

FORMING RURAL HEALTH NETWORKS: A LEGAL PRIMER



James W. Teevans, J.D.

October 1999

The author's work on this document was completed in June 1999
and reflects information available up to that date.



ALPHA CENTER



Alpha Center (www.ac.org), one of the nation's leading health policy centers, is dedicated to improving access to affordable, quality health care. A nonprofit founded in 1976 and based in Washington, D.C., the Alpha Center assists public and private sector leaders in meeting health care challenges by providing technical assistance, research, facilitation, information, and program management.

Copyright © 1999 by the Alpha Center. All rights reserved. No portion of this document may be copied or reproduced without the expressed permission of the Alpha Center. Requests to duplicate any portion of the document should be made in writing to the Director of Communications, Alpha Center, 1350 Connecticut Avenue, N.W., Suite 1100, Washington, DC 20036; 202.296.1825 (fax); or at rural@ac.org (e-mail).

DISCLAIMER: The opinions expressed in this document are those of the author and should not be construed as the opinions or policies of the Alpha Center or its funders.

Funding for this publication was provided through a grant from The Robert Wood Johnson Foundation (www.rwjf.org). Based in Princeton, N.J., The Robert Wood Johnson Foundation is the nation's largest philanthropy devoted exclusively to health and health care. It concentrates its grantmaking in three goal areas: to assure that all Americans have access to basic health care at reasonable cost; to improve care and support for people with chronic health conditions; and to reduce the personal, social and economic harm caused by substance abuse – tobacco, alcohol, and illicit drugs.



PREFACE

This legal primer is the first in a series of technical assistance reports produced under the Networking for Rural Health project, an initiative to strengthen the rural health care delivery system by fostering the development of rural health networks. This initiative is directed by the Alpha Center with grant support from The Robert Wood Johnson Foundation. A primary goal of Networking for Rural Health is to provide a variety of technical assistance tools and services to support network leaders. These technical assistance tools will be made available to rural health networks throughout the nation.

This primer is intended to inform readers about significant legal issues related to network formation, but should not be viewed as a substitute for obtaining legal counsel. Those contemplating network formation are strongly encouraged to consult with a legal advisor who can assist them in addressing their unique needs, within the context of applicable federal, state, and local laws. Inquiries about the substantive issues discussed in the document may be directed to either the Alpha Center or to the author, James W. Teevans, at Rosenberg & Associates, 675 Sixty First Street, Oakland, CA 94609, 510.595.7360 (phone); 510.595.7361 (fax); RoseandA@aol.com (e-mail).

ABOUT THE AUTHOR

JAMES W. TEEVANS, J.D., is the General Counsel and a Senior Consultant with Rosenberg & Associates, a national health care consulting firm located in Oakland, California. Mr. Teevans specializes in rural health care legal issues. He has counseled many public and private entities concerning policy and operational issues related to regulating providers and rural integrated financing and delivery systems. He has also counseled rural health clients with respect to structuring collaborative ventures in the face of health care policy and reimbursement changes. Prior to joining Rosenberg & Associates, Mr. Teevans was a member of a leading national law firm, where he was trial counsel in three major health care actions. Mr. Teevans has been admitted to practice before numerous federal courts and is a member of the California and Illinois Bars, the American Bar Association, and the American Health Lawyers Association. He has published several reports and articles on health care legal and policy issues, including the Alpha Center monograph, *State-Action Immunity: Immunizing Health Care Cooperative Agreements* (1995), and speaks frequently at conferences and workshops across the country. He received his B.A., *summa cum laude* from Loyola University of Chicago and his law degree from the University of Michigan.



ACKNOWLEDGMENTS

The author would like to extend his appreciation to the following individuals for their assistance in preparing this report: Steve Rosenberg and Anne Carney of Rosenberg & Associates; Ira Moscovice, Ph.D., and Dan Campion, co-project directors of the Networking for Rural Health project; Anthony Wellever, a senior consultant to the project; and Katherine Browne, Leah Maples, Carole Lee, and LeAnne DeFrancesco of the Alpha Center staff. Thanks also to Tanya Vanderbilt, Cynthia Reaves, and Mark Lutes of Epstein Becker & Green, P.C., and N. Paul Coyle of Holleb & Coff, who reviewed the initial draft of the document.

We would also like to acknowledge the creative contributions of Levine & Associates for the cover art, and Minker Design for their layout and graphic design services.



TABLE OF CONTENTS

INTRODUCTION	1
CHAPTER 1: NETWORKING FUNCTIONS	3
Shared Services and/or Equipment	3
Single-Signature Contracting	3
Other Shared Activities	4
CHAPTER 2: POTENTIAL GOVERNANCE STRUCTURES: “FORM SHOULD FOLLOW FUNCTION”	5
Unincorporated Associations	6
Corporations	8
<i>For-Profit Corporations</i>	9
<i>Non-Profit Corporations</i>	10
Partnerships	11
<i>General Partnerships</i>	11
<i>Limited Partnerships</i>	12
Limited Liability Companies	12
Distributing Governance Power Among the Network Participants	14
Recommendations	17
CHAPTER 3: TAX-EXEMPT ISSUES	19
Networking and Tax-Exempt Participants	19
<i>Do the Tax-Exempt Entities Have Control Over Network Financial and Charitable Decisions?</i>	20
• No Loss of Exempt Status if Tax-Exempt Entities Have Majority Control of Network Decisions	20
• Potential Loss of Exempt Status if Equal Governance Between the Tax-Exempt and For-Profit Entities	20
• Equal Governance by Tax-Exempt and For-Profit Participants with Community Board Seats	21
• Equal Governance by Tax-Exempt and For-Profit Participants with Reserved Powers for Tax-Exempt Entities	21
<i>Does the Network Ensure That Persons with Substantial Influence Over Tax-Exempt Organizations May Not Profit Improperly from Their Dealings with the Tax-Exempt Organizations and their Networks?</i>	22
<i>Do the Network’s Activities Further Exempt Purposes?</i>	23
Tax-Exemption for Rural Networks	23
IRS Rulings and Advisory Letters	25
Recommendations	26



CHAPTER 4: ANTITRUST ISSUES	27
Relevant Statutes and Agency Guidelines	28
Have the Rural Participants Formed a Pro-competitive Network?	29
<i>Is the Network a Sham to Merely Protect Providers and Not Benefit Consumers?</i>	29
<i>Is the Network a Bona Fide Network?</i>	30
<i>Analyzing a Bona Fide Network — Does the Network Have the Ability to Arbitrarily Raise Prices or Decrease Quality with No Relief for Consumers?</i>	31
• Are there Alternative Choices of Providers for Rural Consumers?	
Need to Define the Relevant Product Market	32
• Need to Define the Relevant Geographic Market	33
• Need to Calculate the Network’s Market Shares — Is the Network Potentially Anti-competitive?	34
Defenses and Immunities to Antitrust Challenges of Rural Networks	35
<i>Community/Payer Support</i>	35
<i>Efficiencies</i>	35
<i>Buyer Power</i>	36
<i>Ease of Entry</i>	37
<i>State Action Doctrine</i>	37
<i>Business Review Letter or Advisory Opinion</i>	39
Operating a Rural Health Network — Antitrust Implications After Formation	39
Recommendations	42
CHAPTER 5: OTHER LEGAL ISSUES	43
Fraud and Abuse Issues	43
Self-Referral Issues	44
Insurance and Health Plan Regulation Issues	45
Tort Liability Issues	47
CONCLUSION	49
Endnotes	51
Exhibit 1: Sample Governance Structure for an Unincorporated Association	7
Exhibit 2: Sample Governance Structure for a For-Profit Corporation	9
Exhibit 3: Sample Governance Structure for a Non-Profit Corporation	11
Exhibit 4: Sample Governance Structure for Partnerships.	13
Exhibit 5: Sample Governance Structure for a Limited Liability Company	14
Exhibit 6: Comparison of Governance Models	16
Appendix A: Example of Governance Rules for a Rural Health Network with Significant Community Participation	55
Appendix B-1: Sample Network Organizational Chart	57
Appendix B-2: Example of the Decision-making Process for a Rural Health Network Board of Directors	58



INTRODUCTION

The health care industry continues to evolve with numerous changes in how health care services are delivered and financed in rural America. To seek more control over these changes, many rural health care providers and their communities are “networking” to address the complex issues facing them. Rural providers, employers, and other community leaders are networking to explore their options for increasing access and increasing quality while also decreasing costs. Many rural residents also want to ensure that any drive to manage costs does not cause people to lose sight of the unique needs of rural patients and providers and the fragile nature of rural economies.

This paper is one in a series of educational materials to be developed under the Networking for Rural Health Project, which seeks to strengthen the rural health care delivery system by fostering the development of rural health networks. For purposes of this paper, a “rural health network” means “a formal organizational arrangement among rural health care providers (and possibly insurers and social service providers) that uses the resources of more than one existing organization and specifies the objectives and methods by which various collaborative functions are achieved.”¹ This initiative stems from the understanding that well-functioning networks have the potential to, among other things, allocate scarce resources more effectively and efficiently increase access to essential health care services, and build beneficial linkages to other nearby providers.

This paper seeks to assist rural communities with the complex legal issues raised in forming a rural health network. It examines three major legal areas, including: (1) governance, (2) tax-exemption, and (3) antitrust. These issues are of particular importance during the network formation stages. This paper also briefly highlights additional legal issues involving: (1) fraud and abuse, (2) self-referral, (3) insurance and health plan regulation, and (4) torts. These issues, while important to networks just beginning to form, are of increasing importance during network operation.

This paper is intended to give network participants and governing bodies a general understanding of the legal issues faced when forming a network. It does not seek to provide legal advice for specific issues, and rural network participants and leaders are encouraged to consult with legal counsel about specific questions.





CHAPTER 1

Networking Functions

Networks can perform many different functions depending upon the unique needs of the network participants. The following addresses some of the common functions that networks perform or hope to perform over time.

SHARED SERVICES AND/OR EQUIPMENT

Many rural health networks create joint ventures between the participants which allow for the sharing of services and/or equipment. For example, in some rural communities, new technology such as a Computerized Tomography (CT) scanner or a mobile Magnetic Resonance Imaging (MRI) unit may be so cost prohibitive that one entity alone could not purchase them. Multiple entities that pool their resources to purchase such technology, however, are better able to accomplish this goal. The network entities can agree on an equitable way to purchase and share the technology over time. This networking can allow the participants to maintain their independence and autonomy while working together.

Shared information systems are another example of networking between rural providers. The high costs associated with telemedicine have deterred some communities from investing in such technology and related services. Networks once again allow rural providers to reduce their capital invest-

ments and costs over time. Participants share the costs and can also apply jointly for grants or other outside funding. In return, patients gain greater access to specialists and health care information.

Additionally, network participants can share in a variety of shared services such as laundry, laboratories, purchasing arrangements, etc. These activities allow the participants to lower their overall costs for the benefit of consumers.

SINGLE-SIGNATURE CONTRACTING

Rural networks may also form for the purpose of allowing network participants to negotiate jointly with payers, including insurance companies and health plans. These networks may designate a single agent to assist in the process of negotiating contracts with such payers. Often rural networks have not chosen this function or have not needed to consider it due to the lack of managed care in their communities. It is anticipated that single-signature contracting will increase in importance for rural networks as urban markets become more saturated and managed care entities look for more covered lives in rural areas. Single-signature contracting will also become more common as Medicare and Medicaid increase their efforts to promote managed care in rural areas.

Rural network participants that are not involved in managed care contracting may see a network as

Rural providers, employers, and other community leaders are networking to explore their options for increasing access and increasing quality while also decreasing costs.

a potential vehicle for better understanding managed care financing arrangements (such as risk withholds and capitation), or for leveling the playing field when negotiating with large payers. Some rural networks are forming with the foresight that managed care is an inevitable next step in their areas.

Some rural networks are forming with the foresight that managed care is an inevitable next step in their areas.

OTHER SHARED ACTIVITIES

Rural networks may also form to increase access to health care services and/or to improve health care quality. For example, a network may endeavor to improve transportation to health services, organize emergency medical services on a regional basis, introduce outreach oncology services to the local community, or improve the availability of mental health and substance abuse treatment services. In addition, joint recruitment and retention

projects, continuing education programs, and health promotion/disease prevention programs may be included in network activities.

To improve the quality of services, rural physicians may collaborate on ways that they can better track patient care, such as developing clinical pathways for specific

types of disease management. Networks may seek to improve the peer review process by increasing the number of reviewers and reducing professional isolation. Conducting network-wide assessments of patient outcomes to overcome the problem of small sample sizes often associated with rural practices is one way that participants can improve quality. Other shared activities may develop depending upon the needs and desires of the rural community and network providers.



CHAPTER 2

Potential Governance Structures:

“Form Should Follow Function”

Before beginning any discussion about how networks can be formed, rural network participants should first decide what activities or functions their network will perform. Most successful networks are ones in which form follows function. This ensures that the network has the right complement of individuals to accomplish the desired goals and that the structure serves those same ends.

For example, in one rural community, a group of physicians was very interested in coming together to deal with the many access, quality, and cost issues facing their community. The physicians quickly decided to form a professional corporation, which by state law limited a substantial majority of board seats to only licensed physicians, before clarifying the corporation's tasks. They assigned leadership positions among themselves before deciding what major activities the network would pursue or what other individuals or entities should be involved. After forming the corporation, the physicians decided that it would be best to develop a local health plan that could contract directly with self-funded employers in the area.

The corporate structure, however, became an impediment to the group's success. The larger local employers wanted to have some say in the governance of the network and felt that a provider-controlled network was not in their best interests,

especially in terms of enforcing better utilization and negotiating reimbursement rates with providers. The existing governance structure, which prevented meaningful employer and other provider

participation, was a roadblock to further negotiations and the success of the network. In hindsight, it would have been preferable for the physicians to determine what the network's functions would be before deciding on the corporate structure. This process would have also helped to build trust among the physicians and other potential network participants.

The form of the network should result from the function or functions chosen by the network. Therefore, it is highly recommended that the parties determine the activities that the network will perform before they start a review of the governance structures. This work on the front end will save time, money, and energy down the road.

For some rural networks, functions may change over time. These changes may necessitate a change in either the legal form (corporation, partnership, limited liability company, etc.) or the governance structure (such as representation on the board of directors). To limit the extent of such changes in form, the networks are better served by carefully contemplating the desired functions and the types of participants.

Some functions or activities may involve potentially higher degrees of business and legal risks,

For-profit corporations may be particularly appropriate for networks that involve only for-profit individuals or entities.

such as single-signature contracting. This may lead rural network members to choose a form that better protects the individual participant's assets and minimizes individual liability (such as corporations or limited liability companies). On the other hand, some functions, such as joint educational workshops, tend to involve less risks and can lead to networking forms that require less time and money to form and operate (such as unincorporated associations).

Different forms of governance structures are available to facilitate the networking process. These include corporations, limited liability companies, partnerships, and unincorporated associations, each of which is discussed below. A governance structure is helpful for many reasons. Some of its merits include:

- providing a clear and manageable process for reaching mutually acceptable decisions;
- setting forth a fair process to enable interested parties to be heard;
- establishing clear boundaries for people to understand what they may and may not discuss or decide (which helps the parties to comply with antitrust [pro-competition] laws and other laws);
- ensuring that a responsible entity exists for representing the group in dealings with third parties and acts as a fiduciary for the participants; and
- helping to minimize individual participants' personal liability arising from the network's actions.

The following section sets forth a general description of some governance options. Keep in mind that specific state laws can either limit or expand the range of possibilities. Prior to addressing the specifics of these different governance options, it may be helpful to discuss briefly how rural network functions can lead to a choice in governance form.

As previously mentioned, certain networking functions will involve higher degrees of business or legal risks, which may necessitate a more formal structure. For example, networks that engage in single-signature contracting will be dealing with confidential, proprietary information, including necessary pricing information. In addition, single-signature contracting can lead to rural networks potentially going at risk for the cost of care or quality of care delivered by network participants. In light of these risks, rural networks may prefer the more formal structure and liability protections offered by a corporation or limited liability company.

Rural networks that are engaged in shared activities that involve less risk, such as joint educational programming or joint health promotion activities (like a health fair), may desire the ease, lower expense, and flexibility of an unincorporated association. Rural network members who are familiar with one another may also choose the partnership form. These forms, however, do not offer the liability protections of corporations and limited liability companies.

It is recommended that networking functions be addressed on a case-by-case basis. The networks should review the potential risks (business and legal), the level of familiarity among members, the network budget and anticipated costs, as well as how quickly a structure must be created. These decisions will help steer networks to the most suitable form.

UNINCORPORATED ASSOCIATIONS

Some new rural networks will start as unincorporated associations. These are groups that generally have not taken steps to formally obtain recognition under state law. Many small clubs and groups, as well as some small churches, operate under this form.

As a loosely formed group, the advantages include: (1) building trust and getting to know your participating members without being locked into a particular governance model; (2) taking time

to see what common goals and proposed activities develop before spending time and money on a particular model; (3) delaying the complicated “control issues” that can slow down progress on more meaningful activities and trust building; and (4) creating a mutually acceptable structure and process rather quickly. In some situations, an unincorporated association may have general guidelines or memoranda of understanding that help to clarify the group’s purposes and framework for making decisions. The extent of formality depends to a great extent upon the relationships between the participants.

