

NAIC

*National
Association of
Insurance
Commissioners*

The Regulation of Health Risk-Bearing Entities

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NAIC

**National Association
of Insurance Commissioners**

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Volume I: Issues Overview

EXECUTIVE SUMMARY

The *Regulation of Health Risk-Bearing Entities* is a white paper by the National Association of Insurance Commissioners (NAIC) State and Federal Health Insurance Legislative Policy Task Force that reviews the changing nature of the health insurance market and the states' regulatory response. This white paper consists of two volumes. In this first volume, the nature of the risk being assumed by organizations operating in the health insurance market, the types of organizations that have entered the health insurance market, and the states' regulatory activities in light of these market developments are discussed. The second volume outlines the Task Force's position on state regulation of health risk-bearing entities.

A significant variety of organizations operate in the health insurance market. Managed care insurance organizations, in particular, represent a diverse range of structural forms and enter into a variety of forms of contractual arrangements. A common element of all managed care organizations is that they deliver or arrange for the delivery of health benefits and services. Managed care organizations engage in the business of insurance when they also assume insurance risk in addition to deliver or arrange for the delivery of health benefits or services. In other words, the managed care organization assumes an individual's, employer's, or other group's risk of financial loss and spreads that risk of loss among a larger pool of persons. When they engage in the business of insurance, managed care organizations are subject to state insurance regulation. Much debate is under way about the application of state insurance regulation to organizations that assume insurance risk and which are owned and controlled by providers. These organizations, to the extent that they engage in the business of insurance, have been and continue to be subject to state insurance laws.

Not all arrangements which managed care organizations enter into with individuals, employers, or other groups involve the assumption of insurance risk. For example, arrangements that only involve discounted fee-for-service payments generally do not involve the essential elements of insurance risk. In contrast, capitation arrangements with individuals, employers, or other groups do involve the essential elements of insurance risk and generally trigger the application of state insurance regulation.

A primary objective of state insurance regulators is to protect consumers against insolvency. All states have insurance laws that apply to managed care organizations which assume insurance risk. These laws include statutes and regulations containing solvency and other consumer protection standards for managed care organizations, such as health maintenance organizations and limited health service organizations. All states endeavor to apply insurance laws in a manner that protects consumers adequately and promotes a competitive marketplace.

The primary approach used by state insurance regulators is to regulate by function. Almost all states regulate managed care organizations performing similar functions through the same laws. A few states have insurance laws that specifically apply to managed care organizations owned or controlled by providers. Most states do not directly regulate the contracts

between managed care organizations and providers. States do monitor these arrangements by imposing certain requirements on the regulated managed care organization.

The states, through individual state initiatives and through the NAIC, are constantly adapting to an evolving marketplace as part of the state regulatory process. The state's tools for regulation continue to become more sophisticated. State insurance regulators are reviewing the range of regulatory issues which have arisen from the growing dominance of all forms of managed care organizations in the health insurance market. In their review, states focus on the insurance function performed. The development of a risk-based capital formula for managed care organizations based on the level of risk being assumed by a managed care organization, and the development of a uniform licensing law for health organizations assuming insurance risk are examples of the states' efforts to regulate by function and adapt to an evolving marketplace.

INTRODUCTION

The health insurance market has undergone significant changes since its inception in the early part of this century. In the last decade, in particular, there has been a significant trend away from the use of traditional insurance arrangements to managed care. The market for the traditional approach used by Blue Cross and Blue Shield plans and commercial indemnity insurers has been in steady decline.¹ In contrast, the market for the managed care approach used by health maintenance organizations (HMOs), which assume insurance risk by accepting a prepayment for medical services rendered to patients, has increased.² Consequently, Blue Cross and Blue Shield plans and commercial indemnity insurers have been working persistently to transform their businesses to offer competitive managed care services. In addition, for a variety of reasons, members of the provider community are moving collaboratively to be recognized as a distinct group of players in the managed care market.

The responsibility and authority for the regulation of health risk-bearing entities—organizations that assume health insurance risk³—rests with the states. This white paper is designed to assist the states by providing the members of the National Association of Insurance Commissioners with a discussion of the issues related to the regulation of health risk-bearing entities. The debate on this issue has primarily involved three distinct questions:

¹ According to statistics recently published by the Health Insurance Association of America, the number of persons covered by indemnity carriers (not including Blues plans) decreased from 83.1 million in 1990 to 74.7 million in 1993 and by Blue Cross and Blue Shield plans decreased from 70.9 million in 1990 to 65.9 million in 1993. HIAA Source Book of Health Insurance Data 1995, 41 (Washington, D.C. 1996).

² The number of individuals covered by health maintenance organizations increased from 36.5 million in 1990 to 45.2 million in 1993. 1995 AAHP Managed Health Care Overview, 193-94 (Washington, D.C. 1996) [hereinafter referred to as AAHP Overview]. The number of individuals covered by health maintenance organizations in 1995 was 58.2 million. 1995 AAHP HMO/PPO Trends Report, 3 (Washington, D.C. 1996).

³ As contemplated in this white paper, risk-bearing entities are entities - consisting of one or more persons - that contract with individuals, employers, or other groups to arrange for or provide health care benefits on a basis that involves the assumption of insurance risk by the risk-bearing entity. A risk-bearing entity does not include an employee welfare benefit plan as defined in the Employee Retirement Income Security Act (ERISA) that is exempted from state law by ERISA. For a thorough discussion on the relationship between ERISA and state insurance laws see the NAIC's Health and Welfare Benefit Plans Under the Employee Retirement Income Security Act: A Guide for State and Federal Regulation, 3d (scheduled to be available to the public in early 1997).

1. What is insurance risk and the business of insurance?
2. What forms of risk-bearing entities are operating in the health insurance market and how are they assuming risk?
3. How do states regulate health risk-bearing entities?

This document addresses each of these questions. Through the white paper, members are provided with a discussion of the definitions of insurance risk (including the distinction between insurance risk and other forms of risk, such as service and business risk) and the business of insurance. The white paper also contains a review of the organizations operating in the health insurance market, the type of insurance arrangements found, and the contractual forms these arrangements are taking. In addition, members are provided with information on how states are approaching the regulation of risk-bearing entities. Finally, the white paper includes a discussion on the NAIC's activities in this regard.

This white paper was written with the expectation that state insurance regulators will develop a model regulatory proposal through the NAIC's health insurance regulatory reform initiative called CLEAR (Consolidated Licensure for Entities Assuming Risk). This white paper is one element of the CLEAR process. State insurance regulators are also conducting a comprehensive review of the current regulatory framework applicable to all risk-bearing entities and all forms of health insurance. Insurance regulators, in their individual states and through the NAIC, are actively pursuing regulatory initiatives designed to recognize market changes and meet important public policy objectives. Underlying state insurance regulators' activities in this area are two central premises:

1. All entities which assume health insurance risk must be subject to the same solvency and other appropriate consumer protection standards, irrespective of the name and structure of the entity; and,
2. Any regulatory framework should foster a level playing field among risk-bearing entities which engage in similar insurance arrangements as opposed to a regulatory framework that favors the development or maintenance of any particular organizational form assuming insurance risk.

State insurance regulators have an important role to play in achieving public policy objectives related to organizations assuming insurance risk and the insurance arrangements in which they enter. Ensuring that appropriate consumer protection standards are in place is a public policy objective of paramount importance to state insurance regulators. State and federal government agencies, private employers, and other consumers have also fostered competition in an effort to lower the cost of health insurance. This document facilitates state efforts to accommodate the various forms of organizations which have sought to assume insurance risk and the diverse methods in which insurance risk has been assumed while at the same time appropriately apply relevant consumer protection standards.

A. Insurance Risk and the Business of Insurance

1. Insurance Risk

Risk is a constant presence in the lives of individuals and businesses and can be handled in different ways. Preventable risk can be minimized or eliminated by careful planning. Or, an individual or business may decide to forego the activity that involved the risk. If the activity is pursued despite the risk, the individual or business may fund directly the costs associated with the risk. Alternatively, in an effort to diminish the costs associated with the risk, all or part of the costs of the risk may be transferred to others.

In insurance, the party that transfers the risk pays another party to assume the risk. The party that assumes the risk agrees, in exchange for the payment, to perform some function (such as payment of a bill or provision of a service) associated with the occurrence of the risk. Often, a party assumes the unknown, future level of risk of a number of persons and pools their risks. By pooling the risks together, the insuring party spreads each individual's risk across the group. Through adequate pricing of the risks and accurate calculation of loss experience and statistical probabilities, the risk-assuming party has the opportunity to cover any costs associated with the risk assumed and make a reasonable financial return as well.⁴ The risk that is transferred and spread is called *insurance risk*. In the lexicon of the insurance industry, the party that transfers the risk to another is called the "insured," the party that assumes and spreads the risk is called the "insurer," and the payment is called a "premium."⁵

2. Insurance Risk and the Business of Insurance

The federal McCarran-Ferguson Act⁶ clarifies that the primary jurisdiction for regulation of the business of insurance lies with the states. State lawmakers rely on a variety of sources when determining whether an arrangement should be subject to state insurance regulation. State statutes and regulations establish criteria for when an arrangement involves insurance risk and the business of insurance. State and federal court opinions are an equally important source of guidance for evaluating when an entity is engaged in the business of insurance.

⁴ The pooling of risk does not affect the level of probability that any specific individual's or business's risk will actually occur. However, the pooling process reflects the statistical probability that costs associated with some of the members of the pool will be below the payment made on their behalf while the costs for others will be greater. On balance, the risk-assuming party anticipates that the premium payment will be sufficient to cover the costs associated with the occurrence of all of the risks insured against and to provide a reasonable profit.

⁵ The Handbook on the Law of Insurance by Vance identifies the following five elements of an insurance arrangement: (1) The insured possesses an insurable interest; (2) The insured is subject to a risk of loss; (3) The insurer assumes that risk of loss; (4) The assumption of the risk of loss is part of a general scheme to distribute actual losses among a large group of persons with similar risks; and, (5) The insured pays a premium to the insurer. Vance underscores that it is the fourth and fifth factors, risk distribution and premium payment, that make a contract insurance. William R. Vance, Handbook on the Law of Insurance, 3d ed., Buist M. Anderson, Ed., 2 (West Publishing 1951).

⁶ 15 U.S.C.A. §1011-15.

In its few cases interpreting the McCarran-Ferguson Act, the Supreme Court has emphasized “the underwriting or spreading of risk as an indispensable characteristic of insurance.”⁷ In *Group Life & Health Insurance Co. v. Royal Drug Co.*, an antitrust case, the Court was called upon to interpret the term “business of insurance” under the McCarran-Ferguson Act. At issue was an arrangement between an insurance company and a number of pharmacies. The pharmacies agreed to fill prescriptions to policyholders for the cost of the drugs (to be paid by the insurer) in addition to two dollars per filled prescription (to be paid by the insured). The insureds could only obtain the two dollar price by having their prescription orders filled by the pharmacies participating in the arrangement with the insurance company.⁸ It was the Court’s opinion that the price arrangement reduced the risk to the insurance company but did not involve any spreading of the insurance company’s risk by the pharmacies. The Court also highlighted the relationship of the parties involved in the arrangement. It noted that the insurer’s arrangement was not with the insured but with pharmacies involved in the sale of goods and services, not insurance.⁹

In *Union Labor Life Insurance Co. v. Pireno*,¹⁰ another antitrust case, the Court also focused on the presence or absence of risk spreading in the arrangement under review. In *Pireno*, the activities of a peer review committee that provided the insurer with advice on the medical necessity of medical services was at issue. The Court held that an arrangement between an insurer and its peer review committee was not the business of insurance. Specifically, the Court stated that the arrangement was not related to the spreading by the insurer of the policyholder’s risk since the arrangement was “logically and temporally unconnected to the transfer of risk accomplished by ULL’s insurance policies.”¹¹

Risk spreading is but one factor that the Court considers when evaluating whether an arrangement involves the business of insurance. Each of the following three factors are relevant:

- (1) whether the activity involves the underwriting and spreading of risk;
- (2) whether the activity involves an integral part of the insurer-insured relationship; and,
- (3) whether the activity is limited to entities within the insurance industry.¹²

Under the Court’s approach, it is not necessary that each of these factors be met in a specific analysis. For instance, in *Pireno*, the Court acknowledged that the pharmacies were not

⁷ *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 212 (1979).

⁸ *Id.* at 209.

⁹ *Id.* at 214. It should be noted that the Court’s narrow reading of the meaning of the term “business of insurance” and its interpretations of the facts have been criticized by notable academic commentators. See e.g. Spencer L. Kimball, *Meaning of the McCarran-Ferguson Act Today*, 10 J. INS. REG. 5, 13 (Fall 1991) (arguing that the Court’s narrow limitation of the “business of insurance” to relationships between insurers and policyholders is contrary to the intent of Congress.)

¹⁰ *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119 (1982).

¹¹ *Id.* at 130.

¹² *Id.* at 129.

traditional players in the insurance industry at that time, but noted that that factor was not dispositive to determining whether an arrangement involved the business of insurance.¹³

The business of insurance analysis developed by the Court in *Royal Drug* and *Pireno* has been used by the Court in the context of the Employee Retirement Income Security Act (ERISA) as well. In *Metropolitan Life Ins. Co. v. Massachusetts*,¹⁴ the Supreme Court held that a state law which mandated that insurers cover certain mental health benefits was not preempted by ERISA.¹⁵ The Court held that the state statute was not preempted by ERISA because the law regulated the spreading of risk; regulated an integral part of the policy relationship between the insurer and the insured; and applied only to entities within the insurance industry.¹⁶

Notwithstanding the presence or absence of the latter two factors in the Court's analysis, it is the risk spreading component that gives rise to the public policy concerns inherent in many arrangements which involve insurance risk. Arrangements that involve the spreading of risk often rely upon complex, actuarial analysis for financial success. In contrast, business risk arrangements that do not involve risk spreading do not inherently carry with them the same nature of risk as insurance risk. Additionally, prepayment for the future delivery of services in an insurance risk arrangement establishes a long-term commitment to the consumers that benefit from the arrangement. State insurance solvency and other consumer protection standards serve to enhance the ability of the players in the insurance market to fulfill their obligations to the consumer and other parties affected by the arrangement.

3. Beyond Insurance Risk

Notably, some arrangements that technically involve insurance risk do not give rise to the same degree of public policy concerns as other arrangements. The courts have struggled with cases that present close public policy questions about whether an arrangement involves insurance risk and should be governed by state insurance regulation and those which involve what the courts have called service risk. Not surprisingly, the case law that has developed from these judicial efforts is highly inconsistent. To understand the applicability of these cases to their states, state insurance regulators will need to review their state statutes and regulations and the specific facts and holdings of the cases decided in their jurisdiction. Regulators may also want to ensure that their state's statutes and regulations explicitly define as insurance those arrangements that invoke the public policy concerns, such as solvency, that insurance regulation is designed to address.

To provide guidance on how to grapple with the inconsistent outcomes of these lower court opinions, academic commentator Robert Keeton identified two factors that should be considered when determining whether an entity is engaged in service risk or insurance risk. These factors rest upon the nature and characteristics of the transaction:

¹³ *Id.* at 133.

¹⁴ 471 U.S. 724 (1985).

¹⁵ *Id.* at 743.

¹⁶ *Id.*

- (1) Did the specific transaction or general line of business at issue involve one or more of the concerns at which the regulatory statutes were aimed?
- (2) Were the elements of risk transference and risk distribution central to and relatively important elements of the transactions (or merely incidental to other elements that gave the transactions their distinctive character)?¹⁷

In the health insurance context, state insurance regulators have developed an overwhelming consensus that arrangements that involve insurance risk invoke the public policy concerns that insurance regulation is designed to address. While states are still exploring issues related to the regulation of the range of risk-bearing arrangements, this consensus applies even if the entity assuming the financial risk is also providing the service. Irrespective of the type of entity assuming the risk, the potential for inaccurate actuarial projections related to cost or intensity or severity or frequency of service is always present. Further, the consequences of adverse outcomes associated with insurance risk is disruptive for the failed entity, the consumer, and other players in the health insurance market (including contracting providers and HMOs) regardless of the form of the organization assuming the insurance risk.

