable organization form for PPOs. This is especially true in circumstances where the parties (1) seek to include a large number of physicians as "investors"; (2) want to structure

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15. 26 U.S.C. § 501(c)(3) (1988 & Supp. 1993).

the transaction in a manner that does not require securities registration; and (3) desire a structure that provides the physician participants with 50% of the board seats. Given the IRS' position of refusing tax exemption when physicians constitute more than 20% of the board, the use of the not-for-profit, taxable structure can satisfy the objectives of the parties.

## II. PPO CONTRACTING

The second important issue associated with PPO formation is the structure and terms of the contracts that link the payers with the providers of health care services. PPOs established by a specific payer and limited to that one payer only require the contract between the payer and the providers. PPOs that serve many payers bring together a network of providers, which gives a payer "one-stop shopping" at the PPO. In the case of PPOs that are separate and independent of payers, two contracts are required: (1) the contract between the payers and the PPO, and (2) the contract between the PPO and the individual providers.

The chain of contracts between payers and providers is the heart of the PPO. The very reason for the development of PPOs is to create a contractual linkage between the payers and the providers of health care services. These contracts seek to cure the fundamental flaw of traditional indemnity insurance: the absence of an agreement between the entities responsible for payment and the providers of services, with the goal of limiting costs. The competitive advantage of PPOs is their ability to make providers more cost sensitive and cost efficient in delivering health care. In most other segments of our economy, the price sensitivity of consumers compels providers of goods and services to be cost competitive and efficient. The fundamental flaw of traditional health insurance has been its removal of economic incentives from patients' consumption decisions. PPOs, through their contracts with providers, re-create the incentives to be cost effective in several ways. First, they obtain price discounts from providers in return for the promise of more patients. Second, they select providers to participate in the PPO on the basis of their quality and cost effectiveness. Third, they require providers to follow established standards for the delivery of health care services. Providers unwilling to comply with these requirements are not permitted to participate. These objectives are achieved through the terms of the contracts linking the payers to the providers through the PPO structure.



In this section, the key features and issues under both the PPO/participating payer agreement and the PPO/participating provider agreement are analyzed. While PPOs that are established by payers do not need a PPO/participating payer agreement, most ultimately make their networks available to other payers for a rental fee, the terms of which are set out in a PPO/participating payer agreement.

### *A. PPO/Participating Payer Agreement*

The PPO/participating payer agreement sets forth the terms under which the PPO makes the network available to participating payers. This agreement generally sets forth the mechanism by which the PPO will be paid for making the network available to the payers. In many cases, payers will pay the PPO a percentage of total claims paid as an administration fee in exchange for access to the network. In other cases, the fee will be calculated on the basis of the total actual costs to the payer compared with expected costs. Under these arrangements, the PPO is generally given an incentive in the form of a larger fee if the PPO is able to save the payer more than an agreed-upon amount. Some payers may be given access to the network without paying a fee, particularly if the PPO is formed by providers. In these cases, the PPO's costs are covered by the fees paid by the participating providers.

The payer agreement generally specifies the other functions that the PPO will provide. These typically include network selection, provider credentialing, utilization review, quality assessment, collection of outcome and performance data, and maintenance of practice standards and guidelines. Many PPOs also engage in practice profiling to gauge which providers are most cost effective. An important issue in this regard is whether the practice profile data will be made available to the payers or will only be used internally by the PPO. Since providers are naturally sensitive about the use of practice profile data, most would prefer that the data be used only by the PPO. On the other hand, the practice profiles are very valuable for payers that are determining which providers to include in the networks. The issue of access to practice profile data is often controversial.

In addition, the payer agreement generally sets forth the terms under which the participating providers will make their services available to the payers. The ideal payer agreement is carefully crafted to coordinate with all the individual provider

participation agreements. In essence, a payer signs one agreement with the PPO that provides the payer with access to the PPO's network under the terms and conditions set forth in the payer agreement, and the PPO enters into a large number of participating provider agreements that cause the providers to be bound to the terms required by the payer. In this way, providers are spared the need to consider a variety of payer contract terms while payers have one-stop shopping access to providers through the PPO network.

The problem with this approach is that it requires the PPO to have a solid knowledge of the specific form that payers will require in the terms that will bind the providers. If a payer does not include the language that the payer desires for a crucial term in the participating provider agreements, the PPO has a dilemma. The PPO can either refuse to offer the network to the payer, or the PPO can attempt to amend all of the existing participating provider agreements to include the language requested by the payer. Over time, of course, the PPO should learn the specific language that payers will require and ensure that the participating provider agreements contain all crucial terms. It is more difficult, of course, for the start-up PPO to include all of the necessary provisions in its participating provider agreements.<sup>16</sup>

The payer agreement should also set forth the obligations of the payer to both the PPO and the participating providers. Potential obligations that should be contained in the payer agreement include: (1) the incentives that the payer will provide to encourage covered persons to utilize preferred providers; (2) the mechanisms that the payer will use to verify enrollment and coverage of individual members; (3) the system the payer will use for promptly processing claims; (4) the payer's utilization review functions; and (5) the payer's obligations to pay claims promptly. If possible, it is useful to include language that protects providers who rely on a determination or communication from the payer regarding coverage or eligibility for payment. It is also useful to set forth a short period of time during which the payer will pay all claims and during which the payer will give

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16. In general, the participating provider agreement will have the terms described above at section I(A). However, because each payer will have its own requirements for each specific provision, it is at best speculation for the PPO to know which clauses will satisfy the payers with which the PPO will contract.

both the PPO and the providers the right to cancel the contract if the payer does not pay the claims on a timely basis.

