2300.04. STATE REGULATION OF PROVIDER RISK SHARING

A. Analysis of Insurance Issues Generally

If a contractual arrangement for the bearing of risk by physicians and hospitals is construed by a state regulator as constituting a contract of insurance that may be issued only by a state-licensed insurance entity, the state may require separate licensure and subject the providers to a wide array of insurance laws.[1] The implications of insurance licensure for providers are significant because licensure may impose significant financial and administrative burdens that are beyond the capabilities of many provider groups. For example, capital surplus requirements may range from several hundred thousand dollars to several million dollars, depending upon the requirements of each state and whether the state adopted a risk-based capital approach. All contracts and other documents describing the provision of health care services are likely subject to review and approval by state regulatory agencies. In addition, the rates of payment received by providers for such services may be subject to regulatory scrutiny.

Thus, the first level of analysis generally involves an examination of whether or not the proposed compensation mechanism involves insurance risk that might be subject to state HMO or traditional insurance regulation.

A second level of analysis involves an examination of who is sharing risk with whom. While HMOs are generally permitted to share risk with individual providers or groups of providers,[2] other payers (e.g., insurers and self-funded employers) often are more constrained.

In any event, where risk sharing is allowed, it may be subject to very specific state regulatory requirements, as illustrated by the discussion in this chapter.

Comment: At the outset, it should be noted that several of the methods of provider compensation described in this portfolio transfer the financial risk related to a particular episode of care to the provider without creating state regulatory issues because they generally do not involve the providers' assumption of the type of risk that is recognized as insurance risk by state insurance regulators.[3] These compensation systems include per diem and per case arrangements for hospitals and global fee programs for physicians.[4] The bundled pricing of the physician and hospital charges for a case is a further example of noninsurance risk transfer.[5]

Private payer and government pay-for-performance programs also shift financial risk to providers and an additional layer of regulation, not discussed in this portfolio, is developing to address these types of programs.

B. The Debate Over Licensure, Registration, Other Approaches

In most states, health care insurance risk is regulated primarily through two distinct statutes: the state insurance code (for those deemed to be health insurers) and the state HMO or managed care act (for those delivering or arranging for the delivery of health services to enrollees, members, or subscriber, on a prepaid basis). Under each of these types of statutes, any person who engages in the business of insurance risk bearing on an indemnified or prepaid basis must typically secure a certificate of authority from the state department of insurance.[6]

In many states, withhold and capitation systems employed by insurance companies or self-insured employers through direct contracts with individual providers are relatively unconstrained. These arrangements are typically viewed by the state insurance department as nothing more than innovative compensation arrangements with the provider of service. However, the capitation of integrated provider networks in which payers shift risk to organizations providing both facility and physician services may be interpreted in some states as constituting the unlicensed business of insurance. Even certain compensation arrangements placing individual providers at risk might be reserved by state law or by regulatory interpretation to licensed HMOs and not other managed care arrangements.

Comment: Arguably, direct provider capitation plans do not thrust an individual provider into the role of an insurer. Unlike an insurer or provider network, an individual provider—as the direct provider of health care services—has substantial control over the risk. Indeed, the risk could be characterized as the provider's risk of doing business, rather than insurance risk—which in-

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[1] Licensure is generally intended to protect consumers by ensuring the licensed entity is financially sound and has adequate resources (including a network of appropriately credentialed providers) to be able to deliver quality care (including mandated benefits). In some states, as in Pennsylvania, discussed *infra*, § 2300.04.D.12., licensing and oversight responsibility is the joint responsibility of the health and insurance departments. *See also State regulation, supra* § 2300.02.D.1.

[2] Generally, health care providers operating within the scope of their licenses are considered impliedly exempt from insurance licensure requirements. *See* California Department of Managed Health Care Staff, Overview of Risk-Sharing Arrangements, Prepared for the Financial Solvency Standards Board Meeting January 29, 2002, text accompanying n.2.

[3] *See Definition of Insurance, supra* § 2300.02.B.

[4] *See Risk Sharing Through Provider Compensation, supra* § 2300.03.A.

[5] *See Risk Sharing Through Integrated Provider Networks, supra* § 2300.03.B.

[6] *See* Group Health Ass'n of America, PHOs and the Assumption of Insurance Risk: A 50-State Survey of Regulators' Attitudes Toward PHO Licensure (July 10, 1995) [hereinafter GHAA Survey], *reproduced infra* Working Papers, Doc. 6.

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volves one party assuming risk for another. [7] Thus, there is an argument that all payers should be able to participate in risk sharing arrangements directly with individual providers without the providers obtaining insurance-type licensure. Nevertheless, some states have concluded that any form of capitation with providers constitutes the business of insurance for which a license is required.[8]

Some states view capitation arrangements between HMOs and provider networks as acceptable without further licensure on the grounds that HMOs are properly structured to monitor and oversee such arrangements and would ultimately be liable for any losses.[9] This is similar to traditional treatment of HMO contracts with independent practice associations.

Comment: It must be emphasized that the answers to the regulatory questions raised by provider risk sharing arrangements vary from state to state and that state regulatory stances can change rapidly. Prior to implementing risk sharing mechanisms, payers and providers should carefully examine the state's statutes and regulations for specific guidance on possible insurance licensure obligations. In many states, however, an analysis of codified provisions will be insufficient and state regulators must be consulted directly. This point is amply illustrated by the 1995 state survey published by the Group Health Association of America, which examined regulatory requirements for PHOs that contract with HMOs and self-insured employers on a risk and nonrisk basis by interviewing the regulators and was able to provide an informative review of the regulatory attitudes at that time.[10] It is important to keep in mind that the codified provisions may not keep pace with evolving risk sharing mechanisms and that in states that grant oversight responsibility to both the health and insurance departments, the interpretations of the two agencies may not be in harmony.[11]

C. Position of the National Association of Insurance Commissioners

In the mid-1990s, the National Association of Insurance Commissioners began a project to address the growing diversity in risk sharing arrangements. It charged a working group with the goal of increasing the use of common definitions and common regulations of similar functional and risk-sharing/risk-transferring entities. The working group[12] initially considered the development of a single-model health care licensing act for all HMOs, PPOs, point-of-service plans, fee-for-service plans, Blue Cross/Blue Shield plans, commercial plans, and all other entities that finance and deliver health care services on a risk sharing basis. It developed a draft of the Consolidated Licensure of Entities Accepting Risk Model Act, popularly known as "CLEAR," that was premised on the principle that entities which accept risk on a prepaid basis (e.g., capitation, etc.) are engaged in the business of insurance.

In 1995, the working group issued a suggested bulletin to state insurance commissioners addressing state regulation of provider-sponsored risk-bearing organizations, which in pertinent part, stated:

> If a health care provider enters into an arrangement with an individual, employer or other group that results in the provider assuming all or part of the risk for health care expenses or service delivery, the provider is engaged in the business of insurance. Providers wishing to engage in the business of insurance must obtain the appropriate license . . . (e.g., health insurer or HMO, etc.) from the Department of Insurance . . . .
>
> For example, if a group of doctors or a hospital enters into an arrangement with an employer to provide future health care services to its employees for a fixed prepayment (i.e., full or partial capitation) the doctors or hospital are engaged in the business of insurance. Examples of other arrangements that may be the business of insurance include risk corridors, withhold or pooling arrangements. The only arrangement where a provider need not obtain a license from the Department of Insurance is when the provider agrees to assume all or part of the risk for health care expenses or service delivery under a contract with a duly licensed health insurer, for the insurer's policyholders, certificate holders or enrollees. An example of

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[7] See *Definition of Insurance*, *supra* § 2300.02.B.

[8] *See, e.g.*, Va. Bureau of Ins. Admin. Ltr. 95-10 (Sept. 11, 1995) (all capitation arrangements between self-insured employers and providers deemed to be the business of insurance for which a license is required); Mo. Dept. of Ins. Bull. 96-03 (Jan. 12, 1996), *reproduced infra* Working Papers, Doc. 4 (a health care provider entering an arrangement with an individual, employer, or other group that results in the provider assuming all or part of the risk for health care expenses or service delivery is engaged in the business of an HMO for which a license is required; a license is not required if the provider agrees to assume all or part of the risk under a contract with a duly licensed health insurer or HMO, for that insurer's policyholders, certificate holders, or enrollees).

[9] See the positions summarized in the GHAA Survey *infra* Doc. 6. The NAIC also included this option in its Model HMO Act, as revised in 2003, as discussed below.