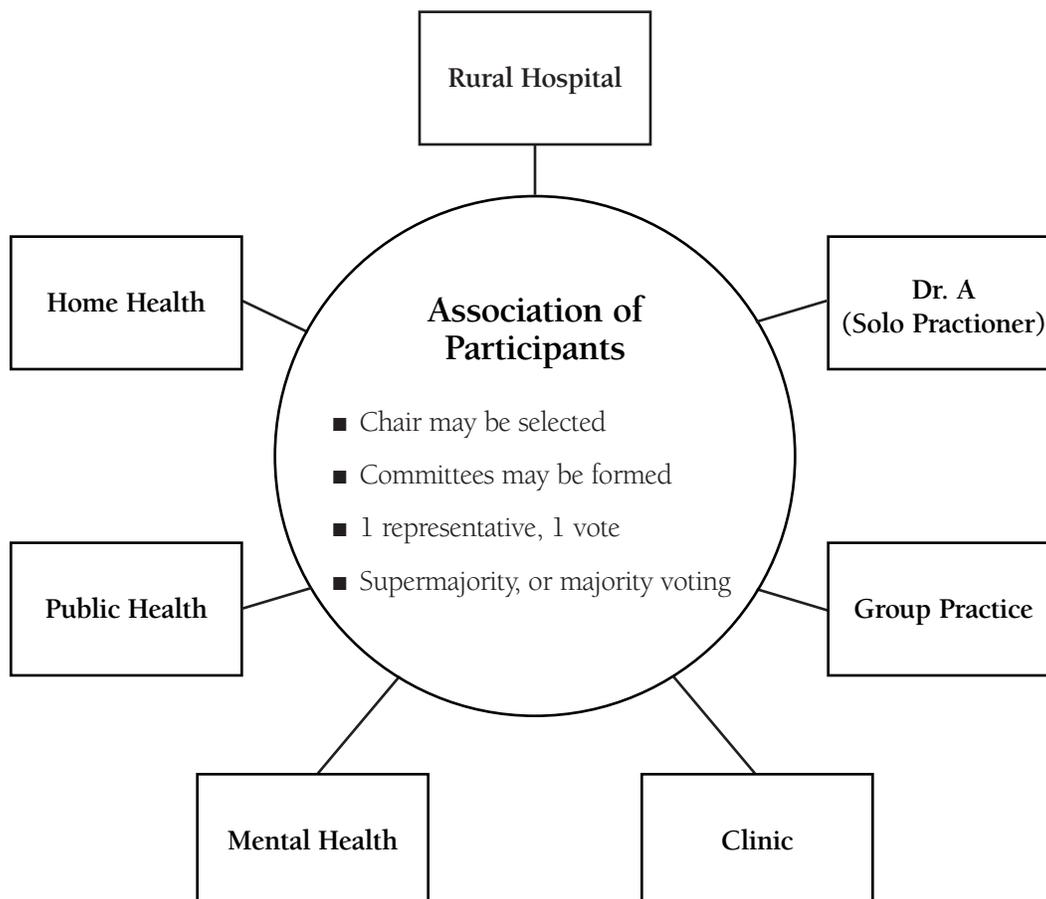
A network, assuming that it is actually doing something on behalf of its members, such as nego-

tiating managed care contracts, sharing equipment and services, performing third-party administrative functions, or planning health promotion activities, should not remain unincorporated for a long period of time. A disadvantage of being unincorporated is that participants can possibly be held personally liable for acts of the association. The corporate shield afforded under state corporate or limited liability company law (see section on limited liability), is usually not available to association participants.

Nevertheless, for those groups not ready for a more formal governance model, this one may be the most appropriate option during the start-up

EXHIBIT 1

SAMPLE GOVERNANCE STRUCTURE FOR AN UNINCORPORATED ASSOCIATION



phase. The network is then free to change to a more formalized structure at a later date depending upon needs of the network. Within this initial informal structure, the network can develop its own unique leadership roles and decision-making process.

Many unincorporated associations often look and act like more formal corporate entities. These associations develop a leadership group and often elect committees to oversee various aspects of the network's activities, such as business development, education, or health promotion. Unlike more formal entities, they are not bound by state requirements concerning governance and decision-making processes.

CORPORATIONS

A corporation is a legal entity created by state law. Creating a corporation generally involves filing the requisite articles of incorporation or other documentation with the state. While the specific requirements for forming a corporation will differ depending upon each state's unique statutes and regulations, most corporations share certain characteristics.

A corporation is the most often used governance model for networks. It is preferred by many rural networks because it minimizes the personal liability of persons or entities participating in the network and clarifies expectations. The corporation holds itself out as being liable for any obligations resulting from corporate or collective action. This "corporate shield" helps to protect participants' personal assets should a judgment ever be rendered against the corporation. A plaintiff seeking to collect a judgment award against a corporation can usually only seize the assets held and controlled by the corporation. Exceptions to this general rule arise if participants abuse the corporate privileges by, among other things:

- failing to adequately capitalize the corporation;
- using the corporation for personal dealings (by,

for instance, co-mingling personal and corporate monies or accounts); or

- failing to adhere to basic corporate formalities (by, for instance, failing to hold meetings or to keep corporate records).

While courts are very reluctant to hold individuals personally liable for the acts of their corporation, network members must respect corporate formalities to ensure that the many protections and privileges afforded by using a corporate model remain intact. This is important considering the extent to which health plans and networks are overseeing quality and utilization decisions and thus may be held increasingly responsible for the inappropriate denial of services and for the acts of their participating providers.

A corporation is typically formed by: (1) drafting and filing articles of incorporation with the appropriate secretary of state's office, and (2) drafting bylaws consistent with state law for internal governance purposes. The articles of incorporation are essentially the initial promises made by the corporation to the state and to the corporation's shareholders or members as to the character of the corporation. The articles generally set forth the corporation's: (1) name and address; (2) purpose; (3) registered agent (an in-state person or entity to receive service of process or official notices); and (4) sometimes, the initial board of directors.

The bylaws are the more detailed governing document. They define the rights and responsibilities of the persons running the organization and set forth the rules concerning how the corporation will be operated within the framework created by the state's corporation statutes. The bylaws also usually address how for-profit shareholders (or nonprofit "members"), directors, and officers will be selected, removed or replaced, when and how meetings will be held, how decisions will be made, and the responsibilities and duties of the governing parties. The bylaws can be amended by the members or the board, depending upon what is

allowed under the bylaws, as the corporation changes over time.

A corporation can be either for-profit or non-profit, as described below.

For-Profit Corporations

For-profit corporations allow individual investors to profit over time should the business venture be successful financially. Under a for-profit structure, net revenues can be distributed to investors in accordance with applicable laws and the corporation's governing documents.

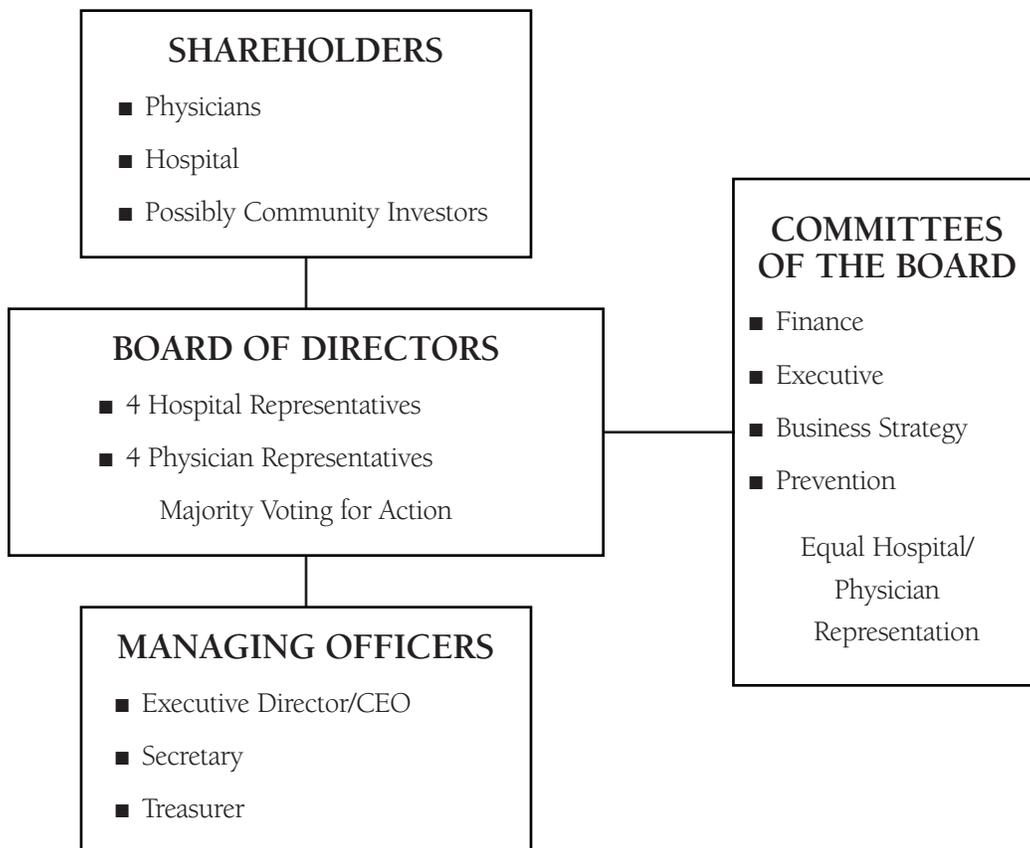
This form may be appropriate for networks that involve only for-profit individuals or entities. Difficult tax-exempt law issues may be raised should the network involve both for-profit and tax-

exempt individuals or entities. As discussed in the next chapter, tax-exempt laws and regulations seek to ensure that tax-exempt dollars do not inure to the benefit of a private party; rural networks should be aware of these laws when choosing a governance structure.

In a for-profit corporation (sometimes referred to as a "stock corporation"), there are essentially three levels of governance. First, a for-profit corporation has shareholders or owners, who are the individuals or entities generally authorized to decide major, fundamental decisions, such as approving the sale, merger, or dissolution of the corporation, or amending the articles of incorporation or bylaws. This group usually sets the overarching policy and mission of the network. Second,

EXHIBIT 2

SAMPLE GOVERNANCE STRUCTURE FOR A FOR-PROFIT CORPORATION



a for-profit corporation has a board of directors. The number of board representatives, how they are elected, and what their rights and duties are can be defined in the corporation's bylaws. The board is responsive to the shareholders and is generally responsible for further developing company policy set by the shareholders and for overseeing management. Third, a for-profit corporation has managing officers who assist the board by putting policy into action and who operate the company on a day-to-day basis. The board may elect or select the officers. These officers often include a chief executive officer or president, secretary, and treasurer. Sometimes, the board may also elect or select one or more vice presidents. Typically, this responsibility is delegated by the board to the chief executive officer.

Non-Profit Corporations

In a non-profit corporation (sometimes referred to as a "non-stock corporation"), all net revenues go to furthering the business of the corporation instead of any individual or shareholder. A non-profit corporation does not have shareholders. The three levels of governance in a non-profit corporation include: (1) members; (2) a board of directors; and (3) officers. Some states' laws permit non-profit corporations without any members, with such corporations being governed solely by the board and officers.

In some rural, non-profit corporations, members may include representatives of the local hospital, representatives of a physician group, and/or representatives of any solo practitioners. In other rural networks, member representatives may encompass all-important health care leaders, including representatives of ancillary health care services as well as key political leaders. The members have similar rights and responsibilities as shareholders in a for-profit corporation, but they do not receive dividends.

The directors and officers in a nonprofit act in a manner similar to directors and officers in a for-profit company, but they are fiduciaries furthering charitable assets as opposed to fiduciaries furthering shareholder interests. The board of directors often includes equal hospital and physician representatives and can include an additional person or persons serving at the mutual agreement of the hospital and physician representatives.

The decision about whether to incorporate as a for-profit or non-profit will depend on a number of factors, such as: (1) whether state or federal tax and other laws prevent existing non-profit, tax-exempt organizations (such as hospitals or clinics)

from participating in a for-profit organization; (2) whether a for-profit corporation is able to rely upon its own revenues without charitable contributions or grant funds, which may be limited to nonprofits; and (3) whether the community is willing to support a for-profit corporation owned by a limited group. Based upon the considerations above, many rural networks, which include many different types of providers and community leaders, are structured as non-profit corporations.

Individual state laws will help to determine the specific type of corporation formed. For example, depending upon the activities that the network intends to pursue, as well as the diversity of the participants, the network can be formed as: (1) a professional corporation, (2) a public benefit or charitable corporation, (3) a mutual benefit corporation, (4) a religious corporation, or (5) a medical corporation. The specific type of non-profit corporation is defined by law and has varying advantages and disadvantages. These may include greater restrictions and thus greater predictability in the continuing purpose of the corporation, greater flexibility to pursue certain regulated activities (such as a professional corpora-

The directors and officers in a nonprofit act in a manner similar to directors and officers in a for-profit company, but they are fiduciaries furthering charitable assets as opposed to fiduciaries furthering shareholder interests.

tion), or exceptions from various other legal requirements (such as corporations formed for religious purposes). The specific state designation may also influence tax-exempt designation under Section 501 of the Internal Revenue Code. Different states will afford different options for network participants.

PARTNERSHIPS

Under the laws of most states, a partnership can be structured in one of two ways: as a general partnership or as a limited partnership. The requirements

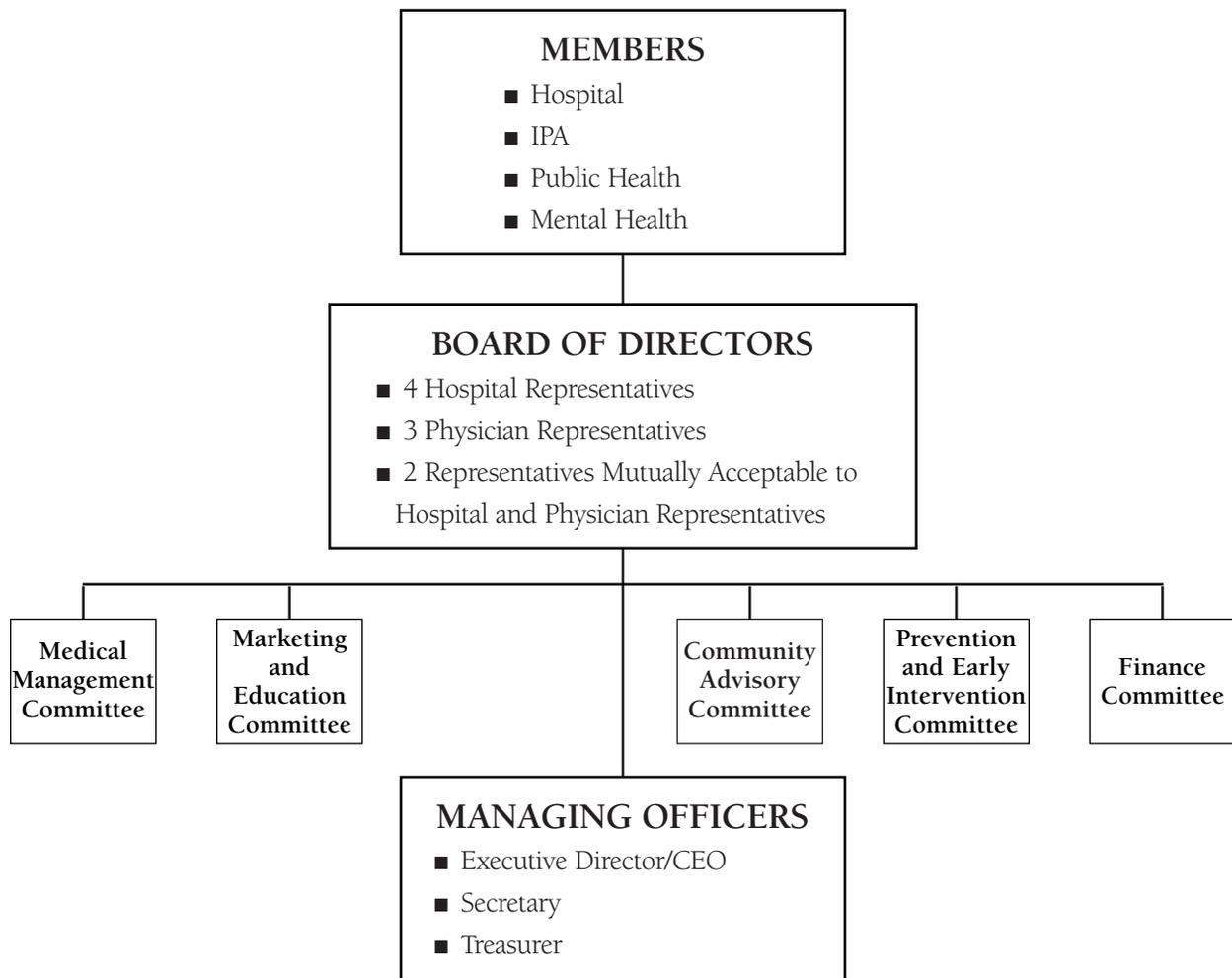
under each structure will depend upon the applicable state statutes.

General Partnerships

The general partnership model originates from the Uniform Partnership Act, which has been adopted by every state except Louisiana. A general partnership is often defined as a “residual form” of partnership because it can arise: (1) intentionally by the parties, with or without a written partnership agreement, or (2) by accident depending upon how the parties conduct their affairs. For

EXHIBIT 3

SAMPLE GOVERNANCE STRUCTURE FOR A NON-PROFIT CORPORATION



example, a court might find that the parties had formed a partnership by expressing a willingness to share liabilities or to avoid treatment as a corporation or unincorporated association. Obviously, the facts of each case will dictate treatment by a court or government agency.

Under a general partnership model, each partner assumes individual liability for the acts of the partnership. Therefore, if one partner incurs liability on behalf of the partnership through his or her actions, the other partners could also be held jointly and severally liable, meaning that any one of the partners could be required to pay the entire amount owed to a third party. All partners could possibly lose their personal assets as well as those invested in the partnership.