Another important issue in connection with the payer agreement is whether the PPO is willing to be named as a fiduciary of an ERISA plan. To the extent that the PPO will be performing functions that are part of the administration of an ERISA health plan, it is likely that the employer will ask the PPO to be a named fiduciary for these functions, which may include determining coverage, credentialing providers, and making preadmission certification decisions.

From the employer's perspective, it is reasonable to name the PPO as the fiduciary for the functions it performs. However, many PPOs resist being a named fiduciary in an ERISA plan, fearing that they will be subject to additional liability risk. It is true that a fiduciary can be sued by plan participants who challenge the decision of the fiduciary. However, if the PPO is in fact making decisions on behalf of the employer, it is likely to be joined in any lawsuit challenging the decision regardless of whether it is a named fiduciary of the plan. Moreover, the PPO is likely to be asked to indemnify the plan for any liability that may be incurred by the plan as a result of the PPO's actions.

While being a named fiduciary to an ERISA plan may not be terribly onerous, a PPO that is a named fiduciary should be given the discretion to make the delegated decisions without undue interference from the other plan fiduciary (typically the employer). ERISA requires that a fiduciary meet the standard of care and diligence that a reasonable business person would employ in the conduct of that person's ordinary business affairs.<sup>17</sup> The ERISA standard is not one of strict liability. Indeed, many insurance companies construe the standard as excluding liability for simple negligence.

Employers are naturally reluctant to retain a PPO to provide services if the PPO is unwilling to be a named fiduciary. By agreeing without undue hesitation to be a plan fiduciary, the PPO greatly enhances its marketability. Of course, the PPO must be diligent to ensure that the wording of the fiduciary language is appropriately limited so as not to bind the PPO beyond the functions that the PPO has taken on.

The PPO should also consider the language of the indemnification clause. Most payers will require the PPO to indemnify it

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17. 29 U.S.C. § 1104 (1988).

for any losses that may be incurred as a result of the PPO's activities. The language of the indemnification must be carefully crafted with two points in mind. First, as discussed below in section B(5), the liability insurance of the PPO may not cover obligations created under an indemnity clause. The PPO must check with its professional liability and errors and omissions carrier(s) prior to agreeing to any indemnification language.

Second, there should be reciprocal language included under which the payer indemnifies the PPO for liability that may result from the activities of the payer. For example, it is possible that a PPO may be sued because a payer denied coverage for a particular treatment. The PPO should not be responsible for the costs of defending such actions where the PPO was not involved in the coverage decision. Similarly, plaintiffs suing ERISA plans are likely to join the PPO with other involved parties. The risk of litigation by an aggrieved covered person should be the responsibility of the ERISA plan unless the suit results from some negligence or other failure of the PPO.

### *B. The PPO/Participating Provider Agreement*

The key document establishing the relationship between the PPO and the participating provider is the participating provider agreement (PPA), which sets forth the obligations of each participating provider. The PPA creates the network of providers offered to the PPO's payers. Unfortunately, providers often sign the PPA with little attention to the obligations that the agreement imposes. In this section, some of the key features of the PPA are addressed.

#### 1. Provider Consent Mechanisms

The first key feature of the PPA is a mechanism for obtaining provider consent to the specific terms that specific payers desire. In essence, the PPA can be set up to obtain such consent in one of two broad ways. The first alternative is for the PPO to develop a mechanism whereby the specific terms required by each payer are offered to participating providers each time they are negotiated between the payer and the PPO. The second alternative is to include in one document all of the pricing, participation, and operating terms that the PPO anticipates will be required by all of the payers with which the PPO contracts.

The first alternative is usually implemented through a variant of the "messenger model," described in section B(3)(a). In par-

ticular, each time the PPO negotiates a specific arrangement with a payer, the PPO circulates the proposed terms to the participating providers. The providers generally have a limited amount of time (for example, 14 to 21 days) to opt in or opt out of the arrangement. Usually, any provider that does not specifically opt out of the arrangement is bound to the proposed terms.

The messenger model poses obvious dilemmas for providers. In particular, each provider must instruct the office manager of the practice to be on the lookout for proposed PPO arrangements. The provider must then review each offer within a very short period of time. Failure to review and reject a contract offer within the designated time can lead to some unintended consequences. The messenger model operates much like a book-of-the-month club, but with much greater consequences if the provider fails to return the selection of the month within the designated time. From the PPO's standpoint, this model is a waiting game—it cannot be sure how many providers will opt out of the arrangement and, therefore, how many providers it will be able to make available to a specific payer until the opt-out period passes.

