Many states are enacting legislation that could cripple the growth of managed care systems. These initiatives often seek to restrict utilization review, to prevent contracting with specific providers, and to limit the reduction of benefit levels for beneficiaries who use nonnetwork providers. This recent activity in the states adds to existing insurance law and health maintenance organization (HMO) licensing provisions, which have been in effect for some time. In fact, virtually every state has some form of HMO licensing requirement that incorporates a process for certification. Most state certification requires a defined benefit package (including certain mandated benefits), quality assurance procedures, and guidelines for the adequacy of the participating provider network.

Thus, an already heavily regulated industry is becoming even more so, and the level of legislative activity in managed care is increasing. The Health Insurance Association of America (HIAA) reports that over 300 legislative proposals affecting managed care were introduced in the states in 1991—more than double the number introduced in 1990.

**Types Of Legislation**

The different types of state legislation were crafted in response to the major principles embodied in managed care. They include laws that restrict networks and utilization review, place limitations on benefits, and impose general restrictions on managed care operations.

**Network restrictions.** The hallmark of managed care is the use of a limited number of credentialed providers, selected by type and specialty, to constitute an organized system. This organized system, or network, is responsible for delivering health services to beneficiaries in the managed care plan. Many of the state legislative proposals are directed at restricting

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Paul Cooper is vice-president, health care policy, at the Prudential Insurance Company in Newark, New Jersey. Kylanne Green is associate director, managed care, at the Health Insurance Association of America in Washington, D.C.
the operations of these networks.

"Any willing provider" laws. The most common provision affecting network operation is the "any willing provider" statute, which requires managed care plans to accept or offer the opportunity of participation to any provider meeting their selection criteria. Such mandates are intended to ensure that all licensed health care practitioners in a state are permitted equal access to the beneficiaries of managed care plans.

These mandates create several problems for networks. First, managed care plans will often limit the number of providers in a given specialty as network participants, since the plans wish to build on existing arrangements among providers in the network and control overhead expense associated with managing the network. In addition, concentrating market share of beneficiaries among a few providers allows the managed care plan to maximize its leverage in negotiating provider discounts and adherence to protocols.

Alongside explicit credentialing criteria to select providers, plans use their own judgment, considering a provider's practice style, utilization patterns, or record of compliance with medical protocols. These considerations are less easily reduced to explicit standards but are crucial to evaluating the quality and effectiveness of providers. The presence of an "any willing provider" statute impinges upon the plan's ability to exercise judgment in selecting providers.

Eighteen states had enacted some form of "any willing provider" legislation by 1991. For example, a 1991 Montana law requires health insurers to enter into preferred provider agreements with any provider willing to meet the terms and conditions of the insurer's preferred provider contract. A 1990 Wyoming statute prohibits insurers from denying entry into a written agreement to any provider willing to meet the established terms and conditions of such an agreement. Some states mandating "any willing provider" are even more specific. A 1991 Oklahoma statute focuses on the health plan for state employees, requiring that the plan contract with any practitioner willing to meet the terms and conditions of the plan's standard provider contract. Statutes have also singled out types of providers protected. A number of states, including Arkansas, Texas, Idaho, and Missouri, have enacted laws applying "any willing provider" mandates to prescription drug plans. These laws restrict the exclusive use of mail order or network pharmacies by managed care plans.

Mandating classes of providers. Laws requiring coverage of services by particular types of providers are frequently found in insurance statutes. The classes of providers that benefit from these statutes are most often chiropractors, optometrists, podiatrists, or psychotherapists. In many
states, provider organizations have lobbied for the passage of these laws out of concern that they will be excluded from some organized delivery systems. Proponents of these laws argue that beneficiaries should have the freedom to choose the type of provider from which they receive services. Supporters of managed care, however, respond that having multiple classes of providers deliver the same service makes the operation of an organized, managed system more difficult. Mandating classes of providers also undercuts the managed care plans’ ability to select the most effective providers for their membership.