Generally, parties will choose the partnership structure because it receives more favorable tax treatment than some corporate models. With a partnership, double taxation — on the organization and the individual partners — is avoided because the profits and losses pass through to the partners.

However, these partnerships are usually developed by small groups of individuals who are very familiar with one another. They are also more typically found in networks that involve only one type of provider, such as networks that include only physicians. When these close relationships exist, the parties are more willing to expose themselves to the possibilities of greater liability. However, this model may not be the best for larger or more diverse groups just beginning to work together.

Limited Partnerships

Another partnership model is the limited partnership model. Under this model, two classes of partners participate: (1) at least one general partner, and (2) the limited partner or partners. The rights and responsibilities of each class of partnership are generally agreed upon by the parties and set forth in a partnership agreement. Particular state laws may dictate certain set obligations under each class of partnership. In a limited partnership, the general partner, which may be a corporation,

can be held personally liable for the acts of the whole partnership. The limited partners are usually liable only to the extent of their investments in the partnership, if at all.

While the limited partnership model has certain tax advantages and places some limits on personal liability, rural networks may prefer the limited liability company model because it offers both tax advantages and greater limits on liability. In addition, under some state laws a limited partnership may be more complex to establish than a limited liability company. Some states require the parties to file more complicated and lengthy paperwork, as opposed to the state-provided forms that may be available under other models.

LIMITED LIABILITY COMPANIES

In most states, a relatively new governance model is the limited liability company (LLC). An LLC is a hybrid form that includes the liability protections offered by a corporation and the tax benefits of a partnership. In fact, most LLCs can now elect to be taxed either as a partnership or a corporation. This model is becoming the preferred one for many networks because it offers the benefits of both corporations and partnerships. One potential disadvantage, however, is the increased cost of filing as an LLC over the costs of filing as a corporation. The initial filing cost and annual costs may be greater over time than with other more traditional models.

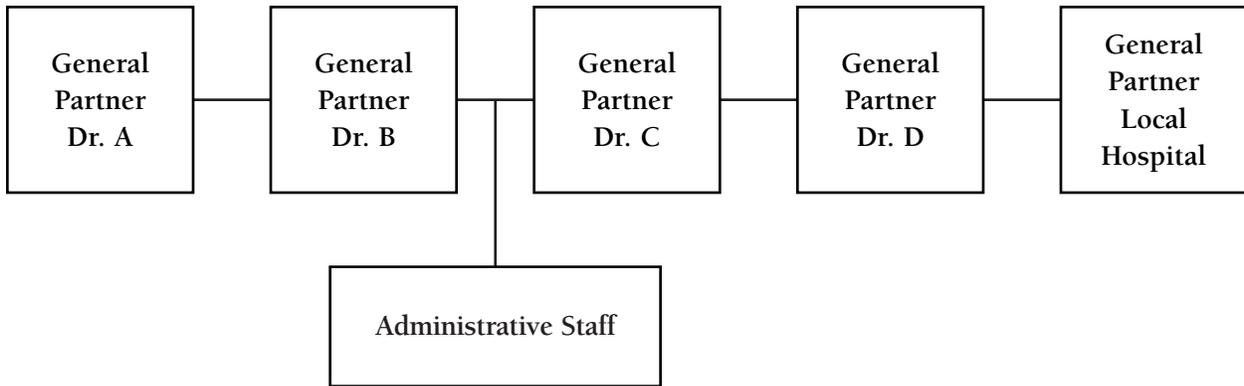
The main features of an LLC are:

- owners of the LLC are called “members;”
- most states require at least two members;
- most states do not limit the number of members (in contrast, many states limit the number of shareholders in “Subchapter S” corporations, which are a type of corporation that enjoys certain tax benefits);
- members file articles of organization with the state; and
- members draft an operating agreement (similar to corporate bylaws), which specifies the rights and responsibilities of the parties involved and

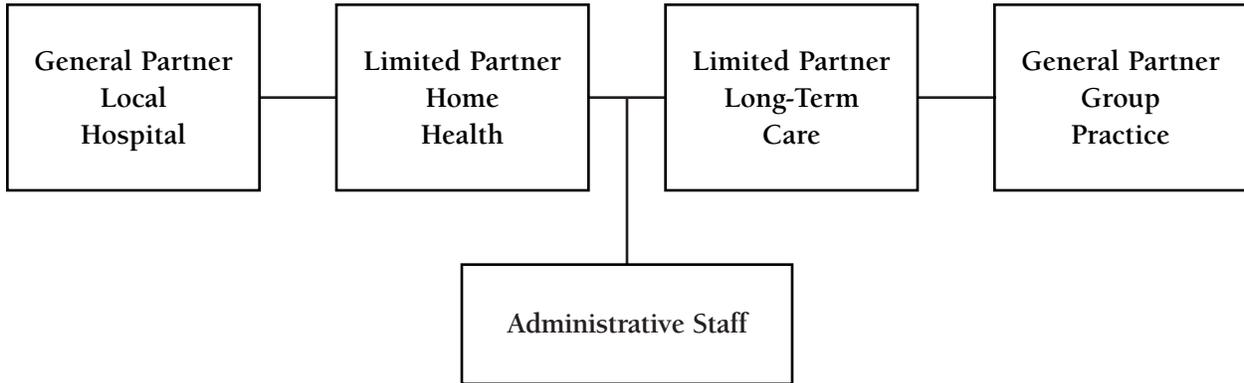
EXHIBIT 4

SAMPLE GOVERNANCE STRUCTURES FOR PARTNERSHIPS

General Partnership Model



Limited Partnership Model



typically designates which members will be “managers.”

An LLC does not have the “double tax” problems faced by non-tax-exempt corporations and exposes the participants to less potential liability than a partnership. Also, as in a traditional corpo-

rate model, the members are not subject to personal liability for the acts of the LLC.

Particular state laws will determine the specific form requirements and benefits should a network decide to pursue this option.

It should be noted that some states are now allowing “limited liability partnerships” and

“limited liability limited partnerships.” Depending upon the particular state law, these forms may provide increased liability protection for persons participating in partnerships. Limited liability partnerships may help minimize liability for general partners who face potential personal liability under the traditional general partnership form. Limited liability limited partnerships may permit limited partners to exercise certain powers traditionally reserved for general partners while offering personal liability protection. Considering the lack of court decisions and network experience testing these newer limited liability governance structures, network participants should thoroughly examine the pros and cons of each form.

DISTRIBUTING GOVERNANCE POWER AMONG THE NETWORK PARTICIPANTS

While choosing the proper governance form (either a for-profit or non-profit corporation, partnership, LLC, or unincorporated association) may

not be a very difficult task for a rural network, allocating control or decision-making authority among the participants can be very complicated. Rural communities may experience involvement by a large number of persons seeking governance positions in a rural network. It may be difficult to accommodate each person’s desires and maintain an efficient network. Potential network participants may also assert conflicting positions as to how authority should be allocated. These conflicting positions may be irreconcilable. Legal requirements (state corporate laws or federal tax-exempt laws) may also pose problems. Because many rural networks choose corporate models, this paper focuses on various methods of distributing decision-making authority among the participants in a corporation. The general guidelines (as set forth in corporate bylaws) can be applicable to most governing models, such as LLCs and partnerships, as well as corporations.

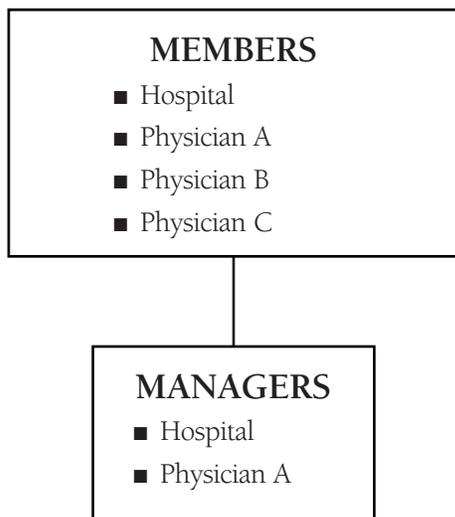
The bylaws will generally set forth how persons will be chosen for the various governance positions. A bylaw provision that allows for easy amendment is sometimes favored to address future changes that the network will need to respond to quickly.

Generally, non-profit networks can have a large number of corporate members. Having a large number of members is workable because there are only a limited number of issues presented to the membership and there are few meetings held by the members. As explained above, members generally help to set overarching mission statements, elect directors, and amend the governing documents. These activities usually require only one annual meeting.

To facilitate a more innovative decision-making process that allows for more participation among the different members, networks can create different classes of membership. For example, one class of members can include just hospital representatives. Another class of members can include just physician representatives. Another class of members can include just non-health care provider representatives. These different classes of members

EXHIBIT 5

SAMPLE GOVERNANCE STRUCTURE FOR A LIMITED LIABILITY COMPANY



can have the right to fill certain designated board seats. Also, the classes can have different voting rights and powers, depending upon the type of contract or matter, if any, presented to the membership for approval.

Choosing the individuals who will sit on the board of directors is usually a difficult task. These seats may be limited in number to allow for efficient decision-making. Some boards may have as few as three persons and some may have as many as 30 persons. State laws may dictate the allowable number of persons serving on a board of directors. As a general guideline, a board may be more efficient if it includes no more than nine individuals.

However, even with as many as 25 board seats, it is not always easy to allocate the seats among the various groups that may participate in a network, such as hospitals, physicians, nurses, public health agencies, ancillary providers, employers, and community leaders. It can also be difficult to reach consensus with so many participants. Therefore, networks need to analyze creative ways of allocating the board's authority. In the end, each party is going to have to be flexible in order to find a workable approach.

Board seats can also be allocated among the various groups participating in the network. For tax-exemption purposes, the majority of seats should probably be controlled by participating tax-exempt entities. Tax-exemption issues are discussed in depth in Chapter 3. Appendix A shows a board with more involved community participation. In certain instances where the rural network function may involve joint venturing for a particular service or single-signature contracting, the providers may expect majority control over board decision-making.

Networks can be creative not only in deciding who will serve on the board and how they will be elected, but also in setting the timing for elections. For example, it is possible to stagger terms and

have elections for different seats in different years. This helps to ensure some experienced individuals remain on the board after each election and helps to avoid major turnovers in the organization. Some state laws permit non-profit corporations to have self-perpetuating boards, whereby the board, not the members, would elect persons to fill vacant board seats.

It may also be useful to create committees to assist with the governance of a network, particularly if there are not enough board seats to accommodate all interests. These committees can include, for example, a : (1) finance committee; (2) contracts committee; (3) quality and utilization committee; (4) marketing committee; and (5) executive committee. These committees are helpful in getting work accomplished between board meetings. The use of outside persons (e.g. local representatives or consultants) on the committees, if permissible under state law, may also help alleviate the work of the few board representatives and increase community participation.

Of course, the activities of the network will dictate what committees are most appropriate. The committees should report to the board for approval of recommended actions.

In certain instances, participation may include so many individuals and entities that there will not be enough board seats. Rural networks can create advisory boards to ensure more community participation. Ex officio board seats can also be created. These options allow for participation and a sense of "buy-in" while maintaining decision-making among a few individuals. These types of increased participation help to minimize any disruption to efficient decision-making.

The officers are generally selected by the board of directors. The officers should have the requisite expertise and experience to run the network. They should have the ability to see that the network's activities are carried out in a competent

Networks can be creative not only in deciding who will serve on the board and how they will be elected, but also in setting the timing for elections.

and cost-effective manner.

Appendix B demonstrates another way of delegating decision-making among a large number of interested parties that are members of a rural health network.

It is often stated that “when you have seen one network, you have seen one network.” Each rural community will need to distribute governance based upon the importance of the parties to the network’s success, the strength of the personalities, and the extent of shared missions among the participants. While state laws will provide a basic structure for networks to follow, these laws permit

great flexibility in meeting each network’s needs. The important thing to remember is that networks come together to address significant health and business issues; therefore, the governing board and officers need to have the experience and knowledge to ensure the long-term success of the network. Setting objective criteria for governance roles and focusing on objective credentials of individuals will help to minimize local politics and to achieve successful outcomes.

See Exhibit 6 for a summary of key advantages and disadvantages of the five basic governance models described in this chapter.

E X H I B I T 6

COMPARISON OF GOVERNANCE MODELS

	Unincorporated Association	For-Profit Corporation	Non-profit Corporation	Partnership	Limited Liability Company
Advantages	Flexible Structure No Filing Requirements Minimizes Control Issues	Personal Liability Protection Flexible Use of Assets/ Distribution Dividends Predictable Governing Process	Personal Liability Protection Predictable Governing Process More Consistent with Traditional and other Providers Possibly Tax-Exempt	Tax Advantages Flexible Governing Process	Personal Liability Protection Tax Advantages More Flexible (yet Predictable) Governing Process
Disadvantages	Personal Liability Less Predictable Process	State Filing and Legal Requirements Private Ownership of Assets (Shareholders) Double Tax (Corporate and Individual)	State Filing and Legal Requirements Possible State Limitations on Asset Distributions	Personal Liability of General Partners Joint and Several Liability Among General Partners	State Filing and Legal Requirements

RECOMMENDATIONS

- Determine potential range of network functions before deciding on an appropriate structure and governance model;
 - Assess level of familiarity between network participants, assess quality of care delivered by the participants, and assess potential liability exposure between network participants before deciding on an appropriate model (remember — less liability exposure with corporations and LLCs; greater exposure with unincorporated associations and partnerships);
 - Consider innovative ways to allow maximum participation (such as different classes of membership (voting and non-voting); many Board seats; ex officio directors and advisory committees); and
 - Ensure governance process allows for flexibility to change form should the network change functions.
-



CHAPTER 3

Tax-Exempt Issues

At the formation stage, when rural networks are deciding on an appropriate structure and how to delegate governance among the participants, tax-exempt issues may arise. Rural networks want to ensure that tax-exempt organizations participating in the network do not lose their tax-exempt status or face sanctions because of their participation. Rural networks may also want to achieve tax-exempt status during the formation stage. The following section addresses these two areas.

NETWORKING AND TAX-EXEMPT PARTICIPANTS

Networks that involve tax-exempt entities must be aware of Internal Revenue Service (IRS) requirements that may pertain to these entities. Organizations are entitled to tax-exempt status because of their exempt purposes (charitable, religious, scientific, or educational). The IRS seeks to ensure that the activities of tax-exempt entities help further their exempt purposes. Because rural networks can involve both tax-exempt and for-profit participants, the IRS seeks to ensure that the formation and operation of a network does not violate tax-exemption rules and regulations. This oversight has a great deal to do with how tax-exempt dollars are controlled and used within the network structure and as the network functions.

Networks should be sensitive to three particular issues as they relate to the participation of tax-exempt entities:

(1) to what extent does the network governance structure allow a for-profit entity to direct or control charitable assets?

(2) to what extent do the network structure and operations allow a person with substantial influence to profit improperly from his or her dealings with tax-exempt entities? and
(3) to what extent do the network's activities further tax-exempt purposes?

The IRS has stated that it is unlikely to challenge a joint venture in which the for-profit participants have a minority vote in all major decision-making by the network.

The IRS permits networking among health care providers. The IRS has cautioned, however, that networking and other integration options need to be carefully tailored

so that tax-exempt dollars are not improperly used, particularly as tax-exempt organizations begin to network with for-profit entities.

In a recent IRS ruling, which is applicable to both rural and urban areas, the IRS has provided some helpful guidance in structuring hospital joint arrangements or networks involving both tax-exempt and for-profit hospitals.² This ruling (discussed in Sections A(1) and (2) below) specifically applies to whole hospital ventures, but can provide insight into how the IRS may analyze other provider networks.

The guidance, however, does leave open questions as to alternative models that may achieve the same goals desired by the IRS (to protect charitable assets), but that may not strictly follow the exam-

ples provided by the IRS. We will address the IRS' advice and possible alternatives for structuring networks.

Do the Tax-Exempt Entities Have Control Over Network Financial and Charitable Decisions?

The IRS, including state attorneys general, requires tax-exempt organizations to provide adequate safeguards so that charitable assets are not used for private benefit. The IRS has cautioned that if a party is allowed to control or use a tax-exempt organization's activities or assets for the benefit of the private party, and the benefit is not incidental to the accomplishment of exempt purposes, the organization will fail to be organized and operated exclusively for exempt purposes. The following networking situations address issues relating to allocation of control and the impact on a party's tax-exempt status.

No Loss of Exempt Status if Tax-Exempt Entities Have Majority Control of Network Decisions

The IRS has sought to minimize the "control" of for-profits in any network or joint venture involving both for-profits and tax-exempt organizations. The IRS has stated that it is unlikely to challenge a joint venture in which the for-profit participants have a minority vote in all major decision-making by the network.³

For example, the IRS has approved a hypothetical hospital network whereby Hospital A, a tax-exempt organization, and Hospital B, a for-profit organization, formed a limited liability company (LLC) to pool their assets. Under the LLC's governing documents, the board consisted of five directors: three persons elected by the tax-exempt Hospital A, and two persons elected by the for-profit hospital B. The three Hospital A representatives were not on the hospital staff and did not engage in business transactions with the hospital.

More importantly, the tax-exempt hospital had a majority of board seats.

The decision-making of the hospital network was in the control of the tax-exempt hospital. Three votes were required for all significant decisions, such as approving annual capital and operating budgets, distributing earnings, selecting officers, acquiring or disposing of health care facilities, contracting in excess of a certain value, changing services, and entering into management contracts. Approval of the tax-exempt representatives was also necessary to amend the governing documents. In effect, the structure placed control of the charitable assets in the hands of representatives for the

tax-exempt hospital. The LLC's governing documents further provided that the LLC had to be operated in a charitable manner.