Under the second alternative, the PPO tries to anticipate all of the terms each payer will require, and then includes those terms in a single PPA. The master PPA sets forth all of the specific terms that will apply for all of the payers. The success of the PPO will depend on how well it can anticipate the needs of payers in the marketplace. There will, of course, be times when the PPO will need to revise or amend the PPA in order to meet the changing needs of the market.

## 2. Pricing Terms

Another critical feature of the PPA is the pricing term, which sets forth the prices that the payers will pay for specific services. In most cases, the prices are set forth as an attachment or an exhibit to the PPA.

The price terms could be as simple as a percentage discount off the usual charges of the provider. In fact, most early PPOs operated with such simple pricing terms. Of course, a straight discount from a provider's usual and customary charges offers limited opportunities for controlling costs since providers can simply increase their charges to offset the percentage discount. In addition, discounts from usual and customary charges are somewhat harder to administer. Charges and costs are less pre-

dictable for payers, since the charge in a particular case depends on the actual provider used. Thus, the growing trend is to develop fee schedules that bind all of the providers in the network.

Fee schedules are sometimes developed on the basis of the Medicare Diagnosis Related Groups (DRGs) for inpatient services and the Resource-Based Relative Value Scale (RBRVS) for physicians' services. Often, the PPO simply develops a conversion factor that will be used. In other cases, the PPO, through a consultant, develops alternative comprehensive fee schedules based on market needs. Under either approach, payers have a greater certainty of the costs for specific courses of treatment without regard to the provider selected to perform the service.

### 3. Pricing Mechanism

Wholly apart from the specific pricing terms is the mechanism by which the PPO comes to an agreement with the providers regarding prices. Indeed, the price determination process raises sensitive antitrust issues. The leading case highlighting the antitrust risks of the price determination process is *Arizona v. Maricopa County Medical Society*.<sup>18</sup> In *Maricopa*, two county medical societies established foundations that could be described as early forms of PPOs. In an express desire to control the costs of medical care, the physician participants agreed that they would not charge patients or payers more than the maximum fees developed by the two foundations. The Court held that the agreement constituted a per se violation of section 1 of the Sherman Act.<sup>19</sup>

The Court's holding is a source of great concern for all provider-sponsored PPOs. However, the crucial facts of *Maricopa* are not likely to be duplicated in modern PPOs. First, the two *Maricopa* foundations included the overwhelming majority of physicians (approximately 70% and 80%, respectively) in the area. Second, the foundations did very little other than offer a cap on fees. They offered no credentialing, quality assurance, risk bearing, or other services common to present-day PPOs. In the absence of other procompetitive activities, a large number of physicians agreeing to the maximum fees they will charge falls within the area of traditional section 1 per se analysis.

On the other hand, a group of providers that accepts a capitation contract with a payer, under which the participating provid-

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18. 457 U.S. 332 (1982).

19. *Id.* at 348.

ers share the risk of overutilization, generally has broad discretion in its negotiations with payers.<sup>20</sup> Indeed, the individual participants in such a provider network generally have to be able to agree among themselves on issues relating to the adequacy of the capitation fee and the distribution of revenues. Thus, the PPO providers accepting capitation can negotiate with payers as a single entity.<sup>21</sup>

In contrast, an unintegrated PPO that does not accept the risk attendant with capitation is more limited in the role it may take in negotiations with payers. In such PPOs, the participating providers may designate the PPO as their agent for purposes of entering into managed care contracts within certain parameters. The PPO should provide cost-control services and be involved in

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20. See, e.g., *Hassan v. Independent Practice Assocs.*, 698 F. Supp. 679, 689-691 (E.D. Mich. 1988) (the determination of a fee schedule by which an independent practice association (IPA) distributed the proceeds from a capitated, risk-bearing HMO contract neither violated the per se rule nor the rule of reason); Notice: Southbank IPA Inc., et al. Proposed Consent Agreement With Analysis to Aid Public Comment, 56 Fed. Reg. 50,912 (1991) (“[t]he proposed [consent] order would not prohibit the physician respondents from: . . . (2) entering into agreements with physicians as participants in an integrated joint venture, as long as the physician participants are free to deal individually with any third-party payor”); 1993 Summary: Department of Justice and FTC Antitrust Enforcement Policy Statements in the Health Care Area, 4 Trade Reg. Rep. (CCH) ¶ 13,151 (Sept. 30, 1994); 1994 Summary: Department of Justice and Federal Trade Commission Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust, 4 Trade Reg. Rep. (CCH) ¶ 13,152 (Sept. 30, 1994).

