PART 3

MANAGED CARE ORGANIZATIONS AND OTHER HEALTH INSURANCE MATTERS

CHAPTER 14

INTRODUCTION TO MANAGED CARE SYSTEMS IN ILLINOIS

by

Karen K. Harris, J.D.
Karen Harris is Of Counsel in the Health Care Law Practice Group at the law firm of Seyfarth Shaw, LLP. Prior to joining Seyfarth Shaw, Ms. Harris was a visiting professor at Loyola University School of Law's Health Law Institute. She is a member of the American Health Lawyers' Association, the Illinois Association of Health Attorneys and past co-chair of the Chicago Bar Association's Health and Hospital Law Committee.

and

by

Deborah Gordon, J.D., M.B.A.
Deborah Gordon is a Partner at Seyfarth Shaw, LLP and Chair of Seyfarth Shaw's Health Care Law Practice Group. Ms. Gordon is a member of the American Health Lawyers Association, The American Bar Association – Health Law Section, the Illinois Association of Health Attorneys and past co-chair of the Chicago Bar Association's Health and Hospital Law Committee.

Scope of Chapter:

This chapter explains the various types of managed care organizations and systems, including HMOs, PPOs, PPAs,

TPAs, and IDSs. Included in the chapter is a discussion of the Federal and Illinois laws that regulate each of these types of entities.

Treated Elsewhere:

For federal and state regulation of managed care organizations, see Chapter 15

For tort liability and defenses of managed care organizations, see Chapter 16

For mandated health insurance coverage rights, including COBRA, see Chapter 17

Insurance, in general, see Illinois Juris, Insurance

Research References:

Text References:

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Federal Legislation:

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State Legislation:

Illinois Health Maintenance Organization Act, 215 ILCS 125/1-1 et seq. Illinois Insurance Code, 215 ILCS 5/1 et. seq.

Auto-Cite®: Cases and annotations referred to in this chapter can be further researched through the Auto-Cite® computer-assisted research service. Use Auto-Cite® to check citations for form, parallel references, prior and later history, and annotation references.

I. MANAGED CARE GENERALLY

II. TYPES OF MANAGED CARE ENTITIES

III. INTEGRATED DELIVERY SYSTEMS

IV. REIMBURSEMENT UNDER MANAGED CARE

V. LEGAL AND REGULATORY ISSUES IN MANAGED CARE

I. MANAGED CARE GENERALLY

§ 14:01. Introduction

Managed care, health maintenance organizations (HMOs), preferred provider organizations (PPOs), physician organizations (PO), physician hospital organizations (PHOs), and integrated delivery systems (IDS) are all terms that have developed over the last few decades. One commonality between all of these types of entities is that they arose as a result of attempts to reform the delivery of health care services.

This Chapter discusses the history of health insurance, the concept and development of managed care, and the recent and predicted trends in managed care.

§ 14:02. History of health care insurance

Until recently it was possible, and indeed sensible, to make a distinction between insurance (e.g. indemnity or service benefit insurance) and managed care as different approaches to financing health care.[1] However, managed care has rapidly come to dominate the United States' health care financing and delivery system.[2] Health maintenance organization (HMO) enrollment was only 51 million in 1994, and rose to 68.8 million in 2004.[3] Additionally, 91.2% of the

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1. Furrow, Greaney, Johnson, Jost and Schwartz, Health Law: Cases, Materials and Problems, West Publishing, 4th Edition, 2001, pg. 505.

2. Peter R. Kongstvedt, Essentials of Managed Health Care, Aspen Publications, 2nd Edition, 1997, pg. 3.

3. The InterStudy Competitive Edge: Part II: The Regional Market Analysis Fall 2004, InterStudy, Fall 2004.

commercial population, 60.3% of the Medicare population[4] and 12.47% of the Medicaid population[5] are enrolled in some sort of managed care plan. Thus, for many, the health care industry is managed care and it no longer makes sense to distinguish between insurance per se and managed care. In order to understand managed care, however, it is important to review the development of health care insurance in the United States.

Health insurance in the United States is relatively quite recent. Prior to World War II, medical insurance was available on a limited basis. In general though, prior to the 1930's, health insurance was very unusual and most Americans paid for health care services out-of-pocket.[6]

The Depression in the 1930s prompted some hospitals to form hospital-sponsored "service benefit" plans, or as they became known as "Blue Cross Plans", to ensure a consistent flow of revenues.[7] States incorporated special statutes and regulatory programs for these plans, including exemption from state taxes. By the late 1930s and early 1940s, the success of the Blue Cross plans prompted physicians to create their own plans.[8]

The growth of health insurance was also accelerated by World War

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4. Centers for Medicare & Medicaid Services: Medicaid Managed Care Penetration Rates by State, December 31, 2003.

5. Centers for Medicare & Medicaid Services: Medicare Managed Care Enrollment by State & Plan, June 2004.

6. Furrow, Greaney, Johnson, Jost and Schwartz, Health Law: Cases, Materials and Problems, West Publishing, 4th Edition, 2001, pg. 505.

7. Id. at 506.

Historians dispute the first place in the country where a Blue Cross plan developed, but many put the origins in Dallas, Texas. "Making Sense of Managed Care Regulation in California," California HealthCare Foundation Report, November 2001, pg. 6.

8. In 1939 the California Medical Association founded the nation's first statewide, medical-society-controlled prepaid health plan, which would later be called Blue Shield of California. "Making Sense of Managed Care Regulation In California," California HealthCare Foundation Report, November 2001, pg. 6.

II when wages were frozen, but benefits were not.[9] Offering health insurance coverage was a way to entice workers that did not violate the ban on increasing wages, and commercial insurers began offering "indemnity plans." Unlike Blue Cross and Blue Shield plans, indemnity plans did not pay providers directly. Instead, such plans indemnified their insureds for health care services (e.g., reimbursed them), first from hospitals and then later from physicians.[10]

By the early 1950s, health care became a routine benefit of the workplace, with nearly 8 out of 10 workers in the private sector covered through employment by some type of voluntary, if limited, health care plan.[11]

Thus, throughout much of the 20th century, there were prepaid health plans. For instance, Kaiser Permanente in California,[12] the

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9. "Making Sense of Managed Care Regulation in California," California HealthCare Foundation Report, November 2001, pg. 7.

10. Furrow, Greaney, Johnson, Jost and Schwartz, Health Law: Cases, Materials and Problems, West Publishing, 4th Edition, 2001, pg. 506.

It should be noted that unlike Blue Cross and Blue Shield plans, commercial insurers were not limited by community-rating and were able to use "experience rating" which allowed them to cherry-pick the less expensive groups for coverage.

11. "Making Sense of Managed Care Regulation in California," California HealthCare Foundation Report, November 2001, pg. 7.

When the Employee Retirement Income Security Act of 1974 (ERISA) was enacted in 1974, self-insured employee benefit plans were freed from state regulation thereby creating a large incentive for employers to self-insure. Furrow, Greaney, Johnson, Jost and Schwartz, Health Law: Cases, Materials and Problems, West Publishing, 4th Edition, 2001, pg. 506. Since self-insurers often purchase stop-loss insurance and administer their health insurance plans through third-party administrators, they are often undistinguishable from insured plans, except for their exemption from state regulation.

12. The Kaiser Foundation Health Plans were started in 1937 by Dr. Sidney Garfield at the behest of the Kaiser Construction Company, which sought to finance medical care for workers and families who were building an aqueduct in Southern California. Peter R. Kongstvedt, Essentials of Managed Health Care, Aspen Publications, 2nd Edition., 1997, pg. 5. A similar program was established in 1942 at Kaiser's shipbuilding plants in the San Francisco Bay area. Id. In 1945 the Kaiser

Group Health Association of Washington, D.C.[13] and the Health Insurance Plan (HIP) of Greater New York[14] have existed at least since the early 1940s.[15]

Federal legislation also encouraged the growth of pre-paid health plans through the enactment of the Federal Health Maintenance Organization Act of 1973.[16] Yet, it was not until double-digit increases in health insurance premiums in the late 1980s and early 1990s that "managed care" became the dominant force in the health care industry.

At that time, the term "managed care" was used to define not only HMOs, but also other forms of health insurance that attempted to not only pay for health care services, but to control the cost of such

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plan was made available to the public. "Making Sense of Managed Care Regulation in California," California HealthCare Foundation, November 2001, pg. 6. Kaiser Foundation Health Plans now serve 9 states and the District of Columbia and has 8.2 million members. www.kaiserpermanente.com.

13. In 1937, the Group Health Association (GHA) was started in Washington, D.C. at the request of the Home Owner's Loan Corporation to reduce the number of mortgage defaults that resulted from large medical expenses. Peter R. Kongstvedt, Essentials of Managed Health Care, Aspen Publications, 2nd Edition, 1997, pg. 5. The District of Columbia Medical Society originally opposed the formation of GHA by restricting privileges for GHA physicians and threatening expulsion from the Medical Society. Id. The U.S. Supreme Court ruled in favor of GHA in the anti-trust case that ensued. Id. In 1994, due to financial woes, GHA was acquired by Humana Health Plans. Id.

14. The Health Insurance Plan of Greater New York (HIP) was formed at the request of New York City in 1947 to provide health insurance coverage to its employees. Peter R. Kongstvedt, Essentials of Managed Health Care, Aspen Publications, 2nd Edition, 1997, pg. 5. HIP is currently licensed in New York, New Jersey and Florida and has 1.4 million members. www.hipusa.com.

15. Such prepaid health plans were not, however, always welcomed by the medical profession. The American Medical Association, for example, opposed such plans. The AMA was, however, convicted of criminal antitrust violations in 1942 for its efforts to suppress such plans. American Medical Ass'n v United States, 76 US App DC 70, 130 F2d 233 (DC Cir 1942), aff'd, 317 US 519, 63 S Ct 326, 87 L Ed 434, 6 Lab Cas (CCH) P 51153 (1943).

16. 42 USCS 300(e) et. seq., and regulations, 42 CFR 417 et. seq.

services. Thus, trying to define the term "managed care" is difficult, as the next section discusses.[17]

§ 14:03. The concept of managed care

The term "managed care" has become a catch-all phrase that implies a multitude of things. For proponents, managed care was viewed as an alternative to the unbridled fee-for-service system that sent blank checks to hospitals, doctors, dentists, etc. and lead to referrals of dubious necessity and unmanaged and uncoordinated care.[18] Yet, what exactly is meant by "managed care" has never been made clear.

