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**\*449** REGULATION OF “DOWNSTREAM” AND DIRECT RISK CONTRACTING BY HEALTH CARE PROVIDERS: THE QUEST FOR CONSUMER PROTECTION AND A LEVEL PLAYING FIELD

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**I. INTRODUCTION**

As the delivery of health care continues to be driven by the search for an effective means of reducing costs and delivering quality care to the greatest number of people, the industry’s most beloved buzzword, perhaps ironically, has a root suggestive of a focus on the individual: capitation.[1](#co_footnote_F1115542113_1) Capitation is widely regarded as a method of realigning economic incentives to produce fair prices, real value, reasonable profits and predictable growth in costs.[2](#co_footnote_F2115542113_1) Beyond being a mere payment mechanism, though, capitation represents a philosophical shift to an accountability approach for health care delivery, whereby focus is increasingly directed on prepayment of capitated amounts to risk-bearing delivery systems.[3](#co_footnote_F3115542113_1) Theoretically, the premise makes a great deal of sense: to achieve optimal levels of care delivered and costs expended, incentivize persons or entities with the capacity to affect such levels so that economic reward follows effective management of resources.

Placing, for the moment, faith in the innovative capacities of the marketplace to seek out new and improved ways of delivering health care, the evolution of the capitated arrangement indicates that what makes sense in theory may also make sense in practice. As capitation becomes the dominant form of payment within the United States health care arena and emerges as an effective tool for cost savings and efficient delivery of care, providers and insurers alike are now appreciating the **\*450** overwhelming dollar amounts that will be represented by the capitated flows.[4](#co_footnote_F4115542113_1) It is now clear that controlling capitation means controlling an increasingly large amount of money. Naturally, what follows is that competing interests--most notably, health maintenance organizations (HMOs), insurance companies, and providers--now vie for command of capitation.

This Article examines regulatory attempts to monitor provider-driven efforts to gain control of capitated premiums. Regulators seeking to tether entrepreneurial physician groups must maneuver through a maze of contractual arrangements, by which varying portions of the capitated dollar and inhering risk are transferred, in search of providers undertaking what amounts to “““insurance risk.” Provider-sponsored organizations (PSOs) are assuming risks previously limited to insurance companies and HMOs,[5](#co_footnote_F5115542113_1) and now state insurance regulators are scrambling to determine to what extent these organizations may be regulated under state authority. The ongoing debate that now rages, as regulators struggle with PSOs and search for a consistent rationale for regulating these risk-bearing entities, calls for inquiries into the very nature of capitation and its place in relation to traditional insurance and the purview of state oversight.

This Article’s analysis of the controversy surrounding the regulation of PSOs proceeds in several parts. Part I sketches some of the various arrangements developing in the health care marketplace, with particular emphasis on the “downstream” and direct contracting in which PSOs have become involved. Part II provides insight into the nature of insurance regulation, including how it may restrict the risk-bearing activities of PSOs. Part II also introduces the complicated and contentious provisions of the Employee Retirement and Income Security Act of 1974 (ERISA),[6](#co_footnote_F6115542113_1) along with relevant case law dealing with the preemptive effect of specific ERISA provisions[7](#co_footnote_F7115542113_1) on the regulatory efforts of state insurance commissioners. Part III outlines some of the approaches taken by different states searching for a coherent regulatory scheme that can account for the dynamic nature of PSO risk contracting. Part IV assesses sundry arguments regarding the regulation of risk-bearing PSOs, devoting special attention to a recent draft white paper of the National Association of Insurance Commissioners (NAIC)[8](#co_footnote_F8115542113_1) and the representative stance of that organization. Part IV also evaluates provider and employer responses to the NAIC and other views, in an effort to distill the essentials for effective regulatory development. This Article concludes that, absent further federal legislation, state insurance regulators would be best advised to limit their efforts to regulate PSO arrangements so not to impede cost-cutting and innovative market advances made by provider organizations. Nevertheless, congressional intervention in this complex and increasingly crucial area of health law is needed to permit PSOs to proceed with new and improved mechanisms for both delivery and insurance of health care.