[10] *Id.*

[11] *See* 31 Pa. Bull. 3043 (June 9, 2001) (explaining how the Department of Health found it necessary to modify its policy statement about MCOs and IDSs because of apparent conflicts with insurance department regulations).

[12] Nat'l Ass'n of Ins. Comm'rs, Health Plan Accountability Working Group of the Regulatory Framework Task Force. The Regulatory Framework Task Force is a standing task force under the NAIC's Health Insurance and Managed Care Committee whose mission is to develop NAIC model laws and regulations for state health care initiatives and consider policy issues affecting state health insurance regulation. According to the NAIC Web site, "The Task Force performs a vital role in protecting the interests of insurance consumers in the ever-changing health care insurance market through the development of model laws and regulations and other activities." Its working groups and subgroups have correspondingly changed over time.

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this is when a group of doctors or a hospital enters into an arrangement with an HMO to provide services to the HMO's enrollees in exchange for a fixed prepayment.[13]

Thus, the working group's recommendations to state insurance commissioners allowed provider-sponsored networks to accept risk from licensed insurance entities. The acceptance of risk directly from employers or individuals, however, under the recommendations, required the provider network to obtain some form of insurance license. A number of states were influenced by the working group's recommendations and adopted the bulletin or something essentially similar.[14]

The NAIC Regulatory Framework Task Force, however, ultimately decided against recommending a new model law and instead pursued the issues raised by health entities assuming risk in the context of existing model laws.[15] With a goal of providing consumers of all types of health plans the solvency and consumer protections afforded by the insurance laws, the task force delineated the following issues: (1) standards that should apply to provider organizations assuming limited risk (e.g., mental health or primary care only); (2) standards that should apply to indemnity plans with managed care elements; (3) standards that should apply when preferred provider organization, point-of-service, and health maintenance organization options are being offered together; and (4) downstream risk.

In 1998, the NAIC developed suggested capital requirements for all health care entities that undertake risk, including HMOs, limited health service organizations, dental or vision plans, hospitals, medical and dental indemnity or service corporation or other MCOs (but not organizations licensed as either life and health insurers or property and casualty insurers).[16] A drafting note to the model RBC act states that the formula was designed for use with PSOs and other similar risk-bearing entities and encourages states to license these entities wherever possible under existing HMO laws or other laws specifically enacted to govern managed care plans to apply consistent regulatory treatment for similar organizations.

The RBC formula under the model act establishes a minimum amount of capital that a health organization must maintain to support its operations, with the level of required reserves calculated based on multiple risk factors. The model act requires health insurers to submit annual RBC reports to the appropriate state regulator. If a report indicates a weak or deteriorating financial condition, regulatory action is authorized to avoid or minimize the impact of insolvency.

Under the model act, regulators consider an insurer's risk profile through four principal risk elements:

1. Asset risk: the risk that the value of existing assets will decline and decrease an organization's surplus.
2. Pricing and obligation risks (actuarial risk): the risk of mispricing in the setting of premium rates or deviations between assumptions and experience in the payment of claims liabilities. This is the predominant risk for health carriers.
3. Interest rate risk: the risk of loss due to unforeseen changes in interest rate levels.
4. General business risk: a catch-all category for the wide range of risks faced by businesses, such as the risk of assessments, administrative expense overruns, and environmental changes.

A number of states have adopted the NAIC model act in part or in whole.[17]

In 2003, the NAIC specifically addressed the issue of downstream risk by amending the Health Maintenance Organization Model Act, which was originally adopted in the 1980s.[18] The model act imposes a registration requirement that places the responsibility for monitoring the continuing financial health of the risk-bearing entity on the HMO.[19] The model act includes requirements for the exchange of information among the HMO, the risk-bearing entity, and the regulator and sets out contracting, auditing, and reporting requirements. Thus, the risk-bearing entity is regulated indirectly through requirements imposed on the HMO to include certain provisions in their contracts with the risk-bearing entities and meet certain standards in the performance of those contracts. It vests the HMO with oversight responsibility, and, ultimately, full responsibility for its "non-transferable obligation to provide health care

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[13] Nat'l Ass'n of Ins. Comm'rs, Health Plan Accountability Working Group, Suggested Bulletin Regarding Certain Types of Compensation and Reimbursement Arrangements Between Health Care Providers and Individuals, Employers and Other Groups (Aug. 10, 1995), *reproduced infra* Working Papers, Doc. 1.

[14] *See* Colo. Div. of Ins, Bull. 8-95 (Nov. 13, 1995); Ga. Dep't of Ins., Life & Health Dir. 95-L&H-1 (Sept. 8, 1995); Kan. Dep't of Ins. Bull. 1995-21 (Nov. 21, 1995); La. Dep't of Ins. Dir. 133 (Sept. 22, 1995); Mo. Dep't of Ins. Bull. 96-03 (Jan. 12, 1996), *reproduced infra* Working Papers, Doc. 4; Nev. Div. of Ins., Bull. 95-002 (Oct. 30, 1995); Utah Dep't of Ins., Bull. 95-4 (Nov. 3, 1995). *Cf.* Ore. Ins. Div. Bull. 96-2 (Apr. 1996).

[15] Proceedings of the Nat'l Ass'n of Ins. Comm'rs (1st Quarter 1999).

[16] Nat'l Ass'n of Ins. Comm'rs, Health Organizations Risk-Based Capital Model Act, Model Act 315-1 (adopted 1998, amended 1999). The model act borrows language from NAIC's Risk-Based Capital for Insurers Model Act, 312-1, originally adopted in 1993, which covers property and casualty insurers as well as life and health insurers. *See Risk-Based Capital Formula Approved; Panel Agrees to Revise CLEAR Draft Law*, 7 BNA's Health L. Rep. 509 (Mar. 26, 1998).

[17] *See infra* Working Papers, Doc. 15 for a survey of state laws adopting elements of an NAIC RBC model act.

[18] Nat'l Ass'n of Ins. Comm'rs, Health Maintenance Organization Model Act, Model Act 430 (adopted Summer 2003).

[19] A committee charged with evaluating the adequacy of current solvency and consumer protection measures for MCOs in light of changes in the marketplace, considered, but decided not to recommend, licensing risk-bearing entities.

services to covered persons in any event, including the failure, for any reason, of a risk bearing entity."[20]

A drafting note in the model act suggests that states may wish to exempt a risk-bearing entity from the registration requirements or otherwise modify the requirements for a risk-bearing entity that accepts risk exclusively from a single HMO, provides direct care to covered persons of that HMO, and where detail of claims payments is available for examination from the health maintenance organization. The HMO may be able to demonstrate to the insurance regulators that the contractual arrangement with the risk-bearing entity will allow it to fulfill the provisions of its contract for the contract year.

The commentary explains that the model act is designed to operate in conjunction with other NAIC state model laws regulating HMOs.[21] The NAIC also adopted a model law regulating the prepaid limited health service organizations.[22]

D. A Sampling of State Approaches

The landscape of state regulation of provider-sponsored risk-bearing organizations is varied and ever-changing. Health care lawyers representing provider organizations that enter into risk contracts with payers must be vigilant in monitoring the activities of the relevant state agencies.

The state regulatory schemes discussed below provide representative examples of the different ways in which state insurance regulators attempt to govern the practice of provider risk sharing.

1. California

In California, HMOs are referred to as health care service plans and are regulated under the Knox-Keene Health Care Service Plan Act.[23]

The Knox-Keene Act covers as a "health care service plan" any person "who 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."[24] It is unlawful to engage in business as a plan without obtaining a license.[25]

The Department of Managed Health Care is devoted exclusively to the licensing and regulation of HMOs and other specialized health care service plans. The Department of Insurance has regulatory authority over indemnity insurance companies, preferred provider organizations, exclusive provider organizations, and third-party administrators, its Department of Corporations has been more active in regulating provider risk sharing. Before comprehensive reform legislation created DMHC in 1999—and, as discussed below, enacted new requirements for "risk-bearing" organizations—the Department of Corporations was active in regulating provider risk sharing.