21. Many providers express reservations about the ability of a provider-sponsored PPO to ever determine pricing, citing the decision in *Maricopa*. However, in *Maricopa*, the foundations performed only three functions: (1) determination of maximum fees that could be charged; (2) review of medical necessity and appropriateness of treatment; and (3) claims processing. The physicians did not in any sense bear any risk or establish any new entity or venture for the delivery of health care services. 457 U.S. at 339. Although the holding in *Maricopa* should be respected as a warning for sham ventures, courts and antitrust enforcers have tended to limit the holding of *Maricopa* to its facts. See, e.g., *Hassan*, 698 F. Supp. 679, 688 (differentiating *Maricopa*, as *Maricopa* dealt with an agreement that affected competitor doctors' fees to an entire community rather than the IPA plan in *Hassan* that only affected the maximum fees the IPA physicians could charge Health Plus members); *Kartell v. Blue Shield of Mass.*, 749 F.2d 922, 930 (1st Cir. 1984) (finding *Maricopa* not on point as it dealt with agreements by competitors to fix prices, as opposed to a single firm setting prices), cert. denied, 471 U.S. 1029 (1985); *Konik v. Champlain Valley Physicians Hosp. Medical Ctr.*, 561 F. Supp. 700, 716-17 (N.D.N.Y. 1983) (holding that *Maricopa* did not apply in situations dealing with professional corporations, as opposed to arrangements between hundreds of competing physicians), aff'd, 733 F.2d 1007, cert. denied 469 U.S. 884 (1984); *St. Bernard Gen. Hosp. v. Hospital Serv. Ass'n of New Orleans*, 712 F.2d 978, 986 (5th Cir. 1983) (differentiating a vertical link from supplier to customer, which burdens outsiders and not insiders, from the strict horizontal restraint found in *Maricopa*), cert. denied, 466 U.S. 970 (1984).

much more than just marketing activities in order to avoid anti-trust challenges.

The best way for an unintegrated PPO to reduce the risk of an antitrust attack on the price determination process is to develop a structure that preserves the independence of each participating provider's pricing decisions. The prices of the PPO's providers should not be the result of agreements among participating providers, the PPO should not permit participating providers to collectively agree upon the prices or discounts that will be offered by the PPO to managed care plans, and the providers should not collectively approve a price list that has been prepared by an outside consultant.

To develop an appropriate structure, antitrust attorneys generally recommend that unintegrated PPOs utilize one of three principal models to arrive at the prices or discounts that their participating providers will accept from payers: (1) the messenger model; (2) the "black box" model; or (3) the power of attorney model. These three models are not the only ways to preserve the independence of pricing decisions. Moreover, they do not guarantee that participating providers will not engage in collective price determinations or use the PPOs' prices in evaluating whether to participate in other managed care plans. However, they do provide a structure that can permit participating providers to make independent pricing and participation decisions.

#### *a. The Messenger Model*

The key aspect of the messenger model is that the entity wishing to purchase health care, that is, the payer, effectively makes the first offer regarding the payment terms. The PPO initially provides the purchaser with a list of providers who are participating in the network. The purchaser then indicates the proposed scope of the network and the type of pricing structure that it desires. The pricing structure could be an overall fee schedule, a percentage discount from customary charges, or any other charge structure. The PPO, of course, can make suggestions to the purchaser based on arrangements adopted in the past.

Once the PPO receives the purchaser's "offer," the PPO communicates the offer to the participating providers. Typically, the providers have a limited period of time (for example, 15 days) in which to opt in or opt out of the proposed arrangement. A key



consideration for the PPO in setting up the messenger model is determining whether providers will be locked into a proposed payment mechanism unless they submit a signed document opting out of the arrangement, or whether only those providers who sign a written acceptance will be part of the arrangement. The latter provides maximum flexibility for providers, but is inefficient and makes the composition and extent of the PPO's provider network uncertain. If the initial offer is not accepted by enough providers, the purchaser may need to change its offer and the process must be repeated. Due to the cumbersome, inefficient nature of the process, the messenger model has not been particularly attractive.

*b. The "Black Box" Model*

The PPO that uses the "black box" model retains an independent consultant to develop and recommend a competitive fee structure for the PPO. The consultant looks to existing prevailing charges and develops a structure that will be competitive. In developing this charge structure, the consultant does not consider the preferences of any individual participants in the PPO. Thus, the determination of the fee structure accomplished through the "black box" approach is completely insulated from the providers.

It is important to appreciate that the "black box" approach need not be limited to a single price for each service. In many cases, the consultant develops three prices for each service. The best (lowest) price is reserved for payers that commit to steering a substantial number of patients to the PPO. The highest price is for payers offering minimal steering of patients or a small patient base. The intermediate price is for payers with an intermediate amount of steering and/or patients.

After the fee structure has been developed, the PPO presents it to the physicians and other providers who have expressed interest in participating in the network. Each physician or provider decides on an independent basis whether or not to participate in the network at the level of reimbursement recommended by the consultant. Providers must be alerted that the "black box" fee schedule is only for the use of the network and should not be considered or used for any individual pricing decision of the providers.

After each provider has independently agreed to the pricing and other terms of managed care arrangements set forth in the

PPA, the PPO markets the network to payers. Under this model, both the PPO and the payers know the terms and extent of the network as of the time of the initial negotiations. The “black box” thus helps facilitate negotiations with payers and makes the process both more efficient and less time consuming.

*c. The Power of Attorney Model*

The power of attorney structure allows participating providers to transfer to the PPO their power of attorney to enter into any managed care arrangement that meets certain standards. For example, each provider can submit to the PPO a price list schedule representing the lowest managed care pricing arrangement that the provider will accept. The PPO then has the discretion to enter into managed care arrangements with purchasers consistent with the constraints designated by each provider. Once the PPO enters into an arrangement, the participating providers are bound, with no opportunity to opt in or opt out of the arrangement. For greater flexibility, providers can offer a menu of prices based on the volume of patients controlled and/or steered to the provider by the payer.