Some lower court cases have declined to categorize as insurance risk certain service contract transactions, such as those involving warranties, which involve risk assumed by the entities responsible for manufacturing or repairing the products.¹⁸ However, not only are the holdings of these and similar types of cases highly inconsistent, they do not neatly apply to the health insurance market. In health care, the service at issue relates to the human body, not products. Risk-bearing entities, whether or not service providers, do not have the capacity to build the human body. Nor do risk-bearing entities control the panoply of risks to which the human body is subject. It is not possible for a risk-bearing entity to predict or control the full range of conditions arising from personal habit, heredity, accident or epidemic which may require medical care.

Further, while the ability to provide services may or may not meaningfully reduce the actuarial risks present in the health care context depending on the specifics of the arrangement, it will rarely reduce the actuarial risk to a de minimis level. The risk would probably be reduced if the risk-bearing entity is an organization owned, in whole or in part, by providers who render clinical services through the organization. However, even if some service providers are willing to work on greatly reduced or nonexistent additional income (an assertion which some question), the risk-bearing entity still may be responsible for a wide range of expenses necessary to support the provision of health care services. Examples of additional expenses may include those related to other clinical personnel, administrative services, laboratory tests, services provided by others, debt service, business expenses, and other liabilities.

¹⁷ Keeton & Widiss, Insurance Law: A Guide to Fundamental Principles, Legal Doctrines & Commercial Practices, §8.3(c), 951 (1988).

¹⁸ See, e.g., *Truta v. Avis Rent A Car System, Inc.*, 193 Cal.App.3d 1093 (1987). But see, e.g., *Griffin Systems v. Washburn*, 505 N.E.2d 1121 (Ill. App. 1Dist. 1987).

In addition, the transfer and spreading of risk is an essential and important element of the transactions developing in today's marketplace. Entities operating in or seeking to operate in the managed care market are struggling to remain competitive by combining the financing and delivery of health care services. It is the nature of the risk inherent in these financing activities that gives rise to public policy concerns in the insurance context.

B. The Assumption of Insurance Risk in the Health Care Market

1. Organizations Operating in the Health Care Market

Historically, traditional indemnity insurers dominated the health care insurance market. With the extraordinary expansion of managed care in the past decade, state insurance regulators are constantly adapting to embrace the variety of organizations which have begun to assume insurance risk. The determination of whether an entity is risk-bearing has, however, become more complex because different forms of managed care organizations and risk-sharing arrangements are emerging instead of a predictable set of prototypes.

a. Traditional Indemnity Insurers

Traditional indemnity insurance plans take on the risk of an insured's loss associated with a medical condition in exchange for a premium. This indemnification relationship may place a contractual obligation on the insurer to reimburse the insured who has already paid for the medical care received. Alternatively, the relationship may place a contractual obligation on an insurer to pay the provider for medical care received by the subscriber; this is the traditional approach for Blue Cross and Blue Shield plans. The insurer is at risk for the financial loss if the cost of an individual's care is greater than anticipated in premium paid by or on behalf of the beneficiary. Traditional indemnity insurance plans may also offer managed care products and have non-insurance risk lines of businesses such as third party administrative services or preferred provider organizations that do not bear insurance risk.¹⁹

b. Managed Care Organizations

Unlike traditional indemnity plans, all managed care plans do not necessarily take on any insurance risk. The different forms of managed care organizations which have been developed, from staff model health maintenance organizations (HMOs) to Preferred Provider Organizations (PPOs) to Physician Hospital Organizations (PHOs), assume varying degrees and forms of risk. It is necessary to examine closely how risk is assumed and whether it is shifted from the insured to the managed care entity to determine the presence of an insurance relationship.

¹⁹ The varying nature of the contractual arrangements being developed in the marketplace often makes it difficult to determine whether an arrangement, on its face, does or does not involve insurance risk. Regulators should be aware that some ostensibly non-risk arrangements, in fact, do involve insurance risk. In addition, some states have statutes and regulations governing third party administrator and preferred provider organizations. Approximately 36 states have adopted the NAIC Model Third Party Administrator statute (model 90) or similar legislation. Approximately 29 states have adopted the NAIC Model Preferred Provider Arrangement Act (model 65) or similar legislation.

HMOs, regulated in most states by state insurance departments, health departments, and other agencies, serve both an insurance and delivery function.²⁰ In consideration for a premium, they arrange the payment for and delivery of health care services. Like the traditional indemnity insurer, the HMO is responsible for the cost of care. HMOs differ from the traditional indemnity insurer in that they are often responsible for the provision of that care as well.²¹ Most HMOs fulfill this responsibility by entering into arrangements with providers or a group of providers whom they reimburse through the various mechanisms discussed below. Like traditional commercial insurers, some HMOs are also beginning to offer non-insurance risk TPA and PPO-type services where the HMOs “rent” the networks that they created and the renters of the network pay for services on a fee-for-service basis.

There are several types of HMOs. While there is no one set of terminology or definition for HMO model types, they can be generally categorized. *Staff Model HMOs* directly employ the physicians who provide health care services to the enrollees on an outpatient basis. They generally contract with hospitals to provide inpatient services. The employed physicians are usually paid a salary with an accompanying incentive package based on performance and productivity. The other forms of HMOs involve a non-employment arrangement with providers or a group of providers. The *Group Model HMO* involves a contract between the HMO and a multispecialty physician practice, which may contract exclusively with an HMO or serve non-HMO patients and the patients of other HMOs as well. The physicians may be reimbursed on a capitation or cost basis. In the *Network Model HMO*, the HMO contracts with several group practices to provide services. The physician groups are typically reimbursed on a capitated basis. Through the *Individual Practice Association (IPA) Model HMO*, the HMO contracts with an association of physicians formed as an IPA. Those physicians who participate in the IPA remain independent practitioners who continue to see non-HMO patients as well. The IPA is typically paid by the HMO on a capitated basis. In turn, the IPA may compensate its physicians on either a fee-for-service or primary care capitation basis. In a *Direct Contract Model HMO*, the HMO enters into direct contracts with individual physicians. These physicians are usually reimbursed on either a fee-for-service or primary care capitation basis.²² It should be noted that an HMO may be a hybrid of these models. For instance, a staff model or IPA model HMO sometimes includes arrangements with multispecialty groups in addition to individual physicians.

PPOs are less likely than HMOs to assume any form of insurance risk, although some may obtain the appropriate license to do so. The PPO contracts with a network of providers who deliver services to enrollees in accordance with a negotiated fee schedule, usually in the form of discounts from charges, bundled charges, per diem rates, or payments based on ambulatory patient groups (APGs) or diagnosis related groups (DRGs).²³ The PPO sells a panel of physicians, hospitals, and other providers who have agreed to provide services at a set discounted fee-for-

²⁰ Every state and U.S. territory except Guam, and the Virgin Islands have enacted an HMO statute or regulation. Approximately 30 states have adopted the NAIC Model Health Maintenance Organization Act (model 430) or similar legislation.

²¹ Eric Wagner, *Types of Managed Care Organizations*, The Managed Health Care Handbook, 3d ed., Peter Kongstvedt, ed., 34 (Aspen Publishers 1996).

²² *Id.* at 17-21.

²³ Patricia Younger, J.D., et al., Legal Answer Book for Managed Care, 10 (Aspen Publishers 1995).

service rate to insurers and employer health benefit plans. The cost of care is higher for enrollees who seek care from providers who are not a part of the PPO. Unlike HMOs, PPOs usually do not take on any insurance risk for arranging the network.²⁴

A more recent popular addition to the managed care arena are Point-of-Service (POS) plans. POS plans are insurance products that are a composite of the approaches used by HMOs and traditional indemnity insurers. Under a POS arrangement, enrollees can receive coverage for the care provided by providers who do not participate in a plan's network. The out-of-network care which can be sought by enrollees is subject to a defined benefits package and coinsurance, deductible and utilization review limitations. POS plans may be freestanding or an option associated with an existing managed care plan. In contrast to PPOs, freestanding POS plans require authorization by a primary care physician prior to an enrollee being able to seek care for all of the benefits available under the plan. The freestanding POS may also have fewer out-of-network benefits available to an enrollee.²⁵

Approximately 15-20 percent of existing HMOs are estimated to be provider-sponsored organizations (PSOs).²⁶ Recently, more provider-sponsored organizations have begun to take on characteristics identical to or closely resembling HMOs. Three of the most commonly discussed forms of PSOs are Physician-Hospital Organizations (PHOs), Individual (or Independent) Practice Associations (IPAs), and Group Practices.

PHOs are joint ventures between hospitals and physicians that are established to create a single marketing and contracting entity. IPAs are physician organizations which contract with payers on behalf of a group of independent physicians to provide health care services. Group Practices are physician groups which provide health care services and share both income and expenses. The physician group practices work together at a limited number of facilities.²⁷

These types of organizations provide a range of services, which may include hospital, physician and ancillary services. PSOs may contract with an HMO, Blue Cross and Blue Shield plan, or traditional indemnity insurance company to provide services or contract directly with an employer group. The nature of these arrangements determines whether they do in fact involve insurance risk. The structure of these organizations and the contractual arrangements in which they enter vary considerably.

Some of these PSOs are structured to engage in direct contracting activities with individuals, employers, and other groups, such as *U.S. Health Group* and *SecureCare of Iowa*. U.S. Health Group was formed by U.S. Health Corporation, a hospital-owned entity, and Medical Group of Ohio, an IPA and owns U.S. Health HMO and a managed care service organization. In

²⁴ According to a survey conducted by the American Association of Health Plans (AAHP), of the respondents, only six percent of PPOs were at full risk. The survey respondents noted that they placed 7.6 percent of the hospitals at financial risk and 10.4 percent of the physicians at financial risk. AAHP Overview at 194-95.

²⁵ *Id.* at 5.

²⁶ Pat J. Butler, J.D., Dr. P.H. and Elizabeth Mitchell, Health Care Provider Networks: Regulatory Issues for State Policy Makers, National Academy for State Health Policy (February 1996) citing Physician Payment Review Commission 1995 Annual Report to Congress.

²⁷ Younger at 14-17.

October, U.S. Health Group will also own an unregulated PPO. The managed care service organization is a licensed TPA that administers PPO products in about 40 of the 88 counties in Ohio. It operates in most of the rural portion of Ohio. It involves about 50 hospitals, about 4,000 physicians, and about 130,000 covered lives. The premium paid to U.S. Health HMO, an entity recently licensed by the Ohio Department of Insurance, will be distributed to pay administrative and marketing expenses, contracting providers, and profits to the provider owners.

SecureCare of Iowa is a PHO that is licensed under the laws of Iowa as an organized delivery system (ODS). The Iowa Department of Public Health has primary regulatory responsibility, but the state's Division of Insurance performs the financial review. The organization is affiliated with Mercy Hospital Medical Center, which is SecureCare's only hospital owner, and has 380 physicians who are stockholders. Of the 380 physician-owners, 100 are primary care physicians and 280 are specialty physicians. The physicians as a group and the hospital each own 50 percent of the organization. SecureCare of Iowa contracts with about 100 employer groups. It currently does not contract with any individuals. It is discussing with other carriers and physician-hospital organizations the possibility of "renting out" its network but has not yet entered into any contracts to do so.

Other PSOs, such as *Advocate Health Partners* and *Lahey Hitchcock Clinic*, do not have insurance licenses and generally do not structure their activities to engage in direct contracting activities but focus on strengthening their relationships with licensed health plans. Advocate Health Partners (AHP), located in Chicago, Illinois, has a structure commonly referred to as a "super-PHO." AHP is an umbrella organization for eight PHOs and two medical groups and develops managed care strategy, performs managed care contracting, and enhances medical management. Each hospital has a PHO which is structured differently. However, they all involve ventures where the hospital and the medical staff each own 50 percent of the PHO. The provider network involves eight hospitals and 3,500 physicians.

AHP contracts with multiple managed care organizations to bring business to Advocate PHOs and contracts for centralized medical management support. The PHOs contract with various providers to provide medical care and are responsible for local medical management and member/provider relations. A medical services organization is responsible for centralized claims, information systems, and administrator support. Currently the AHP services 150,000 capitated members. Global capitation contracts include commercial, Medicare, and Medicaid payors. Currently 6,000 global capitation Medicare members are serviced through Advocate Health Partners.

Lahey Hitchcock Clinic (LHC) is a multispecialty group practice which employs over 900 physicians participating at 60 sites in Massachusetts, New Hampshire, and Vermont. LHC was formed two years ago through the merger of two large multispecialty clinics both of which were founded in the 1920s. Overall, it has 6,400 full-time equivalent employees. In addition to providing primary and specialty professional services, the LHC system includes two hospitals and a full range of ambulatory care services. LHC is a component of the Dartmouth-Hitchcock Medical Center, and is organized as a non-for-profit 501(c)(3) corporation. LHC provides its services through a broad range of payor relationships ranging from fee-for-service to fully

capitated services. LHC currently has approximately 160,000 fully capitated lives. The compensation package for LHC physicians includes a salary and an incentive based upon group performance.

The risk-bearing PSO is very similar to the risk-bearing HMO when contracting directly with an individual, employer, or other unlicensed group. In its 1994 study on the regulation of community health networks in Virginia (specifically referring to similarities between PSOs and staff-model HMOs), the Commonwealth's Joint Commission on Health Care noted the parallels: both organizational forms are established as provider networks; both integrate the service delivery and insurance function; both operate on prepaid revenues; both use managed care; and both have the power to limit provider participation based upon demonstrated capacity.

A recent study of PHOs indicates that at present, most PHOs enter into contractual arrangements with PPOs or traditional insurance entities. According to Ernst & Young's (E&Y) 1994 survey on PHOs, the covered lives served by PHOs were a result of contracts with PPOs (41 percent), HMOs (18 percent), Blue Cross and Blue Shield plans (16 percent), and commercial plans (11 percent). Only 14 percent of the covered lives served by PHOs were pursuant to a direct contract with employers.²⁸ Of the PHOs which contract with HMOs, 63 percent accept capitation. These capitated PHOs are more likely to pass on risk to the hospital and primary care physician than to the specialty practitioners in the network.²⁹ Some major employers still consider most PHOs to be in their infancy and not yet mature enough for significant direct contracting activity.³⁰ In its 1996 survey on a broader range of PSOs that E&Y has labeled integrated delivery and financing systems (IDFS), E&Y reported that 27 percent of the 202 IDFSs that participated in the survey engaged in direct contracting activity with employers.³¹ Neither study provides sufficient information on the nature of the risk being assumed by the PSO.

2. Various Mechanisms for Risk Assumption

Traditional HMOs have taken on insurance risk through a narrow range of payment methods—primarily capitation. PSOs, on the other hand, are subject to a wide range of payment methods³² An analysis of the payment structure is fundamental to the determination of whether insurance risk has been assumed since payment is the manner in which the risk is transferred. The payment methods used depend not only on the form of the managed care arrangement, but

²⁸ Ernst & Young, LLP, Physician-Hospital Organizations: Profile 1995, 8 (February 1995).

²⁹ *Id.* at 9.

³⁰ *Id.* at 14.

³¹ Ernst & Young, LLP, Navigating Through the Changing Currents 3 (1996). In the survey, an IDFS is defined as a provider-controlled organization that delivers an array of services and has the ability to accept a variety of financial arrangements either directly from an employer or from a health insurer.