Although the DOC broadly interpreted the Knox-Keene Act "to arrange for" language to encompass virtually all managed care arrangements, it declined to exercise jurisdiction over PPOs so long as the following principal conditions were met: (1) a direct contractual relationship was established between the payer and the provider that "superseded" any existing contractual relationship between the provider and the PPO entity; and (2) the financial risk for health care services remained with the payer and was not transferred to the provider. This second factor had eroded slightly, though, and the department permitted a PPO to operate using a 20 percent risk withhold in a discounted fee-for-service arrangement with the PPO's providers without requiring the PPO entity to obtain a Knox-Keene license. The general rule remained, however, that without a Knox-Keene license, a payer or PPO arrangement could not capitate providers or otherwise transfer a substantial portion of the financial risk. The PPO could only seek out providers on financial terms that were predominantly fee for service. The DOC regulators took the position that a Knox-Keene plan was permitted to contract on a capitated basis only with licensed providers. A general business corporation, which is the corporate structure for many provider network organizations, could not be capitated because it is not considered to be a licensed provider.

In the wake of several well-publicized failures of large IPAs, the Financial Solvency Standards Board was established within DMHC to set solvency requirements for medical groups that enter into risk-bearing contracts with health plans.[26] California regulates "risk arrangements," which is defined to include both "risk-sharing" and "risk-shifting" arrangements.[27] A "risk-sharing arrangement" is defined as any compensation arrangement between an organization and a plan under which both share a risk of the potential for

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[20] NAIC Model HMO Act § 9.D., Risk Bearing Entity Registration and Contracting Requirements, Continuity of Care.

[21] The model acts cited include the Managed Care Plan Network Adequacy Model Act, the Quality Assessment and Improvement Model Act, the Health Care Professional Credentialing Verification Model Act, the Utilization Review Model Act, the Health Carrier Grievance Procedure Model Act, the Health Carrier External Review Model Act, the Health Information Privacy Model Act, the Unfair Trade Practices Model Act, the Unfair Claims Settlement Practices Model Act, the Insurance Holding Company System Regulatory Act and the Risk-Based Capital (RBC) for Health Organizations Model Act.

[22] Nat'l Ass'n of Ins. Comm'rs, Prepaid Limited Health Service Organization Model Act, Model Act 68-1 (adopted 1989, guideline amendments adopted 2007). It is intended to provide a means to regulate plans that provide, for example, dental care services, vision care services, mental health services, substance abuse services, pharmaceutical services (including Medicare Prescription Drug Plans), or podiatric care services.

[23] Cal. Health & Safety Code §§ 1340-1399.64.

[24] Cal. Health & Safety Code § 1345(f).

[25] Cal. Health & Safety Code § 1349.

[26] Cal. Health & Safety Code § 1347.15.

[27] Cal. Code Regs. tit. 28, § 1300.75.4. The requirements apply to a "risk-bearing organization," which is defined as a professional medical corporation, other form of corporation controlled by physicians and surgeons, a medical partnership, certain medical foundations exempt from licensure, or other lawfully organized group of physicians that "delivers, furnishes, or otherwise arranges for or provides health care services" and: (1) contracts directly with a health care service plan or

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financial loss or gain. A "risk shifting arrangement" is defined as a contractual arrangement between an organization and a plan under which the plan pays the organization on a fixed, periodic or capitated basis, and the financial risk for the cost of services provided pursuant to the contractual arrangement is assumed by the organization.

Since January 2000, licensed health care service plans have been prohibited from contracting with any person for the assumption of financial risk with respect to certain health care services and any other form of global capitation, with certain exceptions, and until January 2002, a license with waivers or limited license has been prohibited from being issued on or to any person for the provision of—or the arranging, payment, or reimbursement for the provision of—health care services to enrollees of another plan under certain risk-assuming contracts.[28]

Every contract between a health care service plan and a risk-bearing organization issued, amended, renewed, or delivered in California on or after July 1, 2000 has had to include certain provisions concerning the risk-bearing organization's administrative and financial capacity.[29] For example, contracts must require that the risk-bearing organization furnish financial information to the plan and meet any other financial requirements that assist the plan in maintaining the financial viability of its arrangements for providing health services in a manner that does not adversely affect the integrity of the contract negotiation process and that the plan disclose information to the risk-bearing organization that enables the risk-bearing organization to be informed regarding the financial risk assumed under the contract (including information about enrollees, incentive payments, and income and expenses assigned to the risk-bearing organization).

In addition, every contract between a risk-bearing organization and a health care service plan has been prohibited from including any provision that requires:

- the risk-bearing organization to be at financial risk for the provision of health care services, unless the provision was first negotiated and agreed to between the health care service plan and the risk-bearing organization, with certain exceptions (however, a risk-bearing organization could accept the financial risk pursuant to a contract that meets the requirements of Cal. Health & Safety Code § 1375.4);[30] or
- a provider to accept rates or methods of payment specified in contracts with health care service plan affiliates or nonaffiliates unless the provision has been first negotiated and agreed to between the health care service plan and the risk-bearing organization.[31]

Since July 2003, special requirements have been in effect with respect to contracting for the assumption of financial risk for certain physician- or self-administered medications determined by the legislature to be better retained by the plan because of their nature and cost.[32]

Senate Bill 260, one component of the 1999 comprehensive statutory reform, required DMHC to develop a process for reviewing or grading risk-bearing organizations according to statutory criteria to provide an early warning signal about risk-bearing organization financial issues. DMHC adopted regulations for grading/reviewing, as well as data collection, disclosure language, and corrective action plans (CAPs) that became effective on September 9, 2005.[33] The regulations, often referred to as the SB 260 regulations, impose the requirements by regulating contracts involving risk arrangements between plans and organizations, imposing requirements on both the organization and the plan.

Grading of financial solvency is based on:

- the percentage of completed claims the organization timely reimbursed, contested, or denied;
- whether the organization has estimated and documented its liability for incurred but not reported (IBNR) claims;
- whether the organization has at all times maintained positive tangible net equity (TNE) and positive working capital; and
- in a requirement added by the regulations, whether the organization has maintained the required cash-to-claims ratio.[34]

More frequent reporting and review is required for organizations serving at least 10,000 covered lives.

2. *Colorado*

By statute, Colorado permits providers to conduct business collaboratively as a provider network, i.e., a group of

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arranges for health care services for the plan's enrollees; (2) is compensated for those services on any capitated or fixed periodic payment basis; (3) is responsible for processing and payment of claims made by providers for services they rendered on behalf of a health care service plan that are covered under the capitation or fixed periodic payment made by the plan to the risk-bearing organization. Cal. Health & Safety Code § 1375.4(g). It does not include: (1) an individual or a health care service plan; (2) a provider organization that is included in the plan's consolidated financial statements filed with DMHC; or (3) a provider organization that contracts only with one plan and whose maximum potential expenses for providing care did not exceed 115 percent of its maximum potential revenue for providing or arranging for those services.

[28] Cal. Health & Safety Code § 1349.3 (since repealed).

[29] Cal. Health & Safety Code § 1375.4 (listing administrative and financial capacity provisions that must be included in every contract between a health care service plan and a risk-bearing organization).

[30] Cal. Health & Safety Code § 1375.5. *See also* Cal. Health & Safety Code § 1375.7, captioned the Health Care Providers' Bill of Rights.

[31] Cal. Health & Safety Code § 1375.6.

[32] Cal. Health & Safety Code § 1375.8.

[33] Cal. Code Regs. tit. 28, §§ 1300.75.4-1300.75.4.5.8.

[34] Cal. Code Regs. tit. 28, § 1300.75.4(f) defines "cash-to-claims ratio" as:

> an organization's cash, marketable securities and receivables, excluding all risk pool, risk-sharing, incentive payment program and pay-for-performance receivables, reasonably anticipated to be collected with in 60 days divided by the organization's unpaid claims (claims payable and incurred but not reported [IBNR] claims) liability.

The ratio was set at 0.60 for Jan. 1, 2006 and escalated to 0.75 beginning Jan. 1, 2007.

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providers formed to provide health care services to individuals.[35] Although the statute prohibits unlicensed provider networks from engaging in the business of insurance without obtaining an appropriate license (e.g., as an insurer or HMO) before the start of business, networks may be able to accept downstream risk from various licensed carriers.[36] The statute explicitly states that the fact that a provider network has a capitated contract with a carrier, including an HMO, whereby the network shares some of the risk of providing services to the carrier's subscribers is not, in and of itself, grounds for a determination that the network is engaged in the business of insurance.[37]

The Colorado Division of Insurance considers a provider network to be engaged in the business of insurance when it enters into an arrangement to provide health care services with an employer on a risk basis.[38] Thus, a provider network that enters into an agreement with an employer to provide future health care services to its employees for a fixed prepayment (e.g., full or partial capitation), is engaged in the business of insurance.