**\*451 II. MOVEMENTS OF THE MARKETPLACE**

Understanding the controversy surrounding the regulation of risk-bearing PSOs depends on recognizing the types of provider organizations involved and the nature of the risks they are assuming in the health care marketplace. Because the market is changing so rapidly, and because the entities involved and the payment arrangements utilized can vary so greatly, it is essential initially to flesh out who is involved and what objectives they have.

**A. THE ENTITIES: PROVIDER-SPONSORED ORGANIZATIONS**

Until only recently, traditional indemnity insurers dominated the health care insurance market.[9](#co_footnote_F9115542113_1) HMOs[10](#co_footnote_F10115542113_1) now play a major role in both health care delivery and insurance, and they are expected to continue to do so in the near future.[11](#co_footnote_F11115542113_1) Doctors and hospitals have now begun to recognize, however, that the shift from fee-for-service (FFS) to capitation has placed them in a unique position to reap some of the monetary rewards generated by industry wide cost-cutting efforts.[12](#co_footnote_F12115542113_1) The doctors and hospitals--the “providers”--are fighting back by forming large organizations and networks to increase their bargaining power relative to insurers and HMOs.[13](#co_footnote_F13115542113_1) These provider-run entities, generically termed PSOs, are the source of much controversy.[14](#co_footnote_F14115542113_1)

Physician-hospital organizations (PHOs) are joint ventures between hospitals and physicians established to create a single marketing and contracting entity.[15](#co_footnote_F15115542113_1) PHOs bring hospital and physician providers together in a separate, vertically integrated enterprise for delivering health care in a managed care environment.[16](#co_footnote_F16115542113_1) Thus, a common characteristic, though not an essential element of PHOs, is the acceptance of capitation risk.[17](#co_footnote_F17115542113_1) PHOs are usually created to develop cooperative relationships between the parties while allowing for flexibility, in terms of both organizational structure and capacity for a variety of activities and growth.[18](#co_footnote_F18115542113_1) Individual (or, independent) **\*452** practice associations (IPAs) are provider organizations that contract with payors on behalf of a group of providers to provide health care services.[19](#co_footnote_F19115542113_1) These types of PSOs operate to bring together otherwise separate providers, usually physicians, in an affiliated manner to provide health care.[20](#co_footnote_F20115542113_1) Most often, the IPA will take the form of a legal entity, such as a professional corporation or professional association, which is separate from the medical practice organizations of the individual providers.[21](#co_footnote_F21115542113_1) IPAs allow physician practices that are otherwise too small to be competitive in the marketplace, to integrate moderately and access managed care contracts.[22](#co_footnote_F22115542113_1) Although not usually organized to engage in the practice of medicine, IPAs can be structured both to practice medicine and to take capitation payments.[23](#co_footnote_F23115542113_1)

Besides PHOs and IPAs, a variety of other entities are structured and function in a manner that they too can properly be classified as PSOs. Group practices, for instance, are physician groups that provide health care services and share income and expenses.[24](#co_footnote_F24115542113_1) Preferred provider organizations (PPOs), which contract with a network of providers who deliver services to enrollees and set charges based on a negotiated fee schedule, may operate as PSOs.[25](#co_footnote_F25115542113_1) Among some of the other entities that can be classified as PSOs, depending on how they are structured, how they operate, on who is describing them, are: physician organizations, integrated delivery systems, provider-sponsored networks, HMOs,[26](#co_footnote_F26115542113_1) organized delivery systems,[27](#co_footnote_F27115542113_1) integrated delivery and financing systems,[28](#co_footnote_F28115542113_1) limited service provider networks,[29](#co_footnote_F29115542113_1) alternative health care delivery and financing systems,[30](#co_footnote_F30115542113_1) integrated service networks and community integrated service networks.[31](#co_footnote_F31115542113_1)

Arcane nomenclature notwithstanding, the impact of PSOs is now difficult to deny. In a September 1996 report, the 202 PSOs surveyed covered more than ten million lives in forty states and generated total revenues greater than four billion dollars.[32](#co_footnote_F32115542113_1) The survey also found that most PSOs were relatively new ventures.[33](#co_footnote_F33115542113_1) As individual entities, however, the PSOs surveyed neither generated great profits nor covered large numbers of enrollees.[34](#co_footnote_F34115542113_1) Assuming current market trends, these organizations **\*453** should continue to develop, improve operations and gain further acceptance in the marketplace.[35](#co_footnote_F35115542113_1)