Almost all states have laws mandating participation by one or more classes of providers. For example, Maryland specifies at least nineteen classes of providers whose services must be reimbursed while the providers are acting within the scope of their practice, if those services are covered benefits under the plan. Regulations in New York require HMOs to provide or make arrangements for all required services without excluding any appropriately licensed class of provider from participation in the HMO. Similarly, Minnesota requires that chiropractors be given the same opportunities to participate in preferred provider networks as primary care physicians, such as internists and pediatricians.

Prohibiting gatekeepers. Many successful managed care organizations consider the use of primary care gatekeepers a key element in their operation. A gatekeeper is a primary care physician chosen by the managed care beneficiary to provide primary medical services and to direct referrals to other participating providers as medically necessary. Managed care organizations contend that gatekeepers are a critical part of the quality and utilization management strategy. An analysis of the claims experience of point-of-service preferred provider organizations (PPOs) with a primary care gatekeeper, conducted by the Wyatt Company, indicates that the savings associated with the gatekeeper function range from 4.23 percent to 13.5 percent of total claims.1

Although HMOs have used gatekeeper physicians successfully for many years, proponents of this legislation contend that the gatekeeper role is less acceptable in less-regulated managed care organizations. For this reason, differences are frequently found in the permitted use of gatekeepers between HMOs and PPOs. For example, Texas, Pennsylvania, and New Jersey allow gatekeepers under current HMO statutes but prohibit them under PPO regulations (in New Jersey, there is no PPO-enabling law).

Other laws impeding network operation. A variety of other state laws impede effective network operation. One such statute is a 1990 Kentucky law that requires each insurer or HMO authorized to do business in the state to offer coverage statewide. It prohibits limiting enrollment on the
basis of residence and therefore does not allow a defined service area. Such a requirement compromises the most highly organized forms of managed care, such as group practice HMOs. It is unlikely that there are sufficient participating providers or population to support this type of managed care program in every area of a state.

State activity also has focused on regulating contractual agreements between managed care plans and providers. In particular, the status of certain risk-sharing arrangements with preferred providers is unclear in some states. One of the most common of these arrangements is capitation. Capitation payments are fixed amounts reimbursed for each beneficiary under the care of a provider. Some state regulators are concerned that a reimbursement arrangement such as capitation, which transfers significant financial risk to providers, should only be permitted under HMO statutes, where regulation and oversight are most stringent.

**Restricting utilization review.** As of 1990, only 5 percent of employer health plans were traditional indemnity plans without utilization management. Because utilization review is common to a wide variety of health benefit plans, including managed care plans, laws restricting the activity have become more commonplace in recent years. While the forms that these legislative initiatives take are too diverse and numerous to recount in detail, they do center on several key elements of utilization review. Of the many proposals in state legislatures, probably the most common require that (1) utilization review be performed by professionals licensed in that state; (2) physicians of the same specialty as the attending physician review all denials for payment; (3) utilization review organizations maintain extended hours of operation; (4) such plans possess specific appeals processes; (5) all utilization review personnel be licensed health professionals; and (6) all clinical protocols and criteria used in utilization review be disclosed.

Legislative debate over these proposals frequently has pitted insurers, Blue Cross/Blue Shield plans, HMOs, and business against organized health care providers within a state. Increasingly, the debate is not over whether utilization review should be regulated, but rather over the number of requirements and amount of detail prescribed. Complicating this debate is the diversity of organizations and programs conducting utilization review. In addition to insurers, who may review internally or through a subsidiary or subcontractor, there are independent utilization firms, provider-sponsored programs or organizations, third-party administrators, and utilization management programs associated with HMOs and PPOs.

**Restricting benefit design.** States’ mandated benefit laws increase costs for managed care plans just as they do for traditional insurance. More
than 800 laws now mandate coverage or extensions of coverage for specific classes of providers or benefits. The benefits for which coverage is most frequently required include mental health care, treatment for alcoholism and drug abuse, mammography screening, and maternity care.\footnote{3}

**Restricting benefit differentials.** An important element of managed care is the use of significant financial incentives to encourage beneficiaries to seek care from providers within the managed care network. Maximizing the amount of in-network care is the single most important factor in the success of a managed care plan that offers out-of-network benefits. Although no studies have conclusively defined the specific benefit differential that achieves optimal results, the Wyatt Company conducted a survey of actuaries at five insurance companies that specifically engage in pricing and analyzing PPO plans. The survey showed that a 30 percent differential in plan reimbursement is considered the desired balance between out-of-network coverage and optimal channeling for in-network care.\footnote{4}

Benefit differentials represent the most effective means of encouraging beneficiaries to use network providers. There are two main types of benefit differentials. The first is a simple coinsurance scheme that requires the beneficiary opting out of the network to pay a percentage of the total charges. A typical managed care plan might also require that an additional deductible be met for out-of-network care.