This approach couples a greater level of provider control (similar to the messenger model) with greater certainty (similar to that possible under the black box model). However, the arrangement is somewhat more cumbersome than the black box approach since there can be a wide range of prices for a given service among the participating providers. The PPO and the purchasers have to determine whether to fix a price schedule that is above the floor designated by the participating providers or to accept multiple levels of reimbursement for the participating providers.

Unlike the messenger model, once providers have set forth in the PPA the terms they are willing to accept, they have agreed to be bound by the PPO’s agreement with the purchaser. Thus, the PPO can present the prices and providers to purchasers and let the purchasers determine who should be in the network.

#### 4. Most Favored Nation Clauses

Some PPOs include a most favored nations clause<sup>22</sup> in their pricing terms. A most favored nations clause guarantees the

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22. For a detailed examination of most favored nation clauses, see Anthony J. Dennis, *Potential Anticompetitive Effects of Most Favored Nations Clauses in Managed Care and Health Insurance Contracts*, 4 ANNALS HEALTH L. 71 (1995).

PPO the best pricing offered by the provider. If the provider enters into a contract with another PPO or another payer in which the provider grants a greater discount or accepts a lower price than is the case with the PPO that negotiated the most favored nations clause (the "protected" provider), the provider is obligated to extend that price to the protected PPO. Such clauses have been especially popular in PPOs sponsored by various Blue Cross/Blue Shield plans.

From the standpoint of the PPO, the justification for requiring a most favored nations clause is simple enough: the PPO is guaranteed to receive the best price and to remain competitive with other PPOs and managed care plans operating in the market. Arguably, the clause is procompetitive by ensuring the best possible pricing for the PPO. The most favored nations clause does not prohibit any price discounts to other payers, but rather simply requires that the protected PPO receive the full benefit of such discounts.

There is, however, an argument that most favored nations clauses can be anticompetitive. It is not uncommon for a provider to agree to a smaller discount for a PPO that has a large patient base than might be offered to a start-up PPO. The start-up PPO may offer incremental patient volume to the provider, justifying a greater discount. In contrast, the same discount provided to a PPO that already represents a large part of the patient base for the provider could be financially devastating for the provider. In particular, a provider might be especially inclined to grant a larger discount to a new PPO that the provider is involved in starting. If one of the dominant PPOs negotiated a most favored nations clause, the provider will not be able to grant a bigger discount to the smaller PPO that offers incremental patient volume. Thus, the most favored nations clause may operate to discourage both price competition and start-up PPOs. Thus, the clause can result in the dominant PPO's further entrenchment into the market niche.

The foregoing argument has been made in the context of a few antitrust cases. While generally the argument has not been accepted, the Antitrust Division of the Department of Justice issued a letter on September 7, 1993, recommending that the Pennsylvania Insurance Department disapprove a most favored nations clause in a Blue Cross/Blue Shield agreement.<sup>23</sup>

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23. Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, United States Department of Justice to Cynthia M. Maleski, Commissioner,

In many cases, providers attempting to resist a most favored nations clause can use the Antitrust Department's recommendation in negotiations with the payer. While it will be hard to bring a successful court challenge to a most favored nations clause, the Antitrust Division's argument may be enough to discourage a PPO or payer from insisting on the inclusion of the clause.

Antitrust issues aside, a most favored nations clause will generally not be in the best interest of providers in the network. A provider who agrees to such a clause effectively grants a large discount any time the provider agrees with one PPO to terms that are more favorable than the terms already offered to the protected PPO. Thus, providers must keep the clause in mind when negotiating rates with all other PPOs.

In some cases, it may be difficult to calculate how discounts offered to one PPO can be translated to another PPO. This is true, for example, where one PPO's prices are calculated on the basis of a fixed percentage discount from usual and customary charges, another PPO utilizes its proprietary fee schedule, another PPO utilizes Medicare DRGs or RBRVS with its own conversion factor, and still another PPO negotiates a global or capitated price for certain services. There is no easy way to translate such divergent discounts into the pricing required under the most favored nations clause.

Similarly, it is difficult for a PPO to enforce such a clause. Short of auditing the provider's PPAs, there few ways to know the precise pricing terms the provider offered to other PPOs. An audit of other pricing arrangements poses anticompetitive problems, as the audit process would give the auditing PPO access to commercially sensitive information regarding the operations of its competitors. In addition, many PPOs require that providers keep the terms of their PPAs confidential. Thus, there can be substantial tension between the operation of a most favored nations clause and the clauses of other contracts of other PPOs.

In sum, the most favored nations clause creates a number of opportunities for conflict and disagreement. From the provider's standpoint, it rarely is desirable to agree to a most favored nations clause. From the PPO's standpoint, it can be very difficult to enforce the most favored nations clause in a rapidly

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Pennsylvania Department of Insurance (Sept. 7, 1993) (on file with author); see Dennis, *supra* note 22, at 73-74, 81.

changing market. In addition, it may be difficult for a PPO to recruit providers with a most favored nations requirement. As a result, most favored nations clauses are rarely used in PPAs.

