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Changing Definitions of PSOs and PSNs

by John S. Hoff

In my last column I described the new regulatory niche that Medicare reform legislation would create for provider service organizations (PSOs) and provider service networks (PSNs). The legislation has changed since then.

First, an update on the tortured process in Congress. The Medicare reform provisions are part of the legislation designed to balance the federal budget by the year 2002. The conference committee responsible for reconciling the House and Senate versions of the legislation changed the provisions I had previously described. The legislation was then further revised to accommodate the Senate's Byrd Rule, which forbids provisions in budget legislation that do not save money. Congress passed the revised legislation and sent it to the president, who vetoed it on December 6, one volley in his fusillade in the battle of the budget.

At this writing it is impossible to predict what will happen. Will Congress and the president agree on a budget plan or not? Regardless of what finally happens, it is worth considering the provisions that deal with PSOs since they are likely to be included in whatever legislation eventually emerges (although they may be modified depending on the outcome of the 1996 elections).

Although the earlier version had provided that PSOs could avoid regulation by the states, the current form of the legislation would require them to be organized and licensed under state law as risk-bearing entities, just like any other MedicarePlus plan. However, the legislation provides that this requirement could be waived, thus ensuring work for lawyers. A PSO would become subject to federal rather than state regulation if the state had not acted on its license application within ninety days or if the state's regulatory process was discriminatory. This is nothing special for PSOs—there is a similar provision (with slightly different standards) for the other types of MedicarePlus plans as well. This provision, therefore, does not seem to provide any special treatment for PSOs.

The federal government would set the standards, including solvency standards, for PSOs. But it would also do so for all plans, not just PSOs. The solvency standards imposed by the Department of Health and Human Services (HHS) could vary on the basis of the "nature and type" (whatever that means) of the plan, but that test appears to be based on function rather than on the identity of the sponsor. The solvency standards will take into account "the delivery system assets" of a PSO, but presumably only to the extent they would be available to creditors, which would be the case in any formulation of solvency standards.

In a further effort to give PSOs something extra, the legislation also provides that HHS could grant the states permission to apply their own solvency standards to PSOs—but only if they are identical to the solvency standards the state applies to other MedicarePlus plans. This is hardly a special boon to PSOs.

The earlier version of the legislation had included what was said to be antitrust relief for PSOs and for PSNs dealing with PSOs. The per se rules of antitrust law would not apply to them; their conduct would be viewed under the rule of reason to determine whether on balance it promoted or restricted competition. It is unlikely that this provision would have made much of a difference in the real world. But the point is moot, at least for the present. The supposed antitrust relief was eliminated from the bill because it did not save the government money and thus ran afoul of the Byrd rule.

While there is much talk of assisting PSOs to form MedicarePlus plans, it is unclear to what extent the legislation has actually given them an advantage over plans sponsored by HMOs and insurance companies. The legislation is confused, and its effect, assuming it is enacted, will not be known until it has been in operation for some period of time. ■

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