Note: From 1996 to 2003, the CDOI had in place a procedure, pursuant to Colo. Rev. Stat. § 6-18-302(1)(b)(II), whereby a provider network that only assumed risk from licensed carriers that retained full legal liability to the covered person for all benefits was not considered to be transacting the business of insurance if it annually certified that it was not engaged in the business of insurance.[39]

Provider networks may apply to the CDOI for a license to transact the business of insurance as: a sickness and accident insurance company; a nonprofit hospital, medical-surgical, and health service corporation; a health maintenance organization; or a limited service licensed provider network.[40] Once licensed, the provider network shall be subject to all the statutory requirements of the Insurance Code under which it was licensed.

The requirements applicable to the special licensure subcategory for LSLPNs are less onerous than those needed to be licensed as a carrier.[41]

An LSLPN must provide only limited services.[42] A provider network that meets the definition of an HMO, or in the CDOI's opinion offers services which do not differ significantly from the basic services offered by an HMO, or

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[35] Colo. Rev. Stat. §§ 6-18-302(1)(a), 6-18-301.5.

For a list of states that expressly regulate provider-sponsored networks, see *infra* Working Papers, Doc. 13.

[36] Colo. Rev. Stat. § 6-18-302(1)(b)(I), (IV).

Section 5(a) of 3 Colo. Code Regs. § 2-1-9, Concerning The Licensure Of Limited Service Licensed Provider Networks, *reproduced infra* Working Papers, Doc. 12, provides:

> A provider network shall not issue any contract of insurance, including risk assumption or risk sharing agreements, nor shall it accept or assume all or part of the risk inherent in a contract issued by another entity, *other than from a licensed carrier or with another entity that contracts with licensed carriers as allowed by this regulation,* without first receiving a license from the commissioner.

(emphasis added).

Colo. Rev. Stat. § 10-16-102(8) defines "carrier" as:

> any entity that provides health coverage in this state including a franchise insurance plan, a fraternal benefit society, a health maintenance organization, a nonprofit hospital and health service corporation, a sickness and accident insurance company, and any other entity providing a plan of health insurance or health benefits subject to the insurance laws and regulations of Colorado.

[37] Colo. Rev. Stat. § 6-18-302(1)(b)(II).

[38] 3 Colo. Code Regs. § 2-1-9(3)(M) states:

> "Risk assumption" or "risk sharing" means a transaction whereby the chance of loss, including the expenses for the delivery of service, with respect to the health care of a person is transferred to or shared with another entity (e.g., Carrier, including an [limited service licensed provider network] LSLPN), in return for a consideration. Examples include, but are not limited to, full or partial capitation agreements, withholds, risk corridors, and indemnity agreements. For the purposes of this regulation, fee-for-service, per diem payments, diagnostic-related group payment agreements, and employee assistance programs (EAPS) are not considered to be risk assumption or risk sharing arrangements.

See also Colo. Ins. Bull. No. 8-95 (Nov. 13, 1995).

[39] 3 Colo. Code Regs. § 702-2(XVII)(A), stated that:

> [a] provider network whose only risk assumption or risk sharing arrangements for the delivery of health care services are with licensed carriers who retain full legal liability to the covered person for all benefits shall not be considered to be transacting the business of insurance if the provider network certifies to the Commissioner that it is not engaged in the business of insurance. The provider network may be paid on a capitated basis and such capitated arrangement between licensed carrier(s) and provider network(s) may include a provision that limits the services to be provided.

If a provider network was unable to certify to the statements contained in the certification form provided by the regulation, it could file a detailed description and explanation of its operations to the CDOI for review to determine if it was engaged in the unauthorized business of insurance.

The certification provision was effective Nov. 1, 1996. Effective Nov. 1, 2003, the provisions addressing a provider network that only assumes risk from licensed carriers were deleted from the regulations.

[40] 3 Colo. Code Regs. § 2-1-9(5)(B).

The regulations define "limited services licensed provider network" as:

> a provider network that offers to contract directly with a consumer(s) (e.g., individual, group, employer, etc.) or their representative(s) to provide health care services restricted to: (i) a narrowly defined health specialty (e.g., substance abuse, radiology, mental health, pediatrics, pharmacology, etc.) or (ii) services narrowly limited to a single type of licensed facility (e.g., inpatient hospital, birth center, long term facility, hospice, etc.) or (iii) home health care services delivered in the covered person's residence only.

3 Colo. Code Regs. § 2-1-9(2)(I).

[41] *See*, in particular, 3 Colo. Code Regs. § 2-1-9(8)-(10) (statutory deposit, bond, annual reporting requirements); appendix (guidelines for annual audited financial reports).

[42] The LSLPN may enter into contractual arrangements for services that are incidental but necessary to the performance of the health coverage plans it offers, but payment for these incidental services may not exceed 10 percent of total capitation fees/premiums the LSLPN received annually by the LSLPN and the contracts must have a hold harmless provision. 3 Colo. Code Regs. § 2-1-9(5)(B)(2)(c).

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that provides, either directly or through contractual or other arrangements with other hospitals and/or physicians, comprehensive or major medical services to enrollees, is not be eligible for licensure as an LSLPN.

Once licensed, an LSLPN is able to contract directly with an employer.

3. *Connecticut*

A preferred provider network may not conduct business in Connecticut unless licensed by the Insurance Commissioner and no managed care organization may maintain a contractual relationship with a PPN that is not licensed.[43] Both the PPN and MCO are subject to detailed financial responsibility, disclosure, and reporting requirements to ensure the PPN maintains financial health and an ability to provide the contracted services to enrollees, and, ultimately, that the MCO can demonstrate to the commissioner that it "can fulfill its nontransferable obligations to provide coverage for the provision of health care services to enrollees in the event of the [PPN's] failure for any reason."[44]

The legislation imposing the licensing requirement also modified the definition of a preferred provider network to mean:

> a person, which is not a managed care organization, but which pays claims for the delivery of health care services, accepts financial risk for the delivery of health care services and establishes, operates or maintains an arrangement or contract with providers relating to (A) the health care services rendered by the providers, and (B) the amounts to be paid to the providers for such services. *"Preferred provider network" does not include . . . (ii) an independent practice association or physician hospital organization whose primary function is to contract with insurers and provide services to providers . . .*[45]

A PPN that provides services pursuant to a contract with an MCO must pay for the delivery of health care services and operate and maintain arrangements or contracts with providers in a manner consistent with the provisions of law that apply to the MCO's contracts with enrollees and providers.[46] A PPN has no recourse against an enrollee for covered benefits provided and an enrollee is not liable to a participating provider for any sums owed by the PPN or MCO.[47]

In addition, Conn. Gen. Stat. §§ 38a-479aa and 38a-479bb require a PPN to:

- file with the insurance commissioner and make available upon request from a provider the general criteria for its selection or termination of providers;
- permit the commissioner to inspect its books and records and examine, under oath, officers and agents of the PPN and its controlling organization with respect to the use of the PPN funds and compliance with both the statutory requirements for PPNs and the terms and conditions of its contracts to provide health care services;
- maintain a minimum net worth of either (1) the greater of $250,000 or an amount equal to eight percent of its annual expenditures or (2) another amount determined by the commissioner;[48]
- maintain or arrange for a letter of credit, bond, surety, reinsurance, reserve or other financial security for the exclusive use of paying any outstanding amounts owed participating providers in the event of insolvency or nonpayment;
- provide the MCO, annually and upon request, a financial statement and documentation that it has sufficient ability to accept financial risk, appropriate management expertise and infrastructure, an adequate provider network, and the ability to ensure the delivery of health care services as set forth in the contract;
- conduct initial reviews of utilization review determinations in accordance with statutory requirements and refer subsequent appeals to the MCO; and
- have a contingency plan to explain how health care will be provided in case of insolvency.

An MCO that contracts with a PPN also is subject to mandates under Conn. Gen. Stat. § 38a-479bb, including requirements to:

- provide the PPN information on an annual basis to assist it in being informed about any financial risk assumed under the contract, including, e.g., enrollment data, primary care provider to covered person

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[43] Pub. Act No. 03-169, amending Conn. Gen. Stat. § 38a-479aa and enacting the remainder of tit. 38a, ch. 700c, pt. 1b, Health Insurance, Preferred Provider Networks. The prohibition on conducting business was effective May 1, 2005. Before the prohibition went into effect, there was a phase-in period, starting May 1, 2004, during which a PPN was required to obtain a license to enter or renew a contract with an MCO.