## 5. Insurance and Hold-Harmless Clauses

Two other important terms in the PPA relate to the provider's insurance obligations. The PPA generally sets forth the minimum level of insurance that the provider is required to maintain. In some cases, the insurance provisions are very minimal: a physician merely has to maintain whatever level of insurance may be required to maintain medical staff privileges. More recently, PPOs have specified minimum levels of insurance, such as \$1,000,000 per claim, \$3,000,000 annual aggregate. Indeed, many employers and other potential purchasers of access to networks insist that PPO networks guarantee that all network providers maintain such minimum levels of insurance.

In addition, many payer contracts and/or PPAs include hold-harmless and indemnification clauses. These clauses require providers to hold the PPO and/or payer harmless from any claims that may result from any actions of the provider and to indemnify the PPO and/or provider for expenses incurred in such actions. On the surface, it is reasonable for the PPO and the payer to request such protection. Unfortunately, the provisions of many providers' professional liability insurance policies specifically exclude coverage for hold-harmless/indemnification obligations, as these are viewed as contractual undertakings and not liability under tort theories covered by the policies. An agreement to undertake an indemnification/hold-harmless obligation may effectively undermine the provider's professional liability coverage.

Of course, it is not in the interest of either the PPO or payers to undermine a provider's liability coverage by requiring a hold-harmless/indemnification clause. The clause is only as good as the assets behind the person agreeing to it. In most cases, the PPO and payer would be better served by having access to insurance coverage rather than an indemnification/hold-harmless clause. The dilemma can be solved by omitting the indemnification/hold-harmless requirement entirely and naming the PPO and the payer as additional insureds on the provider's insurance policy. In other cases, the provider gives assurances that adequate insurance coverage will be maintained and the PPO and

the payer will be indemnified only to the extent that insurance is not available.

## 6. Covenants Not to Compete and Exclusivity

Some PPOs also attempt to restrict the ability of participants in the network to affiliate with other networks or otherwise compete with the sponsoring PPO. At least at this point, such clauses are fairly rare. Most PPOs are nonexclusive in that they do not limit the ability of providers to participate in other PPOs.

PPOs that include such restrictions generally justify them on the basis of trying to ensure provider loyalty to the network. The view is that providers should focus all of their efforts on a single network in order to make that network a success. If providers are involved in a number of networks, they may devote less energy and have less of a commitment to assure that any particular network is successful.

The restriction is particularly useful in the case of a PPO network that is established by a group of providers. Such networks generally require a significant commitment on the part of the providers to ensure the success of the network. The network may also want to ensure that individual providers who learn how to form and operate a PPO through their participation in the network do not appropriate that expertise and form a rival network.

From the perspective of providers, limitations on the networks in which they can participate are not desirable. Most providers participate in a wide variety of networks. It is hard to know which networks will be the most successful. At least in the near term, it will probably continue to be in the best interest of many providers to be a part of many networks.

When reviewing each PPA, providers should look for noncompete or exclusivity clauses. Generally, the first reaction when encountering such clauses should be to try to eliminate the clause entirely. If that is not possible, the next step is to consider the extent of the burden imposed by the clause and to determine if a less restrictive alternative exists.

While providers should avoid clauses that restrict their ability to participate in any other PPO network, a clause that merely restricts a provider's ability to participate in another provider-controlled network may not be that onerous. Such a clause would still permit participation in networks that may be formed

by payers or other independent entities and would provide reasonable protection to the provider-sponsored PPO.

### 7. Term and Termination Provisions

Another important issue associated with PPAs is the length of the term and process for termination. PPAs generally have reasonably extensive term and termination provisions.

The first issue is the initial term of the PPA. The most common initial term is one year. Some PPAs, however, do have somewhat longer base terms. From the provider's perspective, the length of the term determines the period during which the provider will be locked into the pricing provisions. If either the discount or the fee schedule becomes inadequate to generate the revenue requirements of the provider, the provider must wait until the end of the term to adjust the pricing. On the other hand, if the provider fears increasing discounts in the future, a long term holds off the day of reckoning when the PPO will ask for greater discounts or lower fees.

Another important aspect of some PPAs is the "evergreen clause." An evergreen clause provides that the agreement will automatically be renewed for subsequent renewal terms unless either party gives notice of nonrenewal within a specified time prior to the end of the current term. An evergreen clause provides a degree of permanence to the arrangement without the need to renegotiate the contract. However, a disadvantage that it may pose is the inability to adjust fees to reflect changed circumstances. Sometimes fee adjustments are accomplished through a built-in fee escalator tied to some measure of inflation. In other cases, the parties agree to substitute a new fee schedule at the time of the automatic renewal.

The PPA generally provides a number of grounds for its termination prior to the end of its regular term. For example, generally a PPA will automatically terminate if the provider loses a required license or privileges to perform medical services. It may also permit termination on the basis of professional review activity that is a part of the PPO's functions. More and more PPOs are conducting ongoing professional review activities to weed out providers who are either of marginal quality or perceived to be overutilizers of medical services and resources. The PPO has the option of either waiting until the end of the term to eliminate such providers or to terminate them during the term. More aggressive PPOs are including clauses that allow immedi-

ate termination as a result of peer review activities of the PPO. As a protection to the providers, the PPO generally agrees to provide a measure of due process before terminating any provider prior the end of the current term.