³² Each of the following publications were relied upon heavily for the content of this discussion on reimbursement methods: David A. Weil, Esq., and Jack T. Diamond, Esq., *Managed Care Contract Provisions Requiring Attention*, The Health Lawyer, 5-6 (Early Winter 1995); Randolph S. Jordan, *The Regulation of Provider Risk-Sharing, Managing Employee Health Benefits*, 8-10 (Fall 1994); American Hospital Association, Managed Care Handbook, 2d ed. AAHA Practice Guide Series/Volume 1; and Peter R. Kongstvedt, ed., The Managed Health Care Handbook 3d edition (Aspen Publishers 1996).

also on the provider. For instance, risk arrangements with primary care providers usually involve capitation, global fees, and withholds and bonuses. On the other hand, arrangements with specialty physicians and hospitals involve a broader range of payment methods. As previously discussed, not all of these payment methods amount to insurance risk.

The payment methods being used in the managed care context vary along a broad continuum to include methods that do not involve insurance risk to those which clearly do. A common factor among payment methods that generally do not involve insurance risk is that the payment method is linked to the actual delivery of predetermined and identifiable services to a specific enrollee. Consequently, the payment method is not devised to rely on payments for a pool of enrollees to fund care for specific individuals. Fee-for-service payment methods are examples of this form of payment. In contrast, other payment methods are not directly tied to the actual utilization of defined services by a specific enrollee. Instead, these payment methods are analogous to the prepayment of a premium to a traditional indemnity insurer who is liable for the costs associated with the provision of covered services (which may or may not be used) irrespective of whether they exceed the amount of the premium. Capitation and percent of premium payment methods are the most pure form of this type of payment.

Discounted Fee-for-Service arrangements pay providers for services delivered at a discount from regular charges. No payment is received for services which are not delivered. Under a *Per Diem* payment method, the provider receives a fixed payment for each day of the patient's stay. The charge is likely to vary depending upon factors such as the service delivered and length of stay. Additionally, the per diem charge may exclude certain high cost services. *Per Case* payment, often in the form of *Diagnostic Related Groups* (DRGs), is tied to a particular patient's stay as well. The provider receives a flat fee for services rendered during a patient's admission. DRGs, for inpatient care, and ambulatory patient groups (APGs), for outpatient care, involves attaching a payment rate to specific diagnostic codes. Under each of these payment methods, except discounted fee-for-service, the provider receives a prospectively fixed rate for each hospitalization based on the patient's diagnosis. Each of these payment methods are usually not regulated as insurance risk.

With *Bundled Fee* arrangements, a class of providers, such as anesthesiologists, agree to a single fee for the individual services delivered by providers in that class during an episode of care. *Global Fee* arrangements are similar to the per case payment method except that they cover services delivered for an enrollee's entire course of treatment, such as antepartum to postpartum care in the case of an obstetrical patient, for a specific type of medical condition or procedure. Since these fee arrangements are tied to a broader range of services provided, the bundled and global fee arrangements entail a greater degree of risk than many of the other payment methods. These payment methods are also usually not regulated as insurance risk.³³

³³ However, the higher degree of risk evident in these arrangements may prompt some state insurance regulators to explore more closely global fee arrangements. As noted by Kongstvedt, some forms of global fee arrangements involve the use of both capitation and fee-for-service. Peter R. Kongstvedt, "Compensation of Primary Care Physicians in Open Panel Plans," in *The Managed Health Care Handbook*, 3d edition pp. 120-146 (Aspen Publishers 1996).

Withholds and *Risk Pools* are examples of payment methods used in the managed care environment that put providers at partial risk for the costs associated with an individual's total care requirements. To fund withholds and risk pools, the managed care organization deducts a certain amount from each provider's payment and places the money in a fund to pay for referral and/or inpatient hospital services. The provider loses those funds if the cost of services delivered by the providers exceeds the managed care organization's budget. If the cost of the services delivered do not exceed the managed care organization's budget, the withhold pool may be distributed to the providers. This strategy places the providers at risk for the cost of specialty referral services for all of the enrollees in the plan. Some state insurance regulators have indicated that their department may exercise greater latitude for judgment and discretion than with other payment methods involving insurance risk in determining whether a particular withhold or risk pool arrangement or bonus and penalty scheme (see below) requires the imposition of the full panoply of consumer protection standards.

The *Assumption of a Corridor of Risk* is also a form of actuarial risk which may be assumed by a provider when a provider purchases stop loss insurance to pay for costs which exceed the actuarially anticipated risk. Often providers will purchase stop loss insurance to alleviate their risk under these payment arrangements. The corridor of risk is the amount of risk assumed by the provider between 100 percent of the actuarially expected risk and the attachment point for stop loss coverage. Alternatively, an assumption of a corridor of risk may exist when a provider assumes responsibility for a certain percent of the budget. The licensed health plan will cover any costs above the specific percent assumed by the provider. The corridor of risk is the point up to which the licensed health plan begins to cover the costs.³⁴

Capitation arrangements involve the essential elements of an insurance risk arrangement. Under a capitation arrangement, the provider receives a fixed payment per enrollee per month. In exchange, the provider agrees to provide all covered services to the enrollee, despite the amount of services the enrollee used. Depending upon the structure of the arrangement, the capitation payment can include the provider's services, referrals, and administrative costs. Under a global capitation arrangement, the payment can include all the services available to the insured, including physician and hospital services as well as services delivered by non-contracting providers. The provider is liable for expenses beyond the capitation amount. If the enrollee uses fewer services than are covered by the capitation payment, the provider may keep the remaining amount of the payment.

The Maryland Attorney General found that an arrangement involving capitation between a third party administrator (TPA), acting on behalf of employers, and providers, was insurance. Healthnet, a health benefits program, involved an arrangement in which providers received capitation fees from the TPA. Furthermore, the capitation fee was adjusted by a *Bonus and Penalty* scheme, whereby the health plan received 50 percent of the difference if the projected costs for out-of-plan services were more than actual costs and paid 50 percent of the difference if projected costs were less than actual costs. A second bonus and penalty scheme in the arrangement linked the annual projected costs to the actual costs for each enrollee in the program.

³⁴ Patricia Butler, J.D., Dr.P.H., and Elizabeth Mitchell. Health Care Provider Networks: Regulatory Issues for State Policy Makers 8 (National Academy for State Health Policy, February 1996).

If the actual costs were greater than the projected costs, the health plan was assessed fifty percent of the difference. A cap was placed on the assessment. If the actual costs were less than the projected costs, the health plan received fifty percent of the difference. In the 1990 opinion, the Attorney General concluded that this compensation scheme between the TPA, acting on behalf of the employers, and the providers, amounted to the providers' engaging in the business of insurance because the contractual agreement's capitation and end of year risk-sharing arrangement met each of the elements of an insurance arrangement.³⁵

Percent of Premium payments may involve an even greater degree of risk than capitation payments.³⁶ Under a percent of premium arrangement, the provider would receive a portion of the amount of premiums obtained by the managed care organization from the enrollees, irrespective of the amount of services utilized by enrollees. The payment to the provider varies depending upon the number of covered lives enrolled in the plan and the amount of the premium charged by the managed care organization. If the managed care organization reduces the premium that it charges to the individual, employer, or other group, the provider receives a reduced amount of payment.

Payment methods may be a hybrid of two or more of these approaches. For instance, a compensation arrangement often involves either discounted fee-for-service or capitation payment methods combined with withholds, risk pools, or bonus and penalty schemes. In some advanced managed care markets, new payment methods are developing. For instance, a payment method being watched closely by Minnesota's insurance department involves an arrangement between a business group and providers that seems to couple the discounted fee-for-service payment method with a variation on the bonus and penalty payment method. The providers are paid a discounted fee-for-service arrangement in accordance with a predetermined budget target. The provider's fees are reviewed quarterly and are reduced if they exceed the budget targets.

Providers are increasingly entering into managed care arrangements which involve these methods of insurance risk in response to attempts by insurers, HMOs and self-funded employers to shift their own risk, as well as in response to the opportunities available in government-sponsored managed care initiatives such as Medicare and Medicaid managed care. The increased use of these payment methods among a broader group of organizations raises a number of issues for state insurance regulators beyond determining when an arrangement involves insurance risk.

C. Risk Assumption and State Initiatives

The question of which entities bear insurance risk may be less complex than the question of how to regulate fairly and effectively the range of entities which engage in the business of health insurance. States, independently, and through the various task forces of the NAIC, are deliberating about how to modify the regulatory structure to accommodate the changes occurring in the market place. Over the last decade, health insurance entities and plans have begun to offer

³⁵ MD Attorney General Opinion No. 90-030 (1990).

³⁶ Whether a percent of premium payment arrangement involves greater risk than a capitation arrangement depends upon the details in the contract, and in particular, the effectiveness of the premium in reflecting the variations in the risk associated with the covered lives.

the broad range of managed care products. These market activities have blurred traditional regulatory distinctions. Consequently, states are pursuing initiatives to eliminate artificial distinctions that are irrelevant in today's market place.

In undertaking this regulatory review, state insurance regulators seek to:

- make sure entities engaging in similar activities, offering similar kinds of health products, and/or having similar functional and risk-sharing/risk-transferring characteristics are subject to similar regulation;
- streamline the regulatory process wherever possible;
- ensure that the nature and level of regulation is consistent with the nature and level of risk assumed by each regulated entity;
- recognize and allow for new types of risk sharing arrangements and risk assuming entities in the marketplace;
- promote the use of common definitions regarding new types of entities, products, and risk sharing/risk transferring mechanisms; and
- make sure sufficient consumer protections are in place to deal with key concerns and complaints consumers are voicing today.³⁷

Regulators acknowledge the challenge of achieving these objectives in a manner that adequately addresses consumer protection, including solvency, issues and that creates a level playing field for all licensed entities but that at the same time continues to foster the development of innovative, cost-effective health care financing and delivery systems.

Both direct contracting arrangements and downstream risk arrangements have been the focus of deliberations about the regulation of risk-bearing entities. Each type of arrangement involves a separate set of important, complex concerns. This section highlights the perspectives of the participants in this debate on the regulation of direct contracting and downstream risk arrangements and state approaches to the regulation of these arrangements. This section does not portend to be a comprehensive review of each state's regulatory framework for managed care entities; it focuses exclusively on regulatory issues related to risk arrangements. However, this section does highlight the approaches taken by and the trends developing in the states.

³⁷ The NAIC Project on: Consolidated Licensure for Entities Assuming Risk (CLEAR), minutes of the NAIC Regulatory Framework Task Force (June 2, 1996).

1. Direct Contracting Arrangements³⁸

Direct contracting arrangements involve agreements between the risk-bearing entity and individuals, employers, or other unlicensed groups. These arrangements may involve full or partial risk assumption. In other words, through a particular contractual arrangement, the risk-bearing entity may assume only insurance risk or both insurance risk (such as capitation) and business risk (such as discounted fee-for-service).

More providers are seeking to bear risk and are applying for certificates of authority to do so for a variety of reasons. These reasons include the increased interest by HMOs and purchasers to share risk with providers as well as the provider community's desire for greater control over medical management decisions. Other environmental reasons why providers seek to enter into risk-sharing arrangements include the excess supply of beds and physicians, declining premiums, opportunities for Medicaid and Medicare risk contracting, and the entrance of for-profit hospitals into the local market.³⁹

Much of the regulatory debate has focused on the relationship between state insurance regulation and provider-sponsored organizations that bear risk. There is a strong difference of opinion among industry representatives about whether contracting provider groups should be able to contract directly with employers and individuals without being subject to similar requirements as HMOs. Some provider representatives assert that regulatory requirements for HMOs do not accommodate PSOs' organizational structures and advocate for a distinct regulatory framework. At the same time, they argue that, while they do not oppose state regulation, ERISA preempts state regulation of provider-sponsored direct contracting arrangements.

Employers have been a powerful, effective, and important driving force behind many innovative initiatives to enhance competition, lower costs, and improve health care quality. They view opportunities to contract directly with PSOs as a method of further reducing costs for their plans. Some employers have expressed concern that attempts by regulators to develop a framework that levels the playing field will protect, albeit inadvertently, existing licensed entities, and thus, discourage competition and hinder the success of new initiatives. Instead, these employers argue for relatively free entry and exit for risk-bearing provider-sponsored organizations into the insurance market without regulatory barriers.

On the other hand, traditional players in the managed care market, which include currently licensed provider-sponsored risk-bearing entities, dispute the contention that comprehensive regulatory standards should not apply to provider-sponsored organizations. They argue that risk-bearing PSOs do not markedly differ from HMOs and contend that developing a separate and less stringent regulatory structure will only serve to enhance the competitive advantage of PSOs at the HMO community's expense. They also assert that providers assuming

³⁸ This section only reviews regulation of risk arrangements. Entities which engage in non-risk arrangements may be required to comply with a state's PPO laws.

³⁹ P. Gregory Banks, Lahey Hitchcock Clinic, in presentation to NAIC Risk Bearing Entities Working Group (August 23, 1996).

similar levels and forms of risk as HMOs should face the same level of consumer protection and solvency standards as applied to HMOs.

Insurance regulators are primarily concerned with ensuring that, regardless of the nature of the entity, consumers receive adequate protection from insolvency and from incentives to deliver inadequate care. In their own states and through the NAIC, many insurance regulators have stressed the importance of creating a level playing field while at the same time fostering a regulatory environment that permits the development of new organizational forms which can also deliver quality care in a cost-effective manner.

Regulators understand the implications of an unregulated managed care market on the ability of states to invoke specific consumer protections when appropriate. Absent inclusion in a regulatory framework, unregulated managed care organizations that accept insurance risk fall outside of the state's ability to protect consumers in the event of an insolvency or the presence of inappropriate incentives to deliver inadequate care.⁴⁰ Regulators are also very concerned about the consequences of developing a regulatory environment which does not require that some risk-bearing entities obtain a license while other organizations which perform the same or similar functions are required to obtain a license. Some of these concerns relate to fundamental regulatory compliance issues. Some regulated entities which observe unregulated organizations performing the same or similar functions may choose to surrender their license.

The concern about how to develop a regulatory framework that enhances competition resonates widely within the insurance regulatory community. The regulatory initiatives under development are being carefully deliberated to facilitate meeting this goal. Efforts to streamline the regulatory process and create certain capital standards based on the level of risk being assumed by risk-bearing entities are designed to more fairly apply burdens on regulated entities. A primary focus of current regulatory efforts is on creating a regulatory structure that recognizes function as opposed to structure, thereby avoiding the obstacles presented to new players who must await regulatory decisions about or the creation of a new regulatory framework for their unique form of organization. However, state insurance regulators are charged with the responsibility of balancing this objective with ensuring that sufficient consumer protections are available. They especially seek to avoid the recurrence of HMO bankruptcies that occurred in the 1980s.

a. State Regulatory Response

In August 1995, the Health Plan Accountability Working Group (HPAWG) of the Regulatory Framework (B) Task Force sent a draft suggested bulletin to state insurance commissioners regarding the regulation of risk-bearing entities. The draft HPAWG bulletin recommended to state insurance commissioners that they require licensure for any health

⁴⁰ Other implications which state insurance regulators may also need to consider include adverse selection against various players in the health insurance market, premium tax losses (for those states which impose premium taxes on managed care organizations) and the ability to regulate rating and implement other state health insurance reforms.

providers which enter into arrangements 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.⁴¹

As indicated by the HPAWG's bulletin, a strong consensus exists among state insurance regulators that entities which enter into a contractual arrangement with an individual, employer, or other unlicensed group and assume insurance risk pursuant to that contractual arrangement, should be required to obtain the appropriate regulatory license. Most states have informed the NAIC that their state has no existing or proposed statutes or regulations to treat provider-sponsored organizations differently from other types of risk-bearing managed care plans. Some states have developed regulatory frameworks specific to provider-sponsored organizations. A few states have a prepaid limited health service organization statute and others are considering this approach to facilitate bringing a broader range of organizations into the managed care insurance market. A small number of states have indicated that risk arrangements between provider-sponsored organizations and certain employers might not require an insurance license.

The regulatory approaches being pursued by state insurance regulators include:

- applying current regulatory requirements to all participants in the health insurance market. These requirements may vary depending upon the level of the risk being assumed;
- creating a separate category for provider-sponsored entities that reflect similar solvency and other consumer protection standards applicable to HMOs; and,
- creating a separate category for provider-sponsored organizations that imposes different solvency and consumer protection requirements on provider-sponsored organizations than are currently imposed on HMOs.