In general, when thinking of managed care one should distinguish between (i) the techniques of managed care, and (ii) the organizations that perform the various managed care functions.[19]

Managed care can embody a wide variety of techniques such as financial incentives, promotion of wellness, early identification of disease, patient education, self-care, preventive care, and all aspects of utilization management.[20] There are also a wide variety of organizations that implement managed care techniques.[21] Managed care techniques can be employed directly by employers, insurers, union

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17. Many commentators point to the fact that even the expression "managed care" has only been around for the last decade. As one commentator notes "The term 'managed care' does not appear once in Paul Starr's exhaustive 1982 history of American medical care, The Social Transformation of American Medicine, nor can it be found in other books on American health policy written before the early 1980s." Jacob S. Hacker and Theodore R. Marmor, "How to Think About Managed Care" 32 U. Mich. J. L. Ref. 661 (1999).

18. Jacob S. Hacker and Theodore R. Marmor, "How to Think About Managed Care," 32 U. Mich. J. L. Ref. 661 (1999).

19. Peter R. Kongstvedt, Essentials of Managed Health Care, Aspen Publications, 2nd Edition, 1997, pg. 3.

20. Id.

21. Id.

trust funds, Medicare and Medicaid.[22] HMOs are probably one of the most frequent examples of an organization that utilizes managed care techniques. In particular, HMOs attempt to align the financing and delivery of health care by, among other things, requiring enrollees to use network providers and employing primary care gatekeepers. Managed care techniques can, however, also be implemented by PPOs, organizations that allow enrollees to be reimbursed for care delivered by non-network providers, although the enrollees face higher out-of-pocket payments (i.e., cost sharing) if they do.[23] A variety of hybrid arrangements utilizing managed care techniques have also evolved.[24] One example is a point-of-service (POS) program, which operates as a PPO except that, to receive the highest level of benefits, the enrollee must obtain a referral from a primary care physician who is part of the contracted network.[25]

Thus, managed care embodies both cost-saving techniques and also the types of organizations that utilize them.

II. TYPES OF MANAGED CARE ENTITIES

§ 14:04. HMOs generally

HMOs are not, as many believe, a new development. The term "Health Maintenance Organization" was originally coined in 1973 with the enactment of the Federal Health Maintenance Organization Act (the "Federal HMO Act"),[26] as an attempt by federal policy makers to stem the "crisis" in health care cost inflation.[27]

The Federal HMO Act established comprehensive benefits, community rating requirements, administrative oversight procedures, requirements for financial reserves, annual open enrollments, prohi-

22. Id. at 4.

23. Id.

24. Id.

25. Id.

26. 42 USCS 300(e) et seq.

27. "Making Sense Out of Managed Care Regulation in California," California HealthCare Foundation Report, November 2001, pg. 8.

bitions on pre-existing condition limitations, and other similar requirements.[28] The Federal HMO Act recognized several different models of HMOs and provided federal start-up grants for non-profit HMOs to encourage HMO expansion and development.[29]

Under the Federal HMO Act, HMOs could choose to apply for Federal qualification and agree to meet the requirements of the Federal HMO Act.[30] In return, HMOs would be eligible for start-up grants and loans and could market the HMO as meeting federal standards and requirements.[31] In the wake of the Federal HMO Act, the number of HMOs grew dramatically, however, it was not until the mid 1980s when the HMO industry truly started to develop.

An HMO is an organization that receives premium dollars from subscribers in exchange for a promise to provide all health care required by that subscriber for a defined period. In particular, an HMO assumes the risk of delivering both physician and hospital services to its enrolled participants for a fixed sum of money provided on a prepaid basis. An HMO is basically another form of health insurance company.[32]

The money paid to an HMO typically is derived from employers, groups or individuals in return for a promise to provide covered health care services when needed. In order to maintain a profit, an HMO must receive payments from subscribers that are greater than its payments to health care providers and the HMO's administrative costs. Although HMOs also generate some additional revenue from

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28. Id.

29. Id.

30. Id.

31. Id.

32. See also Joseph A. Snoe, American Health Care Delivery Systems, American Casebook Series, West Group, 1998, pgs. 361-364; Rand E. Rosenblatt, Law and The American Health Care System, The Foundation Press, Inc., 1997, pgs. 19-20.

the investment of prepaid health premiums, the interest received on these investments, contrary to popular belief, is typically minor.[33]

As discussed below, there are several types of HMOs. Regardless of the type of HMO involved, all HMOs have similar characteristics. For example, unlike indemnity plans, which provide members with open access to health care providers, HMOs attempt to limit access to care in order to control health care costs. HMOs are perhaps the most restrictive type of managed care entities. HMOs, for example, typically limit their members' access to hospitals and physicians that are part of the HMO's network.

Despite being the most restrictive type of managed care plan, HMOs tend to provide the broadest range of medical benefits, while indemnity plans are typically the most restrictive in terms of scope of coverage.

Although indemnity plans usually pay providers based on actual charges, HMOs require either a discount for participation in the HMO's network or acceptance of a capitated payment. HMOs also use utilization review to eliminate unnecessary services and to provide cost-effective treatment plans.

Given these distinctions, the costs of health care coverage to the employer are usually the lowest in an HMO plan and the highest in an indemnity plan.

§ 14:05. Types of HMOs

There are several types of HMOs: (1) staff model, (2) group model, (3) IPA model, and (4) network model.[34]

In a staff model HMO, the physicians are either employees of the HMO or they provide most of their services to HMO members

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33. For diagram illustrating HMO operations, generally, see Appendix A following this chapter.

34. Peter R. Kongstvedt, Essentials of Managed Health Care, Aspen Publications, 2nd Edition, 1997, pg. 43.

through a contractual relationship.[35] A staff model may also own other related health care providers such as hospitals, but such ownership is not necessary. Staff model HMOs, also known as closed panel HMOs, do not allow open physician participation.[36] Instead, only those physicians employed or contracted by the HMO may provide services to the HMO's members.[37]

Physicians in staff model HMOs typically practice in one or more centralized outpatient or ambulatory care facilities.[38] The staff model HMO then contracts with hospitals and other inpatient facilities to provide non-physician services to its members.[39]

Staff model HMOs are advantageous because they have a greater degree of control over the practice patterns of their physicians.[40] However, staff model HMOs are also more costly to develop and implement since they have large fixed salary expenses for staff physicians and support staff.[41] Also, since a staff model HMO is "closed panel," it only provides a limited choice of participating providers for its members.[42]

Under a group model HMO, the HMO contracts with one or more medical groups to provide all necessary services to HMO members. Thus, the physicians are employed by the medical practice group and

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35. Essentials of Health Care Finance, William Cleverley, Ph.D., Aspen Publications, 4th Edition, 1997, pg. 51.

The latter alternative is often used in states where HMOs cannot employ physicians directly due to corporate practice of medicine prohibitions.

36. Peter R. Kongstvedt, Essentials of Managed Health Care, Aspen Publications, 2nd Edition, 1997, pg. 43.

37. For diagram illustrating the concept of the Staff Model HMO, see Appendix B following this chapter.

38. Peter R. Kongstvedt, Essentials of Managed Health Care, Aspen Publications, 2nd Edition, 1997, pg. 44.

39. Id.

40. Id.

41. Id.

42. Id.

not by the HMO.[43] Usually, medical groups are not exclusively bound to any one HMO and may provide services to several HMOs. The contracted medical groups may be primary care, specialty, or multiple specialty.

There are two broad categories of group model HMOs: (1) the captive group HMO, and (2) the independent group HMO.

In the captive group model, the physician group exists solely to provide services to the HMO's beneficiaries. Usually, the HMO formed the group, recruited the physicians and now provides administrative services for the group.[44]

In an independent group model HMO, however, the HMO contracts with an existing, independent group to provide physician services to its members.[45] The independent physician group may continue to provide services to other patients or it may have an exclusive relationship with the HMO.[46]

Regardless of whether the group model HMO is a captive group or an independent group, they share many common features. For instance, both types are considered "closed panel" since they only utilize physicians who are part of the group. Also a group model HMO, because of the close affiliation between the HMO and the physician group, can frequently control utilization and other activities of the physician group.[47] This is very similar to a staff model HMO. However, unlike staff model HMOs, group model HMOs often have lower capital needs since they do not have large physician salary costs.[48]

Similar to staff model HMOs, group model HMOs also provide

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43. Id. at 42.

44. For a diagram illustrating the Captive Group Model HMO, see Appendix C following this chapter.

45. Id. at 45.

46. For a diagram illustrating the Independent Group Model HMO, see Appendix D following this chapter.

47. Id. at 45.

48. Id. at 45.

members with limited choices of physicians.[49] Additionally, the limited number of office locations of the physician groups may further limit geographical access for patients.[50]

IPA model HMOs involve a much looser affiliation of independent physicians who have not come together and integrated their practices. Rather, the individual physicians maintain their own independent practices and use the IPA only to enter into contracts with HMOs and other health plans to provide services.

Thus, although the physicians are part of the IPA, which is a separate legal entity, they continue to see their non-HMO patients and maintain their own offices, medical records, and support staff.[51] By definition, IPA model HMOs are considered open-panel plans since participation is open to all community physicians who meet the HMO's and the IPA's selection criteria.[52]

IPAs typically recruit physicians from all specialties to participate in their panel so that there is no need to refer HMO members to non-participating physicians for services.[53] IPAs may be formed as large, community-wide entities where physicians can participate without regard to the hospital with which they are affiliated or as hospital-based where only physicians from particular hospitals are eligible to participate.[54]

HMOs sometimes prefer to contract with larger community based IPAs for several reasons. First, hospital-based IPAs can restrict the panel of the IPA to physicians who are familiar with each other's

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49. Id. at 45.
50. Id. at 47.
51. Id. at 46.
52. Id.
53. Id.
54. Id.

For diagram illustrating the IPA Model HMO, see Appendix E following this chapter.

practice patterns, thereby making it easier to manage utilization.[55] Also, use of hospital-based IPAs means that an HMO can limit the impact of a termination of one of its IPA agreements to a smaller group of physicians.[56]

Under the IPA model HMO, the HMO pays the IPA on an all-inclusive physician capitation basis.[57] The IPA then compensates its participating physicians on either a fee for service basis or on a combination of fee-for-service and capitation.[58]

IPA model HMOs are advantageous since they require less capital to operate (e.g., no physician salaries) and have a larger selection of physicians for their members.[59] There are, however, disadvantages as well. First, an IPA must exist or be created as a forum for the individual physician groups to negotiate with the HMO. This organized entity may provide increased bargaining strength for the physicians.[60] Yet, unlike a group practice model HMO, the individual physician IPA members retain their ability to negotiate and contract directly with the HMO. Also, since the members of the IPA typically see themselves as independent, utilization management becomes more difficult and the IPA model HMO may be required to devote more administrative resources to maintaining control over utilization than other types of HMOs.[61]

A network model HMO is a hybrid of the staff, group and IPA model HMOs. In this arrangement the HMO may contract with both medical groups and IPAs, as well as employ individual physicians.