In circumstances where due process is provided, the rationale for doing so is twofold. First, due process is viewed as a method of ensuring fairness to terminated providers. Second, due process conducted in accordance with the guidelines of the Health Care Quality Improvement Act (HCQIA)<sup>24</sup> may provide immunity from liability for peer review activity under the Act. In most cases, full compliance with HCQIA requires that the credentialing body report to the National Practitioner Data Bank any restriction of privileges that is related to quality concerns. Thus, a PPO may have to distinguish between termination for quality reasons and termination for economic reasons: termination for quality reasons would be a reportable event while termination for economic reasons would not.<sup>25</sup>

The extent to which HCQIA applies to PPO credentialing activities is also uncertain. The Act applies to the "professional review action" of a "professional review body,"<sup>26</sup> which is defined as a "health care entity" and its governing board and committees.<sup>27</sup> In turn, a "health care entity" is defined to include an "entity (including a health maintenance organization or a group medical practice) that provides health care services and that follows a formal peer review process for the purpose of furthering quality health care."<sup>28</sup> Thus, a good argument can be made that the credentialing activity of a PPO is subject to HCQIA. Even if it were ultimately found that HCQIA does not apply to PPO activities, a good faith attempt to follow HCQIA requirements is the best defense against liability for credentialing decisions.<sup>29</sup>

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24. The HCQIA, 42 U.S.C. §§ 11101-11152 (1994), requires that professional review activities be taken: (1) "In the reasonable belief that the action [is] in the furtherance of quality health care," (2) "After a reasonable effort to obtain the facts," (3) "After adequate notice and hearing procedures," and (4) "In the reasonable belief that the action [is] warranted by the facts." 42 U.S.C. § 11112(a) (1994).

25. For a general discussion of the HCQIA, see Kathleen L. Blaner, *Physician, Heal Thyself: Because the Cure, the Health Care Quality Improvement Act, May Be Worse Than the Disease*, 37 CATH. U. L. REV. 1073 (1988); Christopher S. Morter, Note, *The Health Care Quality Improvement Act of 1986: Will Physicians Find Peer Review More Inviting?*, 74 VA. L. REV. 1115 (1988).

26. 42 U.S.C. § 11111(a)(1) (1988 & Supp. 1993).

27. *Id.* § 11151(11) (1988).

28. *Id.* § 11151(4)(A)(ii) (1988).

29. See Blaner, *supra* note 25, at 1091, and Morter, *supra* note 25, at 1122 (both discussing immunity under HCQIA).



Of course, the PPA will typically provide for termination for cause, such as a material breach by one party that is not cured within a specified period. These clauses may be fairly specific regarding the definition of a material breach. From the provider's perspective, it is important to specify in this term the ability to terminate the agreement on relatively short notice if the PPO or the payers are not paying the provider for services in a timely manner. Particularly in the case of contracts to provide services to an HMO, providers generally continue to be obligated to provide service to enrollees until the contract is terminated even if the HMO is not making payments. Thus, the provider should be able to terminate the contract shortly after nonpayment.

## 8. Effect of Termination

Just as PPAs are unique in their nature, so is their termination. It is useful to appreciate that the PPO most often stands as a broker between the payers and the providers. On the payer/PPO side, the PPO typically has promised the payer that the payer would have access to the network throughout the term of the payer/PPO contract. On the PPO/provider side, the PPA effectively obligates the PPO to include the provider, and the provider agrees to be included, in any payer/PPO arrangements negotiated during the term of the PPA. To complicate matters, the terms of the various payer/PPO contracts frequently run off cycle from the terms of the PPAs.

To use a simple example, assume that a PPA runs from July 1 of one year through June 30 of the following year. During that one-year term, the PPO is including the provider in all network arrangements that meet the terms specified in the PPA. Most of those network arrangements with payers will have terms other than July 1 to June 30. For example, the PPO may enter into an arrangement with an employer that is effective on June 1 of the second year and runs through May 31 of the third year. All of the providers who signed PPAs effective July 1 of the first year will be included in the network offered to the employer effective June 1 of the second year. If some providers wish to terminate their arrangement with the PPO effective July 1 of the second year, the PPO still needs to ensure the employer that contracted for the network on June 1 of that year that all of the providers will be available to the employer throughout that year.

There are two ways to address the off-cycle dilemma. In some cases, the PPO can negotiate all of the contracts (both the payer/PPO contracts and the provider/PPO contracts) on the same cycle, such as a calendar-year basis. If a payer, such as an employer, wishes to retain the network midyear, it would only be able to contract with the network for a part of the year. The next year, the employer could enter into a year-long agreement. Similarly, all of the PPAs would be established on a calendar-year basis. If a provider expressed an interest in joining the network in the middle of the year, the provider would only be offered a partial-year contract.