Most states have not created distinct legal requirements for PSOs. In a great number of states, provider-sponsored entities engaged in activities which meet the state's definition of the business of insurance are licensed as HMO's. More than half of the states have HMO laws based upon the NAIC's HMO Model Act. The Act governs persons that provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis. Under the model act, HMOs are subject to initial net worth requirements of \$1,500,000 and must maintain net worth requirements of \$1,000,000.⁴² Contracts between the HMO and a contracting provider must

⁴¹ Letter of Kenny Shipley, Chair, NAIC Health Plan Accountability Working Group to all state insurance commissioners (August 10, 1995). A copy of this letter can be found in the Appendix.

⁴² Specifically, the model requires that HMOs maintain a minimum net worth equal to the greater of \$1,000,000; or two percent of annual premium revenues on the first \$150,000,000 of premium and one percent of annual premium revenues in excess of \$150,000,000; or an amount equal to the sum of three months uncovered health care expenditures; or an amount equal to the sum of eight percent of annual health care expenditures (except those paid on a capitated basis or managed hospital payment basis) and four percent of annual hospital expenditures paid on a managed hospital payment basis. NAIC Health Maintenance Organization Model Act, (model 430).

contain a hold harmless provision that prevents the provider from holding the subscriber or enrollee liable if the HMO does not pay the provider.

Wisconsin has a licensure category that permits more limited forms of managed care arrangements as well. Wisconsin's insurance code allows for the development of the limited service health organization (LSHO). These entities provide for or arrange the provision of a limited range of health care services on a prepaid basis.⁴³ Under Wisconsin's regulations, the organization must maintain a compulsory surplus of not less than the greater of three percent of the premiums earned by the LSHO in the previous 12 months or \$75,000. In addition, the LSHO must maintain a security surplus that is not less than 110 percent of the compulsory surplus. If the LSHO has transferred all of its risk of loss to providers through provider agreements, the Commissioner can accept the deposit or letter of credit to satisfy the minimum capital requirements. For LSHOs that do not transfer all of their risk to providers, if the Commissioner finds that the financial stability calls for higher standards, they may be imposed.⁴⁴ Like Wisconsin, a few states have adopted laws like the NAIC Prepaid Limited Health Services Organization Model Act or related legislation.⁴⁵ Some state insurance department staff have stated that they have begun to look at these prepaid limited health services organization statutes to determine whether that approach is appropriate for their state.

Another form of limited managed care plan permitted by statute can be found in *Michigan* where some of the HMOs are Alternative Financing and Delivery Systems (AFDS). M.C.L. 333.21042 authorizes the insurance bureau to license systems of health care delivery and financing in which organizations are only partially at risk for the costs of services. These entities are regulated in the same manner as HMOs except to the extent that the department and insurance bureau, with the advice of an advisory commission, agrees that such regulation is inappropriate.

In some states, like *Oregon*, HMOs and indemnity-type organizations such as Blue Cross and Blue Shield plans are licensed as health care service contractors. Health care service contractors have lower capital and surplus requirements than commercial insurers and they do not participate in the state's guaranty fund. However, health care service contractors are required to incorporate a hold harmless provision in lieu of guaranty fund protection.

A few states have developed laws specific to provider-sponsored organizations.⁴⁶ Most of these laws do not impose requirements that are significantly different from the state's HMO laws. For instance, *Colorado* has created a limited category for provider networks.⁴⁷ The state Departments of Insurance and Health Care Policy and Financing issued regulations in October for limited service licensed provider networks (LSLPN). LSLPNs can provide services related to

⁴³ WIS. STAT. 609.01(3) (1996).

⁴⁴ WIS. ADMIN. CODE (Rules of Commissioner of Insurance) § 3.52.

⁴⁵ Approximately 7 states have adopted the NAIC Prepaid Limited Health Service Organization Model Act (model 68) or related legislation.

⁴⁶ Some states may have introduced or plan to introduce legislation in the state's legislature that would differentiate between provider and non-provider-sponsored risk bearing entities.

⁴⁷ HB 94-1193.

a single specialty or facility license only. The regulation imposes requirements on LSLPNs which are similar to those applied to HMOs and risk-based capital solvency standards similar to those imposed on traditional carriers. The regulation also reduces paperwork requirements under some circumstances and adds some special requirements, such as certification of network adequacy by an independent third party.

In September 1995, the *Georgia* Department issued a bulletin stating that PSOs which assume insurance risk are subject to regulation by the Insurance Commissioner. In July 1996, the Georgia Department adopted regulations for provider-sponsored organizations that want to offer health insurance coverage. The rules create a new chapter to the department's rules: Regulation of Provider Sponsored Health Care Corporations. Under this regulatory framework, Provider Sponsored Health Care Corporations are insurers which must obtain a certificate of authority prior to establishing, maintaining, and operating a health plan. The regulation requires the Provider Sponsored Health Care Corporation to have initial net worth of at least \$1,000,000 and incorporate a hold harmless provision in its contracts. The major distinction between the law for Provider Sponsored Health Care Corporations and for HMOs rests in the capital requirements. In contrast with Provider Sponsored Health Care Corporations, HMOs must meet initial paid-in capital or minimum surplus requirements of \$1,500,000 and maintain an additional minimum \$1,500,000 in capital stock or surplus.⁴⁸

In 1993, *Iowa* became the first state to enact a statute specifically related to provider networks. Chapter 158 of the 1993 Iowa Acts was enacted to provide flexibility for the development of integrated delivery systems, called organized delivery systems (ODS), including antitrust immunity for the entities. Of particular concern was the ability of these systems to develop in rural areas of the state.⁴⁹ While the ODS is licensed and monitored by the state's Department of Public Health, the Department of Insurance conducts the financial reviews of ODSs.

These health delivery systems may assume risk but must comply with solvency requirements. They must maintain the greater of \$1 million or three times the average monthly claims for third-party providers. The insurance commissioner has the authority to increase this requirement if the commissioner finds it necessary to do so in order to protect the enrollees of the ODS.⁵⁰

While the financial and quality requirements of ODS regulations differ from HMOs, the ODS laws are still comprehensive in scope. The capital requirements are higher for the ODS than for the HMO. Since enactment, only one organization, SecureCare of Iowa, has become operational as an ODS. SecureCare complies with the state's HMO regulations. The state has seen a marked increase in HMO applications due in part to the efforts of providers to enter the Medicaid managed care market, which in Iowa requires a HMO license.⁵¹

⁴⁸ GA. CODE ANN. § 33-3-6-7.

⁴⁹ ALPHA Center/Robert Wood Johnson Foundation, *Provider Service Networks: States Grapple with New Regulatory Challenges*, State Initiatives in Health Care Reform, November/December 1995.

⁵⁰ Iowa Admin. Code §641-201.12(2).

⁵¹ State Initiatives in Health Care Reform at 3.

Recently, the *Kentucky* legislature enacted 96 SB 343 which became effective July 15, 1996. Under the new law, a Provider-Sponsored Integrated Health Delivery Network was defined as an insurer that provides, directly, or through arrangements with others, a health benefit plan to consumers voluntarily enrolled with the organization on a per capita or predetermined, fixed prepayment basis. These entities are required to obtain a certificate of filing from the Insurance Commissioner. The statute sets out criteria with which the entity must comply to receive a certificate of filing related to the capacity to administer various aspects of the health plan. The law also imposes financial requirements which include having an initial net worth requirement or a surety bond of \$1,500,000 and maintaining a minimum net worth of at least \$1,000,000.

Entities which obtained a certificate of filing from the Health Policy Board prior to July 15, 1996, have one year to comply with the provisions of the new law.

The capital and surplus requirements for Kentucky's Provider-Sponsored Integrated Health Delivery Network differ from the standards for HMOs. An HMO that is organized as a corporation must have initial unimpaired paid-in capital stock of \$2,000,000 and maintain unimpaired paid-in capital stock of \$1,000,000. The HMO must also maintain \$250,000 in bona fide additional surplus. An HMO that is organized as a partnership shall have an initial capital account of \$3,000,000 and maintain at least \$1,250,000 in its capital accounts.⁵²

Minnesota, another state to enact legislation specific to provider-sponsored networks, has licensed several provider networks as community integrated service networks (CISNs). CISNs are defined as a formal arrangement licensed by the commissioner to provide prepaid health services to enrolled populations of 50,000 or fewer enrollees.⁵³ The 1994 Minnesota Integrated Services Network Act establishes a separate threshold for CISNs with respect to deposit, reserve and solvency requirements. CISNs must maintain a minimum net worth equal to the greater of: \$1,000,000; two percent of the first \$150,000,000 of annual premium revenue plus one percent of annual premium revenue in excess of \$150,000,000; eight percent of the annual health services costs, except those paid on a capitated or managed hospital payment basis, plus four percent of the annual capitation and managed hospital payment costs; or four months uncovered health services costs. Minnesota permits a three-year phase-in period for CISNs to meet the net worth requirements.⁵⁴

The capital requirements for CISNs are similar to the requirements for HMOs. Minnesota's HMO law requires a beginning HMO to maintain a net worth of at least 8 1/3 percent of the sum of all expenses expected to be incurred in the 12 months following the date the certificate of authority is granted, or \$1,500,000, whichever is greater. Following the first full calendar year, HMOs are required to maintain a net worth of at least 8 1/3 percent and at most 16

⁵² KAR § 304.38-070.

⁵³ Minn. Stat. §62N.02(4a) (West 1996).

⁵⁴ Minn. Stat. § 62N.28 (West 1996).

1/3 percent of the sum of all expenses incurred during the most recent calendar year. The net worth may not, however, fall below \$1,000,000.⁵⁵

Minnesota also enacted a law which authorizes the establishment of health care provider cooperatives. Within very narrowly defined parameters, the statute enables a health care provider cooperative to contract directly with certain employers to provide health services.⁵⁶ This provision sunsets December 31, 1999.⁵⁷ A 1994 bulletin clarifies that these licensed provider cooperatives may contract directly with certain self-insured employers on a risk basis.⁵⁸

The *New York* State Legislature recently passed Assembly Bill 11330 which, in part, addresses “integrated delivery systems.” Under the legislation, integrated delivery systems may deliver comprehensive services on a capitated basis upon receipt of a certificate of authority. The superintendent of insurance will be responsible for regulatory activity related to premium rates, subscriber contracts, and fiscal solvency. The fiscal solvency standards developed by the superintendent of insurance shall be similar to and not exceed those governing HMOs. The integrated delivery system shall be subject to the same provisions of the insurance law as HMOs. Certificate of authorities may be issued pursuant to this legislation until April 1, 2002. In New York, provider-based organizations accepting insurance risk traditionally have been licensed as HMOs.

The *Oklahoma* legislature also recently enacted H.B. 2648 which directed the state’s Board of Health to promulgate rules related to the establishment of provider sponsored networks. The law defines provider sponsored networks as “a provider-based managed care entity, including physician-hospital organizations, organized for the purpose of providing, financing, and managing the risk of health care services to subscribers.” Among other items, the law requires that the rules contain financial solvency and network capacity standards. The rules must also contain the same quality assurance standards as are applied to HMOs.

The *Texas* state legislature also enacted H.B. 3111 to create a certification process for Approved Nonprofit Health Corporations (ANHCs), a type of physician-sponsored organization that can provide managed care services. The law permits ANHCs to “arrange for or provide a health care plan to enrollees on a prepaid basis” pursuant to the receipt of a certificate of authority. To receive a certificate of authority, the ANHC must meet the same regulatory standards as an HMO and be accredited by an appropriate accreditation organization as specified in the statute.

A very few states have indicated that they are unlikely to regulate certain PSO arrangements. In April 1996, the *Illinois* Department of Insurance issued a bulletin which stated that a contracting provider group is not subject to regulation by the Department of Insurance when it engages in an arrangement with an employer or licensed entity in which the provider

⁵⁵ Minn Stat. § 62D.042 (West 1996).

⁵⁶ Minn. Stat. §62R.17 (West 1996).

⁵⁷ Minn. Stat. §62R.26 (West 1996).

⁵⁸ Joint Bulletin of the Minnesota Department of Commerce and Health on Issues in Implementing Health Care Provider Cooperatives., September 26, 1994.

sponsored organization assumes no risk, full risk, partial risk or downstream risk and the employer or licensed entity remains on risk for health care costs should the provider group fail to perform. The bulletin states that the provider group is subject to department regulation when the provider group is the ultimate risk-bearer and is directly obligated to provide, arrange or pay for medical services.

In *Idaho*, the Department of Insurance reviews provider arrangements on a case-by-case basis. The Department notes that it would probably not require an insurance license if a provider enters into an arrangement with a licensed insurer or self-funded employer and the responsibility to members remains with the insurer or self-funded employer. Similarly, it is the *South Carolina* Department's position that it may be preempted by ERISA from regulating any provider network which contracts only with self-insured, single employer health plans.

Most state insurance regulators believe that just as states may regulate traditional insurers which accept insurance risk, the state's ability to regulate provider-based entities which have begun to bear insurance risk does not conflict with ERISA. Where the state regulates a provider-sponsored organization entering into a contract with an individual, employer or other group to deliver services on a risk basis in a similar manner as any other managed care organization, the state regulation does not have any more of an effect on the purchaser than the regulation governing other managed care entities which engage in the business of insurance.⁵⁹

2. Downstream Risk Arrangements

Although much of the debate has focused upon direct contracting relationships between risk-bearing entities and individuals, employers, or other groups, downstream risk arrangements are also being discussed by regulators. Downstream risk arrangements are contractual agreements between licensed insurers, such as HMOs, and subcontracting provider entities (organizations or individuals) that involve the provider entity assuming part of the licensed entity's risk.⁶⁰

Many provider organizations are beginning to assume risk downstream for some of the same reasons that provider organizations are beginning to assume risk directly. Health maintenance organizations, in some markets, have an increased interest in sharing their risk with providers. Providers view the acceptance of downstream risk as a way to remain competitive in the marketplace. However, many providers that accept downstream risk are not seeking to contract directly with individuals, employers, or other groups (although they would like to be able to do so legally if they chose).

The reluctance to engage in direct contracting activities can stem from an unwillingness to enter into competition with well-established health plans in the local market with whom the provider has or seeks to have good relations. It may also stem from a strategic decision to invest

⁵⁹ For additional discussion on this issue see NAIC's Health and Welfare Plans Under the Employee Retirement Income Security Act: A Guide for State and Federal Regulation, 3d (scheduled to be available to the public in early 1997).

⁶⁰ Some states may permit traditional indemnity insurers and Blue Cross and Blue Shield plans to transfer risk to providers. Other states may limit the ability to do so to HMOs.

in the provider organization's "core competencies." Many provider organizations do not have the infrastructure, skills, and resources necessary for assuming risk directly. Alternatively, provider organizations that do have the resources available to develop the infrastructure decide to invest those resources in initiatives related more closely to patient care and quality measurement activities. Additionally, a provider organization may decide to remain only in downstream risk arrangements because the PSO does not have the geographic reach to serve adequately a direct contracting purchaser.

Both the provider community and traditional players in the managed care market seem to agree that PSOs which contract with licensed insurers to provide services on a risk basis should not be subject to licensure requirements that are as strict as those imposed on HMOs. The licensed entity, which is held to state solvency and other regulatory standards, also may be required by the state to monitor the ability of the contracting provider group to continue to provide services from both a solvency and quality perspective.

a. State Regulatory Response

Regulators have been exploring whether they can achieve consumer protection objectives in the downstream context without imposing duplicative regulations on an additional level of organizations. The August 1995 HPAWG draft suggested bulletin did not recommend that state insurance regulators require providers accepting downstream risk to be licensed as HMOs. The vast majority of states do not require a downstream contractor to obtain an insurance license to accept insurance risk.