Network model HMOs are an attempt to resolve many of the issues associated with staff and group model plans. Primarily, the broader physician participation in a network model HMO means that HMO

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55. Id.
56. Id.
57. Id.
58. Id.
59. Id. at 47.
60. Id. at 47.
61. Id. at 47.

members have more access to physicians than in either the staff or group model HMOs.[62]

In contrast to the staff and group model HMOs, network model HMOs can be either closed or open panel plans.[63] If it is closed paneled, the HMO will only contract with a limited number of group practices.[64] If it is an open paneled plan, the HMO will contract with any physician group that meets the HMO's credentialing criteria.[65]

§ 14:06. Preferred Provider Organizations/Preferred Provider Associations (PPOs/PPAs)

Preferred Provider Organizations (PPOs) are entities through which employer health benefit plans and health insurance carriers contract to purchase health care services for covered beneficiaries from a select group of participating providers.[66] Typically, the participating providers agree to abide by utilization management and other procedures implemented by the PPO and agree to accept the PPO's reimbursement schedule.[67] In return, the PPO often limits the size of its participating provider panel and provides incentives for its enrollees to use participating providers instead of other providers.[68] A PPO's enrollees may use outside providers, however, it will cost them a higher co-payment and a higher deductible to do so.[69]

PPOs are also sometimes described as Preferred Provider Arrangements (PPAs). The definition of a PPA is usually the same as the definition of a PPO, however, some observers use the term PPA to describe a less formal relationship than would be described by a

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62. Id. at 46.
63. Id.
64. Id.
65. Id.
66. Id. at 38.
67. Id.
68. Id.
69. Id.

PPO.[70] Specifically, the term PPO is used to describe a separate legal provider organization whereas a PPA may achieve the same goals as a PPO through an informal arrangement among providers and payers.[71]

Whether called a PPO or a PPA, there are several typical features of such an arrangement. First, as already discussed, PPOs contract with a select group of providers. These providers are usually selected to participate in the PPO based on their cost efficiency, community reputation, and scope of services.[72] In fact some PPOs assemble massive databases of information about potential providers, including, but not limited to, costs by diagnostic category, before inviting a provider to participate.[73]

Second, most PPO participation agreements require participating providers to accept the PPO's reimbursement rate as payment in full for services rendered by participating providers.[74] These reimbursement rates are negotiated to provide the PPO with a competitive cost advantage and often require the providers to agree to a discount from usual and customary charges, all-inclusive per-diem rates, or payments based on diagnosis related groups.[75]

Also, many PPOs agree to prompt payment requirements in their contracts. For instance, a PPO may agree to pay all clean claims submitted by its providers within a 15-day period in return for a larger discount from charges from the providers.[76] Such a commitment was especially appealing to providers prior to most states' enactment of prompt payment laws, but might not be as attractive now that most states have enacted laws regarding prompt payment.

Perhaps most importantly, PPOs generally allow enrollees to use, for a higher co-pay or deductible, non-PPO providers instead of PPO

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70. Id.
71. Id.
72. Id. at 38 and 39.
73. Id. at 39.
74. Id.
75. Id.
76. Id.

providers when they need health services. This results in enrollees having more access to physicians of their choosing.

§ 14:07. Exclusive Provider Organizations (EPOs)

Exclusive provider organizations (EPOs) are similar to PPOs in their organization and purpose.[77] Unlike PPOs, however, EPOs limit their enrollees to participating providers for all health care services very similar to how HMOs operate. Some EPOs also parallel HMOs in other respects. For example, some EPOs also use a gatekeeper approach to authorizing non-primary care services.[78] In these cases, the primary difference between an HMO and a EPO is that the former is regulated under HMO laws and regulations, while EPOs are regulated under insurance laws and regulations or ERISA, which governs self-insured health plans.[79]

EPOs are usually implemented by employers whose primary motivation is cost savings.[80] Only a few large employers, however, have been willing to convert their entire health benefits programs to an EPO format.[81]

§ 14:08. Point-of-Service plans (POS)

Point-of-Service Plans (POS) developed after many HMOs recognized that the major impediment to enrolling additional members and expanding market share is the reluctance of individuals to commit to using a limited panel of providers.[82] One solution to this problem was to offer some level of indemnity-type coverage as well. In other words, the member is allowed to make a coverage choice at the point

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77. Id.
78. Id.
79. Id.
80. Id.
81. Id. at 40.
82. Id.

of service when medical care is needed. Thus, enrollees can decide whether to use HMO benefits or indemnity style benefits.[83]

The indemnity coverage available under POS options from HMOs typically incorporates high deductibles and co-insurance to encourage members to use the HMO services.[84] Despite the availability of out-of-network benefits, studies have found that most POS plans experience between 65 and 85 percent of in-network use.[85]

There are two primary ways for an HMO to offer a POS option: (i) via a single HMO license, or (ii) via a dual license approach.[86] The single license approach means that the HMO provides the out-of-network benefit using its HMO license.[87] In many states, this restricts the total dollar amount of out-of-network care to 10% or less.[88] The dual-license approach is more flexible in that the health plan uses an HMO license to provide the in-network care and an indemnity license to provide the out-of-network care.[89] Dual license requires either that a single company possess both licenses (e.g., a commercial insurance carrier with a subsidiary HMO) or the HMO to partner with a licensed insurance carrier.[90]

This type of hybrid health benefit coverage represents an attractive managed care option for many employers and their employees. In fact, coverage under HMO POS plans has been the fastest growing segment of health insurance in recent years.[91]

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83. Id.
84. Id.
85. Id.
86. Id.
87. Id.
88. Id.
89. Id.
90. Id. at 40 and 41.
91. Id. at 41.

§ 14:09. Third Party Administrators (TPAs)

A third party administrator (TPA) is an organization that administers group benefits and claims for a self-funded company or group.[92] A TPA normally does not assume any insurance risk and thus is not truly a managed care entity.[93] However, since TPAs are often integral to the activities of managed care companies, they are discussed in this Chapter.

Most states require licensure of TPAs if they do business in a state. Many states require licensure even if there is only one plan participant residing in the state. Approximately five states require licensing if a certain percentage or number of plan participants reside in the state.[94]

About one third of all states provide for an exemption for state licensure if the TPA administers only single-employer self-funded plans.[95]

State TPA laws typically govern the following:[96]

(a) The TPA's written agreement with insurers, including a statement of duties;

(b) Payment methodology;

(c) Maintenance and disclosure of records;

(d) Insurer responsibilities, such as determination of benefit levels;

(e) Fiduciary obligations when the TPA collects charges and premiums;

(f) Issuance of TPA licenses and grounds for suspension or revocation; and

(g) Filing of annual reports and payment of fees.

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92. Id. at 462.
93. Id.
94. Id.
95. Id.
96. Id.

III. INTEGRATED DELIVERY SYSTEMS

§ 14:10. Introduction

As managed care has continued to develop and expand, increasing pressures have been placed on health care providers to reduce costs and improve quality, while protecting their market share. For example, physicians only receive approximately 20% of each health care dollar spent in the U.S.[97] Yet, physicians actually control most health care costs.

By 1988, about 88% of all hospital revenue was derived from traditional inpatient services.[98] Currently, a much larger percentage of hospital revenue comes from outpatient sources. This shift is, in part, related to tremendous cost pressures to perform procedures in an outpatient setting. Not only are outpatient services less costly, but it is arguably safer for the patient. Thus, hospitals have been forced to become more active in outpatient services that were traditionally the domain of physician offices.

Improvements in technology and data sharing have also helped the formation of IDSs.[99] In particular, the ability to share clinical data allows multiple providers, such as hospitals and physicians to work collaboratively. Such sharing of data also provides some additional efficiencies in administrative functions, such as billing and collection.

Finally, increased productivity is another reason for the development of IDSs. In particular, the increased use by HMOs and other managed care organizations of capitation payments has made it essential that hospitals and physicians become more productive and efficient.[1] By working together, hospitals and physicians can efficiently care for more patients thereby increasing their revenues.

In sum, IDSs are a response by hospitals and physicians to the increasing number and type of managed care organizations. The form

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97. Essentials of Health Care Finance, William Cleverley, Ph.D., Aspen Publications, 4th Edition, 1997, pg. 50.

98. Id. at 55.

99. Id.

1. Id.

an IDS takes is somewhat dependent on which of the groups desires to control the enterprise.[2]

As managed care continued to grow, many patient referrals began to be made by HMOs and other managed care entities, instead of physicians, to those hospitals and physicians that were in their network. Thus, fear of being bereft of referrals caused many hospitals and physicians to create alliances in order to increase their negotiating position with health plans. One way of creating such alliances was to align interests through integration. The result is various different types of integrated delivery systems (IDS).

IDSs typically fall into three broad categories: (i) systems in which only the physicians are integrated; (ii) systems in which the physicians are integrated with facilities; and (iii) systems that include insurance functions.

The next sections discuss these various types of IDSs.

§ 14:11. Individual Practice Association/Independent Practice Association (IPAs)

An individual practice association, or independent practice association (collectively an "IPA"), is a legal entity, the members of which are independent physicians who contract with the IPA for the sole purpose of having the IPA contract with one or more HMOs.[3]

An IPA often negotiates with an HMO for a capitation rate inclusive of all physician services.[4] Alternatively, an IPA, like a PPO, instead just negotiates a discounted fee arrangement for services rendered by its physicians. The IPA in turn reimburses the member physicians. Physician reimbursement may or may not include capitation.[5] Under a capitation arrangement, the IPA and its member physicians are at

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2. Id.

3. Peter R. Kongstvedt, Essentials of Managed Health Care, Aspen Publications, 2nd Edition, 1997, pgs. 50 and 51.

4. Id. at 51.

5. Id.

risk for at least some portion of medical costs in that, if the capitation payment is lower than the required reimbursement to the physicians, the member physicians must accept lower income.[6] It is the presence of this risk sharing that stands the IPA apart from a negotiating vehicle that does not bear risk.[7]

The usual form of an IPA is as an umbrella organization for physicians in all specialties to participate in managed care.[8] However, many single specialty IPAs also exist.