Of course, it can be hard to force all of the payers and providers into a calendar-year or fiscal-year structure. Payers that have a benefit year that runs counter to the calendar or fiscal year selected by the PPO would not be able to agree to the annual cycle offered by the PPO. Thus, it is more common for PPOs to try to contract with providers on the basis of a calendar or fiscal year, but to make it clear that the PPA will bind providers for all contracts entered into by the PPO during the term of the PPA. If the terms of specific payer arrangements run beyond the term of the PPA (and most likely they will), the provider agrees to continue providing services to the specific payers through the end of the specific payers' terms. Thus, there will be a "tail" of provider obligations that continue after the termination of the PPA. The termination of the PPA stops the PPO from including the provider in any new arrangements or in the renewal of any existing arrangements. The provider remains responsible, however, for continuing to provide services to payers during the balance of the term of all existing payer/PPO arrangements that may exist on the PPA's termination date.

## 9. Incorporation by Reference

Many PPAs will incorporate a number of documents by reference. In some cases, these documents are not offered to the provider, forcing the provider to ask for them. The language of the incorporation provision attempts to bind the provider regardless of whether the incorporated documents have been given to the provider.

Incorporated documents may include the PPO's rules and regulations, credentialing standards, due process procedures, or specific payer requirements. While the provider may be given a summary of the terms required, if the terms of the full docu-

ments are incorporated by reference, the provider is bound by the full terms.

There is nothing illegal or necessarily inappropriate about incorporating other documents by reference. The only alert for providers is to ensure that they have been given any documents or terms that are incorporated by reference, and that they understand and agree to those terms.

### 10. Continuation of Care Requirements

Many PPAs include terms that require providers to continue providing care to enrollees associated with specific payers during the term of the PPA even if the providers are not being paid by the involved payer. For the most part, these provisions are directed at involvement in an HMO network. Most state laws mandate HMOs to require all providers to continue to provide care without regard to payment. Some states deem the requirement a term of the PPA even if the clause is not specifically included in the PPA, protecting patients by ensuring that all of the care required by enrollees is provided for a single capitation fee.<sup>30</sup> The requirement generally applies until the provider can validly terminate the PPA.

If the PPO wants to make its network available to an HMO, the need to include the continuation of care language for the HMO will generally prohibit the providers from negotiating out of such a clause if they desire to join the PPO. The best way for providers to protect themselves from an insolvent payer is to carefully monitor the financial status of payers before entering into a contract. In addition, the PPA should allow the provider to terminate the payer within a short period of time if the payer falls behind in payments. With that level of financial protection, the continuation of care requirement may not be onerous for providers.

### 11. Contract Reopeners

Regardless of the length of the PPA's term, there may be circumstances that make it desirable to change the contract prior to its expiration. A contract reopener provision is intended to permit the parties to renegotiate certain aspects of the PPA in the event of certain contingencies set forth in the provision. Contingencies may include the passage of health reform meas-

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30. See, e.g., 215 ILCS 125/2-8 (Smith-Hurd 1993).

ures, the changes in need or addition of a large payer, changes in governmental regulations, or other circumstances.

Of course, even in the absence of a reopener, all of the parties could voluntarily agree to reopen the contract. However, there would be nothing to force the parties to renegotiate if one of the parties declined the request to reopen. Thus, the reopener provision is useful in protecting the PPO from recalcitrant providers who may refuse to renegotiate in the absence of the term.

Contract reopeners do not force parties to agree to any terms that may be proposed by the other party. Instead, if one party exercises its right to reopen the contract, the other party is obligated to negotiate the proposed change in good faith. If the negotiations do not resolve the issue, then generally either party may terminate the contract on relatively short notice. In most cases, a well-crafted reopener term provides useful flexibility for all parties to the PPA.

#### CONCLUSION

Many observers believe that, for many reasons, PPOs are somewhat transitory creatures in our health care delivery system. First, PPOs potentially face greater antitrust risks than do integrated group practices contracting directly with payers. Second, PPOs cannot bear risk (for example, offer capitation payments) as well as integrated group practices and HMOs. Third, the looser structure of PPOs may not be as effective in monitoring and controlling utilization and quality. Thus, HMOs are likely to supplant many PPOs as health care reform measures attempt to curtail costs and increase the efficient delivery of care.

However, it is also possible that PPOs will evolve into entities that bear more risk. Some PPOs may accept capitation or other payment arrangements that are close to HMO arrangements. In some cases, PPOs may serve as a vehicle by which providers begin the process of integrating their practices. In any event, PPOs are a necessary transitional structure as our health care delivery system evolves away from the unrestricted fee-for-service system to one of managed care.

Those forming PPOs must realize that there is no silver bullet that guarantees success in our increasingly competitive and rapidly evolving health care system. There is no magic structure that guarantees that the participants in a PPO will become and remain competitive. The success of a PPO depends far more on

the hard work of providers monitoring the care that they provide and changing their practice patterns to become more cost effective than it depends on the precise organizational form or contracts of the PPO. Of course, it is important for a PPO to develop provider agreements and credentialing and utilization review structures that grant proper incentives to providers to improve efficiency and reduce costs. But the ultimate success of any PPO (or any managed care structure) will depend on thousands of individual decisions of providers committed to improving the way health care services are delivered.