State regulators are, however, concerned about the nature of the risk arrangements between licensed entities and provider networks. Some regulators continue to inquire whether having a licensed entity involved in the arrangement is enough to address consumer protection concerns. They are exploring many issues such as the question of when the risk and responsibilities of the PSO transform the contract from one between a HMO and provider group to one between a HMO and a subcontracting HMO.⁶¹ Additionally, some state regulators have expressed very strong concern about circumstances under which provider groups are taking on far more risk than they can handle, particularly in a global capitation context, and placing the continuity and quality of beneficiary services in jeopardy.

States are striving to design regulations that minimize the duplication of regulatory standards while still achieving regulatory objectives. A number of states are doing so by relying upon the licensed entity in the arrangement to ensure that consumer protection standards are in place. Nevertheless, states recognize that if the licensed entity does not monitor effectively the contracting provider group or the provider group takes on too much risk, the insolvency of the provider group may considerably harm the solvency of the HMO and the ability of plan enrollees to receive health care services. Consequently, several states, some of which are discussed below, have begun to impose explicit requirements upon the licensed entity to monitor the financial solvency of its subcontractors and perhaps more minimal requirements on the subcontracting

⁶¹ Ernst & Young at 18.

organization. A few states do require that a subcontracting provider obtain a license in order to accept downstream risk. Not all states have a formal position on the regulation of downstream risk arrangements at this time.

On April 6, 1996, pursuant to authority granted under the state's HMO Act, the *Pennsylvania* Department of Insurance issued a Statement of Policy on Contractual Arrangements between HMOs and IDSs,⁶² and the state's Department of Health issued a Statement of Policy on Approval of Provider Contracting Arrangements Between HMOs and PHOs, physician organizations (POs) and IDSs.⁶³ The regulations impose requirements on HMOs which enter into a downstream risk arrangement with provider-sponsored organizations and have been developed instead of a separate regulatory framework for provider-sponsored organizations.

The policy statement issued by the insurance department applies when an IDS contracts with an HMO to assume risk and responsibility for the performance of other functions (such as marketing and enrollment) in addition to the delivery of health care services. The insurance department's policy statement notes that an IDS includes PHOs, POs, physician-hospital-community organizations, and super PHOs.

The policy statement also notes that an entity, either on its own or through others, which solicits or enrolls members in a plan that will deliver prepaid basic health services and delivers prepaid basic health services to those members is an HMO and must obtain a certificate of authority.

With respect to contracts entered into between HMOs and IDSs, the policy statement outlines filing requirement procedures with which HMOs must comply for initial contracts and amended contracts as well as on an annual basis. The statement also indicates the process by which the department will review HMO materials related to these contracts. Specifically, the department will review the contracts to determine whether the contracts contain certain provisions such as a hold harmless provision and provisions which enable the HMO to ensure the financial viability and condition of the IDS.

The state's Department of Health issued a companion statement of policy which enables HMOs to contract with IDSs. Previous to the policy statement, HMOs were only permitted to contract with individual hospitals and individual practitioners. Among other items, the policy statement outlines licensure requirements and financial protection standards. The statement requires the HMO-IDS contract to be referenced in any contract between the IDS and participating providers which have agreed to provide services to the HMO's enrollees. HMO-IDS and IDS-participating providers contracts may involve risk-sharing on a capitated basis, must contain hold harmless language, and must be reviewed and approved by the department. While the IDS may perform utilization review, quality assurance, and credentialing on behalf of the HMO, the standards used by the IDS must be submitted to, be approved by and considered the standards of the HMO. In addition, under the guidelines, the HMO may delegate primary care

⁶² 31 PA. CODE CH. 301.

⁶³ 28 PA CODE CH.9

gatekeeping functions to the IDS as long as the HMO has an acceptable quality of care oversight plan.

The policy statement also outlined the types of IDS-participating provider contracts which are acceptable and the minimum compliance provisions which should be included in an IDS-participating provider contract. Further, the guidelines specifically require, as part of the HMO filing requirements, that the HMO submit all contracts between the HMO and super-PHO and the super-PHO and subcontracting providers.

The state of *Maine* has also recently developed a draft advisory bulletin to regulate risk transfers present in Licensee-IDS contracts primarily through the licensed entity. Maine's draft guidelines also note that when reviewing contracts, the Bureau of Insurance will consider the presence of a variety of factors including, but not limited to, hold harmless provisions, provisions for the maintenance of books, accounts, and records by the IDS and the Bureau of Insurance, appropriate terms permitting the licensed entity to assure itself of the financial viability and condition of the IDS, including the review of IDS records and the imposition of a financial monitoring plan of the IDS, and the ability of the licensed entity to be advised of and have the right to object to any subcontractors with whom the IDS contracts. The Bureau of Insurance is now contemplating legislation consistent with the draft advisory bulletin.

The *New Jersey* Department of Health and Senior Services adopted new HMO regulations in February 1997. Subchapter 15 of the rules focuses on provider agreements and risk transference. This subchapter permits the assumption of financial risk⁶⁴ by an "authorized payor as defined in N.J.A.C. 8:38-1.2⁶⁵, a provider actually performing the health services (including providing supplies) within the scope of his/her license; an employer with respect to its own employees, and dependents of those employees."

Entities that serve as secondary contractors (*e.g.*, PHOs, PSNs, IDSs, *etc.*) to authorized payors to deliver health care services need not obtain a license if they meet the minimum standards for provider agreements as specified in the rules. These minimum standards must be met in order for secondary contractors to accept limited financial risk. These standards (applicable to all provider contracts) include a requirement that the contract specify the method of reimbursement, that capitation shall not be the sole form of compensation for providers who primarily provide supplies instead of services, that a "privity of contract" provision be present in all contracts or dual contracting of providers be used, and that a hold harmless provision is included in the contract. The proposed rules also include a variety of other minimum standards for the primary and secondary contractor's contracts.

⁶⁴ Financial risk is defined in the final rule at N.J.A.C. 8:38-1.2 as "participation in financial gains or losses accruing pursuant to a contractual arrangement, based on aggregate measures of medical expenditures or utilization."

⁶⁵ An authorized payor is defined in the final rule at N.J.A.C. 8:38-1.2 as "a person licensed and authorized to transact business in this State as a health maintenance organization, an insurer doing health insurance business, a hospital service organization, a medical service corporation, a health services corporation, a dental service corporation, a dental plan organization or a fraternal benefit society."

In *North Dakota*, the Department of Insurance monitors certain types of downstream risk arrangements. In 1995, the state enacted a statute which authorizes health care provider cooperatives to enter into service contracts with certain purchasers on a substantially capitated or similar risk-sharing basis. Chapter 26.1-49-04 of the state's insurance laws authorize the cooperatives to enter into risk-sharing contracts to provide services to the "enrollees, members, subscribers or insureds of a nonprofit health service plan, health maintenance organization, accident and health insurance company, or the state medical assistance plan." The statute also provides the state's insurance commissioner with the authority to reject the contract if, among other concerns, "the provider cooperative assumes a corridor of risk greater than 15 percent in its first year of operation, or greater than 30 percent in any subsequent year."⁶⁶

In 1995, *Texas* enacted SB 1407 which amended the state's HMO law to permit HMOs to contract with other health maintenance organizations on a risk basis. Pursuant to this statutory authority, the HMO regulations have been amended to provide for "Provider HMOs". The Provider HMO is an HMO which contracts directly or indirectly through contracts or subcontracts, with a Primary HMO to provide or arrange to provide health care services on behalf of the primary HMO within an HMO delivery network. ANHCs which are arranging or providing health care services on a risk-sharing or capitated risk arrangement on behalf of a HMO need not obtain a certificate of authority.

The Department has adopted certain requirements for contracts between a primary HMO and an ANHC or a provider HMO. The requirements apply when the ANHC agrees to arrange for or provide health care services, other than medical care or services ancillary to the practice of medicine or the provider HMO agrees to arrange for or provide health care services on a risk-sharing or capitated risk arrangement on behalf of the HMOs. These requirements include the primary HMO submitting a comprehensive monitoring plan for how the primary HMO will ensure that the ANHC or provider HMO has an effective administrative system for providing reimbursement to all physicians and providers under contract with the ANHC or provider HMO; all HMO functions which are delegated or assigned under contract with the ANHC or provider HMO are consistent with full compliance by the primary HMO with all regulatory requirements of the Texas Departments of Insurance and Health; and that the primary HMO has filed with the Texas Department of Insurance a copy of the form of the written agreement with the ANHC or provider HMO. The regulation includes a requirement that the written agreement contain a number of provisions with specific language relating to notice of termination, hold harmless clause, and roles and responsibilities.

In *California*, providers do not have the authority to enter into a risk contract of any form unless they meet licensure and other requirements or exemptions under the state's Knox-Keene Act. However, the Department of Corporations did recently issue a limited license to Pioneer Provider Network to engage in risk-assuming activity. A bill has been introduced in the legislature which would authorize providers to accept downstream risk from HMOs. The

⁶⁶ N.D. CENT. Code § 26.1-49-05 (Michie 1995).

Department of Corporations recently studied issues related to the regulation of risk-bearing provider sponsored organizations through a Subcommittee on Provider Entity Risk Sharing.⁶⁷

Not all states have developed a formal position on the regulation of downstream risk activities. For instance, the *New Hampshire* Department of Insurance has not issued a formal position on downstream risk activities and currently reviews these arrangements on a case-by-case basis. Similarly, the *Arkansas* Department of Insurance has no official position on downstream risk activities at this time.

3. Conclusion

State insurance regulators are reviewing deliberately the full range of options available to address the myriad issues raised by the dramatic changes occurring in the health insurance marketplace. In the direct contracting context, many states believe that all entities that operate in the health insurance marketplace that perform similar functions should be subject to the same or similar regulatory requirements.

State insurance regulators are also exploring issues related to downstream risk arrangements. To avoid imposing another layer of regulation in the health insurance market, some state insurance regulators are placing explicit responsibility for monitoring the solvency of subcontracting provider organizations that assume some of the licensed entity's risk on the licensed entity. Other state insurance regulators are closely studying this approach to the regulation of downstream risk arrangements.

D. NAIC Activity

States are also following closely and participating actively in the deliberations of several NAIC task forces and working groups, particularly the Regulatory Framework Task Force and its Health Plan Accountability Working Group and Health Care Consumer Disclosure Working Group. States are also paying close attention to the activities of the Health Organizations Risk-Based Capital Working Group of the Risk-Based Capital (EX4) Task Force. The activities of these working groups will have a significant impact on the model regulatory scheme ultimately developed for health insurance organizations.

1. CLEAR/Health Plan Standards

The Regulatory Framework (B) Task Force has begun the review of NAIC model laws as part of NAIC's Consolidated Licensure for Entities Assuming Risk (CLEAR) initiative. Through this initiative, the members of the NAIC seek to promote a more competitive market place by ensuring that entities that perform the same or similar functions are subject to a level regulatory playing field. It will also serve to clarify that the wide array of organizations performing managed care functions, including health maintenance organizations, preferred provider organizations, point of service plans, fee for service plans, Blue Cross and Blue Shield plans, commercial plans,

⁶⁷ Under existing law, HMOs are regulated by the California Department of Corporations pursuant to the Knox-Keene Health Act of 1975.

and any other plans which finance and deliver health care, fall within the scope of state regulation.

Some states are reviewing their health insurance statutes with the objective of developing a comprehensive licensure scheme. The *Ohio* Insurance Department recently developed a Managed Care Uniform Licensure Act for Health Insuring Corporations designed to achieve this end. The bill repeals the laws which govern prepaid dental plan organizations, medical care corporations, health care corporations, dental care corporations, and health maintenance organizations, and creates one regulated entity called health insuring corporations (HICs). The HIC is defined broadly enough to encompass all entities that assume insurance risk.

The HIC would be a public or private, profit or nonprofit corporation, domiciled in Ohio and formed under the laws of Ohio, that, pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services or any one or more supplemental health care services, or both of these types of health care services, through a network of providers, in exchange for compensation determined by a contractual periodic prepayment or premium, except for reasonable copayments and deductibles. The HIC would be required to certify annually that provider contracts contain certain provisions. Entities which marketed their services through a panel of providers, but did not assume risk would be required to register with the Department of Insurance. The bill was recently enacted by the Ohio legislature.

The NAIC's CLEAR process will include a review of financial standards and reporting requirements as well as the incorporation of health plan accountability standards. The Health Plan Accountability Working Group made great headway in the development of health plan accountability standards for managed care organizations. In June 1996, the membership of the NAIC adopted the Quality Assessment and Improvement Model Act which establishes criteria for the quality assessment activities of health carriers that offer managed care plans, and for the quality improvement activities of health carriers issuing closed plans, or combination plans having a closed component. The Health Care Professional Credentialing Verification Model Act has also been adopted by the membership of the NAIC. This model requires all health carriers that offer managed care plans to establish a credentialing verification program to ensure that all professionals participating in the carrier's managed care plan meet specific minimum standards of professional qualification.

In September 1996 the NAIC membership adopted three additional models: the Managed Care Plan Network Adequacy Model Act, the Health Carrier Grievance Procedure Model Act, and the Utilization Review Model Act. The Managed Care Plan Network Adequacy Model Act establishes the standards for the creation and maintenance of provider networks by health carriers. The model also requires that the arrangements between participating providers and health carriers offering managed care plans address specific issues set forth in the act, and contains requirements for the contracts between health carriers and intermediaries. The Health Carrier Grievance Procedure Model Act contains standards for the establishment of procedures used by health carriers to resolve grievances submitted by covered persons. The Utilization Review Model Act establishes standards for the structure and use of utilization review services.

The Health Information and Privacy Working Group is in the process of developing a model act related to the confidentiality of health information and discussing issues related to the reporting of health data and information. In addition, the Consumer Disclosure Working Group is reviewing issues related to health care consumer disclosure.

2. Health Organizations Risk-Based Capital

States are seriously contemplating how the impact of the level of risk assumed by an entity should be reflected in regulatory standards. The NAIC Health Organizations Risk-Based Capital Working Group, with the technical assistance of the American Academy of Actuaries (AAA), has been working to develop a risk-based capital formula for health care organizations. The capital standard is designed to measure the risk profile of a specific organization. Life and health insurance companies and property and casualty companies are already subject to risk-based capital requirements.

The process for the development of the risk-based capital formula has been highly inclusive, with the active involvement of representatives from the insurer, HMO, and provider communities. In response to some of the concerns expressed by the HMO and provider communities, the NAIC working group has discussed and explored issues of important and unique interest to these two constituencies, such as the admission of health care delivery assets. The working group will present the proposed formula for consideration in June 1997 and conduct a validation of the formula following the June meeting.

3. Guaranty Funds Issues

In most states, HMOs and other managed care organizations have not been subject to requirements to participate in state guaranty funds. A technical resource group of the Guaranty Funds Issues Working Group is studying issues related to insolvency protection for subscribers and enrollees of hospital and medical service plans, HMOs, and other health care delivery entities. The group is reviewing and conducting further research on a number of proposals relevant to guaranty funds and the experience and issues related to HMO insolvencies.

CONCLUSION

In their individual states, and through the NAIC, state insurance regulators continue to review the current regulatory framework to ensure that it incorporates appropriate consumer protection standards and facilitates market competition for all players operating in the marketplace. State insurance regulators have considerable breadth and depth of experience in the area of regulation of entities that engage in insurance risk. A variety of other organizations and agencies, both public and private, have informed and continue to inform the discussion about the appropriate regulatory framework for risk-bearing entities. By working with representatives for the consumer/purchaser, insurance, and provider communities, state insurance regulators continue to maximize their ability to attain these consumer protection and market competition objectives.