Although PSOs are not overwhelmingly profitable at this stage and, indeed, some will continue to struggle or even fail,[36](#co_footnote_F36115542113_1) PSOs seem to keep proliferating. This proliferation seems to support a growing body of evidence showing that delivery networks perform most effectively when they are lead by providers.[37](#co_footnote_F37115542113_1) Other evidence indicates that salaried physicians are less productive than self-employed physicians, thus implying that potential benefits exist in creating PSOs.[38](#co_footnote_F38115542113_1) Hence, for our purposes, identifying and implementing an appropriate level of insurance regulation for PSOs might suggest that regulatory obstacles such as licensing and reserve requirements actually have a deleterious effect on provider-driven attempts to introduce competitive products into the health care market.[39](#co_footnote_F39115542113_1)

**B. RISK-TRANSFERRING ARRANGEMENTS**

**1. PSO Arrangements**

PSOs operate in such a way that the customary distinction between “providers” and “insurers” quickly disintegrates.[40](#co_footnote_F40115542113_1) This phenomenon occurs largely because capitation is creating the opportunity for providers to assume risk in managed care contracts.[41](#co_footnote_F41115542113_1) By assuming a degree of risk, PSOs begin to look much like insurers. Capitation creates an environment in which, to the dismay of many state insurance commissioners, it becomes difficult to distinguish between appropriate performance incentives and the provision of insurance.[42](#co_footnote_F42115542113_1)

Given the highly competitive and fluctuating markets for health care delivery and insurance, PSOs enter into contractual arrangements that represent varying methods of payment.[43](#co_footnote_F43115542113_1) Comprehending the payment methods, replete with risk-sharing mechanisms, is essential to classifying the nature of the risks that contracts transfer.[44](#co_footnote_F44115542113_1) Prior to contemplating the appropriate level for PSO regulation, though, one must first gain a sense of the different arrangements shaping the market environment.

**\*454** As PSOs become larger and begin to compete with the more sophisticated insurance companies and HMOs in the marketplace, PSOs will enter into contracts and financing structures that are more complex than the basic FFS arrangements that were once the norm.[45](#co_footnote_F45115542113_1) These arrangements include payment mechanisms ranging from capitation arraignments with licensed insurers or HMOs to full or partial risk-sharing with employers.[46](#co_footnote_F46115542113_1)

PSOs may contract with HMOs, Blue Cross and Blue Shield plans, traditional indemnity insurance companies or employer groups to provide health care services.[47](#co_footnote_F47115542113_1) Within these contracts are a wide range of payment methods, which vary according to both the form of managed care arrangement and the provider.[48](#co_footnote_F48115542113_1) For example, risk arrangements with primary care providers often involve capitation, global fees, withholds, risk pools and bonuses.[49](#co_footnote_F49115542113_1) By contrast, arrangements with specialty physician and hospital providers encompass a broader spectrum of payment mechanisms, each involving differing degrees of risk transfer.[50](#co_footnote_F50115542113_1)

**2. Classifying Risk in Payment Arrangements**

Breaking down the risk-transfer arrangements into downstream contracting and direct contracting is essential for analyzing both sides of the regulatory fence.[51](#co_footnote_F51115542113_1)

It is useful to break down the various payment methods into categories based on the nature of the risk transfer involved. These categories help isolate the regulatory issues raised by different contractual arrangements. In a notable PHO survey, the Group Health Association of America (GHAA)[52](#co_footnote_F52115542113_1) evaluated four categories of business arrangements into which PHOs may enter.[53](#co_footnote_F53115542113_1) “““No risk” contracts exist when PHOs contract directly with employers on a FFS basis for all medical services.[54](#co_footnote_F54115542113_1) In these instances, employers retain full insurance risk for the cost of employee medical services.[55](#co_footnote_F55115542113_1) In “““full risk” arrangements, PHOs again contract directly with employers, but here the PHOs are paid on a capitated basis for the provision of all medical services **\*455** employees should require.[56](#co_footnote_F56115542113_1) “Partial risk” contracting exists when PHOs contract directly with employers and agree to stay within a budget allocated to pay for all medical services.[57](#co_footnote_F57115542113_1) Depending on whether the PHO stays within the budgeted amount, the providers either will be liable for any excess expenses up to 10% above the allotted amount or will be able to split with the employers savings generated.[58](#co_footnote_F58115542113_1) Finally, “““downstream risk” exists when PHOs contract directly with licensed HMOs or insurers, rather than with employers, and are paid on a capitated basis.[59](#co_footnote_F59115542113_1)