An IPA may operate simply as a negotiating organization, with the HMO providing all administrative support, or it may take on some of the duties of the HMO, such as utilization management, network development and other responsibilities.[9]

§ 14:12. Physician-Hospital Organization (PHOs)

Physician Hospital Organizations (PHOs) are organizations that are jointly owned and operated by hospitals and their affiliated physicians. A PHO is typically developed to provide a vehicle for hospitals and physicians to contract together with managed care organizations to provide both physician and hospital services.[10] They represent one of the numerous approaches taken by providers who are implementing integrated delivery systems.[11]

PHOs are generally separately incorporated entities in which physicians and one or more hospitals are shareholders or members.[12] These members execute provider agreements with the PHO under which they delegate responsibility for negotiating agreements with

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6. Id.

7. Id.

8. Id.

For a diagram illustrating the IPA Model, see Appendix F following this chapter.

9. Id.

10. Id. at 42.

For a diagram illustrating the Physician Hospital Organization, see Appendix G following this chapter.

11. Id.

12. Id.

managed care organizations (or employers) to the PHO and agree to accept as reimbursement the PHO's payment schedules.[13]

PHOs can offer several advantages for providers, including:[14]

• They may increase the negotiating clout of their individual members with managed care organizations;

• They provide a vehicle for physicians and hospitals to establish reimbursement and risk-sharing approaches that align incentives among all providers;

• They can serve as a clearinghouse for certain administrative activities, including, credentialing and utilization management, thereby reducing the administrative burden on their individual physician and hospital members; and

• They provide an organized approach for physicians and hospitals to work together on managed care issues, including utilization management and quality improvement.

PHOs may also offer advantages to some managed care organizations:

• For organizations that are new to a market, PHOs can provide a means of rapidly establishing a panel of participating physicians and hospitals; and

• If the managed care organization delegates claim processing responsibility to it, the PHO can provide a means of reducing operating costs.

Recent surveys suggest that PHOs have achieved only limited success in contracting with managed care plans and generally have not implemented extensive medical management programs.[15]

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13. Id. at 42 and 43.
14. Id. at 43.
15. Id.

§ 14:13. Physician Practice Management Organizations (PPMs)

PPMs are management companies that integrate physicians or physicians groups. PPMs may in some ways be viewed as a variant of management services organizations (MSOs).[16]

A PPM often purchases physician practices, both primary care and specialty physicians groups, and then signs multi-year management contracts with the physicians in such groups.[17] The physicians may be given some degree of equity participation in the PPM, but this is not required.

Some physicians have found PPMs attractive because a PPM will assume all of the management responsibilities of the practice.[18] Specifically, the PPM provides management for all support functions (e.g., billing and collections, purchasing, negotiating contracts), but remains uninvolved with the clinical aspects of the practice.[19] In exchange for such services, the PPM usually takes a percentage of revenues or a flat fee and the physician agrees to a long term commitment with the PPM.[20]

Since the primary purpose of the PPM is to manage physicians' practices, it theoretically has expertise that the physician running the practice does not have. Also the PPM has the ability to bring substantial purchasing power to bear though combining the purchas-

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16. For a diagram illustrating the PPMS Model, see Appendix H following this chapter.

17. Id. at 52.

18. Id.

19. Id.

20. Id.

It should be noted that percentage of fee arrangements have been held to be fee-splitting, and therefore prohibited by some state laws. Additionally, the Office of the Inspector General in the Department of Health and Human Services has held that percentage of fee arrangements can violate the federal Medicare Anti-Kickback Laws. See OIG Advisory Opinion No. 98 4.

ing needs of several hundred practices.[21] PPMs often make significant changes in the practice if profits are not adequate.[22]

§ 14:14. Group Practice Without Walls/Clinics Without Walls (GPWW)

A group practice without walls (GPWW), also known as a clinic without walls, is another type of IDS.[23] A GPWW is composed of private practice physicians who agree to aggregate their practices into a single legal entity, but the physicians continue to practice medicine in their independent locations.[24] In other words, the physicians appear to be independent from their patient's perspective, but are viewed by contracting entities as a single group.

To be considered a medical group, the physicians must have their personal income affected by the performance of the group as a whole.[25] Although an IPA will place a defined portion of a physician's income at risk (that portion related to the managed care contract held by the IPA), the group's income from any source has an effect on the physician's income and on profit sharing in the group.[26]

The GPWW is owned by the member physicians and governed by them.[27] The GPWW may contract with an outside organization to provide business support services.[28] Office support services are generally provided through the group.

Perhaps the key advantage of a GPWW is that income is affected by the performance of the group as a whole.[29] Therefore, the GPWW has

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21. Id. at 53.
22. Id.
23. Id. at 54.
24. Id.
25. Id.
26. Id.
27. Id.
28. Id.
29. Id.

some ability to influence practice behaviors. If, for example, a member physician is practicing in such a manner as to adversely affect the group as a whole, considerable peer pressure can be brought to bear. The group can even proceed to expel a physician member if the problems are serious and are not rectified. One of the disadvantages of a GPWW is that the physicians essentially remain independent. Thus, many of the economies of scale that exist in truly merged practices do not exist in a GPWW context.[30]

§ 14:15. Consolidated Medical Group

A Consolidated Medical Group, or so-called medical group practice, refers to a traditional structure in which physicians have combined their resources to be a true medical group practice.[31] Thus, unlike a GPWW where physicians combine certain assets and risks but remain in their own offices practicing the way they always have, a true medical group is located in one site and the physicians practice together in one facility.[32]

The group is usually a partnership or professional corporation. After a probationary period, new members of the group are often required to pay a substantial capital contribution to become partners or shareholders of the group.[33] Typically, physicians in group practices are also required to sign non-competition agreements as part of their employment and/or partnership or shareholder status in a group practice.[34]

Medical groups typically have strong economies of scale and the ability to influence their member physicians' behavior.[35] Although the capital investment required of partners or group shareholders can prevent some physicians from joining, it also serves as disincentive for physicians to leave the group thereby promoting stability within

30. Id. at 55.
31. Id.
32. Id.
33. Id.
34. Id.
35. Id.

the group.[36] Nevertheless, such groups can be problematic if they have high overhead or poor utilization patterns which are not rectified.[37]

§ 14:16. Foundation Model IDS

A Foundation Model IDS is created when a hospital forms a not-for-profit foundation and purchases physicians' practices and holds the assets of such practices in the foundation.[38] A Foundation Model IDS is usually used when, for legal reasons, the hospital cannot employ physicians directly (e.g., prohibitions against the corporate practice of medicine), cannot use the hospital's funds to purchase the practices (e.g., the hospital is a not-for-profit entity that cannot own a for-profit subsidiary), or simply forms a subsidiary for the physician practice as a matter of corporate governance and structure.[39] Alternatively, though less common, a foundation can be formed without a hospital and simply exist on its own and contract for services with a medical group and a hospital.[40]

A foundation is usually governed by a board of directors composed of hospital appointees, physician appointees and community members.[41] The foundation owns and manages the practices, and the physicians become members of a medical group that has an exclusive contract with the foundation.[42] The physicians in turn have employment contracts with the medical group.

Technically, all of the entities (e.g., foundation, hospital and physician group) are separate and independent, however, each of them work closely together.[43]

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36. Id.
37. Id. at 56.
38. Id. at 61.
39. Id.
40. Id.
41. Id.
42. Id.
43. Id.

Foundation Model IDS are usually only created when state laws prevent other types of IDSs from being formed. Yet, despite the fact that it can be somewhat unwieldy, a Foundation Model IDS provides the most structural integration of any other IDS discussed thus far.[44] The foundation is typically the only source of revenue for the physician group and has a great deal of control over the group.[45] Also, because of its size, a foundation has greater economies of scale.[46]

The disadvantages, however, are that there is a great potential for conflicts between the governing boards of the hospital and the medical group.[47] Though theoretically these groups are aligned, there is always the potential for disputes based upon the goals and objectives of each group that do not relate to the foundation. Finally, and perhaps more importantly, the not-for-profit status of the foundation can be problematic. Specifically, if the foundation is a not-for-profit entity, it must continuously prove that it provides a community benefit and must also avoid providing any private inurement.[48]

§ 14:17. Staff Model IDS

A staff model IDS,[49] refers to an IDS owned by a health care system rather than by an HMO.[50] Specifically, if the owner is a licensed entity (e.g., an HMO), it is not a staff model IDS.[51] If, however, the IDS is owned primarily by a health care provider, it is considered a staff model IDS. In the case of staff model IDS, the health care system owner is usually more than a hospital, and is instead a larger more comprehensive health care provider.[52]

In a staff model IDS, the physicians are integrated into the system

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44. Id.
45. Id.
46. Id.
47. Id. at 62.
48. Id.
49. Id.
50. Id.
51. Id.
52. Id.

either through the purchase of their practices or through direct employment by the IDS.[53]

It is important to distinguish between a staff model IDS and a staff model HMO. In a staff model HMO we are referring to an organization in which the HMO directly employs physicians. In a staff model IDS, however, a health care system (i.e., provider) would employ the physicians.

Staff model IDS have many advantages including, economies of scale, low start-up costs, and the ability to control physicians.[54] Some of the disadvantages, however, are that since the physicians are salaried employees there is little incentive for them to see high volume of patients.[55] By far, the biggest disadvantage, however, is the high capital requirement necessary to establish and operate a staff model IDS.[56]

IV. REIMBURSEMENT UNDER MANAGED CARE

§ 14:18. Compensation in general

In the traditional fee-for-service health care delivery system, the physician and patient choose treatment options without any financial or other cost-sensitizing factors.[57] All managed care organizations, regardless of type, attempt to systematically control costs while promoting quality in health care.[58] Under managed care, the insurance company, employer or other payor of health care services becomes involved in the determination of services to be provided and the price

53. Id.

54. Id.

55. Id.

56. Id. at 63.

57. Joseph A. Snoe, American Health Care Delivery Systems, American Casebook Series, West Group, 1998, pg. 381.

58. Id.

to be charged (and paid) for health care services.[59] Managed care also attempts to sensitize health care providers to the importance of cost control and efficient treatment through financial incentives to control costs and utilization review.

With conventional health care delivery, independent, fully autonomous providers control a patient's medical treatment (with some input from the patient), determine the charges for the services, and get paid a fee for services rendered. With managed care, by risk shifting, a provider is paid a fixed capitation amount per month per covered person, or through some other financial arrangement discussed below, and the provider treats the patient without further charges.[60] Thus, under managed care, providers theoretically could profit by reducing costs and reducing unnecessary services.