APPENDIX

**STATE ACTIVITY RELATED TO
THE REGULATION OF PSOs INVOLVED
IN DIRECT CONTRACTING RELATIONSHIPS
As of May 1997**

STATE	No Separate Regulatory Structure for PSOs	Provider-Specific Act or Regulation
ALABAMA	X	
ALASKA	X	
ARIZONA	X	
ARKANSAS	X	
CALIFORNIA	X	
COLORADO		X See Note 3
CONNECTICUT	X	
DELAWARE	X	
DISTRICT OF COLUMBIA	X	
FLORIDA	X	
GEORGIA		X
GUAM	X	
HAWAII	X	
IDAHO	See Note 2	
ILLINOIS	See Note 2	
INDIANA	X	
IOWA		X
KANSAS	X	
KENTUCKY		X
LOUISIANA	X	
MAINE	X	
MARYLAND	X	
MASSACHUSETTS	X	
MICHIGAN	X	
MINNESOTA		X
MISSISSIPPI	X	
MISSOURI	X	
MONTANA		X See Note 4
NEBRASKA	X	
NEVADA	X	
NEW HAMPSHIRE	X	
NEW JERSEY	X	
NEW MEXICO		X See Note 4
NEW YORK		X
NORTH CAROLINA	X	
NORTH DAKOTA	X	
OHIO	See Note 2	
OKLAHOMA		X

**STATE ACTIVITY RELATED TO
THE REGULATION OF PSOs INVOLVED
IN DIRECT CONTRACTING RELATIONSHIPS
As of July 1996**

STATE	No Separate Regulatory Structure for PSOs	Provider-Specific Act or Regulation
OREGON	X	
PENNSYLVANIA	X	
RHODE ISLAND	X	
SOUTH CAROLINA	See Note 2	
SOUTH DAKOTA	X	
TENNESSEE	X	
TEXAS		X
UTAH	X	
VERMONT	X	
VIRGIN ISLANDS	See Note 2	
VIRGINIA	X	
WASHINGTON	X	
WEST VIRGINIA	X	
WISCONSIN	X	
WYOMING	X	

Source: Written and verbal responses by state insurance regulators to NAIC survey (1996).

Note 1: In a few states, legislation related to the regulation of provider-sponsored organizations has been or is anticipated to be introduced in the state legislature.

Note 2: A few states, such as Idaho, Illinois, Ohio, and South Carolina, have indicated that they may not regulate certain provider-sponsored organizations that enter into insurance risk arrangements with certain employers. Ohio has a provision in its Health Insuring Corporation law specific to provider-sponsored organizations.

Note 3: Colorado has a bifurcated regulatory system for provider-sponsored organizations. Where the PSO is providing limited services, it is regulated as a Limited Service Licensed Provider Network. In all other circumstances involving prepayment, the PSO is subject to HMO regulation.

Note 4: Montana and New Mexico's provider-specific insurance statutes are not applicable to organizations operating in the commercial market.

Acronym Guide

AAA	American Academy Of Actuaries
AFDS	Alternative Financing And Delivery Systems
AHP	Advocate Health Partners
AMCRA	American Managed Care Review Association
ANHC	Approved Nonprofit Health Corporation
APG	Ambulatory Patient Group
CISN	Community Integrated Service Networks
CLEAR	Consolidated Licensure For Entities Assuming Risk
DRG	Diagnostic Related Group
ERISA	Employee Retirement Income Security Act
E&Y	Ernst & Young
HIAA	Health Insurance Association Of America
HIC	Health Insuring Corporation
HMO	Health Maintenance Organization
HPAWG	Health Plan Accountability Working Group
IDFS	Integrated Delivery And Financing System
IDS	Integrated Delivery System
IPA	Individual Practice Association
LHC	Lahey Hitchcock Clinic
LSHO	Limited Service Health Organization
LSLPN	Limited Service Licensed Provider Networks
ODS	Organized Delivery System
PHO	Physician-Hospital Organization
POs	Physician Organizations
POS	Point-Of-Service
PPO	Preferred Provider Organization
PSO	Provider-Sponsored Organization
RBEWG	Risk-Bearing Entities Working Group
TPA	Third Party Administrator
ULL	Union Labor Life Insurance Company

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Bulletin from the NAIC Health Plan Accountability Working Group
to State Insurance Commissioners

To: All Commissioners, Directors and Superintendents
From: Kenney Shipley (Florida), Chair, Health Plan Accountability Working Group
Date: August 10, 1995
Re: Suggested Bulletin Regarding Certain Types of Compensation and Reimbursement Arrangements Between Health Care Providers and Individuals, Employers and Other Groups

The Health Plan Accountability Working Group of the Regulatory Framework Task Force was charged in 1995 with consideration of the development of a single model health care licensing act for all “health carriers” (referred to as the Consolidated Licensure of Entities Accepting Risk Model Act—CLEAR) that would cover HMOs, preferred provider organizations (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/risk-assuming basis. In developing a recommendation, the working group was asked to consider jurisdictional issues raised by such a project and to identify those areas that appropriately rest with state insurance departments and other regulatory agencies. The working group made its recommendation concerning CLEAR to its parent at the Summer National Meeting in June. To formulate the recommendation, the working group held a series of public meetings to determine, in part, the types of entities operating in the marketplace to better define what types of risk-bearing arrangements are engaged in the business of insurance.

The public hearings made the working group aware that groups of health care providers may be entering into certain types of compensation, reimbursement, and risk-sharing arrangements that rise to the level of being the business of insurance without first obtaining a license or certificate of authority from state insurance regulators, in violation of state laws. These groups of health care providers are commonly referred to by a variety of names, such as “integrated provider organizations—IPOs,” “integrated provider arrangements—IPAs,” “physician hospital organizations—PHOs,” and “provider sponsored networks—PSNs.” It was the overwhelming opinion of the members of the working group that if these entities are accepting risk on a prepaid basis (e.g., capitation, etc.), they are in the business of insurance and need to be concerned about existing insurance licensure laws.

The only exception to this opinion is where the entity is accepting “downstream risk” from a duly licensed health carrier (e.g., HMO), on that carrier’s policyholders, certificate holders or enrollees.

To bring this serious problem to your attention, the working group has drafted a suggested bulletin for your consideration to alert the marketplace to your state’s laws and regulations. The bulletin focuses only on risk-sharing arrangements where a provider agrees to assume all or part of the risk for health care expenses or service delivery from an individual, employer or other group. Examples of the types of insurance arrangements that may be occurring in your state are provided in the sample bulletin.

Several states have already found it necessary to address this ever-increasing problem. Copies of a letter used in Ohio and a bulletin released in Minnesota are enclosed as background for your review. However, prior to using the bulletin we urge your staff to undertake a thorough review of your statutory and case law and to modify the bulletin to conform to your state's legal requirements. To assist you in this review, we have enclosed copies of a Maryland Attorney General Opinion, No. 90-030, and one from Georgia, No. 82-71, that pertain to this subject, together with some other thoughts and analysis developed from our many hours of deliberations and discussions.

We hope you find this information helpful. If you would like to obtain any further information on this subject or on our deliberations, please feel free to contact either me or Greg Stites (NAIC/SSO) at (816) 842-3600, extension 460.

Draft Bulletin

This bulletin sets out the position of the Commissioner of Insurance [insert Director or Superintendent, as appropriate] regarding certain types of compensation and reimbursement arrangements between health care providers (e.g., doctors, hospitals, networks and others) and individuals, employers and other groups. It is the Commissioner's goal to see that consumers have the solvency and consumer protections afforded by the insurance laws.

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 [certificate of authority] (e.g., health insurer or HMO, etc.) from the Department of Insurance [insert Division, Bureau, etc., as appropriate].

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 that 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.

The Department of Insurance invites health care providers who have entered into an arrangement, or who are considering doing so, to ask for clarification if they are uncertain whether the arrangement violates state law. The Department will be pleased to work with providers to bring any arrangements into compliance with state insurance law or other laws applicable to health carriers.

August 10, 1995, Memorandum Addendum

Thoughts and analysis on groups of health care providers engaging in the business of insurance.

A. Bulletin Fact Situation:

“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.”

B. Various Definitions for “Insurance”:

In Colorado—“means a contract whereby one, for consideration, undertakes to indemnify another or to pay a specified or ascertainable amount or benefit upon determinable risk contingencies, and includes annuities.”

In Tennessee—“means an agreement by which one party, for a consideration, promises to pay money or its equivalent, or to do some act of value to the assured, upon the disruption or injury, loss or damage of something in which the other party has an insurable interest ...”

In Florida—“is a contract whereby one undertakes to indemnify another or pay or allow a specified amount or a determinable benefit upon determinable contingencies.”

C. Accepted Case Law Definition for an “Insurance Contract”:

“... five elements are normally present in an insurance contract, which are:

1. An insurable interest.
2. A risk of loss.
3. An assumption of the risk by the insurer.
4. A general scheme to distribute the loss among the larger group of persons bearing similar risks.
5. The payment of a premium for the assumption of risk.

See Professional Lens Plan, Inc. vs. Department of Insurance, 387 So. 2d 548 (Fla. 1980)

D. Analysis of Fact Situation Applying a Definition of Insurance and Case Law:

For purposes of this scenario, assume Florida’s definition of insurance, namely, “a contract whereby one undertakes to indemnify another or pay or allow a specified amount or a determinable benefit upon determinable contingencies.” Apply the five elements normally present in an insurance contract as set forth in the Florida case cited above:

1. An insurable interest. The employer in this example is a consumer and has an insurable interest in the health and welfare of its employees (and importantly their dependents) especially where it has established a health benefit plan that obligates it to pay for or provide health care benefits to its employees.

2. A risk of loss. The employer has a risk of loss when it establishes a health (employee) benefit plan that obligates it to pay for or provide health care benefits to its employees. The design of most major medical health benefit plans sponsored by an employer puts it at major financial risk. If employees stay healthy, this risk is diminished. However, if numerous employees become catastrophically sick the risk dramatically increases. Please keep in mind that lifetime maximums for total health care expenses per covered life under a health benefit plan are commonly set at \$1 million or even \$2 million. Multiply that by the number of employees in the company and one gains a better understanding of the potential amount at risk of loss. Traditionally, employers will purchase insurance to cover this risk of loss, or, if they are of sufficient size in terms of the number of employees covered and financial strength, they will self-insure using the general assets of the company.

3. An assumption of the risk by the insurer. In this scenario, the providers become the insurer because they have accepted the risk of providing a schedule of health care benefits on a fixed prepayment basis (usually a fixed monthly charge or fee per employee). The schedule may be all or just part of the benefits required to be covered under the employer's health benefit plan. Regardless, the risk accepted is that of having to provide health care benefits to employees as needed. Again, just as in the discussion of the employer's risk in Paragraph 2 above, the providers have now assumed all or part of the risk to pay for or provide health care benefits "upon determinable contingencies," that is, that only a certain number of employees get sick enough to require benefits. The providers will make a profit if utilization of their services is at or less than the level priced for when they negotiated their contract with the employer. The providers will lose money, and potentially be forced out of business, if overall utilization for the number of employees they have agreed to treat is higher than the total of the fees they have agreed to accept from the employer.

As an aside, if this scenario was not an example of the "assumption of risk," departments of insurance around the country would not be receiving policy form filings from duly licensed insurance companies who have been asked by providers to insure this very risk (e.g., the risk of capitation).

As another aside, some providers have argued that since the employer remains primarily obligated (i.e., stays at risk) to pay or provide for the benefits of the health benefit plan even if the provider group goes insolvent that somehow, magically, this fact removes these transactions from being the business of insurance. This is not the case. Here the employer is seeking to remove all or part of its determinable contingent risk arising from its obligations under the health benefit plan it established for its employees. Employers know that they stay ultimately obligated under the plan to their employees.

However, the employer has an expectation that when it prepays a fixed amount to someone to take over a variable obligation belonging to them, that the person or entity will be there when the time comes to perform. Insurance laws are designed to protect all consumers. Employers are consumers. Employers purchase all types of insurance to help cover risks that they are primarily liable for.

4. A general scheme to distribute the loss among the larger group of persons bearing similar risks. The scheme to distribute losses among a larger group of persons arises from a theory that having to provide more services to one employee will be balanced out by under-utilization of many other employees. At the end of the month, the provider is seeking to have made a profit by having provided a total amount of services of a value at or less than the total amount of the fixed prepayment from the employer (and in most cases, many employers). It is highly unlikely that a provider will join one of these groups and engage in these activities solely with one employer. Even where they have done so, this analysis would hold true, namely, that the activities would be the business of insurance.

5. The payment of a premium for the assumption of risk. The payment of a premium for the assumption of risk occurs when the providers have agreed to accept a fixed prepayment in exchange for providing certain health care benefits for a set number of lives (employees and their dependents). Actuaries are commonly hired by providers to assist them in determining the amount of risk they are accepting before they negotiate one of these contracts.

Conclusion: Any group of providers is engaged in the business of insurance whenever it contracts directly with an employer to provide future health care services on a fixed prepaid basis (e.g., capitated basis). However, varying fact situations must be individually reviewed and analyzed in a similar fashion before the same conclusion can be reached.

E. General Discussion of the Marketplace:

Typically, when an employer chooses to establish a health benefit plan for its employees, it first decides how to fund or fulfill its obligations under the plan. It can choose to self-insure (also referred to as “self-funding”) or to purchase insurance. The plan itself is usually designed by the employer in consultation with a health benefits consultant or with a licensed insurer, which ultimately will either “administer the self-insured plan” or “fully insure it.” Either way, the plan is an employee benefit plan under ERISA. It is important to keep in mind that few employers pay 100% of the cost of a health benefit plan. Employees are regularly subject to copayments and deductibles and in many instances are required to contribute monthly “premiums” toward the cost of the plan. Unfortunately, most employees are not privy to whether their plan is self-insured or fully insured. The NAIC’s white paper “ERISA: A Call for Reform” points out the lack of protections for employees under a self-insured plan.

If the employer chooses to self-insure, the amount of money it must pay each month varies depending on how often its employees receive treatment (i.e., it depends on claims experience). Self-insured employers will often hire an actuary to determine its theoretical monthly financial obligation to set a global budget for the amount at risk and the statistical odds of exceeding this budget. The larger the number of covered lives in the group, the more predictable the risk.

An employer afraid of the variable financial risk required by self-insuring may choose to transfer the risk (or a portion thereof) by paying someone else to accept it. Traditionally employers will go out and solicit bids from various types of insurers to “take over the group,” meaning to

remove them from the risk of being obligated beyond a defined amount each month, referred to as premium.

As medical expenses have risen in recent years and new market systems have moved more lives into some form of managed care, employers have been forced to find non-traditional ways to try and reduce their costs and obligations. At the same time, providers have become increasingly frustrated with their standing in traditional managed care arrangements. It appears that provider groups have recently begun joining together in ever-increasing business combinations to sell and provide their services directly to employers with self-insured health benefit plans on a fixed prepayment basis (and other risk-assuming arrangements). Remember that these two groups have been doing business with one another for years and years, only on a “fee-for-service,” “discounted fee,” “cost-plus” basis, “DRG” basis, etc. All of these more traditional types of contracts paid the providers for actual services incurred only when someone got sick and needed them. The trigger mechanism for payment was someone getting sick. None of these contracts paid providers for when people did not get sick. Under the capitated payment mechanisms, the providers are counting on the vast majority of people they are under contract to serve not getting sick, yet these agreements expose them to the risk that everyone will.

As stated earlier, an employer is a consumer that deserves the protection of the insurance laws. The employer has made a fixed prepayment (a premium) to the providers to provide future (randomly used) health care services to its employees. If the providers become insolvent, the employer has lost its premium, yet it is still obligated to continue to pay for or provide for all the health care benefits under the health benefit plan. This scenario is further made grievous where the employees have contributed toward the fixed prepayment by paying a “premium” to their employer for the health benefit plan. Now both parties have paid for something they won’t get except by paying someone else for the services.

This scenario also places the employees at risk since most providers will look to them for full payment for the services they have individually received in a situation where the employer falls on hard times and becomes in arrears for payment of the fixed prepayment.

Since no privity of contract exists between the providers and the employees, the providers can look for payment from the person who personally received the treatment. It has been reported that few of these risk-sharing agreements have hold-harmless provisions to protect the employees if the employer were to become insolvent.

To: John E. Callender, Senior Vice President, Ohio Hospital Association
From: David J. Randall, Deputy Director, Ohio Department of Insurance
Date: July 28, 1994
Re: O.H.A. Questions at Managed Care Seminar

You had asked that the Department respond in writing to the following questions which you had proposed at the Managed Care Seminar.