This ruling would be applicable to rural network arrangements. Rural providers can utilize this ruling to guide them in the formation of networks which are in conformance with current IRS thinking. The above example is one way recommended by the IRS for protecting tax-exempt assets used in a network context.

The important consideration is to minimize the control of for-profit entities over the fate of charitable assets used in the formation and operation of the network.

Potential Loss of Exempt Status if Equal Governance Between the Tax-Exempt and For-Profit Entities

On the other hand, the IRS has rejected a hypothetical hospital network structure that merely provided for equal board representation between the two participating hospitals, one tax-exempt and one for-profit. Under this rejected hypothetical situation, the board would have consisted of three representatives of the tax-exempt hospital and three representatives of the for-profit hospital. The IRS was not comfortable with the fact that with majority decision-making required under the bylaws, the for-profit representatives could block charitable action.

Also, the IRS was troubled by the fact that the proposed management company for the two hospitals would have been an affiliated company of the for-profit hospital. Under this arrangement, the agreement would have run for successive five-year periods at the discretion of the management company, and would have been terminated only for cause. The management company also would have retained certain reserved powers over such items as the acquisition or disposal of facilities, changes in services, and execution of contracts up to a certain dollar level. This control by an entity affiliated with, and to some extent controlled by, the for-profit network participant, greatly concerned the IRS.⁴

The IRS' conclusion that the tax-exempt hospital would violate IRS rules governing exempt status in this situation was somewhat troubling. The conclusion seemed to put form over substance and appeared contrary to other IRS cases. This IRS ruling, however, needs to be carefully considered in light of the IRS' interest in examining tax-exempt networking arrangements with for-profit entities.⁵

By its rulings, the IRS has not foreclosed creative arrangements in structuring networks with shared governance and limited for-profit control, but it has clearly expressed a preference for minority board representation by for-profits and a minority vote for network decision-making.

Equal Governance by Tax-Exempt and For-Profit Participants with Community Board Seats

As an intermediate step between the two hypotheticals addressed above by the IRS, some rural networks have sought to limit for-profit control, but still have equal governance by adding community representatives to the board. These added community representatives would not work for any of the provider entities (tax-exempt or for-profit) and would not engage in business transactions with the provider entities. This form could allow for the equal governance expected by for-profit participants, while still ensuring that the for-

profit participants could not block charitable purposes.

For example, the network could be composed of seven board members: two members could represent tax-exempt entities, two members could represent for-profit entities, and three members could be non-provider community representatives mutually acceptable to both sides (tax-exempt and for-profit). Of course, depending upon the number of different interests being brought to the table, the number of total board seats can be increased. It is recommended, however, for effective and efficient decision-making, that the total number be reasonable. The important consideration is to minimize the control of for-profit entities over the fate of charitable assets used in the formation and operation of the network.

This model also requires that providers are willing to forego control on the board, and such an agreement can be difficult to achieve. A general educational session on tax-exempt issues and requirements can help to overcome this potential problem.

This intermediate proposal, however, has not been addressed by the IRS. One issue likely to be raised by the IRS with respect to this intermediate proposal is whether, in the absence of supermajority or other rights vested in the exempt organization, the exempt organization has the ability to initiate charitable directives or to ensure that charitable assets are not put at risk. The IRS would also be most interested in knowing the affiliations of any "community representatives."

Equal Governance by Tax-Exempt and For-Profit Participants with Reserved Powers for Tax-Exempt Entities

Another option for rural networks is to allow for equal governance between the for-profit and tax-exempt entities, without including community representatives, and leave major decision-making with the tax-exempt entity. Thus, with a six-member board — three representing the tax-exempt entity and three representing the for-profit

entity — certain crucial financial, access, and charity care decisions can reside solely with the tax-exempt board representatives. The bylaws can set forth the delegation of decision-making responsibilities and ensure that such tax-exempt decisions override all other network decision-making. This option, which the IRS has not yet ruled on, helps to address the concerns raised by the IRS in its previous ruling, but does not deviate from the form of equal governance.

In an IRS continuing professional education text for its agents, the IRS recommends that the agents address some of the following questions when analyzing networks or joint ventures between for-profits and tax-exempt entities:

- Does participation in the joint venture by the exempt organization further its exempt purpose?
- Is the venture required by its governing documents to promote the health of a broad section of the community, and is there actual evidence of such health promotion?
- How is the governing board of the venture selected?
- Do representatives of the exempt entity who serve on the venture's governing board have a conflict of interest with their ability to represent community interests?
- Is there a management firm, how is it selected, how is it paid, and what are its duties?
- Who sets medical and ethical standards for the venture?

With the development of many types of innovative structures, the IRS has stated loud and clear that it prefers that tax-exempt organizations maintain control over key decisions that impact the use of charitable dollars.

These same issues will likely affect federally qualified health centers (FQHCs) and FQHC Look-Alikes as they begin to network with entities not entitled to the same federal dollars and not

subject to the same federal restrictions.⁶ The Bureau of Primary Health Care (BPHC), which is involved in the oversight of FQHCs and FQHC Look-Alikes, issued a Policy Information Notice (PIN) on July 22, 1997, which addressed guidelines for permissible networking or affiliation by FQHCs and FQHC Look-Alikes. The purpose of the PIN was to address BPHC's concerns that some affiliation agreements may compromise FQHCs' and FQHC Look-Alikes' compliance with federal requirements. The characteristic of concern to BPHC regarding affiliation agreements was that compliance with governance, management, or clinical operations requirements was, or may be, diminished by virtue of the powers given to one or more other entities in a proposed affiliation agreement. BPHC did not want a FQHC or FQHC Look-Alike to serve merely as a conduit to another party for federal benefits and/or vest in another party the ultimate authority to oversee and approve key aspects of the Look-Alike's activities. To help protect the integrity of such federally funded programs in any networking situation, the FQHC or FQHC Look-Alike should maintain control over any policy decisions affecting the clinic, including the essential areas of health care, personnel, finance, and quality assurance.

Control of network decision-making raises complex legal and political issues for rural communities in the network formation process. It is important to obtain appropriate counsel when aligning such diverse interests.

Does the Network Ensure that Persons with Substantial Influence Over Tax-Exempt Organizations May Not Profit Improperly from their Dealings with the Tax-Exempt Organizations and their Networks?

The IRS has expressed concern that persons with "substantial influence" over tax-exempt entities may improperly benefit from the use of charitable assets. This may involve, for instance, (1) excessive compensation paid by a network involv-

ing a tax-exempt organization to a third person, or (2) unfair business dealings between a network involving a tax-exempt entity and a third party.

In 1996, Congress enacted intermediate sanctions legislation.⁷ This legislation resulted in proposed regulations, which were issued by the IRS in 1998. The proposed regulations would allow the IRS to impose penalty excise taxes on insiders who profit improperly from their dealings with tax-exempt entities. Insiders or persons with substantial influence include officers and directors of the organization, substantial contributors, and family members of officers and directors. The IRS will use a fact-based test to assess a person's ability to control or determine a significant portion of an organization's capital expenditures, operating budget, or employee compensation. While the regulations focus on tax-exempt organizations, they supply important guidance for networks involving tax-exempt entities that contribute tax-exempt dollars.

The IRS has recommended the following steps to help minimize liability in this area:

- The network board or committee establishing compensation should assess fair market value and review comparable data;
- Persons with actual or potential conflicts of interest, who could benefit from any decision, should not decide compensation or payment issues; and
- Analysis and action should be documented and filed with corporate records.

IRS representatives have stated that tax-exempt organizations should have a process in place and should keep track of documentation. The same recommendation should apply to many transactions involving tax-exempt organizations as well as to networks involving tax-exempt entities. For

example, networks involving tax-exempt entities should carefully consider and document decisions concerning "gainsharing agreements," whereby network physicians are paid additional sums for meeting cost savings targets. In the end, sound business judgment reflected in meeting minutes will help to protect networks and their tax-exempt participants.

Do the Network's Activities Further Exempt Purposes?

The IRS will also examine whether the rural network furthers the exempt purposes of the tax-exempt participants. Depending upon the partici-

pants' tax-exempt purposes, the network's articles, bylaws, mission and vision statements, as well as other organizational documents, should demonstrate a commitment to pursuing and achieving such exempt purposes.

Rural networks can anticipate that many tax-exempt participants are charitable entities under Section 501(c)(3) of the Internal Revenue Code. These participants may have acquired exempt status by caring for persons regardless of ability to

pay, entering into Medicare risk sharing contracts, and pursuing health promotion activities for their communities. As such, the network should have a good understanding of the missions and goals of their tax-exempt participants prior to finalizing what functions the network will perform. The following section addresses in further detail how one examines whether exempt purposes are being pursued by an entity.

TAX-EXEMPTION FOR RURAL NETWORKS

Some networks that include tax-exempt organizations are interested in finding out whether their networks can obtain tax-exempt status. To answer this question, network participants must first determine whether their network's activities and

A network should have a good understanding of the missions and goals of their tax-exempt participants prior to finalizing what functions the network will perform.

purposes are truly exempt under IRS statutes, rules, and regulations.

Most health care providers and other exempt organizations in rural areas are exempt under Section 501(c)(3) of the Internal Revenue Code. Section 501(c)(3) provides, in part, for the exemption from federal income tax of entities organized and operated exclusively for charitable, scientific, or educational purposes, provided that no part of the organization's net earnings inures to the benefit of any private shareholder or individual.

IRS regulations provide that the term "charitable" is used in its generally accepted sense.⁸ For example, rural networks seeking to provide or enhance health promotion activities are likely to obtain exempt status. The promotion of health has long been recognized as a charitable purpose, including providing health education, efforts to increase access to care, and studying and implementing ways to resolve health problems. However, the real test for tax-exemption is the promotion of health and something more. To distinguish a charitable entity from one that merely provides a service for private benefit, the IRS will look to see whether services are offered to all persons regardless of ability to pay, among other indicators of a "charitable" purpose. Such activities or services should benefit a broad cross section of the community.

Thus, to obtain such status, networks need to:

- document the clear charitable purposes of the network early in the formation process (e.g., providing care regardless of a person's ability to pay, openness to public (Medicare and Medicaid) managed care programs, and engaging in health promotion and disease prevention activities);

- create a governing board that is broadly representative of the community; and
- ensure that charitable purposes outweigh profit maximization purposes when operating over time.

For example, a rural network located in Lompoc, Santa Barbara County, California, recently received tax-exempt status by establishing its charitable intentions. The network, including the local 60-bed district hospital, an independent physician association (involving most of the primary care physicians and specialists in town), as well as many community and political leaders, explained to the

IRS that the network sought to jointly increase access, improve quality of care, and lower costs to all people in the Lompoc area. In particular, the network intended to study ways to also expand care to the indigent population. The network proposed, among other things, to develop continuing education programs for the public and providers, to define and implement clinical pathways, to combine administrative (management) services, and to coordinate disease prevention and health promotion activities. The Lompoc network emphasized the charitable, as well as administrative efficiency, aspects

of the network.

Networks that focus solely on providing administrative support services, such as claims processing, management, consulting, and other third-party administrator services, will have difficulty obtaining tax-exempt status unless they promote charitable functions. The IRS and courts have regularly held that the provision of management services to unrelated exempt entities in exchange for a fee sufficient to produce a small profit does not exclusively

To distinguish a charitable entity from one that merely provides a service for private benefit, the IRS will look to see whether services are offered to all persons regardless of ability to pay, among other indicators of a "charitable" purpose.

further exempt status.⁹ A recent pronouncement by the IRS stating that Great Plains Health Alliance — a rural hospital management company that provided services for tax-exempt hospitals — was not itself tax-exempt further confirms the difficulty for networks seeking exempt status for administrative support functions.¹⁰

In addition, in December 1998, the IRS ruled that the tax-exemption for an Health Maintenance Organization (HMO) owned by Intermountain Health Care was to be revoked.¹¹ The IRS decided that the HMO did not provide a community benefit. The HMO did not operate a facility that provided emergency care and did not treat non-enrollees. For rural networks seeking tax exemption, it is important to define and pursue a charitable purpose.

IRS RULINGS AND ADVISORY LETTERS

Rural networks can learn more about how their activities may be interpreted under the Internal Revenue Code and its regulations by reviewing IRS pronouncements. The IRS provides guidance in the form of revenue rulings, letter rulings, determinations, and information letters.¹²

Revenue rulings are interpretations by the IRS of how the law will be applied to a specific set of facts. Revenue rulings are published in the

Internal Revenue Bulletin and are issued only by the national office. These published rulings, unlike most other IRS pronouncements, may be used as precedent to support a position in another matter. However, networks are cautioned against reaching the same conclusion in other cases unless the facts and circumstances are substantially the same.

A letter ruling is a written statement issued to a taxpayer or tax-exempt entity by the IRS' national office. These rulings interpret and apply the tax laws or any non-tax laws applicable to employee benefit plans and exempt organizations to a specific set of facts. These rulings may be revoked or modified for any number of reasons unless they are accompanied by a final closing agreement between the IRS and the requesting party. As a part of the IRS' review of specific facts, the IRS also issues tax-exemption determinations for networks seeking tax-exempt status.

Also, the IRS issues information letters. These letters are statements issued either by the IRS national office or by a key district director. They call attention to well-established interpretations or principles of tax laws without applying them to a specific set of facts. To the extent that resources permit, an information letter may be issued if a network's inquiry indicates a need for general information.

RECOMMENDATIONS

- Know which network participants are tax-exempt and which are for-profit;
 - Ensure that contributions from tax-exempt entities are directed solely for the use of tax-exempt purposes (document charitable purpose so network participants understand goals and use of network funds);
 - Ensure that tax-exempt entities have control over how tax-exempt dollars will be utilized (either with majority representation on the board or reserved powers over financial matters and other matters impacting the use of tax-exempt dollars, such as selection of officers);
 - Ensure that network participants or third parties are not paid excessive compensation (for example, assess fair market value and review comparable data; people with a conflict of interest should recuse themselves from decision-making; document your analysis and decision-making processes); and
 - Seek advice from an attorney or the IRS.
-



CHAPTER 4

Antitrust Issues

Successful networking requires rural providers and other network participants to be sensitive to the antitrust issues that govern their activities. Antitrust laws are important when considering how to form, as well as how to operate, your network.¹³

In the health care arena, pro-competition laws, known as the antitrust laws, seek to ensure that health care consumers have competitive choices for services. The antitrust laws are based on the premise that, in general, competition leads to lower prices and higher quality. This means that with many doctors or hospitals or other types of providers competing for the same patients in one area, these patients will have more choices. In turn, these competing providers will be required to offer the lowest prices and highest quality of care to attract the patients.

These general presumptions, however, do not necessarily work effectively in rural areas. Unlike in urban areas, the problem in rural areas is usually attracting enough providers to handle the demand of rural patients. At times, all available providers are needed to sustain a viable network, by assisting with call coverage, lowering overhead costs, and spreading the financial risk of treating managed care patients. Some studies indicate that health care costs can increase in rural areas if providers

compete due to, among other things, the duplication of staff and resources.¹⁴ These costs cannot be easily spread over a small population base.

Instead, rural providers have learned that they may need to cooperate as opposed to compete in order to lower costs, increase access, and increase quality.

The antitrust enforcement agencies have learned a great deal about the needs of rural areas over the past few years and the differences between rural and urban areas.

With this increased understanding of the unique needs of rural areas, state and federal antitrust enforcement agencies have allowed rural providers to come together and cooperate for the benefit of consumers.¹⁵

Recently, the Seventh Circuit

Court of Appeals, a federal appellate court based in Chicago, addressed the need for cooperation among rural providers who are trying to offer quality health services. Specifically, the court remarked that networking between the defendant physicians was necessary to practice modern medicine:

If the Marshfield Clinic is a monopolist in any of these areas it is what is called a “natural monopolist,” which is to say a firm that has no competitors simply because the market is too small to support more than a single firm. If an entire county has only 12 physicians, one can hardly expect or want them to set up in compe-

With an increased understanding of the unique needs of rural areas, state and federal antitrust enforcement agencies have allowed rural providers to come together and cooperate for the benefit of consumers.

tion with each other. We live in the age of technology and specialization.¹⁶

This analysis reflected a modern view of the practice of medicine in rural America and is helping to redefine antitrust analysis in rural health care cases.

Whenever rural providers cooperate in a network, there are antitrust issues that should be considered by the participants. Different network functions, however, raise different levels of antitrust risk. For example, when providers are participating in single-signature contracting or joint ventures involving the sharing of equipment or services, the antitrust risks are generally higher due to the involvement of price and other confidential or proprietary information. On the other hand, when providers are involved in very limited joint ventures, such as cooperating in different health promotion activities (for example, conducting health fairs, developing clinical pathways, sharing non-fee-related information), the antitrust risks are not as great. Once again, the facts of each case will determine the level of antitrust risks.

Different network functions raise different levels of antitrust risk.

RELEVANT STATUTES AND AGENCY GUIDELINES

With respect to antitrust enforcement, network activities are generally analyzed under the following statutes:

- Sections 1 and 2 of the Sherman Act;
- Section 7 of the Clayton Act; and
- Section 5 of the Federal Trade Commission Act.

While there are distinctions among these statutes, it is important for rural networks to understand that the general analysis under these statutes is very similar. In addition, most state antitrust laws track the language and analysis of the federal statutes, case law, and guidelines.

Guidance in analyzing the antitrust implications of networks under these statutes can be found in the Department of Justice (DOJ) and Federal Trade Commission (FTC) Horizontal Merger Guidelines.¹⁷ The Merger Guidelines represent the federal antitrust enforcement agencies' policies regarding acquisitions and mergers, including networking, which most lawyers call joint venturing. The National Association of Attorneys General also have a similar set of Merger Guidelines for the application and analysis of state antitrust laws.¹⁸ It is important to remember that all of these guidelines are merely pronouncements by the enforcement agencies and are not binding on the courts or even on the agencies. Nevertheless, they provide a very helpful understanding of how the courts may analyze your networking activities.