Just as there are multiple types of managed care organizations, there are multiple compensation systems in managed care. Many of them may even come into play in the same managed care network. What compensation plan is best suited to a particular provider and managed care organization depends on the organizations' goals and objectives and the willingness of providers to accept the compensation plan. Economic realities such as the volume of patients, patient demographics, the prevalence of managed care in the service area, and the compensation package itself all come into play.[61]

The remainder of this section discusses the variety of different payment methodologies available: (i) salary; (ii) fee-for-service; (iii) capitation; (iv) withholds and risk pools; and (v) pay-for-performance. Additionally, this Section will discuss how capitation rates are calculated.

§ 14:19. Salary

If the health care provider is actually owned by or is an employee of the managed care organization, the managed care organization

59. Id.
60. Id.
61. Id. at 383.

merely pays the health care provider on a salary basis, with perhaps some incentives for above-average performance. A straight salary is the most common payment mechanism in staff model HMOs and is often found in group models as well, where the group's salary costs are passed back directly to the plan.[62] Some private group practice groups use straight salary, usually a base, after which productivity, medical costs or other modifiers are applied.[63]

§ 14:20. Fee-for-service

Under a fee-for-service payment arrangement a health care provider is paid on a volume related basis. Specifically, the physician is paid under either a charge-based system or a fee schedule. In a charge-based system, the physician is paid on the basis of total charges, typically at some negotiated percentage of charges such as 85 percent.[64] Although receiving less money for each treatment, the physician increases revenues and profits by rendering more services. In a fee schedule based system, the physician is paid on the basis of some fee schedule that is predetermined between the payor and the physician. With respect to hospitals, a payor typically pays hospitals on either a charges or a per diem (or per case) basis. As with physicians, in a charge-based system the hospital is paid on the basis of some discounted percentage of the hospital's actual charges. On a per diem basis the hospital is paid a flat fee per patient per day depending on the type of case (e.g. surgery is paid a different daily rate than maternity). Regardless of the exact methodology chosen, under this type of arrangement the provider is not rewarded for monitoring costs.

As discussed earlier, managed care organizations were developed to help move the health care industry away from fee-for-service and

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62. Peter R. Kongstredt, Essentials of Managed Health Care, Aspen Publications, 2nd Edition, 1997, pg. 88.

63. Id.

64. Essentials of Health Care Finance, William Cleverley, Ph.D., Aspen Publications, 4th Edition, 1997, pg. 50.

towards more cost-sensitive payment systems. Yet, recently, the backlash against HMOs and other types of managed care systems has led many managed care organizations to consider moving back towards fee-for-service or discounted fee-for-service type compensation.

§ 14:21. Capitation

The traditional form of managed care payment is capitation. Under capitation, the provider receives a fixed fee for providing care for the managed care organization's beneficiary for a fixed period of time. If the services the beneficiary receives cost more than this payment, the provider loses money; if the services the beneficiary receives cost less, the provider makes money. In other words, the provider becomes the true insurer; i.e. risk bearer, with respect to the patient.[65]

A primary care physician may be capitated for his or her own services, but can also be paid on a capitated basis for other services the patient may need for specialist services, laboratory tests, or ancillary services. Some of these services, however, cost far more than primary care services, and putting a single primary care physician, or even physician group, at risk for these services might impose unreasonable risks.

Instead, managed care organizations usually put the primary care provider only partially at risk.[66] This is done through the use of bonuses or withholds. A pool is established either from money withheld from payments made directly to the physician (a withhold) or from funds provided in addition to regular payments (a bonus).[67] Specified expenses, for specialists or laboratory tests, for example, are paid out of this pool.[68] Any money left over at the end of an accounting period is paid over to the physician.

While incentives are an effective way to hold down costs, they can

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65. Furrow, Greaney et al., Health Law, American Casebook Series, West Group, 4th Edition, 2001, pg. 596.

66. Id.

67. Id.

68. Id.

also result in service reduction if the responses they elicit from providers become unreasonable. It is more difficult to regulate incentives, however, than it is to regulate network or utilization controls because it is more difficult to identify discrete unacceptable practices or to create procedures that address these practices.[69]

Many managed care organizations, however, use more sophisticated forms of capitation. For example, a managed care organization may appoint the primary care physician as a "gate keeper." Under this system, the primary care physician receives the capitation payment, but must pay any specialists that the primary care physician refers to from this capitation payment.[70] By making the primary care physician financially responsible for the specialists' fees, the primary care physician will not be tempted to over-refer patients to specialists for care. Through this "downstream assumption of risk," the primary care physician becomes more cost sensitive.

To safeguard the primary care physician against potentially ruinous liability to specialists, many such downstream assumption of risk contracts include stop-loss protections.[71] Stop-loss protection means the physicians or physician group is limited in the amount of loss it can suffer because of its assumption of financial responsibility, directly or indirectly, to pay other providers. For instance, under federal law, any HMO receiving capitation payments through Medicare or Medicaid programs must provide adequate stop-loss protection for any physician or physician group placed at "substantial financial risk" for services to Medicare or Medicaid enrollees not performed by the physician or physician group.[72] Additionally, Federal Medicare regulations set the maximum amount a physician or physician group can be required to pay other providers at 25% of the potential

69. Id.

70. Joseph A. Snoe, American Health Care Delivery Systems, American Casebook Series, West Group, 1998, pg. 383.

71. Id. at 384.

72. 42 USCS § 1395 mm(i)(8)(A)(ii)(I).

payments the physician or physician group receives from the HMO.[73] After the primary care physician or physician group reaches the 25% threshold, the HMO must cover at least 90% of the remaining referral costs.[74]

States have generally not required a physician or physician group, who in return for accepting capitation payments, agrees to bear the financial risks for other providers' services, to be licensed as an insurer or HMO as long as the entity contracting with the physician or physician group itself is a licensed insurer or HMO. If, however, the physician or physician group accepts the financial responsibility for other providers in direct contracts with employers, unions, the public or other unlicensed group, the state insurance regulatory agency generally will require the physician or physician group to comply with state insurance or HMO legislation.[75]

Alternatively, HMOs pay capitation payments to both primary care physicians and referral physicians. A full capitation system aligns primary care physicians' and referral physicians' incentives with that of the managed care organization.

§ 14:22. Withholds and risk pools

As discussed above, a withhold is an amount or percentage that is withheld from the payment due to the health care provider and paid later if certain thresholds (such as utilization rates or quality levels) are met. Risk pools are similar to withholds, in that a portion of the payment due to the health care provider is withheld and deposited in a risk pool, such that if certain thresholds are meet by the entire group of providers then each of them will share in the risk pool amounts.

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73. 42 USCS § 1395 mm(i)(8)(A)(ii)(I).

74. 42 USCS § 1395 mm(i)(8)(A)(ii)(I).

75. Essentials of Health Care Finance, William Cleverley, Ph.D., Aspen Publications, 4th Edition, 1997, pg. 384.

§ 14:23. Setting prices in capitated contracts

Revenues from HMOs consist of three categories: (i) premiums, (ii) co-payments, and (iii) coordination of benefits.[76] The largest element is premiums received from HMO subscribers.[77] In addition to those premiums, HMOs may also receive additional revenues from co-payments for selected services. For example, an HMO may have a co-payment for an office visit collected at the time of the visit. This provides an incentive for patients not to overuse services. Coordination of benefits relates to the recovery of payments from other insurers when two or more insurance policies are involved.[78] An HMO member may, for instance, have a coverage under a spouse's insurance policy. If the HMO pays for the member's coverage, the two insurance companies would need to work together to determine which insurance company is responsible or to divide the costs between themselves.[79]

The largest area of expenses for HMOs are inpatient expenses and physician payments.[80] Inpatient expenses are mostly payments to hospitals for covered admissions, whereas physician payments reference amounts paid to both primary care and specialty care physicians.[81] These payments could be fee-for-service or capitation.

An HMO or managed care organization that is attempting to either set a price or assess the profitability of an existing price must determine its expected costs of servicing its patient base.[82] Thus, a formula, such as Per Member Per Month (PMPM)=Expected Encounters per year multiplied by cost per encounter divided by 12, is needed.[83]

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76. Id. at 55.
77. Id.
78. Id.
79. Id.
80. Id.
81. Id.
82. Id.
83. Id.

Cost is a simple function of expected utilization and cost per type of encounter.[84] The more difficult part about determining price is the actual forecasting that is necessary to determine utilization.[85] If a forecast is too high, it will reduce the HMO's or managed care organization's negotiating power. If a forecast is too low it will result in the HMO or managed care organization losing money and not being profitable.

Other factors that need to be considered in setting prices are the set of services to be provided.[86] Some services are particularly expensive and if they are included in the capitation rate, the rate should be increased or, alternatively, such services should be specifically carved-out of the capitation rate.[87] Additionally, the volume of patients who could potentially receive services is another factor that must be examined in order to determine the provider's break-even service volume.[88] Whether stop-loss coverage is available and its cost is also important. In particular, the provider may want insurance, either from the HMO or a third party insurance company, or federal law may require, that if the cost of care of a patient or group of patients exceeds a certain amount that the HMO or third party insurance company will be responsible for any costs above such threshold.[89] Finally, thought should be given to issues of adverse selection. In particular, providers need to consider the demographic composition of the population to be covered.[90] If the population has a large number of chronically ill or older patients, it is likely that utilization levels, and thereby costs, will be higher.[91]

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84. Id.
85. Id.
86. Id.
87. Id.
88. Id.
89. Id.
90. Id.
91. Id.

§ 14:24. Pay-for-performance

In the late 1980s and early 1990s, managed care organizations prospered in large part because they catered to the employer's needs to control runaway inflation in health care costs. Once health care costs stabilized, many employers reviewed health care coverage with an eye to expanding benefits, quality of care, and employee satisfaction.[92] Currently, many HMOs are designing compensation arrangements, especially bonus and withhold targets, to reward providers based on quality of care and patient satisfaction in addition to direct financial savings.[93] Under this so-called "pay for performance" type of compensation arrangement, an HMO may review treatments, and financially reward providers with better than expected outcomes.

The basic premise behind pay-for-performance is that savings can be achieved by reducing medical errors, lowering complications and using quality-guided resource utilization management to provide cost-effective, appropriate treatment. In order to do this measures of performance must be collected.

Thus, HMOs and hospitals might survey patients to determine patient satisfaction, since some HMOs interpret patient turnover as indicative of patient satisfaction or dissatisfaction with the provider.[94] Some HMOs review patient charts for completeness and for quality assurance, while others consider a provider's medical malpractice experience or reward providers that complete preventative care programs.[95]

§ 14:25. Gainsharing

The rise in health care costs has led hospitals and physicians to look for additional ways to reduce expenses. Some hospitals and physicians

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92. Joseph A. Snoe, American Health Care Delivery Systems, American Casebook Series, West Group, 1998, pg. 305.