1. Please discuss, in general, the concept "business of insurance." When does a contract between two parties, that a third party may be a beneficiary of, become the business of insurance?

The Department looks to the factors outlined in Ohio Attorney General Opinion No. 72-034 for guidance on the definition of the concept "business of insurance." Opinion No. 72-034 cites the case of *State ex rel. Duffy v. Western Auto Supply*, 134 Ohio State 163 (1938). The Duffy Court stated, "Broadly defined, insurance is a contract by which one party, for a compensation called the premium, assumes particular risks of the other party and promises to pay to him or his nominee a certain or ascertainable sum of money on a specified contingency." Duffy, at page 168. The Duffy Court noted that the promise could be for some value other than the payment of money.

In addition, Opinion No. 72-034 noted five elements which comprise the business of insurance based on an insurance treatise, *Vance on Insurance* (third edition, 1951, page 2). These factors are:

- a. The insured must have an insurable interest,
- b. The insured's interest is subject to a risk of loss upon the happening of some outlined peril or contingency,
- c. The insurer assumes the risk of loss,
- d. The assumption is part of a scheme to distribute the losses among a group with similar risks, and
- e. The insured pays a premium as consideration for the insurer's promise to pay.

In addition, the Department looks at several factors the United States Supreme Court presented in determining whether something falls within the "business of insurance." These factors are:

- a. Is the risk transferred and spread,
- b. Is the practice an integral part of the policy relationship between the insurer and the insured, and
- c. Is the practice limited to entities in the insurance industry?

Metropolitan Life Ins. Co. V. Massachusetts, 471 U.S. 724 (1985).

Because there is no clear definition of the "business of insurance," the Department reviews each situation on a case-by-case basis and uses the above outlined factors in its analysis.

2. Does ODI recognize a difference between an insurance/actuarial risk and a business risk?

Yes. The difference between the two is that an insurance/actuarial risk is a risk transference (i.e., spreading) while a business risk is not. The best way to explain this is by example. A capitated payment is an insurance/actuarial risk because the provider receives a set fee per number of participants, regardless of actual utilization. A business risk, on the other hand, could be exemplified by the usual PPO arrangement, where a provider discounts its fee-for-service in anticipation of a greater volume of business. If no services are rendered, the provider is paid nothing, unlike the capitated provider who receives the same payment regardless of utilization.

3. Can a fully integrated physician hospital organization (PHO) enter into a capitated arrangement with any of the following?

- a. HMO?
- b. Indemnity insurer?
- c. Self-insured employer?

The Department permits HMOs and indemnity insurers to capitate because there is a regulated entity involved in the transaction that is capable, by statute, to be part of a risk sharing arrangement. In a capitated arrangement between a PHO and a self-insured employer, on the other hand, all the risk is transferred from the self-insured employer to the PHO. The PHO is acting as an insurer without being licensed by the state. This violates Ohio Revised Code §3905.42, which states that no one shall engage in the business of insurance or something substantially amounting to insurance unless expressly authorized by state law.

4. Is there a “degree” of risk assumption that a provider may assume that would be acceptable to ODI, e.g., if a capitated arrangement was limited to services only provided by a particular provider or if the contract was reinsured via stop loss coverage?

No. There is no “degree” of risk assumption that would be considered de minimis to the prohibition contained in Ohio Revised Code §3905.42. It is like being “a little bit pregnant.”

5. What is ODI’s position regarding the potential creation of “alternative licensing arrangement,” (ALA) to accommodate the pending OhioCare waiver? Will ODI support, if necessary, the creation of an ALA for Medicaid recipients?

The Department and the Administration are currently exploring options regarding the potential creation of alternative licensing arrangements for, and in conjunction with, the OhioCare waiver. However, the Department’s strong belief in this matter is that all licensed entities should meet the requirements of Chapter 1742 of the Ohio Revised Code.

6. Our reading of Chapter 1742 appears to allow a local political subdivision to create an HMO without creating a separate corporation. Do you agree? If yes, what financial reserve requirements must these entities meet?

No. The Department's view is that political subdivisions do not fall within the definition of "person" contained in Ohio Revised Code §1742.01(K). The term "political subdivision" is often included in various sections of the Ohio Revised Code where the intent is to specifically include them. As the term is not included in §1742.01(K), the Department believes they are not permitted to operate an HMO without creating a separate entity.

Once again, I would like to thank you on behalf of myself and the other ODI participants in the managed Care Seminar for the opportunity to come and address the above issues. If O.H.A. members have further questions, please feel free to contact Amy Renshaw or Charles Perin of the Department's Legal Services Division at (614) 644-2640.

TO: Interested Persons
FROM: John Gross, Supervisor, Life and Health Analysis, Minnesota Department of Commerce
Nanette M. Schroeder, Director, Occupational and Systems Compliance Division, Minnesota Department of Health
DATE: Sept. 26, 1994
RE: Issues in Implementing Health Care Provider Cooperatives

We were recently asked to clarify several issues which may be important to those interested in health care provider cooperatives, as authorized under the Minnesota Health Care Cooperative Act ("the Co-op Act"), which was enacted as Article 11 of the MinnesotaCare Act of 1994 (Laws of Minnesota 1994, Chapter 625). Our responses cite the applicable sections of law.

I. Direct Contracting with Self-Insured Plans

We have received questions about whether and under what circumstances, a health care provider cooperative ("provider co-op") can contract to provide services directly to a self-insured employer.

Section 6, Subdivision 1 of the Co-op Act requires contracts between provider co-ops and purchasers to provide for payment on a "substantially capitated or similar risk-sharing basis." The transfer of risk that is inherent in such contracts makes them "insurance" as defined in Minnesota Statute §60A.02, subdivision 3:

"Insurance" is any agreement whereby one party, for a consideration, undertakes to indemnify another to a specified amount against loss or damage from specified causes, or to do some act of value to the assured in case of such loss or damage. A program of self-insurance, self-insurance revolving fund or pool established under section 471.981 is not insurance for purposes of this subdivision.

Accordingly, a self-insured purchaser that purchases such a product has purchased insurance, and would therefore be subject to benefit mandates, premium taxes, MCHA assessments and various other state law provisions from which self-insured purchasers are ordinarily exempt under the preemption provisions of the federal Employee Retirement Income Security Act.

Moreover, a provider co-op that enters into such contracts directly with purchasers, rather than with a licensed health plan company, such as a Community Integrated Service Network (CISN), health maintenance organization (HMO), indemnity insurer or Blue Cross/Blue Shield of Minnesota, would be deemed an "insurance company" as defined in Minnesota Statute §60A.02, subdivision 4. As such, it may not transact business in this state without holding an insurance license issued by the Commissioner of Commerce. See Minnesota Statute §60A.07, subdivision 4.

An exception to the general rules stated above was provided in the MinnesotaCare Act of 1994. Under a series of provisions (including, among others, Article 1, Sections 3 and 4, and Article 8,

section 1), a narrow exception as crafted under which certain large self-insured purchasers may purchase health care on a capitated basis, through a CISN, Integrated Service Network (ISN), HMO, or preferred provider organization (PPO), subject to certain specified state insurance regulations, without otherwise becoming subject to state insurance regulation. Pursuant to these provisions, a provider co-op may provide capitated services to some self-insured purchasers, through a CISN, ISN, HMO or PPO.

Finally, it should be noted that the statutory provisions discussed above do not prohibit the providers in a provider co-op from forming an affiliated entity and using that entity as a vehicle for contracting with self-insured plans on a fee-for-service or discounted fee-for-service basis, provided that the entity complies with antitrust and other applicable laws.

Please contact Terry Desmond of the Department of Commerce at (612) 296-9429 if you have any questions concerning this issue.

II. Enforcement of the Requirement that Provider Co-ops Contract with Purchasers on “Substantially Capitated or Similar Risk-Sharing Basis.”

Section 6, subdivision 1 of the Co-op Act provides as follows:

Any contract between a provider cooperative and a purchaser must provide for payment by the purchaser to the health provider cooperative on a substantially capitated or similar risk-sharing basis. Each contract between a provider cooperative and a purchaser shall be filed by the provider network cooperative with the Commissioner of Health and is subject to the provisions of Section 62D.19.

Pursuant to the provision quoted above, the Commissioner of Health will review provider co-op contracts for two purposes: to ascertain whether the contract satisfies the requirement that payment be made on a substantially capitated or similar risk-sharing basis, and to ascertain whether the contract constitutes an unreasonable expense for the purchaser. The Commissioner may invalidate a contract on either basis.

In determining whether a contract provides for payment on a “substantially capitated or similar risk-sharing basis,” the Commissioner will consider the totality of the circumstances involved. Given the absence of a definition in the Co-op Act of “substantially capitated or similar risk-sharing basis,” the Commissioner will look for guidance to definitions provided in Article 1, Section 8, subdivision 4 and Article 1, Section 9, subdivision 2 of the 1994 MinnesotaCare Act (defining “capitation” and “capitated basis,” respectively), but such definitions are not necessarily controlling in applying the Co-op Act.

Please contact Kent Peterson of the Department of Health at (612) 282-5616 if you have any questions concerning this issue.

Maryland Attorney General Opinion

(Opinion dated June 19, 1990)

Insurance—jurisdiction of insurance
commissioner—health benefits program.

You have requested our opinion on whether a health benefits program known as “Healthnet” is subject, in whole or in part, to the jurisdiction of the Insurance Commission. Although Healthnet, which is currently being marketed, prompted your inquiry, other similar programs have been proposed.

For the reasons stated below, we conclude that the providers of health care under Healthnet and other similar programs are engaged in the business of insurance and are thus subject to the jurisdiction of the Insurance Commission. As insurers, the providers are subject to the licensure, minimum capital, reserve, rate-setting, and other applicable requirements of the Insurance Code. The intermediary administrative entity, however, is not engaged in the business of insurance.⁶⁸

I. The Healthnet Plan

The Healthnet plan is a means through which health benefits are provided to employer groups. The plan is marketed and advertised by Willse & Associates (Willse), an unlicensed third-party administrator, to employer groups known as sponsors. The sponsors enter into a contract with Willse, pursuant to which Willse undertakes to purchase medical services for the sponsors’ employees and their dependents (called “covered persons” in the contract).

Sponsors pay Willse a predetermined fee, called a “capitation fee,” that is set at X dollars per covered person per month. A portion of this fee is retained by Willse as compensation for purchasing the medical services and for administering the payment of medical bills during the life of the contract. Willse’s administrative fee is fixed by this contract. While the total amount paid to Willse may vary depending upon plan utilization, the capitation fee does not.

To have medical services available for covered persons, Willse also enters into contracts with various “health plans,” some of which are licensed health maintenance organizations (“HMOs”) and some of which are not. Indeed, we understand that at least one and possibly more of the health plans participating in Healthnet do not provide health care benefits at all. Rather, these plans themselves enter into contracts with physicians or physician groups, and sometimes with HMOs, to render the necessary care.

⁶⁸ These conclusions apply only to the Healthnet program and others that might be structured similarly. An assessment of whether an entity is engaged in the provision of “insurance” can only be made case-by-case, after close analysis of the particular facts. We also note that if a program were to be structured so as to be a “preferred provider insurance policy,” it would be subject to regulation under newly enacted Chapter 578 (House Bill 558), Laws of Maryland 1990 (effective July 1, 1990).

You have informed us that, while payment to these health plans is made in a variety of ways, in all contracts Willse first deducts its administrative fees from the capitation payment and then forwards the remainder of that payment to the health plan⁶⁹. In exchange, the health plan agrees to provide the medical services enumerated in its contract with Willse to the covered persons⁷⁰. Some contracts require copayments for certain services; others do not. No plan provides hospitalization for covered persons. The cost of hospitalization is borne solely by the sponsor, although Willse undertakes to oversee bill payments. Nor does any contract provide benefits for emergency services.

At this point in the compensation scheme, the contracts fall into two differing types:

Under the first type of contract, there is an annual “adjustment” to the capitation fees paid by Willse on the sponsor’s behalf. You described this adjustment formula as follows: The sum of each sponsor’s capitation fees and the copayments made by the covered persons are compared to the actual costs to the health plan of providing the services. If the cost of services is less than the sum of fees paid to the health plan, the health plan refunds 50% of the difference to Willse, which forwards this amount to the sponsor. The health plan retains the other 50%. If the cost of services is more than the sum of the fees paid to the health plan, the sponsor is not required to pay any further fee. The loss is absorbed by the health plan.

In addition, under this type of contract, the health plan receives a bonus or incurs a penalty based on the services outside the contract with the health plan. That is, the health plan either receives or pays 50% of the difference between projected costs of these out-of-plan services and the actual costs⁷¹.

⁶⁹ The capitation payment is determined by including Willse’s negotiated administrative fee into the health plan’s negotiated payment. In other words, Willse negotiates a “per-member per-month” contract with the health plan, adds its own “per-member per-month” administrative charge, and then uses that figure as its total cost to the sponsor.

⁷⁰ Typically, the health plan agrees at a minimum to provide physician services, diagnostic services, chemotherapy, ambulance services, physical examinations, maternity care, and well-baby care.

⁷¹ In this respect the plan differs from a plan in which the employer, through an administrative services-only (ASO) contract, undertakes the provision of health care benefits. An ASO contract, in which the employer pays dollar-for-dollar the actual amount of the cost of the benefits, does not contain the bonus or penalty provisions of the plans at issue here. The plan also differs from a typical HMO. See § 19-701(e) of the Health-General Article.

The Healthnet program in some respects resembles a traditional preferred provider organization (PPO), in which insureds are offered panels of physicians from which to choose their care. In both types of programs, these panels of physicians work under contract to the plan administrator or insurer. However, it is our understanding that the PPO structure does not contain certain

The second group of contracts contains a different approach to annual adjustments. First, an annual projected cost per-employee per-month is developed for each sponsor. The annual projected cost includes not only the capitation fees paid the health plan, but also the projected amount that will be spent for each sponsor's covered persons for the year for hospital fees, emergency care, and other out-of-health-plan benefits. At the end of the year, a comparison is made between the annual projected cost and the actual cost of services. The actual cost of services equals the cost of services provided by the health plan plus the cost of hospital, emergency, and other out-of-health-plan benefits actually paid. If the actual cost of services exceeds the annual projected cost, a penalty is assessed against the health plan equal to 50% of the difference, with an overall dollar limit. Willse administers the penalty for the sponsor against the health plan by reducing the capitation payments made to the health plan. The sponsor is responsible for the remainder of the loss. If the actual cost of services is less than the annual projected cost, a bonus equal to 50% of the difference is paid to the health plan.

II. Applicability of Insurance Code

A. Introduction

The legal question is whether the Healthnet program, in whole or in part, is "insurance" and thus subject to regulation.⁷²

"Insurance" is defined in Article 48A, § 2 of the Maryland Code as "a contract whereby one undertakes to indemnify another or pay or provide a specified or determinable amount or benefit upon determinable contingencies." This definition "includes not only promises of strict indemnity but also promises to pay or provide a specific or determinable amount or benefit upon determinable contingencies. By using the term 'provide' the statute includes contracts for the rendition of service." 63 Opinions of the Attorney General 422, 424 (1978).⁷³

provisions, such as the hospitalization bonus or penalty, contained in the Healthnet contracts. We find this distinction to be significant.

⁷² It is almost universally held that "the insurance industry is affected with a public interest and may be regulated by the states within constitutional limits." *Maryland Medical Services v. Carver*, 238 Md. 466, 484, 209 A.2d 582 (1965). See also, e.g., *Saffore v. Atlantic Casualty Insurance Co.*, 21 N.J. 300, 121 A.2d 543 (1956) *Insurance Department v. City of Philadelphia*, 196 Pa. Super, 221, 173 A.2d 811 (1961) *Brown v. Bernard*, 376 So.2d 1034 (La. App. 1979).