In an effort to further clarify how the two federal antitrust enforcement agencies would analyze the laws and Merger Guidelines governing certain cooperative activities in the health care industry, the FTC and DOJ have issued Statements of Antitrust Enforcement Policy in Health Care ("Policy Statements").¹⁹ The FTC and DOJ jointly issued these Policy Statements in 1993 and revised them in 1994 and 1996. The 1996 Policy Statements contain "safety zones" in eight areas, including: (1) hospital mergers; (2) hospital joint ventures involving high technology and other expensive equipment; (3) hospital joint ventures involving specialized clinical or other expensive services; (4) providers' collective provision of non-fee-related information to purchasers of health care services; (5) providers' collective provision of fee-related information to purchasers of health care services; (6) provider participation in exchanges of price and cost information; (7) joint purchasing arrangements among health care providers; and (8) physician network joint ventures. The Policy Statements also include an analysis of multi-provider networks. For our purposes, we shall focus on the agencies' analyses in the physician

network and multiprovider network Policy Statements.

It is important to keep two points in mind when applying the Policy Statements to any rural network activities. First, similar to the agencies' Merger Guidelines, the Policy Statements are not binding on the courts or agencies and they do not immunize individuals or parties. Second, conduct that may fall outside the safety zones does not necessarily mean that such conduct is illegal or impermissible.

We will now examine the general analysis of rural networks under these Guidelines and Policy Statements.

HAVE THE RURAL PARTICIPANTS FORMED A PRO-COMPETITIVE NETWORK?

Is the Network a Sham to Merely Protect Providers and Not Benefit Consumers?

Under the DOJ and FTC Guidelines and Policy Statements, the agencies will typically analyze cooperative activities under either: (1) the *per se* analysis, or (2) the rule of reason analysis.

Under the first type of analysis, the courts and the antitrust enforcement agencies have been clear that certain activities almost always violate the antitrust laws. The courts and agencies have stated that price fixing, market divisions, and certain group boycotts are *per se* illegal. Under these situations, the courts have explained that consumers are almost never benefitted; therefore, the courts have quickly condemned the practices with little opportunity for the defendants to justify their actions. These actions can result in both civil and criminal penalties.

Price fixing, for example, occurs when independent providers, such as Physician A and Physician B, who are not in a single practice, agree on what price both will charge, such as for an initial office visit or particular procedure. This action prevents the type of price competition that

could conceivably result in lower prices for patients. The purpose is merely to stabilize or increase prices.²⁰

Market divisions occur when independent providers, such as Hospital A and Hospital B, agree that Hospital A will provide OB/GYN services and will not provide orthopedic services and that Hospital B will provide orthopedic services and will not provide OB/GYN services. This dividing of the market reduces competition and may enable the providers to increase prices. This type of activity, whereby private parties agree as to how the market will be divided, is factually and legally different from instances in which a state dictates

such divisions in the interest of the public. The *per se* illegal market division occurs in the absence of any efforts to benefit consumers in any way.

Group boycotts occur when independent providers, such as Hospital A, Physician A, and

Physician B, enter into an explicit or implicit agreement not to deal with an HMO. Instead of independently deciding for themselves whether to participate in the HMO provider panel, the providers decide jointly to refuse to sign any participating provider contracts. These agreements prevent innovative programs from entering the market and further eliminate choices for consumers.

Thus, a sham network typically involves providers that come together merely to increase their revenues by fixing prices or reducing quality without any interest in benefitting health care consumers. Networks in these types of cases are used as a defense mechanism for providers to prevent managed care from entering a rural community. These situations represent the most blatant antitrust violations and are heavily reported by the press.

In one high-profile case arising out of Tucson, Arizona, the DOJ brought a criminal case against a group of providers who allegedly used a network-type structure to limit the ability of managed care

A bona fide network is one that seeks in good faith to benefit consumers.

plans to compete in the market.²¹ Without seeking to improve the way they delivered health services, the providers agreed on a reimbursement level that they wanted from health plans. The providers then refused to contract with any plan that did not meet their stated reimbursement demands. The DOJ received a complaint and later decided to bring a criminal complaint of price fixing against the providers. At trial, the providers were found criminally liable for their actions. While this criminal case was unusual for a health care antitrust case, criminal antitrust cases have been quite common in other industries with corporate executives and boards being held criminally liable for *per se* antitrust violations.

Is the Network a Bona Fide Network?

The agencies and courts understand that pro-consumer benefits can result from legitimate networking between rural providers and area citizens. A pro-consumer or pro-competitive network is one which is “bona fide” and not a “sham” to raise prices or to prevent managed care from coming into a rural community. Bona fide networks are ones that seek in good faith to benefit consumers.

To be considered a bona fide network that benefits consumers, the antitrust enforcement agencies will look to see whether the network participants have agreed to incentives to control costs or to better utilize services. Examples of bona fide networking include situations where providers share substantial financial risk for providing care, such as agreeing (even through a letter of intent or mission statement) to provide services: (1) at a “capitated” (fixed, predetermined) rate; (2) at a predetermined percentage of premium or revenue; (3) subject to a withhold from compensation to meet cost-containment goals; (4) subject to substantial financial rewards or penalties based upon a group performance target; or (5) subject to other innovative methods of lowering costs for consumers.²²

Rural networks that do not involve the sharing of substantial financial risk also may be lawful if

they involve sufficient clinical integration to demonstrate that the network is likely to produce significant efficiencies.²³ For example, in the Policy Statements concerning physician networks, the agencies state that “sufficient” integration can be evidenced by the network implementing an active and ongoing program to evaluate and modify practice patterns by the network’s participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.²⁴ Such a program may include establishing sound mechanisms to achieve the goals of cost controls and enhanced quality, choosing physicians that are likely to meet these goals, and making a significant investment of capital (human and monetary) to realize the stated goals. The agencies have mentioned such network activities as engaging in case management, pre-authorizing certain services, performing concurrent and retrospective review of inpatient stays, and developing practice standards and protocols to govern treatment and utilization of services. Other activities can include investing in information systems necessary to gather aggregate and individual data on the cost, quality, and nature of services provided by the network, as well as to measure performance against benchmarks and monitor patient satisfaction. The agencies are willing to consider many different types of innovative arrangements involving substantial clinical integration.

The agencies recognize that, similar to physician networks, multiprovider networks that do not share substantial financial risk may also involve sufficient integration to demonstrate that the venture is likely to produce significant efficiencies.²⁵ Examples of sufficient clinical integration may include implementing systems to establish network and individual provider goals relating to quality of care and the appropriate utilization of services by network participants, and evaluating the participants’ and the network’s performances and modifying practices where necessary. The examples stated above concerning clinical integration in the physician network setting can also be applicable in some

cases in the multiprovider network setting. Clinical integration may also include service allocation or specialization where it is reasonably necessary for the network to realize significant pro-competitive benefits.

The agencies will analyze the substance, not just the form, of clinical integration efforts. Obviously the more integration programs that are implemented and utilized, the more likely the network will be found to have sufficient clinical integration. Keep in mind that while sufficient clinical, as well as financial, integration may make it possible for networks to be analyzed under the rule of reason as opposed to the *per se* rule, these types of integration do not permit the networks to engage in otherwise *per se* illegal acts, like a group boycott or price fixing arrangements.

To help avoid potential civil and criminal penalties and to be found to be a bona fide joint venture, network participants need to continue emphasizing the pro-competitive goals of the network, which include how the participants can improve care for health care consumers and can continually protect confidential business information. Case law and federal antitrust enforcement speeches recommend that networks include the following elements:

- initial pooling of capital by providers to show commitment to the network;
- initial agreements or letters of intent by providers to share substantial financial risk (through capitation, withholds greater than 15 percent, or other means to incentivize providers to efficiently provide health services) or to be committed to engaging in sufficient clinical integration (through provider participation in, among other types of activities, cooperative quality assurance, and utilization review programs);
- meeting agendas during the formation process that emphasize the network's pro-consumer goals and limit the range of topics; and

- antitrust compliance policies and procedures that ensure that participants understand the limits of their cooperative activities.

The DOJ has sued networks that have failed to take actions like those recommended above. For example, in September 1995, the DOJ challenged two physician-hospital organizations (PHOs): one in St. Joseph, Missouri (55 miles from Kansas City) and one in Danbury, Connecticut (80 miles from New York City). The DOJ alleged that these were sham PHOs and were *per se* illegal.²⁶ The DOJ's complaints stated that the providers did not substantially integrate their operations. The

providers allegedly made no efforts to reduce costs or to examine how to increase quality. In addition, the PHOs were not committed to accepting capitation or otherwise accepting risk. Their efforts consisted of adopting fee schedules and presenting them to managed care entities. The government relied heavily on network documents evidencing concerns about managed

care coming into the areas. The parties eventually signed a consent decree.²⁷ The reasoning in these cases would apply to instances where rural networks fail to integrate their operations or to examine and implement efforts to reduce costs or increase quality.

In forming a rural network, it is important to document the pro-consumer goals that motivate cooperative activities. It is also important to continually remind network participants of the network's mission and goals and to ensure provider commitment to achieving those same goals.

Analyzing a Bona Fide Network — Does the Network Have the Ability to Arbitrarily Raise Prices or Decrease Quality with No Relief for Consumers?

Assuming that a proposed rural network is truly a bona fide joint venture (involving some

**“Market power”
can be thought of
as the ability to raise
prices or reduce
quality beyond
competitive levels.**

measure of economic integration and commitment to providing quality, cost-effective care), courts will next analyze whether the network has the ability to hurt consumers. This analysis generally involves assessing whether the network is too big. In other words, are there other health care choices for consumers if they do not like a particular network? For example, are there other similar non-network providers, whether they be primary care physicians, hospitals etc., where a consumer can turn if the networking providers raise prices or fail to offer quality services? This analysis looks at the percentage of the market controlled by the network (the providers' market shares) to see whether the network has "market power," which is the ability to raise prices or reduce quality beyond competitive levels.

Are There Alternative Choices of Providers for Rural Consumers? — Need to Define the Relevant Product Market

The first step in analyzing whether consumers have options outside of a provider network is to define the relevant group of competing providers. This is known as defining the relevant product market. Defining a relevant product market is primarily a process of describing those groups of providers that, because of the similarity of their services, have the ability — actual or potential — to take significant amounts of business away from one another.

For instance, in analyzing most hospital networks or mergers and acquisitions, the courts have typically deemed general acute care inpatient hospital services as the relevant product market. Hospitals are the group of competing providers that offer acute care inpatient hospital services and compete for the same patients. Therefore, under antitrust analysis, one would look to see how many hospitals are included in a rural network.

In the context of physician services, the courts

and agencies have defined the relevant product market in terms of physician specialties. In one federal case for example, the court examined the extent to which an HMO had contracted with too many "primary care physicians" on an exclusive basis.²⁸ The principal argument centered around the definition of a primary care physician or which types of physicians competed to provide primary care services. Ultimately, the court relied on a general definition that included physicians practicing in the areas of family practice, general surgery, internal medicine, obstetrics, and gynecology. However, the definition can vary from case to case. For instance, in a business review letter, the

DOJ limited the definition of a "primary care physician" to general practitioners, family practitioners, and internists.²⁹ Much of this analysis depends upon the particular community and available supply of providers.

The DOJ and FTC have found that, in general, all services provided by each physician specialty can be considered to be a separate relevant product (service) market. The agencies have sometimes defined physician product markets according to particular specialties, such as cardiologists, primary care physicians, or

gastroenterologists. In the 1996 Policy Statements, however, the agencies remarked that there may be instances in which services provided by different physician specialties will overlap significantly. In these cases, all of these physician specialties will be added to the pool of available providers in the market area, thus potentially reducing a network's market share percentage. The agencies are also willing to consider other categories of providers. This analysis looks at a variety of factors such as licensing and regulatory requirements, as well as consumer recognition of different provider types as adequate alternatives.

The DOJ and FTC have set limits on a single network's ability to control a health care market. High market share percentages can expose rural networks to an antitrust investigation or challenge.

In the health care network context, it is expected that courts and agencies will examine separate specific product markets, such as acute care hospitals, primary care physicians, or home health agencies, etc. The court or agency would be interested in learning how many and what percentage of each type of provider are included in the network's panel. Because of the limited number of providers in rural areas, a narrow definition of a type of provider could raise antitrust issues for a rural network that contracts with, for instance, all of the primary care physicians or all of the orthopedists or all of the general surgeons in the area.

Need to Define the Relevant Geographic Market

Once the courts or agencies have defined the relevant type of competitors, such as primary care physicians or orthopedists, the next step is to determine the relevant geographic area containing the total supply of such providers. The percentage of like providers included in a network determines the market share held by the network. To accomplish this second step, a network should know the general extent of its antitrust market area. This second step is known as defining the relevant geographic area or market.

For example, when a rural community is located approximately 60 miles away from an urban center, many rural providers may not consider that urban center to be part of their market. Rural providers may not attract patients from that urban area. A provider's service area, however, does not necessarily constitute a market area for antitrust purposes. If a substantial number of patients (greater than 10-15 percent) within a rural service area are willing to travel to a nearby urban center (known as outmigration), that urban center may be included in the antitrust geographic market.³⁰ Obviously, the broader the geographic market, the larger the supply of providers and, possibly, the lower the market shares of the rural network.

Courts have generally stated that health care markets are local. Therefore, in determining the

geographic market in which a relevant set of competitors can be found (here we will define the product market as primary care physicians), the agencies have typically relied upon travel distances of 25 to 40 miles for primary care services. This is a very conservative analysis for antitrust purposes. Thus courts will consider where patients can practically go to seek a primary care physician. From this geographic area, the market shares can be calculated. For example, if a rural network contracts with ten primary care physicians in a geographic area that contains 40 primary care physicians, the rural network has a 25 percent market share.

It is important to keep in mind that there is no subject in antitrust law more confusing than market definition.³¹ Courts will consider economic theories as well as the practical realities of the market area (such as roads, provider locations, population demographics, etc.).

People in rural areas generally tend to travel further than people in urban areas, whether to see family and friends, purchase goods, or for entertainment purposes. Likewise, rural people also tend to travel further than urban people for health care services, sometimes even bypassing local providers. Rural networks are seeking to stem this outmigration of patients who may perceive that urban providers can offer better or lower cost services. In a rural hospital merger case, for example, the merging hospitals were able to prove that many rural health care consumers would travel approximately 55 to 60 miles (from Ukiah, California to Santa Rosa, California) for primary and secondary care that was available in Ukiah.³² It is recognized that people in rural areas tend to travel further than their urban counterparts for primary and secondary care, particularly obstetrical care.³³

Antitrust law does not define typical or standard radii that are applicable to all markets or even rural markets. Many factors (including, but not limited to, testimony and empirical data) are used to define a particular market. Because many people do not like to travel far for primary care

services, rural networks need to be conservative at first to determine their markets under the worst possible scenarios. It can be expected that persons challenging a rural network will utilize very narrow market definitions, such as a single county, or possibly, a few zip code areas within a local area. It is important to understand, however, that while a person or entity challenging a rural network under the antitrust laws (the “plaintiff”) may utilize conservative market definitions of 25-, 30-, and 40-mile radii around a rural community, the actual market may be larger or smaller depending upon commercial realities. Important factors that courts take into account are:

- road and speed conditions;
- patient preferences;
- payer preferences;
- current travel patterns; and
- physician privileges and practices.

Nonetheless, a relatively conservative rule of thumb of 25- to 30-minute travel distance is another helpful starting point to assess the antitrust implications of a rural network.

Need to Calculate the Network’s Market Shares — Is the Network Potentially Anti-competitive?

Within a specific product and geographic market (let us take for example primary care physicians (PCPs) within a 45-minute travel distance around a rural community) a rural network will try to contract with as many qualified PCPs as possible in this market area. There are many beneficial reasons for doing this. First, as stated previously, rural areas have had difficulty recruiting and retaining providers so the rural networks must contract with as many PCPs as possible to attract managed care contracts. Second, to adequately spread the financial risks of treating a poorer, sicker, and more elderly population, it

helps to have more PCPs shouldering that burden. Third, benefits can inure to patients when providers work together cooperatively to address quality issues affecting the community, such as more comprehensive call coverage, more coordinated case management, etc.

Some rural networks will not only try to contract with a large number of providers, but will also seek to contract exclusively with the most qualified and most desired providers. Some factors that rural networks look to include board certification or qualification, leadership abilities, managed care experience, strength of practice, etc. This type of contracting further increases the network’s ability to attract

managed care contracts. It also ensures a stable supply of providers to care for the network’s patients.

The DOJ and FTC, however, have set limits on a single network’s ability to control a health care market. To promote consumer choice of providers and health plans, the antitrust enforcement agencies have sought to discourage networks from unduly limiting the supply of providers from which other networks of health plans may contract. The DOJ and FTC have stated in their Policy Statements and Guidelines that, absent extraordinary circumstances, provider networks will not be challenged if

they do not exceed 30 percent of the total supply of a particular provider type.³⁴ This 30 percent safety zone assumes that the contractual arrangements are non-exclusive, meaning that the providers are free to contract with other health plans or networks.