**3. Downstream and Direct Contracting**

Downstream contracting includes arrangements between PSOs and licensed insurers, such as HMOs or PPOs, whereby the PSOs act as subcontractors and accept risk transferred from the insurance entities.[60](#co_footnote_F60115542113_1) By assuming risk downstream from the “upstream” licensed entities, PSOs hope, by retaining portions of capitation streams, to remain competitive in the marketplace.[61](#co_footnote_F61115542113_1)

PSOs’ downstream risk contracting may give them enhanced market power without contracting with employers and assuming risk directly from them. By using upstream insurers as intermediaries, PSOs can avoid possible pitfalls in becoming directly involved with employers, including lack of organizational discipline, insufficient management expertise and incomplete infrastructure for bearing risk.[62](#co_footnote_F62115542113_1) Downstream arrangements may also aid PSOs that lack the geographic reach to satisfy the health care needs of a direct contracting purchaser.[63](#co_footnote_F63115542113_1) From a strategic business perspective, PSOs can prefer downstream contracting to direct contracting, which breeds conflicting cooperation and competition survival tactics with larger area health plans.[64](#co_footnote_F64115542113_1) Perhaps the most substantial barriers keeping PSOs from acting as direct contractors, as will be discussed, are the significant capital requirements and regulatory hurdles.[65](#co_footnote_F65115542113_1)

Direct contracting, which arises in three of the four categories in the GHAA survey,[66](#co_footnote_F66115542113_1) involves agreements between a PSO and individuals, self-insured employers or other unlicensed groups.[67](#co_footnote_F67115542113_1) These arrangements may involve no risk, full risk or partial risk transfers.[68](#co_footnote_F68115542113_1) Direct contracting arrangements with self-insured employers **\*456** that include full risk or partial risk transfers are perhaps the most controversial of the risk-bearing PSO contracts.[69](#co_footnote_F69115542113_1)

Direct contracting is crucial to entrepreneurial PSOs because it allows them to bypass insurers and HMOs and to assume risk directly from employers. PSOs have, since the early 1990s, been using various forms of risk-transferring agreements to take on full or partial risk from licensed HMOs and indemnity insurers.[70](#co_footnote_F70115542113_1) Currently, however, PSOs are becoming involved in direct contracts with self-insured employers who are exempt from obtaining a state insurance license because they are regulated under ERISA; and PSOs in some instances are developing their own insurance products, insurance companies or HMOs.[71](#co_footnote_F71115542113_1)

Thus, PSOs in various forms are actively seeking to adapt to the capitated payment system, doing so through a potpourri of risk-transferring mechanisms. Using both downstream and direct risk contracting arrangements, allows provider organizations the opportunity to compete with indemnity plans and HMOs and to regain some of the control they have lost to these insurance entities. But this PSO activity raises considerable controversy, because PSOs do not readily fall within the ambit of traditional insurance regulations in many states and because they are increasingly bearing more risk and assuming larger chunks of capitated payment streams relative to the insurers and HMOs they now resemble.[72](#co_footnote_F72115542113_1) To what extent risk-bearing PSOs should be covered by state insurance regulations, then, is a serious issue.