93. Id.

94. Id. at 385.

95. Essentials of Health Care Finance, William Cleverley, Ph.D., Aspen Publications, 4th Edition, 1997, pg. 68.

have implemented "gainsharing" arrangements to address rising health care costs. Under a "gainsharing" arrangement, a hospital and physicians implement certain designated cost-saving measures, and the hospital pays the physicians a share of the cost savings attributable to the physicians' efforts.

The Office of the Inspector General ("OIG") has addressed the issue of "gainsharing" through its issuance of six advisory opinions, which offer useful guidance for acceptable gainsharing arrangements.[96] Basically, gainsharing arrangements must not have an adverse impact on patient care. In February, 2005, the OIG issued six advisory opinions addressing similar gainsharing arrangements.[97] In each case, the OIG concluded that it would not impose administrative sanctions with respect to any of those arrangements.[98]

The approved gainsharing arrangements each contained one or more of the following cost-saving measures:

- Product standardization of certain specified devices;
- Limitation of the use of certain specified devices;
- Performance of certain procedures only as needed;
- Opening packaged items only as needed; and
- Substituting less costly items for items currently being used.

The OIG determined that the arrangements included sufficient safeguards to enable the OIG to elect not to impose administrative sanctions. Such safeguards included:

- Clear, separate identification of specific cost-saving actions and resulting savings.
- Credible medical support for the conclusion that the arrangement would not result in an adverse effect on patient care.
- Payments to the physicians would be based on all surgeries, regardless of third-party payor.
- Payments to the physicians with respect to cost savings in

96. OIG Advisory Opinion No. 05-01 through 05-06.
97. OIG Advisory Opinion No. 05-01 through 05-06.
98. OIG Advisory Opinion No. 05-01 through 05-06.

connection with Medicare and Medicaid beneficiaries would be subject to a cap, limiting the impact on those beneficiaries.

• The hospital and physicians established baseline thresholds for specified services; reductions of services below those thresholds would not result in any additional gainsharing payments to physicians, thus limiting the physicians' incentive to reduce services.

• In the case of product standardization, individual physicians would continue to have access to the same selection of devices as before, so that savings would be obtained from "inherent clinical and fiscal value", not from limitation on available devices.

• The physicians and hospital would provide patients written disclosure about the arrangements and patients would have the right to review the arrangements.

• The arrangements were limited to one year.

• The physician groups each distributed profits on a per capita basis, limiting any incentive for individual physicians to engage in inappropriate reductions in services.

• The arrangements were limited to physicians already on the medical staffs of the hospitals.

Accordingly, any gainsharing arrangement must be structured in light of these advisory opinions. In particular, any gainsharing arrangement must tie payments to physicians to specific, identifiable, and verified cost savings, and not to overall cost savings. Similarly, any gainsharing arrangement must be for a limited period of time and include reasonable limitations on the amount of payment that the physicians can receive in order to reduce any incentive to limit patient care. Finally, any gainsharing arrangement should be limited to physicians on a hospital's medical staff and must not have any adverse impact on patients.

V. LEGAL AND REGULATORY ISSUES IN MANAGED CARE

§ 14:26. Introduction

Integration and innovation by managed care organizations are rapidly changing the health care marketplace.[99] These changes pose significant challenges for state and federal regulators charged with protecting consumer interests and maintaining a level regulatory playing field.[1] A central goal of licensure requirements is to ensure that consumers receive the medical coverage that they have been promised.

Regulators, through appropriate statutory authority, must continually issue, update regulations and oversee health plan operations to provide strong consumer protections for all health plan enrollees.[2] The organizational structure of managed care plans, however, usually determines how they are regulated by government officials, especially in the states.[3] In addition to enabling statutes and regulations, other sources of authority govern managed care operations.[4] Regulators supplement their regulations with written policy statements, and internal office policies help them address specific issues.[5] Federal oversight also may play an important role, depending on the managed care product offering.[6]

§ 14:27. HMO legal and regulatory issues

On the state level, HMOs may be regulated by more than one agency.[7] Regulatory supervision could be shared by the departments

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99. Peter R. Kongstredt, Essentials of Managed Health Care, Aspen Publications, 2nd Edition, 1997, pg. 66.

1. Id. at 453.

2. Id.

3. Id. at 454.

4. Id.

5. Id.

6. Id.

7. Id.

of insurance and health.[8] Insurance regulators typically assume principal responsibility for the financial aspects of HMO operations, whereas health regulators typically focus on quality of care issues, utilization patterns, and the ability of participating providers to provide adequate care.[9] In Illinois, HMOs are regulated by the Illinois Division of Insurance.[10]

As explained in more detail in the next Chapter, in Illinois an HMO must obtain licensure to operate from the Illinois Division of Insurance by applying for a certificate of authority (COA). An organization may be incorporated for the sole purpose of becoming licensed as an HMO, or an existing company may sponsor an HMO product line through a subsidiary or affiliated organization.[11] In its application, the HMO must include: (i) corporate bylaws, (ii) sample provider and group contract forms, (iii) evidence of coverage forms, (iv) financial statements, (v) financial feasibility plan, (vi) description of service area, (vii) internal grievance procedures, and (viii) the proposed quality assurance program. Payment of licensing fees, which is currently $200.00, is also required.[12]

Regulators review this information in order to determine whether the HMO will provide adequate availability and accessibility of medical services, that the HMO's contracts with providers include certain information (e.g., a list of covered services, details about how physicians will be paid, hold-harmless language, the contract term, termination procedures, and an obligation to adhere to HMO quality assurance and utilization management programs).

Regulators also are concerned about provider risk-sharing arrangements. Most HMOs share the risk for the cost of health care with their

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8. Id.

9. Id.

10. 215 ILCS 125/1-1 et seq.

11. Peter R. Kongstvedt, Essentials of Managed Health Care, Aspen Publications, 2nd Edition, 1997, pg. 454.

12. 215 ILCS 5/408(1)(p).

providers (principally primary care physicians) through performance based reimbursement, including capitated payment mechanisms, and periodically through withholds and pooling arrangements.[13] Regulators carefully scrutinize these types of reimbursement formulas to ensure that quality of care is not compromised and that provider solvency is not jeopardized.[14]

The HMO Act also establishes specific capital, reserve and deposit requirements for HMOs in Illinois to protect consumers and other interested parties against insolvency. As mentioned above, Illinois also requires HMOs to include hold-harmless clauses in their provider contracts. In situations where the HMO fails to pay for covered medical care, such clauses prohibit providers from seeking collection from the enrollees. Illinois is also one of the few states that require HMOs to participate in guaranty fund programs.[15] This program provides funding to cover an HMO's potential liabilities for health care services if it becomes insolvent. Regulators may use this money to reimburse nonparticipating providers, to pay for the continuation of benefits, and to cover conversion costs.

Illinois also employs a number of methods to ensure that licensed HMOs remain in compliance with the law. HMOs must file an annual report with the Illinois Division of Insurance.[16] This report must include audited financial statements, a list of participating providers, an update and summary of enrollee grievances handled during the year, and any additional information deemed necessary to make a proper review of the organization.

Regulators also can conduct specialized inquiries, which often examine HMO finances, marketing activities, and quality assurance programs.[17] In part, the objective of these regulatory reviews is to determine the HMO's financial solvency and statutory compliance and

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13. Peter R. Kongstvedt, Essentials of Managed Health Care, Aspen Publications, 2nd Edition, 1997, pg. 455.

14. Id.

15. 215 ILCS 125/6-1 et seq.

16. 215 ILCS 125/2-7 et seq.

17. 215 ILCS 125/2-7 et seq.

whether any trends can be identified that may cause problems in the future. As part of the examination process, regulators may conduct a site visit to see the HMO's operations first hand, to review health plan documents, and to assess the efficiency and soundness of plan operations. The site visit may be relatively brief or it can take place over a period of days or weeks. Occasionally, regulators contact participating providers and enrollees directly to determine how the HMO is operating.

§ 14:28. Point-of-service plan legal and regulatory issues

HMOs prefer to market point-of-service products on their own by underwriting out-of-plan benefits, referred to as a stand-alone product. Most state laws, however, prohibit HMOs from offering a point-of-service product without entering into an agreement with an insurance company to cover the out-of-plan usage, referred to as a wrap-around product. Unlike the majority of states, Illinois permits an HMO to offer a point-of-service products on a stand-alone basis if certain conditions are met. Among other requirements, the HMO must include as in-plan covered services all services required by law to be provided by an HMO, include a statement explaining that limited benefits may be paid when non-participating providers are used, the HMO may not spend more than 20% of its total expenditures for all its members for out-of-plan covered services.[18]

§ 14:29. PPO legal and regulatory issues

PPOs are regulated on the state level, usually by the state insurance department.[19] Most states have adopted PPO enabling legislation. In some states, PPO activities are regulated by insurance laws governing indemnity plans and managed care functions. PPO regulatory supervision is not as intense as HMO oversight since PPOs are not, in and of themselves, actual insurance products.

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18. 215 ILCS 125/4.5-1 et seq.

19. Peter R. Kongstvedt, Essentials of Managed Health Care, Aspen Publications, 2nd Edition, 1997, pg. 459.

Of the states that have enacted specific PPO laws, the most common areas of regulatory oversight include provider participation requirements, utilization review, restrictions on provider incentives, access to providers, and benefit level differentials.[20] Other areas include manner of provider payments, emergency care, quality assurance and improvement, grievance procedures, enrollee contracts and solvency requirements.[21]

In Illinois, PPOs are considered "administrators" under the Illinois Insurance Code.[22] An administrator is defined as any person, partnership or corporation, other than an insurer or health maintenance organization holding a certificate of authority under the Illinois HMO Act, that arranges, contracts with, or administers contracts with a provider whereby beneficiaries are provided an incentive to use the services of such provider.[23] A PPO clearly falls within this definition.