The most common form of state legislation restricting differentials limits the coinsurance level to a certain amount. Twenty states have such legislation; most set the coinsurance limit at 20 percent, although three allow as much as a 30 percent differential (Nevada, Texas, and California), and one state allows only a 1.5 percent differential. The intent of this mandate is to ensure that a beneficiary is not unduly financially disadvantaged by seeking out-of-network care.

The way in which the limitation is applied can hamper the effectiveness of managed care as well. Under its PPO regulations, Texas interprets the limitation to apply separately to each service covered, rather than to the total value of the in-network versus the out-of-network plan. For example, if well-child care is covered by participating providers, then it must also be covered by any licensed provider outside the network. This requirement undercuts an important incentive for beneficiaries to use network providers and to develop a relationship with a physician.

**Other laws restricting operations.** A relatively new development in managed care, the point-of-service plan combines the features of the HMO and PPO. The point-of-service plan allows the beneficiary to opt out of the HMO delivery system at the time of service. Although the
HMO structure still exists, the beneficiary is allowed to use out-of-network providers at a greater level of out-of-pocket payment (generally, higher copayments or coinsurance).

Because point-of-service plans are attracting larger numbers of the population into managed care, laws restricting or prohibiting the plans may hinder future managed care development. Several state laws, as well as the federal HMO Act of 1973, restrict the amount of services that can be furnished by nonparticipating providers under a point-of-service plan. From the standpoint of the state HMO regulator concerned with solvency, coverage of out-of-network services exposes the HMO to increased financial risk. As a result, some states subject HMOs offering point-of-service plans to financial requirements more typical of insurance regulation, including capitalization and net worth requirements more stringent than those required of the closed-panel HMO. A number of states, including California, Florida, Missouri, and New York, prohibit point-of-service plans, unless out-of-network services are indemnified under a separate insurance contract with a licensed insurer.

**Impact Of Legislation**

The impact of these state laws on the development of managed care cannot be quantified. Indeed, the number of beneficiaries enrolled in managed care plans continues to grow significantly each year, despite the proliferation of state regulations posing barriers to network development, utilization review, and other managed care operations. Studies have estimated the operating costs associated with legislative provisions that restrict managed care programs. In 1991, HIAA commissioned the Wyatt Company to study the costs relative to six mandates. Wyatt determined that “any willing provider” mandates would increase PPO administrative costs up to 34 percent. Claims savings could drop by 8.8 percent because of unfavorable negotiating positions with individual providers. Wyatt determined that there is a point at which the increased percentage of network participation and associated costs as a result of “any willing provider” provisions nullify any cost savings of a PPO. Wyatt also determined that if the critical function of gatekeeper is prohibited by state law, a 6.8 percent cost savings associated with the utilization management function would be eradicated.

The Wyatt study also explored the impact of laws impeding utilization review. Some states require utilization review organizations to have only physicians licensed in that state perform review and to have physicians of the same specialty as the attending physician review all denials for payment. If this requirement were more widespread, significant opera-
tional restructuring would be required. As a result of this restructuring, first-year administrative costs could increase by as much as 42.5 percent. Second- and third-year cost increases would be less but would level off at a substantially higher level than prior to restructuring. Cost estimates of mandating a utilization review firm to extended hours of operation (twenty-four hours a day, seven days a week) would increase the overall cost of utilization review by as much as 47 percent.

The impact of restricting benefit differentials appears to be less dramatic but can still significantly affect claims costs. For states mandating a maximum differential of 20 percent between in-network and out-of-network benefits in PPOs, claims costs would increase by about 2 percent.