**III. THE BREADTH OF STATE INSURANCE REGULATION OF THE PSO AND THE ERISA ROADBLOCK**

The responsibility and authority for regulating insurance lies primarily with the states.[73](#co_footnote_F73115542113_1) Thus, states must regulate entities that bear health insurance risk, such as risk-bearing PSOs.[74](#co_footnote_F74115542113_1) State regulators are charged with three tasks: (1) identifying the numerous species of risk-bearing entities operating in the health insurance market; (2) determining whether each species involves “insurance risk” or the “business of insurance”; and (3) deciding which entities to regulate.[75](#co_footnote_F75115542113_1) These are not easy chores to complete, for, in many cases, they force a re-thinking of some of the most fundamental rationales for regulating health insurance and require action consistent **\*457** with the overall regulatory climate and objectives.[76](#co_footnote_F76115542113_1) Furthermore, when PSOs contract with certain self-insured entities, regulating provider organizations is further complicated by ERISA’s potential preemptive effect on state laws.

This section of the Article examines the principles underlying state efforts aimed at regulating health insurance, including certain risk-bearing activities now being undertaken by PSOs. A preliminary review of some foundational philosophies supporting health insurance regulation provides a context for assessing what states may reasonably regulate as insurance risk and the business of insurance. This Article then parses ERISA statutory provisions and case law to determine ERISA’s preemptive effect before ultimately analyzing justifications for states’ regulating the more controversial downstream and direct contracting PSO arrangements.

**A. FUNDAMENTALS OF STATE INSURANCE REGULATION**

**1. Insurance Regulation**

Each state has the ability to regulate the “business of insurance,” as clarified by the McCarran-Ferguson Act.[77](#co_footnote_F77115542113_1) State insurance regulations are typically based on market regulation[78](#co_footnote_F78115542113_1)--ensuring fair and reasonable insurance prices, products and trade practices, and solvency regulation--protecting policyholders against the risk that insurers will not be able to meet their financial obligations.[79](#co_footnote_F79115542113_1) Market regulations include, most prominently, rates and policy form regulation and market practice regulation.[80](#co_footnote_F80115542113_1) Solvency regulations, the more problematic form of regulations for the purposes of the issues raised, encompass minimum capital and surplus requirements, financial reporting requirements and solvency monitoring.[81](#co_footnote_F81115542113_1) Capital standards may arguably be the linchpin of solvency regulation,[82](#co_footnote_F82115542113_1) and that these standards seem to end up in the middle of the debate over PSO regulation is not surprising.

**\*458** Two fundamental concerns are motivating factors for state health insurance regulators: consumer protection and a level playing field.[83](#co_footnote_F83115542113_1) Insurance regulators view their role in regulating health insurance as both ensuring that the public is protected against insurer insolvency, and encouraging competition among health insurers to lower the overall cost of health insurance.[84](#co_footnote_F84115542113_1) Depending on the view one takes about the proper function of health insurance regulation, the goals of consumer protection and maintaining the fairness of the competitive environment may create conflicting concerns.[85](#co_footnote_F85115542113_1) Nonetheless, state laws typically operate to balance these competing concerns, to the extent they can, by requiring insurers and managed care entities to cover certain mandated benefits, to maintain solvency standards, to include required contractual language in written policies and to fulfill access and reporting obligations.[86](#co_footnote_F86115542113_1)

Before establishing authority over certain entities or activities, state insurance regulators must make a threshold determination as to which entities assume insurance risk and thereby engage in the business of insurance. Only after defining the scope of the industry shibboleths can one examine which PSO activities may fall under a state’s regulatory umbrella.

**2. “Insurance Risk” and “Business of Insurance”**

Distinguishing insurance risk from other types of risk is crucial to understanding states’ abilities to regulate activities as the business of insurance.[87](#co_footnote_F87115542113_1) Although the word *risk* is often used generically to denote exposure to the chance of loss,[88](#co_footnote_F88115542113_1) the term *insurance risk* takes on a more specific meaning.