Because of the amendment, some entities that previously may not have been required to maintain a utilization review license became subject to the licensure requirement. Conn. Dep't of Ins. Bull. HC-59 (Nov. 25, 2003).

[44] Conn. Gen. Stat. §§ 38a-479aa, 38a-479bb. Because states are increasingly adopting contracting requirements that address similar issues, these provisions *are reproduced infra* Working Papers, Doc. 2.

[45] Conn. Gen. Stat. § 38a-479aa(7) (emphasis added). The definition was later amended in 2006 to exclude from the definition of PPN "a clinical laboratory . . . whose primary payments for any contracted or referred services are made to other licensed clinical laboratories or for associated pathology services" and again in 2007 to exclude "a pharmacy benefits manager responsible for administering pharmacy claims whose primary function is to administer the pharmacy benefit on behalf of a health benefit plan."

[46] Conn. Gen. Stat. § 38a-479cc.

[47] Conn. Gen. Stat. § 38a-479aa(k), (l).

[48] Amendments in 2008 provided that minimum net worth and financial security requirements do not apply to a consortium of federally qualified health centers funded by the state, providing services only to recipients of programs administered by the Department of Social Service.

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ratios, provider to covered person ratios by specialty, a table of the services that the preferred provider network is responsible for, expected or projected utilization rates, and all factors used to adjust payments or risk-sharing targets, and information about the amount and method of remuneration it is to be paid;

- post and maintain a bond, letter of credit, etc. to satisfy the risk accepted by the PPN (or require such of the PPN); and
- monitor the PPN's financial condition and ability to deliver services and report to the commissioner if the PPN is not adequate.

4. *Florida*

The Florida HMO statute defines an HMO as an organization that, among other things, "[p]rovides physicians' services . . . under arrangements with a physician or any group of physicians." [49] Upon the request of the insurance office an HMO must file "financial statements for all contract providers of comprehensive health care services who have assumed, through capitation or other means, more than 10 percent of the health care risks of the health maintenance organization." [50] The Florida statute requires that provider contracts contain a hold-harmless clause.[51]

Upon the request of the insurance office, an HMO must submit any contract with a provider other than an individual physician.[52] The insurance office can cancel the contract if it determines that the contract:

- requires the HMO to pay an unreasonably high fee; or
- is with an "entity" that is not licensed under state statutes, if such license is required, or is not in good standing with the applicable regulatory agency. [53]

The Florida regulations define an IPA-model HMO as a "Health Maintenance Organization health care delivery model in which the HMO contracts with individual physicians, a medical group, or physician organization which in turn may contract with other individual physicians or groups. The IPA physicians may practice in their own office and continue to see their fee-for-service patients." [54]

By statute, an HMO that, through a health care risk contract, transfers to any entity [55] the obligations to pay any provider for any claims arising from services provided to or for the benefit of any of its subscribers, the HMO remains responsible for any violations of the prompt pay and other claim payment laws.

Neither providers or group practices providing services under the scope of the license of the provider or the members of the group practice nor a hospital providing billing, claims, and collection services solely on its own and its physicians' behalf and providing services under the scope of its license are "entities" that would require licensure for purposes of this provision.

Thus, the ability of HMOs to contract with physician organizations is expressly authorized in the HMO regulations and capitation compensation systems used by HMOs in connection with direct contracts with individual physicians are permissible.[56]

5. *Georgia*

In 1996, Georgia promulgated regulations governing the licensure of provider-sponsored health care corporations. A PSHCC is defined in the regulations as a corporation formed pursuant to Ga. Code Ann. § 33-20-5 that "provides medical services to enrollees or subscribers." [57] The regulations' requirements are similar to Georgia's HMO licensure statutes and regulations, except that the financial requirements are less onerous. For example, Georgia's net worth requirement for PSHCCs ($1 million) is one-fourth of that for HMOs.[58] Georgia HMOs must maintain $1.5 million in capital stock or surplus and an additional $1.5 million surplus.[59] However, unlike an HMO, a PSHCC must obtain an aggregate excess reinsurance policy commensurate with its financial strength.[60]

6. *Illinois*

In a bulletin issued in 1996 by the Illinois Department of Insurance, a relaxed position on the subject of provider risk sharing was espoused.[61] The Department of Insurance bulletin described four types of contractual arrangements between provider-sponsored networks and self-insured employers, HMOs, or health insurers:

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[49] Fla. Stat. § 641.19(7)(d). The entity must receive certificates from both the Agency for Health Care Administration, Office of Health and Rehabilitative Services (health care provider certificate) and the Department of Financial Services, Office of Insurance Regulation to operate as an HMO.

[50] Fla. Stat. § 641.2342.

[51] Fla. Stat. § 641.315. The statute states that every contract between an HMO and a provider shall contain a provision "that the subscriber shall not be liable to provider for any services covered by the subscriber's contract with the HMO."

[52] Fla. Stat. § 641.234(1).

[53] Fla. Stat. § 641.234(2). It appears that, except for the exception for individual physicians, HMOs may be limited to entering risk contracts only with entities licensed as administrators. The statute requires the contracts to include a provision stating that the contract is canceled upon issuance of the order, subject to administrative fine.

[54] Fla. Admin. Code Ann. r. 69O-191.024. The regulations also recognize staff-model HMOs that employ and compensate their physicians, as well as combination-model HMOs that employ and contract with physicians.

[55] Fla. Stat. 641.234(4)(b) (enacted 2002) defines "health care risk contract" as a contract under which an entity receives compensation in exchange for providing the HMO with a provider network or other services, which may include administrative services.

[56] The statute also provides for special solvency requirements for provider-sponsored organizations and Medicaid provider service networks. Fla. Stat. § 641.2261.

[57] Ga. Comp. R. & Regs. r.120-2-75-.03(d).

[58] Ga. Comp. R. & Regs. r.120-2-75-.06(1).

[59] Ga. Code Ann. §§ 33-3-6, 33-3-7.

[60] Ga. Comp. R. & Regs. r.120-2-75-.06(2).

[61] David Grant, *Provider based market systems—when to regulate*, Ill. Ins. (Ill. Dep't of Ins. Apr. 1996), *reproduced infra* Working Papers, Doc. 3.

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- A "no risk" arrangement, in which an employer contracts directly with a provider group on a fee-for-service basis;
- A "full risk" arrangement, in which an employer contracts with a provider group on a prepaid capitated basis for all medical services;
- A "partial risk" arrangement between an employer and a provider group, in which a budget is established for medical services, and savings and losses are shared; and
- A "downstream risk" arrangement between an HMO or health insurer and a provider group, through which the provider group is paid on a prepaid capitated basis.

The Department of Insurance has stated that in all of these arrangements, the provider group is not subject to regulation "because there is no direct contractual obligation to the employees covered under the self-insured agreement. The contractual relationship is only between the provider group and the self-funded employer, licensed insurer or HMO, which continues to have full and direct responsibility to the individual. If the provider group fails to perform, the employer, insurer or HMO is still on risk to either provide or pay for health care services."

The department's position appears to be grounded on its perceived lack of jurisdiction when a provider group does not contract directly with individual patients. The bulletin stated, "The Department has regulatory jurisdiction when any health care provider group becomes the ultimate risk bearer and is directly obligated to individuals to provide, or pay for medical services. In these situations, the provider group must be appropriately licensed as an HMO, limited health service organization or insurance company."

7. *Kentucky*

In 1996 Kentucky authorized the creation of provider-sponsored integrated health delivery networks that are owned, governed, and managed by providers, subject to obtaining a certificate of authority.[62]

The requirements for certification as a provider network are similar to those imposed upon HMOs to demonstrate financial solvency, capacity to administer the health plans it is offering, and ability to provide the appropriate level and type of health care services. To obtain certification, a provider network must provide financial information and subscriber forms, a description of its grievance procedures and quality assurance programs, and a list of its management personnel and providers. It must demonstrate that it does not limit the participation of any health care provider in its provider network in another provider network, does not discriminate in enrolling members, uses standardized electronic claims and billing processes and format, participates in coordination of benefits, and discloses to the cooperative reimbursement arrangements with providers.