Administrators are required to register with the Illinois Division of Insurance.[24] As part of such registration PPOs are required, among other things, to maintain certain solvency thresholds,[25] maintain fiduciary accounts and post indemnity bonds.[26] Failure to register means that the PPO will be considered an authorized insurer and therefore subject to penalties.[27]

§ 14:30. PHO legal and regulatory issues

In circumstances where PHOs assume full or limited insurance risk directly from the employer, most state regulators believe that they have the statutory authority to require the licensure of a PHO as a

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20. Id. at 460.
21. Id. at 459.
22. 215 ILCS 5/370f et seq.
23. 215 ILCS 5/370g(g).
24. 215 ILCS 5/370k.
25. 215 ILCS 5/370k.
26. 215 ILCS 5/370l.
27. 215 ILCS 5/370p.

health plan to safeguard consumer interests.[28] However, most states do not regulate PHOs.[29]

Illinois does not currently regulate PHOs. Thus, a PHO does not need to acquire a certificate of authority prior to operating in Illinois. Nor are PHOs required to meet any solvency requirements and this has lead to some financially troubled HMOs. Instead, both the hospital and the physician group are merely required to maintain their respective licensure.

§ 14:31. IDS legal and regulatory issues

There are a number of issues that affect how an IDS is formed. These include antitrust concerns, not-for-profit status and inurement, payment to physicians, and the corporate practice of medicine prohibition, which are discussed in the following sections.

§ 14:32. — Antitrust

One concern with the type of loose affiliations of physicians into managed care organizations such as IPAs or other IDSs involves the Federal antitrust laws. There are two types of risks that potentially arise from the development of an IDS: (1) the risk of forming the entity (i.e., monopoly and other competition collaboration risks), and (2) the risk arising from on-going operations (i.e., tying arrangements and other illegal activities).[30]

In 1996 the Federal Trade Commission (FTC) and the Department of Justice (DOJ) issued guidelines for developing physician networks.[31] These guidelines allow providers to establish networks to negotiate and enter into payor contracts even if there is no financial

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28. Peter R. Kongstvedt, Essentials of Managed Health Care, Aspen Publications, 2nd Edition, 1997, pg. 460.

29. Id.

30. Id. at 518.

31. Department of Justice and Federal Trade Commission Statements of Anti-Trust Enforcement Policy in Health Care, 1996 at www.ftc.gov/reports/hlth35.htm.

integration resulting from the capitation payments.[32] Instead, the FTC/DOJ will examine other forms of integration such as withholds, quality assurance programs, and other measures that indicate providers are working together to provide a better product to the market.

§ 14:33. — Inurement

If a non-profit entity is involved in the creation of an IDS or the IDS desires to apply for not-for-profit status, it must be careful to ensure that it meets certain requirements.

In particular, IRS rules require that a nonprofit entity may not have its resources inure to, or be used for, the benefit of any individual, but rather that such resources are used exclusively for its charitable purpose.[33] To ensure that "private inurement" does not occur the IRS uses a "community benefit test."

IRS Revenue Ruling 69-545 requires a hospital to meet a "community benefit standard." To meet this standard, the hospital must have an independent board with members from the community, it must have an operating medical staff, it must provide emergency room access for all patients regardless of ability to pay, it must accept Medicare/Medicaid patients and any excess funds must be used for charitable purposes.[34] The failure to meet any one of these criteria will not be determinative, but rather the facts as a whole will be taken into consideration.

More recently, in its 2001 Field Service Advice manuals, the IRS has given the following guidance with respect to the issue.[35] Specifically, the IRS has stated that merely adopting a charity care policy is

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32. Department of Justice and Federal Trade Commission Statements of Anti-Trust Enforcement Policy in Health Care, 1996 at www.ftc.gov/reports/hlth35.htm.

33. Revenue Ruling 69 345, 1969 C.B. 117.

34. Revenue Ruling 69-345, 1969 C.B. 117.

See also Karen K. Harris, "Hospitals Not-for-Profit Status Under Attack: An Integrated Approach to Managing this Challenge," American Health Lawyers Association, Hospital and Health Systems Newsletter, Spring 2005.

35. 1996 continuing Professional Education Exempt Organizations Technical Instruction Program (CPE), pg. 390-391.

not enough. Instead a hospital must show that (i) such policy is communicated to the public; (ii) charity care is actually provided at reasonable levels; and (iii) charity care patients are not routinely discriminated against. With respect to charity policies the Field Service Advice manual explains that these policies should be in (i) writing, (ii) specifically state any exceptions to the policy, (iii) be communicated to the hospital and staff, (iv) require the ER to be open to all regardless of their ability to pay, (v) ensure that the full range of inpatient, outpatient and diagnostic services are provided free of charge or at reduced rates to indigent patients and specifically state any circumstances under which charity care will be denied, (vi) how and when a determination is made that a patient is eligible for free or reduced-cost services, (vii) the terms of any documents patients are required to sign, (viii) the contents of policy on admissions of poor or indigent persons, (ix) explain any patterns of referrals of indigent patients to other facilities, and (x) whether the hospital maintains records of its provision of charity care and if it maintains a separate account for such care and if bad debts are distinguished from charity care.[36]

Additionally, if the IDS applies for federal tax exempt status, it will also need to meet the safe harbor requirements regarding governance that are imposed by the IRS. To meet these requirements, no more than 20% of an IDS board should consist of physicians who are financially related, directly or indirectly, to the IDS.[37]

§ 14:34. — Payments to physicians

Payments to physicians that provide incentives for fewer services may not be legal if they provide incentives to provide less than

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36. 1996 Continuing Professional Education Exempt Organizations Technical Instruction Program (CPE), pg. 390 391.

See also Karen K. Harris, "Hospitals Not-For-Profit Status Under Attack: An Integrated Approach to Managing this Challenge," American Health Lawyers Association, Hospital and Health Systems Newsletter, Spring 2005.

37. Peter R. Kongstvedt, Essentials of Managed Health Care, 2nd Edition, Aspen Publications, 1997, pg. 509.

medically necessary services. Practically all present HMO arrangements currently have financial rewards of some sort for meeting certain utilization thresholds, however, so long as these rewards are not directly tied to the denial of care they should be permissible.

Additionally, all payments to physicians must be structured to comply with the Medicare Anti-Kickback Statute's safe harbor prohibitions[38] and the Stark Law's exceptions.[39] The Anti-Kickback Law prohibits the solicitation or receipt of any remuneration in return for referring a patient for services or in return for purchasing, leasing or ordering goods or services paid for by Medicare or Medicaid.[40] Stark prohibits a physician who has a financial relationship with an entity from making a referral to that entity for the furnishing of designated health care services.[41]

§ 14:35. — Corporate practice of medicine

In some states, corporations may not employ physicians unless the corporation is a professional service corporation owned entirely by physicians. This type of prohibition, known as the corporate practice of medicine prohibition, may limit the kind of organizational structures that can be used by managed care entities. In states, such as Illinois, where the corporate practice of medicine prohibition is enforced,[42] staff model HMOs and other types of managed care organizations in which the physician is actually employed by the organization may be prohibited, unless an exception exists.

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38. See 42 USCS § 1320a-7b(b).

39. See 42 USCS § 1395nn.

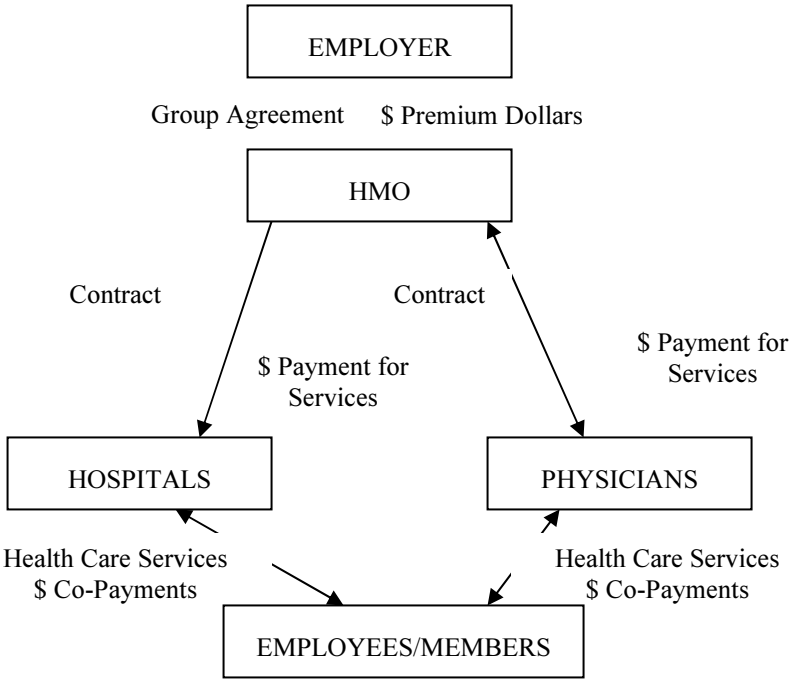
40. 42 USCS § 1320a-7b(b).

41. 42 USCS § 1395nn.

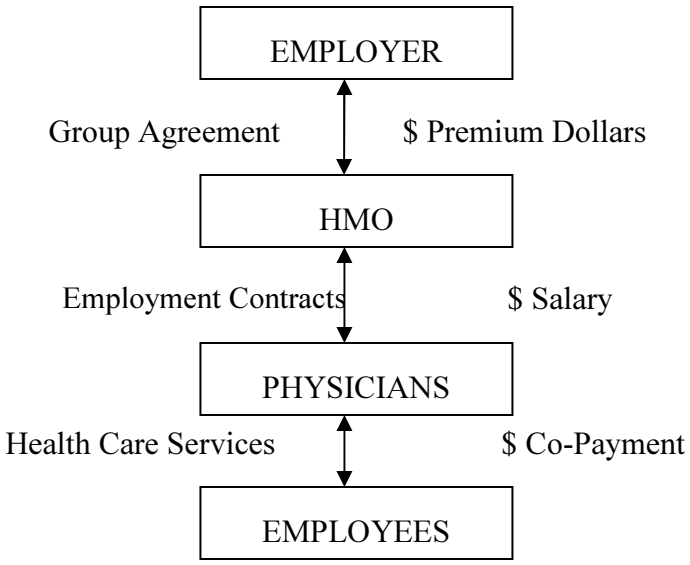
42. 225 ILCS 60/1 et seq.

See also Berlin v Sarah Bush Lincoln Health Ctr., 179 Ill 2d 1, 227 Ill Dec 769, 688 NE2d 106, 13 BNA IER Cas 727 (1997) (upholding Illinois' prohibition against the corporate practice of medicine).