To diminish the costs associated with a given risk, parties can choose to establish what may loosely be described as a contract of insurance.[89](#co_footnote_F89115542113_1) For example, one **\*459** party, the “insured,” may choose to transfer all or part of a given risk to another party, the “insurer.”[90](#co_footnote_F90115542113_1) In this type of transaction, the party that assumes the risk also agrees, in exchange for a premium payment, to perform some function in the event that the risk occurs.[91](#co_footnote_F91115542113_1) The insurer quite often assumes the unknown, future levels of risk faced by a number of insureds and “pools” the risks together in order to spread each risk across the group.[92](#co_footnote_F92115542113_1) The insurer establishes a proper price for risk assumption and calculates loss experience actuarial probabilities, hoping the premium payments received will be ample to cover the costs associated with the risks assumed and provide a fair profit.[93](#co_footnote_F93115542113_1) The risk that is transferred from the insured to the insurer is referred to as insurance risk.[94](#co_footnote_F94115542113_1)

Delineating what is insurance risk is a useful starting point when seeking to designate a range of activities as the business of insurance. That insurance risk exists, however, is not the only factor analyzed when defining the business of insurance.

Because the McCarran-Ferguson Act makes clear Congress’s intent that the states are responsible for regulating the business of insurance, each state has been left the task of defining what activities fall within the Act. Each state, in turn, has developed its own interpretation of the business of insurance.[95](#co_footnote_F95115542113_1) Although some state regulators believe the business of insurance is implicated, for example, when an organization engages in underwriting or risk-spreading, other regulators view risk-spreading as only one of the factors to consider in locating such business activity.[96](#co_footnote_F96115542113_1) Besides state statutes and regulations that establish criteria for determining when an arrangement involves insurance risk, state and federal court cases are also important references for making such determinations.[97](#co_footnote_F97115542113_1)

The Supreme Court has had several opportunities to define what constitutes the “business of insurance.” Two of the most pertinent instances arose from antitrust cases requiring interpretation of the McCarran-Ferguson language. *Group Life & Health Insurance Co. v. Royal Drug Co.*[98](#co_footnote_F98115542113_1) and *Union Labor Life Insurance Co. v. Pireno*[99](#co_footnote_F99115542113_1) laid the foundation for developing a congruous health insurance regulatory framework.

**\*460** In *Royal Drug,* where the Court examined a relationship between an insurance company and a group of pharmacies, the issue was the proper interpretation of the “business of insurance” language in the McCarran-Ferguson Act.[100](#co_footnote_F100115542113_1) The relationship in question allowed the insurer’s policyholders to buy prescription drugs from the participating pharmacies for two dollars, and it obligated the insurer to reimburse those pharmacies for the cost of the drugs.[101](#co_footnote_F101115542113_1) Essentially, the insurer was able to cap its costs for the drugs and thus reduce the amount it was required to pay to its insureds.[102](#co_footnote_F102115542113_1) After observing that an indispensable characteristic of insurance spreading and underwriting of policyholder risk, the Court further noted that the legislative history of the McCarran-Ferguson Act “strongly suggest[s] that Congress understood the business of insurance to be the underwriting and spreading of risk.”[103](#co_footnote_F103115542113_1) The Court proceeded to find that the arrangements between the insurer and the pharmacies did not constitute the business of insurance.[104](#co_footnote_F104115542113_1)

The *Royal Drug* opinion continued with several other pertinent observations regarding the business of insurance language and the relationships of the parties involved in the case. The Court found the “contract between the insurer and the insured” to be “[a]nother commonly understood aspect of the business of insurance,”[105](#co_footnote_F105115542113_1) and it further noted that Congress, in enacting the McCarran-Ferguson Act, was concerned with the “‘relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement.”DD’[106](#co_footnote_F106115542113_1) Finally, the Court refused to define the arrangement as the business of insurance[107](#co_footnote_F107115542113_1) because it involved “the mass purchase of goods and services from entities outside the insurance industry.”[108](#co_footnote_F108115542113_1)

In *Pireno,*[109](#co_footnote_F109115542113_1) the Supreme Court was faced with deciding whether an alleged conspiracy to eliminate price competition among chiropractors, using a “““peer review committee” for advising an insurance company on the necessity and reasonableness **\*461** of medical services, constituted the business of insurance.[110](#co_footnote_F110115542113_1) Holding that the issue was controlled by *Royal Drug,* the Court identified three criteria relevant to determining when a particular practice is the business of insurance under the McCarran-Ferguson Act: (1) whether the practice involves transferring or spreading a risk of policyholders; (2) whether the practice encompasses an “integral part of the policy relationship” between the insurer and the insured; and (3) whether the practice is limited to entities within the insurance industry.[111](#co_footnote_F111115542113_1) Using these three criteria to evaluate the activities of the peer review committee in question, the Court concluded that they did not consider the arrangement to be the business of insurance.[112](#co_footnote_F112115542113_1)