The provider network must have an initial minimum net worth of $1.5 million prior to certification and must, thereafter, maintain at a minimum a net worth equal to $1 million. The ongoing net worth requirement may increase based upon the financial performance of the provider network.[63]

In 2003, Kentucky established minimum standards for self-insured employer-organized association groups to assure that such groups are providing adequate coverage for health benefit liability risks, including a certificate of filing requirement.[64] The association must submit descriptions of: the health services to be offered; financial risks to be assumed; initial geographic area to be served; pro forma financial projections for the first three years of operation; the persons to be covered; any proposed reinsurance arrangements and management, administrative, or cost-sharing arrangements; and its proposed method of marketing.[65] The self-insured employer-organization association must initially demonstrate, and maintain, capital and surplus of at least $500,000.[66]

8. *Maryland*

Maryland's HMO statute makes express references to an HMO contracting on a capitated basis with a physician provider organization for physician services.[67] The HMO statute defines an HMO in pertinent part as "any person, including a profit or nonprofit corporation organized under the laws of any state or country, that:

> Primarily provides services of physicians:
>
> . . .
>
> (ii) *Under arrangements with one or more groups of physicians, who are organized on a group practice or individual practice basis*, under which *each group*:
>
> 1. *Is compensated for its services primarily on the basis of an aggregate fixed sum or on a per capita basis*; and
>
> 2. Is provided with an effective incentive to avoid unnecessary inpatient use, whether the individual physician members of the group are paid on a fee-for-service or other basis.[68]

The Maryland HMO statute was amended in 1991 to include a section covering "administrative service provider contracts" entered into between HMOs and contracting provider network organizations. The statute encompasses almost all capitation arrangements between HMOs and pro-

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[62] Ky. Rev. Stat. Ann. § 304.17A-300.
[63] Ky. Rev. Stat. Ann. § 304.17A-310.
[64] Ky. Rev. Stat. Ann. §§ 304.17A-800 through 304.17A-844.
[65] Ky. Rev. Stat. Ann. § 304.17A-808.
[66] Ky. Rev. Stat. Ann. § 304.17A-812.
[67] *See also* Md. Op. Att'y Gen. No. 90-30, which was included as an attachment to the NAIC Health Plan Accountability Working Group bulletin and is reproduced with that bulletin *infra* Working Papers, Doc. 1.
[68] Md. Code Ann., Health-Gen. § 19-701(g)(5) (emphasis added).

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vider network organizations.[69] The statute defines an "administrative service provider contract" as:

> . . . a contract or capitation agreement between a health maintenance organization and a contracting provider which includes requirements that:
>
> (i) The contracting provider accept payments from a health maintenance organization for health care services to be provided to members of the health maintenance organization that the contracting provider arranges to be provided by external providers; and
>
> (ii) The contracting provider administer payments pursuant to the contract within the health maintenance organization for the health care services to the external providers.[70]

"Contracting provider" means "a person who enters into an administrative service provider contract with a health maintenance organization." [71] "External provider" is defined as "a health care provider, including a physician or hospital, who is not: (i) A contracting provider; or (ii) An employee, shareholder, or partner of a contracting provider." [72]

An HMO may not enter into an administrative service provider contract unless: (1) The HMO files with the Maryland insurance commissioner a plan that satisfies certain stated requirements; and (2) the insurance commissioner does not disapprove the filing within 30 days after the plan is filed.[73] The plan must require the contracting provider to:

- provide the HMO with quarterly reports that identify payments made or owed to external providers;
- provide the HMO with an annual financial statement of the contracting provider each year;
- maintain a segregated fund (which may include withheld funds, letters of credit, escrow accounts, or similar arrangements), or to make available other resources that would satisfy the contracting provider's obligations to external providers for services rendered to HMO members;
- explain how the segregated fund or other resources, as required above, will create funds sufficient to satisfy the contracting provider's obligations to external providers for services rendered to HMO members; and
- require the HMO, at least quarterly, to audit and inspect the contracting provider's records and operations relevant to the provider's contract for the purpose of determining the contracting provider's compliance with the plan.[74]

The HMO is responsible for monitoring the contracting provider to ensure compliance.[75] If the contracting provider fails to comply with the plan or terminates the administrative service provider contract for any reason, the HMO shall assume the administration of any payments due from the contracting provider to the external providers on behalf of the contracting provider.[76]

9. Missouri

The Missouri Department of Insurance issued a bulletin in 1996, outlining the position of the director of insurance regarding certain types of compensation and reimbursement arrangements between health care providers and individual employers and other groups. The bulletin provides:

> If a health care provider enters into an arrangement with an individual, employer, or other group that results in the provider assuming all or part of the risk for health care expenses or service delivery, the provider is engaged in the business of health maintenance organization (HMO). The only arrangement where a provider need not obtain a license from the Department of Insurance is when the provider agrees to assume all or part of the risk for health care expenses or service delivery under a contract with a duly licensed health insurer or HMO for the insurer's policyholders, certificate holders, or enrollees. An example of this is when a group of doctors or a hospital enters into an arrangement with an HMO to provide services to the HMO's enrollees in exchange for a fixed prepayment.
>
> For example, if a group of doctors or a hospital enters into an arrangement with an employer to provide future healthcare services to the employer's employees for a fixed prepayment (i.e., full or partial capitation) the doctors or hospital are engaged in the business of insurance.[77]

10. North Carolina

North Carolina state agencies have issued conflicting opinions over whether an unlicensed provider network may accept risk from a self-insured employer. The Department of Insurance has taken the position that an unlicensed network or individual provider may not accept any risk from a self-insured employer in the form of capitation payments or through a fee-for-service payment with significant with-

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[69] The exception is a contract between an HMO and contracting provider that is affiliated with the HMO through common ownership within an insurance holding company system, if the HMO files consolidated financial statements with the insurance commissioner that include the contracting provider and records a reserve for the liabilities of the contracting provider. Md. Code Ann., Health-Gen. § 19-713.2(b).

[70] Md. Code Ann., Health-Gen. § 19-713.2(a)(2).

[71] Md. Code Ann., Health-Gen. § 19-713.2(a)(3).

[72] Md. Code Ann., Health-Gen. § 19-713.2(a)(4).

[73] Md. Code Ann., Health-Gen. § 19-713.2(c).

[74] Md. Code Ann., Health-Gen. § 19-713.2(d).

[75] Md. Code Ann., Health-Gen. § 19-713.2(h).

[76] *Id.*

[77] Mo. Dep't of Ins. Bulletin (Jan. 12, 1996), *reproduced infra* Working Papers, Doc. 4.

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holds. Regulators at the NCDOI have stated that if any form of risk is taken by a provider network through a contractual relationship with a self-insured employer, they will no longer recognize the self-insured plan as a plan governed by ERISA and will regulate the provider network as if it were an HMO.[78]

However, the North Carolina attorney general has released an advisory opinion that contradicts the NCDOI's view and expands the ability of self-insured ERISA plans to contract with unlicensed provider networks.[79] In the opinion, the AG generally took the position that ERISA preempts state insurance regulation of self-funded employers. The AG concluded that provider networks that contract with ERISA plans to provide health care services are not subject to regulation as HMOs in North Carolina because the HMO Act is preempted by ERISA. Thus, it appears that the AG would permit unlicensed networks or individual providers to take at least some form of risk from a self-funded ERISA plan.

The AG cited several important factors in allowing an unlicensed provider network to contract with an ERISA plan on a risk basis. First, in the contract reviewed by the AG, the provider was capitated for a limited set of services. The provider network "has no financial risk for the provision of service outside of the provider's scope of practice, due to medical emergencies, out-of-network services or referrals beyond the extent that the provider can manage the care, or tertiary or catastrophic care, unless directly provided within the network." Second, the employer retains the responsibility for health care services to its employees should the provider be unable to provide such care. Lastly, under the contract, the provider network covenants that providing health care services to the employees will not unreasonably overextend the provider network's ability to provide services to the provider network's patients.

A significant part of the AG's analysis was whether the North Carolina HMO Act "regulates insurance" and is thereby saved from preemption under ERISA's savings clause. According to the AG, "if the proposed contractual arrangement for health care services is insurance, regulation thereof through the HMO Act is 'saved' from preemption." The AG stated that the "touchstone of this analysis is whether there is a shift or assumption of an insurance risk." The AG explained that in the situation presented, "the principal purpose of the proposed contract is obtaining health care services, not protecting against financial risk." Therefore, concluded the AG, "there is no insurance contract as defined in N.C.G.S. § 58-1-10, and no regulation of insurance."

It is important to note that the AG did not opine on how this conclusion would apply if the terms of the contract with the provider were not just as described above. However, it appears that, based on the AG's analysis, if the self-insured ERISA employer is the entity ultimately at risk for the covered services provided by a provider network, that provider network would not need to be licensed as an HMO in North Carolina.