For exclusive contracts, the agencies have stated that, absent extraordinary circumstances, the agencies will not challenge a bona fide exclusive network that contains 20 percent or less of the relevant providers in the relevant geographic market.³⁵ However, in a FTC consent decree involving pulmonologists, a 25 percent market

It is important to note that the standard guidelines and safety zones from the DOJ and FTC are not binding, and they tend to be less applicable to rural areas or other areas in which there is a small or inadequate supply of providers.

share figure was found to be acceptable. No bright line test exists in these matters. Rural network market shares and their potential impact on consumers will be judged on a case-by-case basis. Based upon case law and agency policy, more than 25 percent of market share does increase the risk of investigation or challenge. Keep in mind, however, that the agencies have specifically stated that merely because a network does not come within a safety zone does not mean that it is unlawful under the antitrust laws.³⁶

High market share percentages can expose rural networks to an antitrust investigation or challenge. In Mesa County, Colorado, the FTC filed a complaint against the Mesa County Physician Independent Practice Association, Inc. (MCPIPA) alleging that MCPIPA erected barriers to suppress competition by third-party payers. MCPIPA included approximately 85 percent of the physicians in private practice within the county. MCPIPA contracted with payers to provide services to subscribers of health benefit plans such as HMOs and PPOs. The FTC claimed that, among other things, MCPIPA undertook measures to assure that each physician member would refuse to deal with any other third-party payer that could stimulate competition among physicians to reduce fees or to provide services more effectively. The FTC entered into a consent decree with MCPIPA requiring it to modify its behavior to allow for greater consumer choice.³⁷

It is important to note that the standard guidelines and safety zones from the DOJ and FTC are not binding. More importantly, they tend to be less applicable to rural areas or other areas in which there is a small or inadequate supply of providers. In certain cases, networks operating in rural areas have been able to contract on a non-exclusive basis with a greater percentage of providers, including up to 75 to 100 percent of a particular provider type.³⁸ However, in these special circumstances, the plans or networks have generally been required to justify the need for such a large percentage of participating providers and to

ensure that proper safeguards are in place to protect confidential competitive information. These exceptions have also involved very strong support from large employer payers in the community. The lesson here is that the larger the percentage of participating providers, the greater the antitrust risk, particularly if such a large percentage is not tied to any demonstrated consumer need for such extensive provider participation. Some of these rural exceptions are addressed below.

DEFENSES AND IMMUNITIES TO ANTITRUST CHALLENGES OF RURAL NETWORKS

Rural providers are typically found in highly concentrated markets and face potential antitrust risks if they collaborate. It is important, therefore, to know the possible defenses and immunities to any antitrust challenge.

Community/Payer Support

An important fact in helping to either avoid an antitrust investigation or to strengthen a defense to an antitrust claim is the level of community or payer support. Remember that the antitrust laws are intended to protect consumers, not competitors. Therefore, in smaller rural communities where community leaders and citizens are involved in developing the network and supporting its operations, this fact will help minimize antitrust consequences. Courts will be hesitant to find an antitrust violation where there is little or no consumer opposition. It is important to keep in mind that the federal antitrust agencies are likely to pay particular attention to the views of managed care payers.

Efficiencies

To help rebut a third party's claims that a network's market shares are too high — which may raise anticompetitive concerns — networks can seek to use an efficiencies defense. This defense allows a network to argue that the cost savings and other financial benefits resulting from rural provider cooperation outweigh any anticompetitive concerns.³⁹ The strength of this argument

lies in the understanding that by reducing providers' duplicative administrative and clinical costs through networking, cost savings can be passed on to consumers. Networks would need to prove that the cost savings are so substantial that the alleged market share concerns are not worthy of preventing a positive collaborative arrangement, which is difficult to accomplish.⁴⁰

Two basic efficiencies can be achieved by networks: (1) a network can allow a new product or service to be marketed that otherwise would not be available to consumers because the network participants could not offer the product or service on an individual basis; and (2) a network can lower the participants' costs and cause a product or service to be marketed at a lower price. For example, the addition of a cardiac cath lab may be cost-prohibitive for one rural provider to invest in and to sustain on its own. However, with multi-provider involvement (financially and operationally), the new service could be added to the rural community. This efficiency saves dollars for the parties and results in efficiencies both on the capital expenditure side and the annual cost side for ongoing operations.⁴¹

Efficiencies defenses, however, are difficult to prove and the courts have imposed a heavy burden on parties alleging them in prior health care cases. This burden is greater if the alleged adverse competitive effects are more serious. Frequently, courts, as well as the DOJ and FTC, have been very skeptical of efficiencies arguments because they are based on speculation and on information controlled by the defendant network. Parties are often required to prove that their efficiencies claims are cognizable (capable of judicial determination) and substantial.

To best assert an efficiencies defense, a network should:

- identify specific desired efficiencies in the early

stages of network formation or operation;

- clearly document efficiencies as the network proceeds; and
- to the extent feasible, utilize the services of an objective third party to determine projected and/or actual costs savings.

Networks must be able to convince a court or agency that the potential efficiencies motivated the parties to network and that the projected efficiencies are being pursued by the parties. The weakness of this defense is that a network must typically go through a full trial on its merits to be successful

if the network is sued. In addition, very few parties have successfully prevailed with an efficiencies defense. For instance, in one hospital merger case in which the parties documented millions of dollars of *actual* efficiencies for five years after the deal closed, these facts were still insufficient to establish a defense.⁴² Nevertheless, efficiencies claims are often helpful in demonstrating good faith reasons for coming together and avoiding an antitrust investigation or complaint.

Courts, as well as the DOJ and FTC, have been very skeptical of efficiencies arguments to antitrust challenges because they are based on speculation and on information controlled by the defendant network.

Buyer Power

The existence of large, powerful buyers of a service is also helpful in rebutting an antitrust attack. In the health care industry, most providers have no ability to control the price that most of the buyers of health care pay. Large HMOs and other third-party payers control prices charged by health care providers. Medicare and state health insurance programs account for approximately 65 to 70 percent of many rural providers' revenues. These customers exert strong economic power; they can drive hard bargains and typically enter into long-term contracts that guarantee their pricing. Market share statistics do not always accurately reflect the ability of a rural provider network to unilaterally

raise prices or diminish the quality of service. The reality is that these large buyers often have more control over price than the providers. Thus, the “buyer power” argument should be considered when defending any collaborative arrangement. This defense has been successfully asserted in many cases.⁴³

Ease of Entry

Another argument that can help refute a claim that a network is anti-competitive is that another competitive entity could easily enter the relevant market. For example, if a network contracted with a payer, courts would question whether other networks could form to contract with participating providers or whether a competing payer could contract with the network and its providers. Obviously, with networks contracting exclusively with providers and/or health plans, entry would be very difficult in some rural areas.

It is recommended that rural networks that are located in small, isolated areas without many providers, such as a limited number of PCPs or hospitals, enter into non-exclusive contracts at first. This will help to strengthen arguments that other networks or health plans could easily enter by trying to contract with the network’s participating providers. If a network wants to contract exclusively with participating providers, it should limit those contracts to only 20 to 25 percent of the available provider type. Moreover, it is not recommended that networks contract exclusively to serve only one health plan if the network contracts exclusively with more than 30 percent of the providers available in a relevant geographic area. Since rural networks generally need to involve a substantial percentage of providers, rural networks should focus on primarily non-exclusive arrangements to minimize antitrust risks.

To shield a network from antitrust liability, the state must articulate a clear and affirmative policy to allow potential anti-competitive conduct and actively supervise the conduct undertaken by the parties.

State Action Doctrine

States have begun to recognize the limitations of the current federal antitrust standards and review processes as they relate to rural providers. To provide more prompt action and to immunize beneficial rural networking, some states have started to exercise their rights to immunize such collaborations.

Under the Constitution of the United States, the states are sovereign except to the extent that Congress has constitutionally subtracted from their authority. Because neither the plain language nor the legislative history of the federal antitrust laws implies that the antitrust laws were intended

to restrain state action or official action directed by a state, the states may adopt and enforce legislation that immunizes activity from antitrust liability. This shield from federal antitrust liability is known as “state-action immunity.”⁴⁴

State-action immunity can be an effective shield from antitrust challenges. A finding that the state has articulated a clear and affirmative policy to allow potential anti-competitive conduct, and, in the case of private parties, that the state has actively supervised the conduct

undertaken by the parties, will protect the parties from antitrust liability. While anyone is free to bring suit in this country, state-action immunity not only reduces that possibility, but also helps to reduce the effort required for a defendant to prevail in court. Typically, a party protected by state-action immunity can seek to dismiss the action without a drawn-out factual inquiry into the purpose or effect of the challenged networking activity.

A rural hospital network in the panhandle region of Florida recently received state-action immunity to, among other things, use a single agent to negotiate managed care contracts on behalf of the hospitals.⁴⁵ The significance of this

immunity arises from the fact that the hospitals' agent may: (1) review each hospital's costs and current levels of reimbursement; (2) make recommendations to each hospital on bargaining strategy; (3) negotiate with each payer on behalf of the hospitals; and (4) reject a payer's offered reimbursement rates or methods if they do not fall within the parameters set by any one of the hospitals.

The DOJ and FTC have generally approved network price negotiations that prohibit the network's agent from negotiating contract rates, binding network members, making recommendations to the network participants, and discussing with network members the terms that other network members have accepted or rejected. In most rural networks that include many area providers, network agents can usually only act as a conduit or "messenger" of information between payers and the network participating providers. This Florida-approved "attorney-in-fact" approach allows the rural hospitals to utilize expertise not present in-house and to be more flexible in utilizing the talents of the agent vis-a-vis experienced negotiators for the payers. The agent is given greater flexibility to actually negotiate on behalf of the network-participating hospitals. This model helps to level the playing field with large HMOs that have the power to dictate price terms.

The network here, the Panhandle Hospital Services Cooperative Inc., is a Florida non-profit corporation involving five hospitals located in rural areas of the Florida panhandle. Due to the significant number of patients leaving these hospitals' service areas to use larger, urban hospitals, the State of Florida recognized the need for these hospitals to work cooperatively. The state based its decision on, among other things, the network's plans to cooperate toward increasing the accessibility of low-cost, high-quality health care services to

rural residents; consolidating technologies and sharing administrative services to avoid duplication; improving quality and efficiency through rural-appropriate methods of utilization management and quality assurance; pursuing group purchasing opportunities; preserving essential jobs; and retaining rural wealth. Absent state-action immunity, the hospitals faced uncertainty and potential claims of price fixing concerning their use of a single negotiating agent. With the immunity, the hospitals are unlikely to be held liable under either federal or state antitrust laws for negotiating as a single group.

It is important to note that state-action immunity requires "ongoing" active supervision by the state. The State of Florida requires the Agency for Health Care Administration, with assistance from other state agencies, to monitor networks that have been granted state-action immunity. Networks must maintain a current file documenting compliance with state criteria and must submit an annual statement attesting that the network is in compliance. This file is available for state inspection.

Rural network participants must make sure that the state has an

effective monitoring system in place to review the state-permitted conduct. Some states have an annual review process, but these states may not have the necessary funding or staffing to carry out such supervision. Unless the state actually reviews such networking conduct on an annual basis and actually approves the network's actions after such a review, the process of initial state approval could potentially be worthless in immunizing the network and its participants. The Supreme Court has not yet addressed what constitutes "active supervision" in the network review context. However, the Court has stated that silence and inactivity by a state (sometimes referred to as a negative option system) is not enough.

The DOJ, which issues business review letters, and the FTC, which issues advisory opinions, can determine from the agencies' perspectives whether they would challenge a proposed network activity.

Business Review Letter or Advisory Opinion

Rural networks can also seek advice from the DOJ or FTC about whether their activities may violate the federal antitrust laws. The DOJ, which issues business review letters, and the FTC, which issues advisory opinions, can determine from the agencies' perspectives whether they would challenge a proposed network activity. Networks do not have to file a request with both agencies; the agencies share this responsibility and each will generally respect the other agency's opinion on a specific matter.

One DOJ business review letter concerned a rural network involving nearly 100 percent of the rural area's providers. This network included the local hospital, a medical group of approximately 25 physicians, a smaller, three-person medical group, and a solo practitioner. In the spring of 1995, this group of providers, located in Ridgecrest, California — a community of about 30,000 people in the high desert — were approached by local employers who had an interest in seeing the providers work cooperatively to decrease health care costs. The providers in town collectively formed an integrated network that would strive to lower costs and increase the quality of care. The network wanted to be locally responsible for tracking utilization and quality. Because the employers wanted to make sure that their employees had access to all of the approximately 35 practitioners in Ridgecrest through the network, rather than the 30-40 percent of those practitioners that has been the standard of the enforcement agencies, the proposed network asked the employers to allow the network three to six months in order to obtain a business review letter from the DOJ.

On August 14, 1996, more than one year after the request for the business review letter was submitted, Sierra CommCare, Inc. (the name of the rural network) finally received its favorable ruling. After obtaining clearance from the DOJ to operate the network, the network contracted with the local hospital to provide care to the hospital's employees and dependents. The hospital is one of the larger

employers in the community. As a result of this collective action involving well over 30 percent of the area providers, the hospital saved more than 10 percent in health care costs from the previous year.

This experience highlights two major points. First, that while standard antitrust rules may cause some uncertainty for rural areas (such as safety zones for non-exclusive networks with less than 30 percent of the market), the agencies expressed a willingness to be flexible to consider carefully the unique needs of rural communities. Second, that the amount of time that it takes to obtain a business review letter or advisory opinion may be too long for the immediate needs of the network. The amount of information requested by the federal antitrust agencies may increase the length of time from the parties' requests to the agencies' responses. Networks need to be thorough in collecting and sending necessary information to the agencies. Incomplete requests can prolong the amount of time between the request and the response.

Similarly, the DOJ took over a year in another rural situation to issue a review letter. The Rural Wisconsin Health Cooperative Network submitted its request to the DOJ on May 3, 1995.⁴⁶ The DOJ finally issued a business review letter on November 12, 1996. A delay of more than one year may be unacceptable to rural networks that require an expedited response in a fast-moving marketplace. Nevertheless, to appease antitrust concerns, DOJ or FTC review may be the most appropriate resolution for your community.

OPERATING A RURAL HEALTH NETWORK — ANTITRUST IMPLICATIONS AFTER FORMATION

Even if a network is found to be procompetitive — assuming that it is bona fide and maintains an acceptable percentage of providers — it must still be careful to avoid antitrust issues. Two major issues confronting start-up rural networks are: (1) selecting participating providers and avoiding group boycott claims; and (2) negotiating prices or addressing cost concerns and avoiding price fixing claims.

In many rural areas, start-up networks typically face some initial resistance. This resistance may be due to either fear of the unknown, a desire not to change a fee-for-service system where some providers have been doing well financially, or specific concerns about the quality and utilization expectations of care management. For quality reasons, networks may not wish to contract with every provider in an area and, for the antitrust reasons discussed above, may not be able to assume the risk of including such a large percentage of providers. It is likely that excluded providers may try to undermine the formation of a rural network that is attractive to health plans and self-funded employers. Providers may see a significant loss in patients if they are not included on provider panels that are less expensive to plan members.

To help avoid a group boycott claim by excluded providers, networks should establish objective criteria in choosing their participating providers. These objective criteria include quality and cost-containment considerations. For instance, some networks assess whether providers are board-certified, eligible or qualified, whether providers have lost or settled malpractice claims, whether providers are doing well financially in any managed care arrangements, or whether their practice is suffering financially under any payer system. Networks can also decide to include geographically dispersed providers and avoid unnecessary duplication. Using provider/population ratios can also help to justify limiting a panel. For example, it is expected that a network will seek to increase quality of care; one means to that end is to limit the provider panel so that volume is directed to a few providers. This limitation of participating providers can also potentially help in better distributing capitation to providers who are at risk for the cost of care. In

reviewing these factors and making panel decisions, it is also recommended that an objective third party assist network providers in assessing qualifications for panel selection.

On the other side of the table, independent rural providers that are deciding whether to join a network need to be careful that they do not collectively boycott the network. Providers must independently decide whether to participate.⁴⁸

Moreover, networks need to be careful about how they negotiate and set pricing. Pricing that is merely ancillary to accomplish the network's legitimate goals is appropriate, however, networks must avoid what is referred to as the inappropriate

spillover effect. "Spillover" refers to the exchange of information or agreements between cooperating network providers that is unnecessary to the operation of the network. Providers discussing prices together is almost always inappropriate and often illegal.

Networks should hire or contract with an administrator or negotiating agent. This agent can be the access point for confidential information and can ensure that no spillover occurs. Various models include the "messenger model" and "attorney-in-fact" approaches to negotiating prices. The agencies have emphasized that any contract-

ing arrangement that is designed simply to minimize costs of contracting, and that does not result in collective determination by the competing network providers on prices or price-related terms, is not per se illegal price fixing.⁴⁹

Under the messenger model, a rural network engages an agent or third party to convey to purchasers information obtained individually from the providers about the prices or price-related terms that the providers are willing to accept.⁵⁰ In some messenger model situations, the agents merely convey information to the providers that

To help avoid a group boycott claim by providers excluded from panels, networks should establish objective criteria, including quality and cost-containment considerations, when choosing their participating providers.

the agents received from payers. The agent is merely a messenger or conduit of information. The antitrust agencies have stated that in other situations, the contracting agents may accept contract offers if the agents receive individual authorizations from the providers. Agents can help providers understand offers by using empirical or objective data, but network agents should not decide for a provider under this model. If a network chooses to use the messenger model, it needs to strictly follow it. The DOJ has stated that it will not tolerate abuses of the third-party messenger model in negotiations with health plans and networks.⁵¹

Some networks utilize an attorney-in fact approach which provides more flexibility for the negotiating agent, but increases the level of risk because the agencies will examine such situations on a case-by-case basis. Under this approach, the individual providers give the agent a price range within which to negotiate and accept contract offers on their behalf. The importance here is to ensure that decision-making is as much as possible at the individual provider level. Individual provider price ranges or decisions should not be shared with other network providers. The agencies will look to see whether any arrangement creates or facilitates an agreement among competitors on price or price-related terms. Rural networks should seek advice from counsel to minimize risks in this complex area.