HMO OPERATIONS GENERALLY



STAFF MODEL HMO



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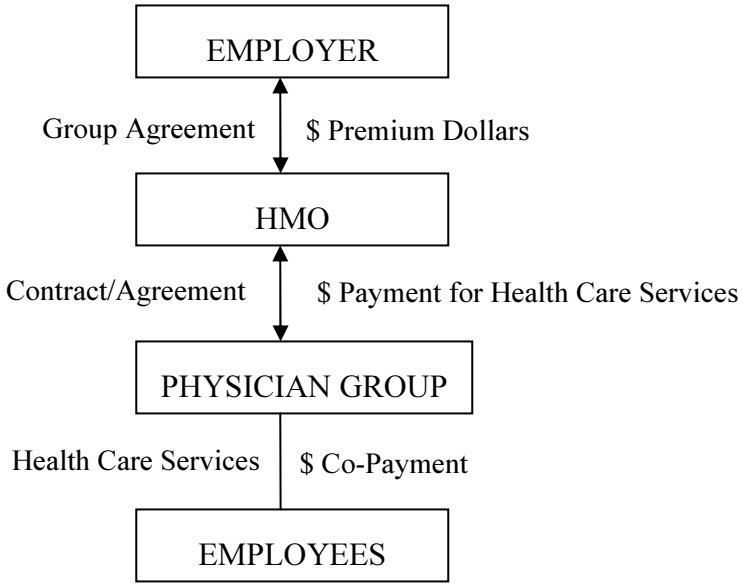
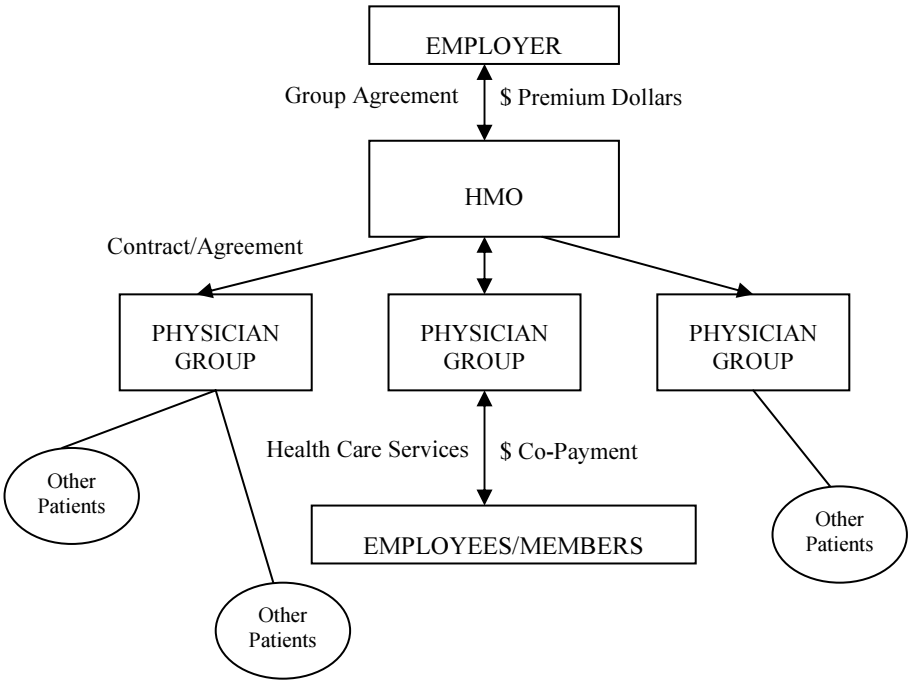
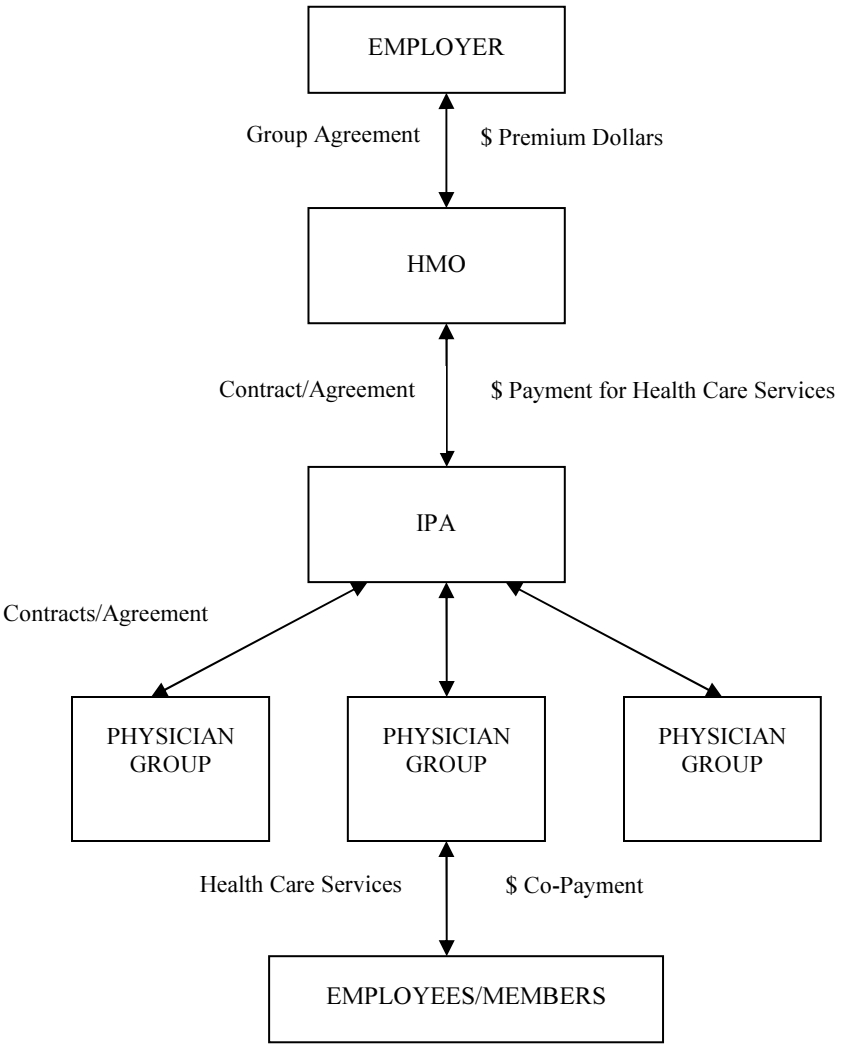


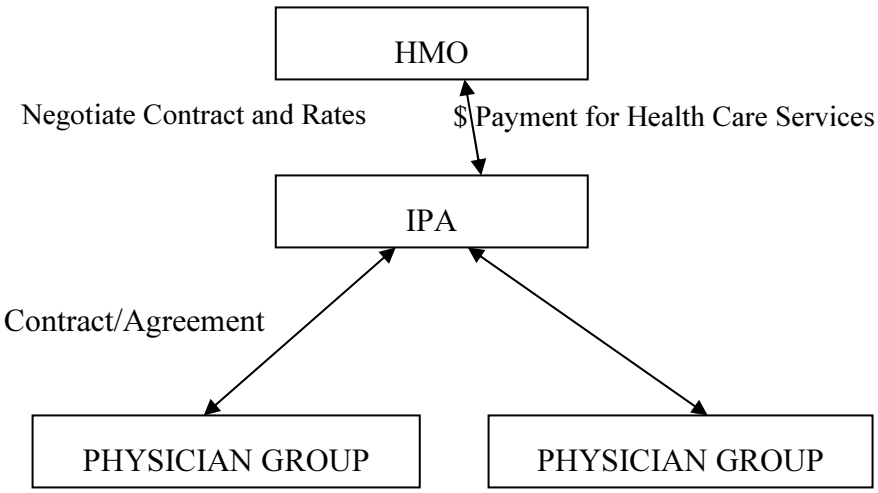
INDEPENDENT GROUP MODEL HMO



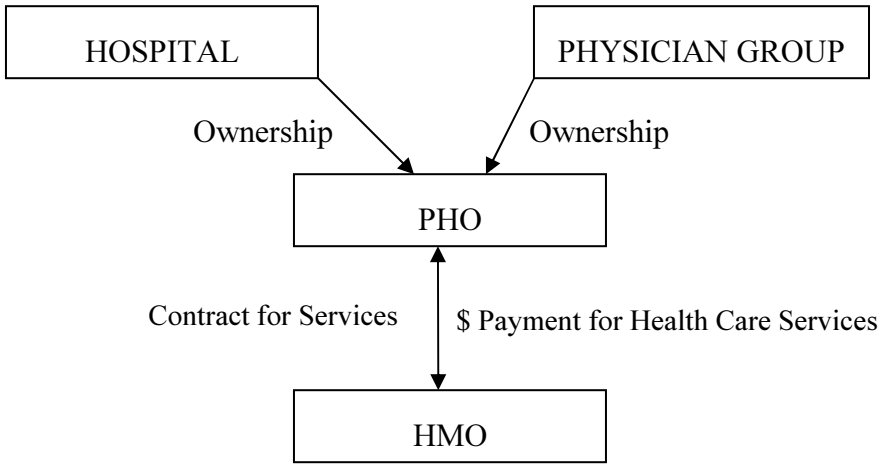
IPA MODEL HMO



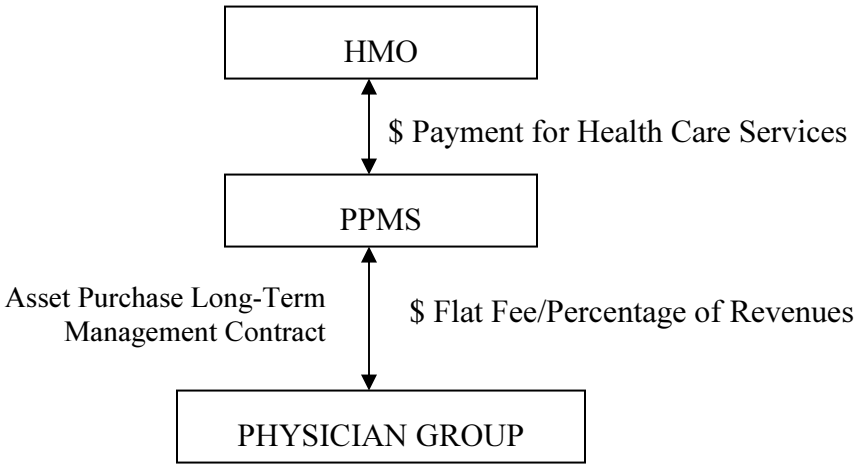
IPA MODEL


HMO
Negotiate Contract and Rates
$ Payment for Health Care Services
IPA
Contract/Agreement
PHYSICIAN GROUP
PHYSICIAN GROUP

PHYSICIAN HOSPITAL ORGANIZATION



PPMS MODEL


HMO
$ Payment for Health Care Services
PPMS
Asset Purchase Long-Term
Management Contract
$ Flat Fee/Percentage of Revenues
PHYSICIAN GROUP