⁷³ The "insurance business" is defined as follows in § 8:

(a) The "insurance business" includes the transaction of all matters pertaining to a contract of insurance, both prior to and subsequent to the effectuation of such a contract, and all matters arising out of such a contract or any claim thereunder.

The following five elements of an insurance contract have long been applied in determining whether a particular plan falls within the definition of “insurance”:

- (a) The insured possesses an interest of some kind susceptible of pecuniary estimation, known as an insurable interest.
- (b) The insured is subject to a risk of loss through the destruction or impairment of that interest by the happening of designated perils.
- (c) The insurer assumes that risk of loss.
- (d) Such assumption is part of a general scheme to distribute actual losses among a large group of persons bearing somewhat similar risks.
- (e) As consideration for the insurer’s promise, the insured makes a ratable contribution, called a premium, to a general insurance fund.

42 Opinions of the Attorney General 254, 256-57 (1957) (quoting Vance, Law of Insurance § 1 (3d ed. 1951)). See also 72 Opinions of the Attorney General 167 (1987); 55 Opinions of the Attorney General 196 (1970). As this office also noted, “[d]istribution of risk of loss among a large group of persons bearing somewhat similar risks lies at the heart of the concept of insurance.” 63 Opinions of the Attorney General at 425.

B. Status of Intermediaries

In our view, no contract of insurance exists between Willse and the sponsors. Willse assumes no risk of loss, and the fees that it receives from the sponsors pay for administration, not for the actuarial cost of spreading that risk. It carries out its contractual obligation by entering into contracts, either directly with the providers of medical services or with entities that then contract with the providers.

In acting as a conduit and not accepting the contractual responsibility to provide the medical care in exchange for premiums, Willse is not an insurer. Its role is merely that of administrator.

We have been informed that in certain instances an entity, Healthcare 2000, contracts with Willse to provide health care services and, in turn, enters into its own contracts with providers. Much as does Willse, Healthcare 2000 receives an administrative fee and passes the premium along to the actual providers. Again, the entity accepts no financial risk, receives no premiums, and provides only administrative services. It is not an insurer.

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- (b) The “insurance business” does not include the pooling together by public entities for the purpose of self-insuring casualty risks.

C. Status of Providers

When Willse contracts directly with providers, we understand that Willse pays them for services at reduced rates. The theory behind this arrangement is that the volume of business generated for the providers will offset the income forgone through the reductions. Under both the contract types described in Part I above, the providers assume the risk of loss, which, we have been informed, can be quite substantial. Here we reach the insurance component of the plan.

It is true that assumption of risk of loss does not automatically convert a contractual obligation into one of insurance. Were that true, all contracts of warranty would automatically become insurance contracts. This office has opined to the contrary. See 42 Opinions of the Attorney General 254 (1957).

Here, however, all five elements necessary to find an “insurance” arrangement are present:

- (1) The insureds, the “covered persons,” possess an insurable interest in their health.
- (2) The covered persons face substantial risk of loss through the occurrence of designated perils, such as disease or accident.
- (3) The health care provider assumes the risk of loss by accepting capitation payments under the contracts described above.
- (4) The health care provider spreads the cost over a large group of covered persons.
- (5) The provider accepts a “premium”—the capitation payment.

Our conclusion is in accord with pertinent decisions from other jurisdictions. For example, *Manasen v. California Dental Services*, 424 F.Supp. 657 (N.D. Cal. 1976), rev’d on other grounds 638 F.2d 1152 (9th Cir. 1979), involved a plan under which employers paid fixed, per capita premiums to a provider in exchange for dental services to the plan’s beneficiaries. The provider assumed the risk that these premiums would be enough to cover the costs of the services. This plan was the “business of insurance,” the court held. See also, e.g., *Klamath-Lake Pharm. Ass’n v. Klamath Med. Serv. Bureau*, 701 F.2d 1276, 1286 (9th Cir. 1983) (health care provider’s policies with insureds are the business of insurance “insofar as they shift the risks of medical costs” to the provider); *State v. Blue Crest Plans, Inc.*, 421 N.Y.S. 2d 579, 580, 72 A.D.2d 713 (1979) (legal services plan constitutes insurance when contract contains prepayment; distributes loss among large group; has insurable interest; and contains legally binding promise, premium payments and profit motive for service providers). Cf. *Professional Lens Plan v. Department of Insurance*, 387 So. 2d 548 (Fla. App. 1980) (contract to furnish replacement lenses is not insurance where there exists neither premium payments, assumptions of a risk, or a risk-spreading mechanism).

Our conclusion is not changed by the fact that Willse enters into the contract with the provider on behalf of the employer. Willse, in entering into these contracts, is expressly acting as agent for

the employer. The ultimate beneficiary of the services remains the employees. Moreover, we do not believe that merely interjecting a claims payment administrator into the relationship alters the provider's underlying obligation to provide care to those employees who participate in the benefits plan. Simply placing a conduit between insured and provider does not render the provider's obligation to employees anything other than "insurance."⁷⁴

Finally, we do not believe that the employer's creation of a self-funded employee benefits package, protected from state regulation by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C.A. § 1001 et seq., exempts the providers of those services from state regulation as well. "While ERISA supersedes state law regulation of employee benefits plans, the Act allows the States to continue to regulate the sale of insurance." *Taggart Corp. v. Efros*, 475 F. Supp. 124, 125 (S.D. Tex. 1979). See *Matthew 25 Ministries, Inc. v. Corcoran*, 771 F.2d 21 (2d Cir. 1985); *Bell v. Employee Security Benefit Association*, 437 F. Supp. 382 (D. Kan. 1977).

Insurers and those acting as insurers are not released from state statutory obligations merely because those to whom they sell products and services fall under the protection of ERISA. ERISA was intended to permit employers to craft creative methods of providing benefits to employees. But ERISA was not intended to exempt sellers of insurance from applicable state laws. H. Conf. Rep. No. 93-1280, 93d Cong., 2d Sess. (1974), reprinted in 1974 U.S. Code Cong. & Admin. News 5038, 5162.

IV. Conclusion

In summary, it is our opinion that the Healthnet program is partially subject to the jurisdiction of the Insurance Commissioner. Willse, acting as agent of the employer, does not fall within that jurisdiction. However, we believe that the providers of health care services themselves are engaging in the business of insurance by insuring the provision of health care benefits on the occurrence of certain determinable contingencies, for the payment of a premium in the form of a capitation payment.

J. Joseph Curran Jr.
Attorney General

Editor's Note⁷⁵

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⁷⁴ Nor does it matter if Willse contracts with Healthcare 2000 or some other additional administrative intermediary.

⁷⁵ Editor's Note—No section III per original.

Georgia Attorney General Opinions

Selected Attorney General's Opinions

Opinion No. 82-71 Prepaid Dental Plans May Not be Licensed as Health Maintenance Organizations

August 27, 1982

You have requested my official opinion as to whether certain types of prepaid dental plans constitute the offering of insurance and, if so, may those plans be licensed as health maintenance organizations pursuant to Ga. Ins. Code Ch. 56-36. Before addressing the specific types of plans mentioned in your letter, an examination of what constitutes the offering of insurance in Georgia is in order.

Georgia Insurance Code § 56-102 [§ 33-1-2] defines “insurance” broadly as “a contract which is an integral part of a plan for distributing individual losses whereby one undertakes to indemnify another or to pay a specified amount or benefits upon determinable contingencies.” Thus, to constitute insurance, a plan must involve a “contract” that agrees to pay “specified amount[s] or benefits upon determinable contingencies” and contain an element of risk distribution. Op. Att’y Gen. 74-48. See *Piedmont Life Insurance Co. v. Bell*, 109 Ga. App. 251, 260 (1964); Op. Att’y Gen. 72-62.

All of the plans discussed in your request, including that of a particular corporation (Dent-A-Care of Georgia, Inc.), involve contracts that call for the provision of specified benefits on determinable contingencies. That the benefits provided are services, as opposed to cash, is not relevant. Op. Att’y Gen. 74-48. Thus, whether these plans are insurance depends upon whether they also involve “a plan for distributing individual losses,” i.e., risk distribution.

The first generic type of plan addressed in your request is one whereby a participant pays a fixed amount for all the scheduled dental services which may be needed during the period of the contract. Since this type of plan presumably will charge a premium which is considerably below the cost of the services potentially available to each participant, it necessarily anticipates the distribution of losses among its participants and constitutes insurance.

Another generic type of plan discussed in your letter involves an arrangement by which the participants pay a fixed amount for the right to participate and the dentists involved agree to provide scheduled services at reduced cost to participants, usually 20 to 25 percent of the normal and customary fee for such services. Assuming that the percentage charged is substantially below the dentists’ actual cost of providing the services, the effect of this arrangement is also to distribute losses and thus the plan constitutes insurance. See Op. Att’y Gen. 72-62. Of course, if the amount charged each time a service is rendered at least approximates the dentists’ actual cost, no risk distribution and thus no insurance is being effected.

The final generic type of plan discussed in your request is described as a “capitation” plan whereby the sponsoring plan pays participating dentists a fixed fee for each participant enrolled by that dentist (as opposed to reimbursing participating dentists for services rendered as per the first type of plan discussed above) and the dentist agrees to provide all the services scheduled for this fixed fee. As with the type of plan first discussed above, if the fee charged to participants is highly disproportionate to the maximum benefits theoretically available to participants, the plan constitutes the offering of insurance.

As described in your request, the Dent-A-Care plan is a combination of the first and second generic types discussed above which involves a set periodic fee for which participants receive free specified preventive dental services and more comprehensive dental services at reduced charges. As with the first and second types discussed above, the arrangement will constitute risk distribution and thus insurance unless the amounts charged to each participant at least approximate the cost of the services rendered to that participant.

In short, it is my official opinion that all of the above-discussed prepaid dental plans constitute the offering of insurance if their financial success depends upon some participants not fully utilizing the available benefits so as to offset the cost of participants who fully utilize available benefits. Alternatively, if in fact a plan’s charges to each participant approximate the cost of the services rendered to that participant, no insurance or risk distribution among participants would be involved. An examination by your office of the fee structure and costs of operation of a particular plan may be necessary to reach the proper determination as to that plan.

Finally, you have asked that in the event it is determined that a prepaid dental plan is offering insurance, may that plan be licensed as a health maintenance organization pursuant to Ch. 56-36 of the Georgia Insurance Code. Pursuant to Ch. 56-36, all health maintenance organizations must provide “basic health care services.” Ga. Ins. Code § 56-3603(2)(c) [§ 33-21-3]; Department of Human Resources Regulation 290-5-37-.03. Since this term is defined in Ch. 56-36 to include as a minimum ... inpatient hospital and physician care, and outpatient medical services” (Ga. Ins. Code § 56-3601(2)) [§ 33-21-1], it is my official opinion that a plan offering only dental services may not be licensed as a health maintenance organization since it does not provide basic health care services.

Michael J. Bowers
Attorney General

Volume II: Position Paper

INTRODUCTION

The Regulation of Health Risk-Bearing Entities is a two-volume white paper that reviews regulatory issues prompted by the rapidly evolving health insurance marketplace. Volume One contains a review of the nature of insurance risk, types of organizations operating in the health insurance market, form of arrangements in which they are entering, and states' regulatory activities. Volume Two contains the National Association of Insurance Commissioners State and Federal Health Insurance Legislative Policy Task Force's position on state regulation of health risk-bearing entities.

Organizations that engage in the business of insurance are subject to state insurance regulation. The states' examination of how they regulate health risk-bearing entities has been prompted by the tremendous growth in the presence of organizations offering managed care services in the health insurance market and the diverse forms which these organizations are taking. This evolving market challenges state regulators in their efforts to balance key regulatory objectives. States are particularly concerned about balancing the following three regulatory objectives:

- protecting consumers;
- regulating health risk-bearing organizations that perform the same or similar functions in the same or similar manner while preserving flexibility for unique or innovative organizations; and
- evaluating and adapting health insurance regulation to the rapidly evolving health insurance market.

These three regulatory objectives are important for a number of reasons. Consumers are best protected when standards are applied to all organizations operating in the health insurance market under a regulatory approach that appropriately regulates organizations given the nature of their insurance functions. Protecting consumers, regulating by function, and adapting to the marketplace facilitate a fair and competitive health insurance marketplace.

A. Protecting Consumers

State insurance regulation's principal purpose is to protect consumers. States perform this function through a comprehensive range of standards and monitoring activities. These standards are applied to risk-bearing organizations that perform a health insurance function.

Health insurance is offered in a variety of different ways. State insurance regulation is structured to reflect the ways in which insurance coverage is provided. For instance, some organizations offer indemnity insurance coverage. Other organizations offer managed care

insurance coverage that involves both the financing and delivery of health services. Volume One of this white paper provides a more detailed overview of these alternatives.

Both of these approaches—indemnity insurance coverage and managed care insurance coverage—raise many of the same types of consumer protection issues, most notably issues related to financial solvency and market conduct. States protect consumers through a range of activities including:

- approving organizations for licensure to engage in the business of insurance;
- applying appropriate financial requirements;
- monitoring an organization's financial condition and market conduct continually through extensive examinations and financial analysis;
- acting quickly to supervise and rehabilitate if a licensed organization shows signs of financial distress;
- maintaining sophisticated financial databases for auditing and exchanging information within the state and among the states through the NAIC;
- monitoring and regulating market conduct practices including benefit payment practices;
- licensing and providing disciplinary oversight for the agent sales force; and
- processing and providing redress for complaints and grievances.

Organizations that both finance and deliver health care are also subject to other standards, including those related to health care quality and provider network adequacy.

Financial solvency, market conduct, and other state standards and monitoring activities are relevant to all organizations that perform an insurance function. Other additional standards and monitoring activities appropriate for organizations that deliver and finance health care are applied to all managed care insurance organizations. This is the case regardless of the organization's structure or ownership.

The nature and emphasis of these standards may be affected by the organization's structure or ownership but they remain relevant to, and are applied to, all forms of risk-bearing organizations.

B. Regulating By Function

There is a diversity in the structural forms of health risk-bearing organizations licensed by the states, particularly with respect to managed care insurance organizations. State insurance

regulation appropriately reflects these structural differences. Examples of structural differences include the following:

- Some managed care insurance organizations may be for-profit while others may be not-for-profit;
- Some managed care insurance organizations may be owned by the providers who actually deliver the services while others are owned by non-providers;
- Some managed care insurance organizations may employ the providers who deliver the services while others contract with those providers, or combine these approaches.

These structural differences do not alter the insurance function performed by these organizations. Nor do these structural differences alter the necessity for states to fulfill their consumer protection responsibilities.

More than half of the states have adopted laws similar to the NAIC's Health Maintenance Organization Model Act. The remaining states have adopted other laws to govern managed care insurance organizations. These laws have enabled the states to accommodate the wide range of structures present among managed care organizations.

C. Adapting to an Evolving Marketplace

State regulation is a dynamic process. States are continuously evaluating and adapting regulatory standards in light of activities occurring in the marketplace. Examples of state efforts to adapt to today's evolving marketplace include:

- The managed care standards related to quality, network adequacy, and other areas that have been adopted in a variety of states;
- The uniform licensing law for all health insuring organizations proposed by the Ohio Department of Insurance and being considered by the Ohio General Assembly; and
- The risk-based capital formula for managed care organizations being developed by state insurance regulators through the NAIC.

These state initiatives apply to all organizations that perform insurance functions. Through these initiatives more sophisticated approaches are used to adjust standards based on the nature and level of risk being assumed by an organization.

CONCLUSION

These three key regulatory objectives—protecting consumers, regulating by function, and adapting to an evolving marketplace—are the guideposts of state regulators as they examine the relationship between the health insurance market and state insurance regulation. State regulation

is predicated upon the goal of protecting consumers. States have used a broad range of sophisticated and time-tested standards and tools to perform their consumer protection responsibilities. State regulation also is predicated upon the goal of promoting a competitive marketplace. As the competitive marketplace evolves, states have continued to meet the challenge to adapt and refine their regulatory standards and tools.