It is worth mentioning that many networks also utilize an opt-in or an opt-out feature in which each provider in the network is able to decide whether to participate (opt-in) or decline to be included (opt-out). The agencies have stated in the Policy Statements that an unintegrated network in which the providers give the agent the authority to negotiate on their behalf is per se illegal, even if the providers have the right to opt-in or opt-out.⁵² Therefore, an opt-in or opt-out provision, standing alone, is not enough to avoid antitrust liability.

It is possible that a court may find that in a case of an integrated network employing an opt-out or opt-in feature, the network providers may have some negotiating independence. In light of the agencies' dismissal of such provisions, however, it is not recommended that even integrated networks rely on this fact alone to ensure compliance with the antitrust laws.

Also, while networks are appropriate to facilitate the negotiation of payer contracts with providers, a network cannot be used to prevent the entry of managed care should an impasse be reached between a payer and the network. Networks should address what powers participating providers have in the event of a negotiations impasse. Some government consent decrees include requirements that network providers be free to negotiate individually with third-party payers upon impasse between the payer and the network.

RECOMMENDATIONS

- Ensure that the network is intended to pursue pro-competitive goals (document in mission statement, governing documents and/or meeting agendas and minutes the goal and actions to achieve increased access, increased quality and/or lower costs for patients);
 - Ensure that the network is pursuing substantial financial risk (including capitation, withholds, or other innovative means to incentivize providers to control costs) or that the network is pursuing sufficient clinical integration (including meaningful participants' involvement in such programs as cooperative quality assurance and utilization review programs);
 - Develop and adopt antitrust compliance policies and procedures that ensure that participants understand the limits of their cooperative activities;
 - Be aware of the rural network's market shares by analyzing the number of providers offering like services within the relevant geographic market area;
 - Ensure that the network has a process in place to prevent sharing of pricing and other confidential information;
 - Document pro-consumer accomplishments (increased access; quality improvements and/or actual efficiencies achieved);
 - Seek the advice of an attorney if any questions or concerns arise; and
 - Consider the advantages or disadvantages of a DOJ business review letter or FTC advisory opinion.
-



CHAPTER 5

Other Legal Issues

The aforementioned legal issues are very important during the formation stage of rural network development. Other legal issues, however, may arise during the formation stage and may also have an impact during the ongoing operation of a rural network. The following section discusses very briefly the additional legal areas of: (1) fraud and abuse, (2) self-referral, (3) insurance and health plan regulation, and (4) torts. These areas are not discussed in depth and, therefore, many issues within these areas may not be addressed or may not be explored as fully as possible. This section is intended solely to sensitize rural networks and their members to these areas and is not intended to provide legal advice. It is recommended that rural networks seek appropriate legal guidance should they have any specific questions or concerns.

FRAUD AND ABUSE ISSUES

Many integrated networks will include physicians or physician organizations that have the ability to refer patients to other network providers. Any payments to these participating network physicians must be in accordance with the federal anti-kick-back statute, which, among other things, prohibits payments or other incentives (remuneration) to induce the referral of Medicare or Medicaid patients.⁵³ The potential penalties include criminal prosecution, punishable by hefty fines and possible imprisonment.⁵⁴ This area is important for networks to be aware of considering the increased efforts at the federal and state levels to investigate and prosecute fraud cases.⁵⁵

The Office of Inspector General (OIG) has analyzed four factors in assessing potential fraud and abuse risks due to certain payment or bonus schemes:

- increased risk of overutilization;
- increased costs to Medicare, Medicaid, or other federal programs;
- limits to patient freedom of choice; and
- potential unfair competition.

The OIG will also examine the extent to which the requisite intent to induce referrals is present.⁵⁶

Rural networks may involve both hospitals and physicians that are in a position to refer patients to the hospital participant. Shared hospital and physician ownership in a network can raise fraud and abuse issues. Networks should ensure that the ownership interests of the physicians are generally in proportion to their capital contributions.

Networks should also ensure that their reimbursement and financial incentive programs do not directly or indirectly encourage providers to refer to a particular network member. Provider payments should be based on the provider's demonstrated quality and cost-effectiveness of delivering services — not on his or her referral patterns or ability to refer patients — even in a network context.

Many networks try to structure creative financial or gainsharing arrangements that will better align the participants' incentives and result in better utilization and quality. Under a gainsharing arrangement, a network could reward participating

providers by giving them a portion of the cost savings realized by the network when the providers deliver high-quality care in a cost-effective manner. Such gainsharing arrangements can be seen in hospital efforts to lower costs and increase efficiency in a clinical department of the hospital. Financial bonuses can be earned by department physicians and staff if they can achieve cost savings targets set by the hospital. In a rural network context, a network may determine that diabetes is a problem affecting many residents in the network's service area. After projecting the anticipated costs associated with treating diabetes, the network may agree with a payer to share in the financial rewards of lowering the associated costs of treating diabetes. This financial incentive may encourage providers to improve prevention and health promotion efforts and to more closely examine their utilization of services in treating diabetes.

The OIG is looking carefully at some proposed gainsharing arrangements to ensure that they are not a mask for either purchasing referrals or reducing the provision of necessary care.⁵⁷ To best ensure compliance, it is recommended that networks document:

- that the fair market value has been paid to network participants (use of an independent, third party is helpful here);
- that there is a need for gainsharing;
- that the gainsharing has yielded beneficial results with no harmful impact on patients (and terminate if no real outcomes);
- that gainsharing is offered to all relevant participants and not just referral sources;
- that gainsharing is not linked to the value or volume of referrals; and
- that there are caps on gainsharing amounts to minimize abuse of the financial incentives.

Rural networks should be aware that the OIG issues safe harbor regulations and fraud alerts, which provide guidance and can help networks to

avoid investigations or challenges. Some of these safe harbors cover the areas of investment interests, personal services, and management contracts and referral services. In addition, the Health Care Financing Administration (HCFA), through the OIG, also issues advisory opinions.⁵⁸ Rural networks should consider the advantages and disadvantages of seeking such an opinion.

Of particular note is the safe harbor applicable to investment interests. For rural networks, particularly for-profits that create a return on a provider's investment in the network, the investment safe harbor creates strict requirements that the network must follow to fall within the range of "permissible conduct."⁵⁹ These requirements should be reviewed with counsel to best ensure protection from potential fraud and abuse liability.

SELF-REFERRAL ISSUES

Even if an investment safe harbor is applicable, networks and participating physicians need to adhere to self-referral prohibitions. The anti-self-referral laws prohibit physicians from referring patients to certain entities in which the physicians have a financial interest, unless specific exceptions apply.

The federal physician self-referral prohibition is commonly known as the "Stark Amendment," named after its sponsor, Congressman Fortney "Pete" Stark (D-Calif.). In general, the Stark Amendment prohibits physicians from making Medicare or Medicaid referrals to entities providing clinical laboratory services and other designated health services with which the physician (or immediate family member) has a financial relationship. A prohibited financial relationship can include ownership and investment interests, as well as compensation interests. In January 1998, HCFA published proposed regulations, which expanded the Stark law by covering additional ancillary services.

Integrated networks that have physician participants should be sensitive to outside financial relationships of their physicians in order to minimize any network liability exposure. Physician partici-

pants should be required to disclose any ownership, investment or compensation arrangements with health care entities. In situations where the rural network is contracting with a group of physicians or IPA, the rural network should receive a representation from the group or IPA concerning the ownership, investment, or compensation arrangements between its member physicians and health care entities.

As with the fraud and abuse laws, certain exceptions apply to the self-referral prohibitions. A rural provider exception is applicable solely to the ownership and investment prohibitions. This exception permits referrals to an entity in which the physician has an ownership or investment interest if, in the case of designated health services furnished in a rural area, substantially all (at least 75 percent) of the designated health services are furnished to individuals residing in such rural area.⁶⁰ For instance, Doctor A from Oklahoma City could not open a “shell” facility in a rural area (outside of the Metropolitan Statistical Area) to treat her urban patients. The specific facts of each case will dictate whether it meets the exceptions to self-referral prohibitions.

INSURANCE AND HEALTH PLAN REGULATION ISSUES

Some rural networks come together to deal or to be prepared to deal with new financial risk-sharing requirements such as capitation, risk withholds, percent of premiums, etc. As these networks mature and are able to operate efficiently, some may want to control as much of the premium dollar as possible. Directly contracting with self-funded employers is one means to that end. By directly contracting with employers, networks can contract for the whole premium dollar and eliminate the percentage typically taken by a health plan to cover its administrative and overhead costs. While this

increased acceptance of financial or business risk raises important questions as to whether the network is able to operate efficiently and effectively with increased responsibilities, this section deals with accepting a different kind of risk, known as “insurance risk,” and financial risk as a health care service plan or HMO (“health plan risk”).

How insurance risk or health plan risk are defined will depend upon particular state statutes. Insurance can generally be defined as an agreement whereby an insurer for consideration promises to pay another party money or its equivalent or to perform acts of value on the destruction, death, loss of, or injury to someone or something by specified

perils. Essential to insurance is the element of shifting the risk of loss, subject to contingent or future events, by a legally binding agreement. In some states, this transfer of risk needs to be a major element of a transaction to fall under a state regulatory scheme.

On the other hand, health plan risk can generally be defined as when a person or entity undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for such services, in return for a prepaid or periodic charge paid by or on behalf of such subscribers or enrollees. In

essence, a health plan can generally be distinguished from an insurance plan in that the latter features indemnity paid to an insured. The insurance plan reimburses the insured for all or part of an obligation that he or she has incurred. The principal feature of a health plan, however, is that as far as the benefits it provides are concerned, a physician has agreed to look exclusively to the health plan for payment; the member owes nothing.

Thus, the process of a rural network directly assuming greater insurance or health plan risk - without contracting with a licensed insurance

The Stark Amendment prohibits physicians from making Medicare or Medicaid referrals to entities providing clinical laboratory services and other designated health services with which the physician (or immediate family member) has a financial relationship.

company or health plan or being licensed as an insurance company or health plan - raises complex state licensing and regulation issues as well as federal preemption issues (to the extent that federal laws that may permit direct contracting by self-funded programs with unlicensed networks may supersede state laws prohibiting such contracting). States have enacted extensive statutory and regulatory schemes that govern who can assume these types of risk and what steps are required to obtain state licensure if such risk is assumed. State regulatory agencies are generally more tolerant of arrangements in which an insurance company, HMO, or other appropriately licensed entity is involved since such entities (which are required to maintain reserves and comply with government restrictions) can be held responsible if a network is unable to provide care for which it has been paid.

Whether rural networks are subject to these laws depends largely upon the substance of the contractual arrangements. Certain networks have been able to negotiate discounted rates, absent accepting capitation, to avoid state risk regulations. Moreover, in Illinois, the state Department of Insurance announced that it would not regulate provider networks that engage in direct contracting and full risk assumption with self-insured employers. Because of the differences among the states, each factual issue needs to be compared to the scope of the applicable state laws.

With the advent of provider networks, state insurance commissioners and trade associations representing insurers and health plans are pressing for amendments to state laws to cover the activities of these networks. Some states, therefore, will have specific laws covering the activities of networks. These laws should be reviewed to understand whether state licensure or filings are necessary.

In addition, in some instances where a network may be covered by a state law, these laws may be preempted by federal law. The Employee Retirement Income Security Act (ERISA), which seeks to provide predictability of regulation for employers (particularly those with multi-state operations) and to preserve ERISA plan discretion, preempts certain state laws and regulations that relate to self-funded employee benefit plans. Courts have often rejected state efforts to regulate self-funded plans.⁶¹ Thus, networks should consider whether ERISA preempts state laws possibly applicable to their activities with self-funded employers.

Networks can also consider the possibility of contracting directly with the federal government to manage the care of Medicare beneficiaries. Beyond the cost and reimbursement issues that networks need to address, HCFA has sought to minimize the legal obstacles for networks. The Balanced Budget Act of 1997 (BBA) allows provider-sponsored organizations (PSOs) to participate in the Medicare+Choice program.⁶² The BBA also preempts certain state licensing and reserve requirements that have traditionally prevented provider networks from assuming risk in this area. Most networks have been reluctant to pursue this option for many reasons, including the cost and complex program

requirements necessary to become a PSO.

Ultimately, many rural networks realize that they will be required first to seek licensure under the applicable state laws and, assuming they are able to get a PSO waiver from state requirements, to be licensed by the state approximately three years after becoming a PSO.

To date, few networks have opted to become recognized as PSOs. The first PSO to be approved by HCFA is the Clear Choice Health Plan. This

Depending upon a network's governance structure — either a corporation, limited liability company, or partnership — network participants need to consider the extent to which they may be held liable for the actions of the network or its individual participants.

PSO is owned by the Central Oregon IPA and seven small hospitals in central Oregon. Clear Choice was founded in 1995 and has 21,000 members in its Medicaid managed care program. Clear Choice will offer services to Medicare beneficiaries in rural central Oregon.⁶³

Many reasons have deterred some networks from opting to pursue the PSO option, including low reimbursement for Medicare managed care contractors, which have been historically low for rural areas even in light of recent legislative increases; the complex and burdensome licensure application process; the high reserve requirements; and the limited time period for PSO eligibility. It may be preferable for rural networks to apply for a state HMO or insurance license, and, in the event that state licensure is not possible, to consider the risks in seeking approval as a PSO. In approximately three years, HCFA will require licensure under the state.

TORT LIABILITY ISSUES

Network participants must also be sensitive to potential liability for malpractice or other tort claims brought by third parties. Tort claims involve private or civil wrongs or injuries, other

than breach of contract, for which the plaintiff seeks a judicial remedy. Depending upon a network's governance structure — either a corporation, limited liability company, or partnership — network participants need to consider the extent to which they may be held liable for the actions of the network or its individual participants.

The number of tort cases alleging breaches of duty by those that make utilization decisions have been on the rise.⁶⁴ Recently, courts have been willing to hold health plans liable for the acts of their panel providers.⁶⁵ One court even held that a health plan could be liable for malpractice as well as more typical breach of contract claims.⁶⁶ To the extent that networks begin to assume the responsibilities traditionally held by health plans, these networks will also be taking on increased risks, both legally and financially.

It is helpful to ensure that individual participants are adequately insured, that liability exposure is limited as much as possible through network agreements, and that reasonable utilization review and peer review processes are in place, if possible. Network participants must always carefully consider the quality of the participants being considered as network members.



Conclusion

The purpose of the Networking for Rural Health initiative is to foster the development of rural health networks as a strategy for strengthening the rural health infrastructure and improving access to quality health care services in rural areas. This goal can be better achieved in the long run by helping rural networks to understand the many legal issues that govern their formations and operations. This paper has sought to take that first step by educating rural networks and their members about four major legal areas that affect rural network formation, and sensitizing rural networks and their members to four additional legal areas. While this paper has sought to

simplify complex issues, it is recommended that networks and network members seek appropriate counsel to address specific factual matters.

The discussion demonstrates the many legal issues facing rural networks. Adequate preparation during the network formation stage will help to ensure legal compliance down the road and save money and time in the long run. Rural health networks should seek to educate their members continually about the various laws governing their actions. This invaluable education will keep members on the direct path to accomplishing the common goals supported by the networks and the Networking for Rural Health initiative.



ENDNOTES

1. Alpha Center, “Networking for Rural Health: An Initiative to Strengthen the Rural Health Care Delivery System By Fostering the Development of Rural Health Networks,” Proposal Submitted to The Robert Wood Johnson Foundation (March 26, 1998) at 1.
2. Internal Revenue Service, Revenue Ruling 98-15 (March 4, 1998).
3. Barbara Yuill, IRS Official Identifies Key Factors in Whole Hospital Joint Venture Ruling, Health Law Reporter, Vol. 7, No. 30 (July 23, 1998) at 1177.
4. Id.
5. See Redlands Surgical Services v. Commissioner of Internal Revenue Service, U.S. Tax Court Dkt. No. 11025-97 (filed Oct. 17, 1997).
6. A Federally Qualified Health Center (FQHC) is a center receiving a grant under the Public Service Act or an entity receiving funds through a grantee of the Act. These include community health centers, migrant health centers and health care for the homeless population. FQHC services are mandated Medicaid services, health education, and mental health services. A Federally Qualified Health Center Look-Alike is a health center that meets the same basic requirements as a FQHC but does not receive Public Health Service grants.
7. Internal Revenue Code Section 4958.
8. See Internal Revenue Service, Revenue Ruling 98-15 (March 23, 1998) (citing Section 1.501(c)(3)-1(d)(2) of the Income Tax Regulations).
9. See BSW Group Inc. v. Commissioner, 70 T.C. 352 (1978); HCSC Laundry v. United States, 450 U.S. 1 (1981).
10. IRS Private Letter Ruling 9822004 (Great Plains Health Alliance) (Tax Ct. Dkt. 9998-98 (May 29, 1998)).
11. Kristen Hallam, IRS Targets Utah HMO, Modern Healthcare (Dec. 21-28, 1998) at 4.
12. See Internal Revenue Service, Department of the Treasury, Internal Revenue Bulletin, No. 1998-1 (Jan. 5, 1998).
13. See Neil P. Motenko, Ira Moscovice, Ph.D. & Anthony Wellever, M.P.A., Rural Health Network Evolution in the New Antitrust Environment (May 1997).
14. William J. Lynk, Nonprofit Hospital Mergers and the Exercise of Market Power, 38 Journal of Law and Economics 437, 444 (Oct. 1995); Health Care Cost Containment Board, Dimensions of Local Competition in Florida: 1984-1990 (Jan. 1992); J. Robinson & H. Luft, The Impact of Hospital Market Structure on Patient Volume, Average Length of Stay, and the Cost of Care, 4 Journal of Health Economics 333-56 (1985).
15. Robert F. Leibenluft, Assistant Director, Health Care, Bureau of Competition, Federal Trade Commission, Remarks at the Meeting of the Network Development Grantees, Sponsored by the Federal Office of Rural Health Policy (Feb. 20, 1998).
16. Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic, 65 F.3d 1406 (7th Cir. 1995).