The AG also analyzed the HMO Act, and concluded that "the express exception of 'professional associations' from the definitions of 'persons' in the act would appear to permit individual health care practice physician groups to contract directly with an ERISA employer to provide services under the contractual provision described."[80] The AG further explained that "a network of physician groups would reasonably fall within the same exception since all members of the network would be professional associations."[81] Additionally, the AG concluded that North Carolina's HMO Act licensure provisions "relate to" the proposed ERISA plan contract because they apply directly to such plans by determining which entities the plan may and may not contract with for the proposed services." Therefore, the AG determined that these licensure provisions are preempted by ERISA.

Nevertheless, the NCDOI disagrees with the AG's opinion and plans to continue to enforce the HMO laws and regulations in accordance with the NCDOI view.[82]

On another front, North Carolina has amended its HMO regulations to provide additional guidance regarding contractual relationships between HMOs or insurers and intermediary organizations.[83] The regulations require the filing and approval of such contracts with the NCDOI.[84] Each contract must contain specified provisions as set forth in the regulations.[85]

11. Ohio

In 1997, Ohio replaced its HMO act with a single statutory scheme applicable to all risk-bearing managed care entities, calling them "health insuring corporations" (HICs). A health insuring corporation is defined to include any entity that "pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services, supplemental health care services, or specialty health care services, or a combination of basic health care services and either supplemental health care services or specialty health

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[78] Letter from N.C. Dep't of Ins. to John L. Crill, Esq., 3 (Oct. 22, 1996). While ERISA preempts state laws regulating employee welfare benefit plans, the federal statute does not preempt state laws that regulate insurance. The NCDOI letter explains that because "the provider network and its members are assuming risk," *id.*, a contract of insurance has been created. Thus, ERISA preemption would not apply, and the network would be required to be licensed as an HMO. *See ERISA*, *supra* § 2300.02.D.2.

[79] Letter from N.C. Att'y Gen. to John L. Crill, Esq. (Oct. 9, 1996).

[80] The North Carolina HMO Act defines those persons who are covered by the act to include "associations, trusts, or corporations, but does not include professional associations, or individuals." N.C. Gen. Stat. § 58-67-5(g).

[81] Letter from N.C. Att'y Gen., at 3-4.

[82] Letter from N.C. Dep't of Ins., at 1.

[83] "Intermediary" or "intermediary organization" is defined as "any entity that employs or contracts with health care providers for the provision of health care services, and that also contracts with a network plan carrier or its intermediary." N.C. Admin. Code tit. 11, r. 20.0101(b)(4).

[84] N.C. Admin. Code tit. 11, r. 20.0201.

[85] N.C. Admin. Code tit. 11, r. 20.0202.

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care services, through either an open panel plan or a closed panel plan." [86]

Every HIC is required to obtain a certificate of authority.[87] If a managed care entity does not have any of the characteristics set forth above, then it does not bear risk. Nonrisk-bearing managed care entities need not apply for a COA, but such entities must send a letter to the insurance department certifying that they are exempt from the COA requirement.[88]

A nonrisk-bearing entity includes an "intermediary organization," which is defined as a network or other entity that "contracts with licensed health insuring corporations or self-insured employers, or both, to provide health care services, and that enters into contractual arrangements with other entities for the provision of health insuring corporations and self-insured employers." [89] The HIC statute does *not* require an intermediary organization to obtain a COA, regardless of how the intermediary organization is reimbursed, provided that the health insuring corporation or a self-insured employer "maintains the ultimate responsibility to assure delivery of all health care services required by the contract between the health insuring corporation and the subscriber . . . or between the self-insured employer and its employees." [90]

The statute incorporates a sliding scale of net worth requirements under which HICs that offer basic health services or multiple types of services must maintain a higher net worth than HICs that only provide specialty or supplemental health care services. In addition, the scale changes for HICs that meet the definition of a "provider sponsored organization." In order to qualify as a PSO under the statute, the organization must be at least 80 percent owned or controlled by one or more hospitals, one or more physicians, or any combination of such physicians and hospitals. The insurance department will presume such control exists if at least 80 percent of the voting rights of a PSO are "directly or indirectly owned, controlled, or otherwise held by any combination of the physicians and hospitals." [91]

All HICs are required to maintain total admitted assets equal to at least 110 percent of the liabilities of the HIC.[92] The net worth requirements operate on a sliding scale as set forth below:

- *HIC providing basic health care services:* maintain minimum net worth of $1.2 million [93] and deposit of securities with the insurance department of not less than $250,000.[94]
- *HIC providing only supplemental health care services:* [95]maintain a minimum net worth of $500,000 [96] and deposit of securities with the insurance department of not less than $150,000.[97]
- *HIC providing only specialty health care services:* [98]maintain a minimum net worth of $250,000 [99] and deposit of securities with the insurance department of not less than $75,000.[100]
- *HIC providing both basic health care services and supplemental health care services:* maintain a minimum net worth of $1.7 million [101] and deposit of securities with the insurance department of not less than $400,000.[102]
- *HIC providing both basic health care services and specialty health care services:* maintain a minimum net worth of $1,450,000 [103] and deposit of securities with the insurance department of not less than $325,000.[104]
- *HIC qualifying as PSO and providing basic health care services:* maintain a minimum net worth of $1 million [105] and deposit of securities with the insurance department of not less than $250,000.[106]
- *HIC qualifying as PSO and providing basic health care services and supplemental health care services:* maintain a minimum net worth of $1.5 million [107] and deposit of securities with the insurance department of not less than $400,000.[108]
- *HIC qualifying as PSO and providing basic health care services and specialty health care services:* maintain a minimum net worth of $1,250,000 [109] and deposit of securities with the insurance department of not less than $325,000.[110]

12. Pennsylvania

The Pennsylvania PPO statute affirms the right of any health care insurer or purchaser to:

> . . . [e]nter into agreements with providers or physicians relating to health care services which may

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[86] Ohio Rev. Code Ann. § 1751.01(P) (as amended 2008). An insurer that offers only open panel plans under which all providers and health care facilities participating receive their compensation directly from the insurer is not an HIC.
[87] Ohio Rev. Code Ann. § 1751.02.
[88] Ohio Rev. Code Ann. § 1751.02(H).
[89] Ohio Rev. Code Ann. § 1751.01(Q).
[90] Ohio Rev. Code Ann. § 1751.02(G).
[91] Ohio Rev. Code Ann. § 1751.01(BB).
[92] Ohio Rev. Code Ann. § 1751.28.
[93] Ohio Rev. Code Ann. § 1751.28(A)(1).
[94] Ohio Rev. Code Ann. § 1751.27(A)(1).
[95] Supplemental health care services include services such as dental, vision, or mental health services, which are not considered to be "basic health care services." Ohio Rev. Code Ann. § 1751.01.
[96] Ohio Rev. Code Ann. § 1751.28(A)(2).
[97] Ohio Rev. Code Ann. § 1751.27(A)(2).
[98] A HIC that only provides a single supplemental health care service on an outpatient basis is said to be providing "specialty health care services." Ohio Rev. Code Ann. § 1751.01(C).
[99] Ohio Rev. Code Ann. § 1751.28(A)(3).
[100] Ohio Rev. Code Ann. § 1751.27(A)(3).
[101] Ohio Rev. Code Ann. § 1751.28(A)(4).
[102] Ohio Rev. Code Ann. § 1751.27(A)(4).
[103] Ohio Rev. Code Ann. § 1751.28(A)(5).
[104] Ohio Rev. Code Ann. § 1751.27(A)(5).
[105] Ohio Rev. Code Ann. § 1751.28(A)(6).
[106] Ohio Rev. Code Ann. § 1751.27(A)(1).
[107] Ohio Rev. Code Ann. § 1751.28(A)(7).
[108] Ohio Rev. Code Ann. § 1751.27(A)(4).
[109] Ohio Rev. Code Ann. § 1751.28(A)(8).
[110] Ohio Rev. Code Ann. § 1751.27(A)(5).