Industry Response To Legislation

Because they operate, by necessity, in a pluralist health care system, managed care plans must maintain flexibility to accommodate the differing state requirements. To aid managed care plans, several national accrediting organizations have emerged, in part stimulated by the vagaries of requirements found in states’ managed care statutes. These accrediting organizations apply a universal set of standards to various aspects of managed care, creating a seal of approval of national significance. Many believe that as this national accreditation achieves greater acceptance, certain state requirements will be waived in lieu of national certification.

The Utilization Review Accreditation Commission (URAC) has developed national standards for utilization review organizations and began accrediting in mid-1991. URAC is recognized in the District of Columbia as the certifying body of workers’ compensation utilization review organizations. Several other states that currently require state certification of utilization review organizations are expected to adopt similar laws in their 1992 legislative sessions.

Another organization, the National Committee for Quality Assurance (NCQA), has developed national standards for managed care plans that include standards for provider credentialing, quality assurance, and utilization management. After just four years of independent operation, NCQA is fast becoming recognized by employers as a seal of approval for managed care plans. Several large employers with multistate locations are mandating NCQA accreditation for their managed care plans. The American Association of Preferred Provider Organizations (AAPPO) is developing its own accreditation for PPOs, incorporating many of the same elements as NCQA. The AAPPO accreditation process is based on an evaluation and rating of eight functional areas of PPO structure and operating performance.
Employers are also responding to managed care legislation in the states. Self-funding of the managed care plan by the employer may present a means for avoiding most state requirements because of the Employee Retirement Income Security Act (ERISA) preemption of state laws affecting employee benefit plans. Self-funded employee benefit plans are financed entirely by the employer and involve no risk to the insurer or a shared risk between the employer and insurer. In the case of managed care, an insurance carrier, third-party administrator, the employer, or some other entity negotiates contracts with participating providers and administers the processes of a managed care network, including credentialing, provider relations, quality assurance, and utilization review.

There are questions surrounding the self-funded option. The protection afforded by ERISA in this area is largely unproven. Some attorneys assert that the ERISA preemption covers only activities related to employer benefit plans. While some areas such as benefit design clearly meet this test, activities related to quality assurance and utilization review might not fall within the ERISA preemption because of their clinical nature. In addition, only employers of a certain size (at least 250 employees) are large enough to comfortably assume the financial risk of self-funding.

Insurers and managed care organizations have assumed an active role in attempting to influence state legislative activity. State laws affecting managed care have been a primary focus of government relations activity for commercial carriers, Blue Cross/Blue Shield plans, and HMOs in recent years. The thrust of these activities has been to oppose or amend legislative proposals of the type described here. Increasingly, sponsors of managed care plans have formed coalitions with employers and business organizations to advance their point of view. Insurance and HMO trade associations, as well as some employer organizations, have greatly stepped up their involvement in legislative activities related to managed care because of a concern that the number of proposals to restrict managed care activities has increased significantly in recent years. Some managed care companies, while encouraged by the increasing support of business organizations, are still concerned over the continued outlook for a stable and viable regulatory environment. At the same time, many state medical societies and other health care provider organizations have stepped up their activities to promote and sponsor legislation to restrict certain managed care activities. The vehicles for these proposals might be the state insurance code, the HMO laws, state medical practice statutes, or other statutory or regulatory authorities.

Some managed care advocates favor federal legislation to override or preempt restrictive state practices, citing the need for relief in the most
restrictive states, as well as for consistency in administering programs for groups with members in multiple states. Others feel, however, that such an approach would invite federal regulation replacing that of the states, which might or might not produce a more favorable business climate and could result in complicated dual regulation.

Conclusion

In our view, managed care represents the most viable alternative for structuring health care delivery in a fashion that stresses greater cost-effectiveness, adherence to accepted clinical guidelines, and positive health care outcomes. Managed care represents a vehicle to bring about significant and desirable change in provider behavior. A marketplace consisting of managed care organizations, competing on the basis of cost and quality, may hold greater promise for effective reform than any alternative strategy has shown to date. If managed care plans are to demonstrate their potential as the vehicle for health care delivery reform, the legal and regulatory climate must allow them to both flourish and continue to evolve.

NOTES

5. Ibid.
6. Ibid.
7. Ibid.
8. Ibid.