17. United States Department of Justice and Federal Trade Commission Merger Guidelines, 4 Trade Reg. Rep. (CCH) ¶ 13,104 at 20,569 *et seq.* (1992 and as revised April 8, 1997).
18. National Association of Attorneys General Merger Guidelines, 4 Trade Reg. Rep. (CCH) ¶ 13,406 at 21,193 *et seq.* (1993).
19. United States Department of Justice and Federal Trade Commission, Statements of Antitrust Enforcement Policy in Health Care, 4 Trade Reg. Rep. (CCH) ¶ 13,153 (hereinafter “1996 Policy Statements”).
20. *In re M.D. Physicians of Southwest La., Inc.*, FTC File No. 941-0095 (June 19, 1998).
21. *United States v. Alston*, 974 F.2d 1206 (9th Cir. 1992).
22. 1996 Policy Statements, *supra* note 8, at 20,816.
23. *Id.* at 20,817.
24. *Id.*
25. *Id.* at 20,827.
26. *United States v. Health Choice of Northwest Missouri, Inc.*, 1996-2 Trade Cas. (CCH) ¶ 71,605 (W.D. Mo. 1996); *United States v. Healthcare Partners, Inc.*, 1996-1 Trade Cas. (CCH) ¶ 71,337 (D. Conn. 1996).
27. A consent decree is a stipulated settlement entered into between the government and the defendant whereby the defendant agrees, among other things, to cease activities asserted as illegal by the government and the government agrees not to pursue its action against the defendant.
28. *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d at 589, 598 (1st Cir. 1993).
29. Letter from Joel I. Klein, Assistant Attorney General, Department of Justice, to Christopher H. Casey, 6 Trade Reg. Rep. (CCH) ¶ 44,908 at 43,494 (Sept. 15, 1998).
30. See Elzinga & Hogarty, *The Problem of Geographic Market Delineation in Antitrust Suits*, 18 Antitrust Bull. 45 (1973); Elzinga & Hogarty, *The Problem of Geographic Market Delineation Revisited: The Case of Coal*, 23 Antitrust Bull. 1 (1978).
31. A federal judge remarked on the confusion surrounding market definitions: “One reason is that the concept, even in the pristine formulation of economists, is deliberately an attempt to oversimplify — for working purposes — the very complex economic interactions between a number of differently situated buyers and sellers, each of whom in reality has different costs, needs, and substitutes. [citation omitted]. Further, when lawyers and judges take hold of the concept, they impose on it nuances and formulas that reflect administrative and antitrust policy goals. This adaptation is legitimate (economists have no patent on the concept), but it means that normative and descriptive ideas become intertwined in the process of market definition.” *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d at 589, 598 (1st Cir. 1993) (Judge Boudin).
32. *In the matter of Adventist Health System/West*, FTC Dkt. No. 9234, 1992 FTC LEXIS 297 (Dec. 9, 1992).
33. Bronstein & Morrissey, *Bypassing Rural Hospitals for Obstetrics Care*, Journal of Health Politics, Policy & Law, Vol. 16, No. 1 (Spring 1991) at 87; see generally Smith, “Rural Health Care Often a Matter of Transportation,” *Rocky Mountain News* (Jan. 31, 1993) at 5C.



34. 1996 Policy Statements, supra note 8, at 20,815.
35. Id.
36. Id. at 20,800.
37. Mesa County Physician Independent Practice Association, Inc., FTC Dkt. No. 9284 (Feb. 19, 1998).
38. Letter from Anne K. Bingaman, Assistant Attorney General, to James W. Teevans, (Sierra CommCare, Inc.) 6 CCH Trade Reg Rep. (CCH) ¶ 44,096 at 43,427 (August 15, 1996).
39. United States Department of Justice and Federal Trade Commission Merger Guidelines, 4 Trade Reg. Rep. (CCH) ¶ 13,104 at 20, 573-11 (as revised April 8, 1997).
40. Erwin A. Blackstone and Joseph P. Fuhr, Jr., Rural Hospital Mergers, Antitrust Policy and the Ukiah Case, Journal of Health Politics, Policy and Law, Vol. 23, No. 6 (Dec. 1988).
41. See William J. Lynk, The Creation of Economic Efficiencies in Hospital Mergers, Journal of Health Economics, Vol. 14 (1995) at 507.
42. In the matter of Adventist Health System/West, FTC Dkt. No. 9234, 1992 FTC LEXIS 297 (Dec. 9, 1992).
43. United States v. Baker Hughes, 908 F.2d 981, 986 (D.C. Cir. 1990); FTC v. R.R. Donnelly & Sons Co., 1990-2 Trade Cas. (CCH) ¶ 69,239 at 64,852 (D.C. Cir. 1990); United States v. Syufy Enterprises, Inc., 903 F.2d 659, 669 (9th Cir. 1990).
44. James W. Teevans, State Action Immunity: Immunizing Health Care Cooperative Agreements, (Daniel M. Campion, Alpha Center, contributing editor, Dec. 1995).
45. Letter from James Howell, Secretary of Health, State of Florida, to Robert Bowen, Chairman of the Panhandle Hospital Services Cooperative, Inc. (Oct. 26, 1998).
46. Letter from Joel I. Klein, Acting Assistant Attorney General, to Michael S. Weiden, 6 Trade Reg. Rep. (CCH) ¶ 44,096 at 43,433 (Nov. 12, 1996).
47. Rural network participants can access Department of Justice Business Review Letters and Federal Trade Commission Advisory Opinions at “www.usdoj.gov” and “www.ftc.gov,” respectively.
48. Merck-Medco Managed Care, Inc. v. Rite Aid Corp., No. L-96-499, 1998 WL 514104 (D. Md. Aug. 13, 1998) (court found no group boycott with credible evidence of defendants’ independent bases for electing not to join health plan provider panel).
49. 1996 Policy Statements, supra note 8, at 20,831.
50. Letter from Anne K. Bingaman to Scott Withrow (Southern Health Corporation), 6 Trade Reg. Rep. ¶ 44,096 at 43,402 (March 5, 1996) (approving rural network including high percentages of providers and utilizing the messenger model).
51. “Antitrust Issues in Health Care Workshop,” Remarks by Gail Kursh, Chief, Health Care Task Force, Antitrust Division, Department of Justice, before the Antitrust Section, American Bar Association (Oct. 16, 1998) (citing United States v. Federation of Physicians and Dentists, Inc., No. 98-475 (Aug. 12, 1998), a case pending before the federal district court in Wilmington, Delaware alleging abuse of the third-party messenger model).
52. 1996 Policy Statements, supra note 8, at 20,834-35.



53. 42 U.S.C. § 1320a.
54. 42 U.S.C. § 1320a-7b(b).
55. Ursula Himali, Final Federal Budget Package Includes More Than Money to Crack Down on Fraud, Health Law Reporter, Vol. 7. No. 44 (Nov. 5, 1998) (The Office of the Inspector General has approximately \$119 million to fight health care fraud in 1999 under the federal budget).
56. Office of the Inspector General, United States Department of Health and Human Services, Advisory Opinion No. 98-7 (June 11, 1998) (approving ambulance restocking and continuing education program).
57. Remarks by Kevin G. McAnaney, Branch Chief, Industry Guidance, Office of the Inspector General, before the American Health Lawyers Association (Oct. 23, 1998).
58. Rural network participants can access HCFA advisory opinions at “www.hcfa.gov.”
59. Office of the Inspector General, United States Department of Health and Human Services, Advisory Opinion No. 98-12 (Sept. 16, 1998) (approving physician-owned ambulatory surgical center).
60. See Robert A. Berenson, Director, Center for Health Plans and Providers, Health Care Financing Administration, Advisory Opinion No. HCFA-AO-98-001 (Oct. 29, 1998) (approving physician ownership and referral to an ambulatory surgical treatment center under the rural provider exception). Section 1877(g)(6) of the Social Security Act requires HCFA to issue written advisory opinions.
61. See Larsen v. American Med. Security Inc., No. 97-218, cert. denied, 66 U.S.L.W. 3796 (U.S. Sup. Ct. June 23, 1998) (denying review of a Fourth Circuit Court of Appeals decision holding that ERISA preempts Maryland’s insurance regulation that fixes minimum attachment point for stop-loss insurance policies issued to self-funded employee benefit plans).
62. Balanced Budget Act of 1997, 42 U.S.C.A. §§ 1395 w-21-w-27 (West Supp. 1998).
63. “First PSO Approved, Two in Pipeline as Other Provider-Backed HMOs Pull Out,” News and Strategies for Managed Medicare & Medicaid, Vol. 4, No. 41 (Nov. 16, 1998) at pages 1-2.
64. See, e.g., Plocica v. NYLCare of Texas, Inc., No. 141-175780-98 (Tex. Dist. Ct. filed Oct. 19, 1998).
65. See Lazorko v. Pennsylvania Hosp., No. 96-4858 (E.D. Pa. June 30, 1998).
66. Dunn v. Praiss, No. A-58 (N.J. 1995).



APPENDIX A

Example of Governance Rules for a Rural Health Network with Significant Community Participation

I. *Membership Body*

A. **Classes of Membership**

1. **Class A Voting Members** – Community Representatives (Non-Providers)

Criteria: Each of six (6) defined geographic areas, through their community health committees, will designate two (2) representatives who shall attend Membership meetings.

2. **Class B Voting Members** – Area Employers (Non-providers)

Criteria: Any entity doing business in the defined counties with one or more employees. Each employer would select one representative to attend Membership meetings.

3. **Class C Voting Members** – Area Providers

Criteria: Any licensed provider residing in and providing services in the defined counties. Each licensed provider would select one representative to attend Membership meetings.

B. **Powers** (of the Membership Body)

1. Vote on fundamental corporate changes
2. Amend articles and bylaws
3. Elect directors
4. Consult and advise the board

C. **Voting**

Need majority vote of each class of members for action except election of directors (whereby each membership class elects its own designated board seats).



II. Board of Directors

A. Election Process for the Board of Directors – Seven (7) Directors

1. Three (3) Directors Elected by the Community Health Committee Representatives

Process: The Community Health Committees would provide their two (2) Membership Body representatives with up to three (3) proposed nominations of committee members to serve on the Board.

Each Representative Member from the Community Health Committee would vote for five (5) individuals from the total nominated slate of individuals.

Criteria:

1. Residents of the defined counties
2. Non-providers
3. Business experience or expertise
4. Share in the mission and vision of the corporation as set forth in the Articles of Incorporation and Bylaws

2. Two (2) Directors Elected by the Employers

Process: Employer representatives interested in serving on the Board will need to submit their names by a certain date.

Criteria: One representative elected by employers with 50 or more employees.

One representative elected by employers with less than 50 employees.

If no representative(s) from one group of employers, then empty seat can be filled by the other group of employers.

3. Two (2) Directors Elected by the Providers

Process: Provider representatives interested in serving on the Board will need to submit their names by a certain date for a vote by the defined provider membership.

Criteria: One director elected by institutional providers (hospitals, community clinics, hospices, public health depts., etc.) located in the defined counties.

One director elected by independent practitioners residing and practicing in the defined counties.

B. Powers

1. Manage the business and affairs of the corporation
2. Select officers
3. Report to the Members

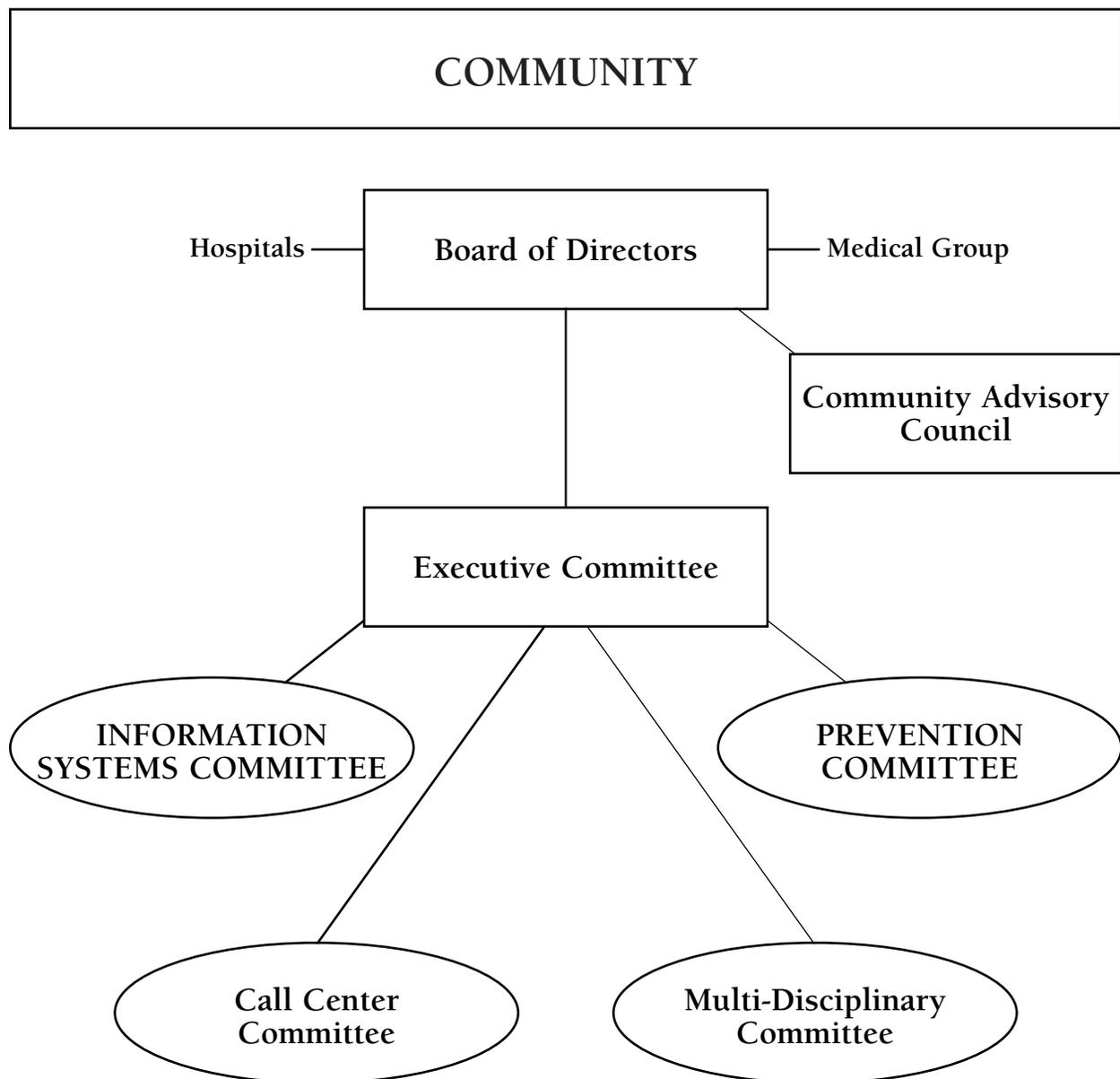
C. Voting

Need five (5) of the seven (7) Directors for quorum and four (4) votes for action.



APPENDIX B-1

Sample Network Organizational Chart





APPENDIX B-2

Example of the Decision-Making Process for a Rural Health Network Board of Directors

The rural health network described in Appendix B-1 (the “Network”) includes more than 65 professionals, agencies and institutions in five counties. Each of these individuals or entities have signed membership agreements with the Network. In November of each year, the Network holds a membership meeting and members elects Directors for the coming year.

The board of directors has 27 individuals. The region’s five (5) hospitals and five (5) public health agencies have board seats and their administrators serve as their representatives on the board. The Network Bylaws require that a majority of the board of directors be physicians. By state law, a consumer and representatives of business and local government must also be part of the board. A pharmacist is also a Director representing allied health providers.

The board of directors meets once a month, often in conjunction with educational programs. The location of meetings is rotated among the five (5) hospitals. All membership applications are voted on by the full board, after approving the applicant’s “indigent care statement.” The board has a written conflict of interest policy and a policy requiring attendance at 50 percent of board meetings. Notices of the Network meetings are published in the local newspaper.

Issues and proposed actions are discussed by a smaller group of board members at Executive Committee meetings twice a month. The Executive Committee includes the four (4) officers plus an additional five (5) Directors elected by the board. Between meetings of the board, the Executive Committee has the authority of the board in management of the business of the corporation. A majority of Executive Committee members can act for the board and may approve expenditures of \$5,000 or less.

There are at least two (2) other standing committees: Prevention and Information Systems. The chairs of all standing and ad hoc committees are board members who also serve on the Executive Committee. This helps to ensure that committees overseeing functional projects are operating with an understanding of the board’s strategic goals.

The Network Board created a Community Health Advisory Council to advise the board on its plans and programs. The Advisory Council Chair serves as a non-voting member of the board, unless the Network consumer representative is that person. Currently, area school board members, representatives of civic clubs, and representatives of advocacy organizations, like Children’s Home Society, also serve. This group has undertaken projects independent of the board of directors.

The Executive Director works under contract to the board of directors. The contract stipulates that the Executive Director serves the interests of the Network as a whole rather than those of any member. The Executive Director is responsible for all Network activities, working under the direction of the Executive Committee and board. The board chair supervises the Executive Director between meetings.