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be rendered to persons for whom the insurer or purchaser is providing health care coverage, including agreements relating to the amounts to be charged by the provider or physicians for services rendered.[111]

A PPO that assumes financial risk must report required information to the Insurance and Health Departments before commencing operations. It may commence operations after 60 days if neither department informed it of deficiencies and may continue to operate unless and until such time as one of the departments identifies significant deficiencies and the PPO fails to correct the deficiencies within 60 days of notification.[112] Specifically, the Pennsylvania PPO regulations require that a PPO application must be filed with the Department of Health. The application must contain, among other things, the following items:

- a description of the proposed service area of the provider organization, including geographic boundaries;
- a copy of every standard form contract with physicians and providers establishing preferred provider arrangements;
- a detailed description of the types of financial incentives for preferred physicians and providers within the preferred provider arrangements;
- a copy of procedures, if any, for referral of covered persons to non-preferred providers by the preferred provider organization or the preferred provider;
- a description of the incentives for enrollees to use the services of a preferred provider contained within the preferred provider organization's enrollee contracts; and
- a financial analysis prepared for the purpose of determining that the proposed preferred provider organization will have adequate working capital and reserves. The analysis must include a feasibility study, a business plan with projected financial statements for the next three years, a review of proposed provider and physician contracts and charges, a review of proposed rates and a market opportunity analysis. It must be made under the direction of a qualified actuary or certified public accountant.[113]

Changes or additions, or both, to any of the provisions in the application must be filed with the Department of Health at least 60 days prior to use or the effective date after commencement of operations. In addition to these requirements, a PPO must file semiannually changes or additions, or both, to the list of preferred providers.[114]

In 1996, the Departments of Health and Insurance jointly issued statements of policy regarding the approval of provider contracting arrangements between HMOs and integrated delivery systems (provider network organizations).[115] The policy statements have the effect of authorizing certain risk sharing arrangements between HMOs and networks of providers, but permit the Insurance Department to challenge such arrangements when 50 percent or more of the HMO's premium revenue is transferred to a single network or when 75 percent or more of the HMO's premium revenue is transferred to multiple networks.[116]

According to the Department of Health, HMOs must submit all risk sharing provider contracts with IDSs to the department for review and approval. This requirement requires submission to the department of the contract between the HMO and the IDS and any downstream contracts between the IDS and the individual providers. The provider contracts are required to include specific terms, including limitations on billing enrollees; the Department of Health's right to inspect the IDS's records; and the ability of the HMO to terminate the contract for noncompliance with the HMO's quality assurance, utilization management, and grievance procedures. All provider contracts not acted upon by the Department of Health within 45 days are presumed to meet the department's requirements and may be used. If the department finds at any time that the contract violates the law, the plan must correct the violation.[117]

In addition, the policy statements specify the conditions under which the HMO may delegate the responsibility for provider credentialing, quality assurance, and utilization management to the IDS.

13. Texas

The Texas HMO Act explicitly states that an HMO may arrange for medical services through "groups of physicians who have independent contracts with the health maintenance organizations." [118]

Texas defines an HMO as "a person *who arranges for* or provides to enrollees on a prepaid basis a health care plan, a limited health care service plan, or a single health care service plan."[119] Texas regulators in the past narrowly interpreted the Texas HMO Act. This position was confirmed by statutory amendment in 1995.

Under the statute (as amended in 2001, as part of the recodification of the Insurance Code), a certificate of authority is not required to the extent a "person is: (1) a physician engaged in the delivery of medical care; or (2) a provider

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[111] 40 Pa. Stat. Ann. § 764a(a).
[112] 40 Pa. Stat. Ann. § 764a(f).
[113] 31 Pa. Code § 152.3.
[114] *Id.*
[115] 26 Pa. Bull. 1629 (Apr. 6, 1996), announcing the adoption of 28 Pa. Code § 9.401-9.416 (since withdrawn and replaced with provisions in the other subchapters of the MCO chapter of the Department of Health regulations) and 31 Pa. Code §§ 301.301-301.314 (Department of Insurance). The currently effective version of the Health Department regulations, as well as the Insurance Department policy statement, are *reproduced infra* Working Papers, Doc. 5.
[116] 31 Pa. Code § 301.314(c).
[117] 28 Pa. Code § 9.722
[118] Tex. Ins. Code Ann. § 843.101(a).
[119] Tex. Ins. Code Ann. § 843.002(14) (emphasis added).

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engaged in the delivery of health care services other than medical care as part of a health maintenance organization delivery network. "[120] The rationale for the nonapplicability language is that the Texas Department of Insurance can regulate networks through its regulation of HMOs, and hence, in limited situations, a separate HMO license for the network is not necessary.

The amended Texas HMO statute explicitly states that an HMO may arrange for medical services through "groups of physicians who have independent contracts with health maintenance organizations." [121] The statute allows providers to contract or arrange for the provision of health care services through subcontracts with other licensed providers.[122] In addition, a provider network may be compensated "on a fee-for-service arrangement, a risk-sharing arrangement, or a capitated risk arrangement." [123]

Although the act permits providers to contract (or subcontract) with other providers to provide a health care service they are not licensed to provide, it imposes a cap of 15 percent of the total amount of services the provider is to provide or arrange to provide.[124] This provision severely limits a network's ability to arrange for the provision of health care services for which it is not licensed. Any network that subcontracts for more than 15 percent of health care services it is not licensed to provide would need to be licensed as an HMO.

A physician or provider who employs or enters into a contractual arrangement with a provider or group of providers to provide basic or limited health care services or a single health care service generally is subject to the certificate requirements.[125]

Texas also has rules for "delegated entities" [126] that do not apply to an individual physician or a physician group practice (practicing under one federal tax identification number), whose total claims paid to providers not employed by the group constitute less than 20 percent of the group's total collected revenue computed on a calendar year basis.[127]

Texas allows HMOs to contract on a global capitation or risk-sharing basis with approved nonprofit health corporations (ANHCs).[128] The ANHCs, certified under § 5.01(a) of the Texas Medical Practice Act, permit physicians and member hospitals to operate as nonprofit corporate entities.

Generally, ANHCs that provide health care services on a prepaid basis are required to obtain a certificate of authority from the Texas Insurance Department. However, ANHCs that contract with HMOs on a risk sharing or capitated basis or contract with payers to provide only medical care (defined as practicing medicine) are not required to obtain a certificate of authority.

The rules require that ANHCs that seek certification must comply with the same requirements as a state-licensed HMO. ANHCs must also demonstrate that they are accredited by the NCQA (formerly the National Committee on Quality Assurance) or the Joint Commission (formerly the Joint Commission on Accreditation of Health Care Organizations).

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[120] Tex. Ins. Code Ann. § 843.073(a). Tex. Ins. Code Ann. § 843.002(15) defines a "health maintenance organization delivery network" as " a health care delivery system in which a health maintenance organization arranges for health care services directly or indirectly through contracts and subcontracts with physicians and providers."

[121] Under Tex. Ins. Code Ann. § 843.002(24), a "provider" is a:

- a person, other than a physician, who is licensed or otherwise authorized to provide a health care service in this state, including: (i) a chiropractor, registered nurse, pharmacist, optometrist, registered optician, or acupuncturist; or (ii) a pharmacy, hospital, or other institution or organization;
- a person who is wholly owned or controlled by a provider or by a group of providers who are licensed or otherwise authorized to provide the same health care service; or
- a person who is wholly owned or controlled by one or more hospitals and physicians, including a physician-hospital organization.

It is significant to note that excluded from the definition of "provider" are intermediary organizations, except for PHOs, that are not licensed or authorized to provide health care services.

[122] Tex. Ins. Code Ann. § 843.318.

[123] Tex. Ins. Code Ann. § 843.318(e).

[124] Tex. Ins. Code Ann. § 843.318(d). There is no cap on a provider subcontracting with similarly licensed providers to provide the service the provider is licensed to provide or on subcontracting for ancillary services. Tex. Ins. Code Ann. § 843.318(c), (b).

[125] Tex. Ins. Code Ann. § 843.073(b).

[126] Tex. Ins. Code Ann. § 843.002(30) defines a "delegated entity" as:

> an entity, other than a health maintenance organization authorized to engage in business under this chapter, that by itself, or through subcontracts with one or more entities, undertakes to arrange for or provide medical care or health care to an enrollee in exchange for a predetermined payment on a prospective basis and that accepts responsibility for performing on behalf of the health maintenance organization a function regulated by this chapter.

[127] *Id.*

[128] Tex. Admin. Code § 11.1703; 21 Tex. Reg. 2253 (Mar. 19, 1996). *See Insurance Commissioner Approves Final Rules on Global Capitation*, 5 BNA's Health L. Rep. 437 (Mar. 21, 1996).

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