First, the Court found that the peer review committee was not involved in transferring or spreading any policyholder risk that is characteristic of insurance, noting that the arrangement was “logically and temporally unconnected to the transfer of risk accomplished” by the insurer.[113](#co_footnote_F113115542113_1) Second, because it was “obviously distinct” from the contracts between the insurer and the insureds, the Court determined that the arrangement in dispute was not an integral part of that relationship.[114](#co_footnote_F114115542113_1) Third, the Court found the challenged peer review activities were not limited to entities within the insurance industry, because practicing chiropractors were inescapably involved.[115](#co_footnote_F115115542113_1)

Besides these two antitrust cases, the Supreme Court has also had occasion to define the business of insurance in other contexts. In *Metropolitan Life Insurance Co. v. Massachusetts,* the Court used a similar analysis to evaluate whether a state law requiring health insurance policies to cover a minimum level of health benefits was preempted by ERISA.[116](#co_footnote_F116115542113_1) By examining whether the law fell within the three factors articulated in *Pireno,* the Court found that the Massachusetts law satisfied all three criteria.[117](#co_footnote_F117115542113_1) Thus, the Court concluded that the law regulated insurance and was not subject to ERISA preemption.[118](#co_footnote_F118115542113_1)

**\*462** In *Jordan v. Group Health Association,* the D.C. Circuit Court of Appeals analyzed an arrangement similar to that in *Royal Drug.*[119](#co_footnote_F119115542113_1) In *Jordan,* a nonprofit health care corporation contracted with independent physicians and other providers to render certain health care services to its members.[120](#co_footnote_F120115542113_1) Under those contracts, the providers accepted a fixed payment amount and were required to perform all of the health care services that members required.[121](#co_footnote_F121115542113_1) Although the court recognized that the providers, rather than the nonprofit corporation, had contractually assumed the risk of loss, the court found that such an agreement “should not be classified as insurance if the paramount purpose in its formation was to be the rendition of the services rendered.”[122](#co_footnote_F122115542113_1) Thus, in finding that the principal object and purpose of the arrangement was not to assume insurance risk but to provide health care services, the court held that insurance regulation was inapplicable.[123](#co_footnote_F123115542113_1)

**B. ERISA’S PREEMPTIVE EFFECT**

ERISA further complicates state efforts to regulate insurance. Generally ERISA regulates the management and administration of employee benefit plans and, with a notable exception, specifically preempts any state laws that “““relate to” such plans.[124](#co_footnote_F124115542113_1) The exception relevant here is that which “saves” state insurance laws from preemption.[125](#co_footnote_F125115542113_1) Although ERISA’s design and intended effect on state law appears fairly simple at first glance, dissecting the statutory language and attempting to gauge its actual operation is quite complex.[126](#co_footnote_F126115542113_1) Because ERISA has the potential to **\*463** hamstring certain state efforts to regulate health insurance, it is critical to consider the language of the statute along with interpretive case law.

**1. ERISA’s “Relate to” Provision**

We must interpret the “relate to” provision to measure ERISA’s reach. The U.S. Supreme Court made an early attempt to clarify the scope of this clause in *Shaw v. Delta Air Lines, Inc.*[127](#co_footnote_F127115542113_1) In determining whether New York State antidiscrimination and disability benefit laws, operating to require employers to pay certain employee benefits, were preempted by ERISA, the Court opted for a broad reading of the “relate to” language.[128](#co_footnote_F128115542113_1) The Court stated that “[a] law ‘relates to’ an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such plan.”[129](#co_footnote_F129115542113_1) This generous reading, although somewhat confined by one of the opinion’s footnotes,[130](#co_footnote_F130115542113_1) would not be effectively restricted until a more recent landmark decision.

In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.,*[131](#co_footnote_F131115542113_1) the Court was faced with a challenge to a New York law requiring hospitals to collect surcharges from those patients covered by commercial insurers but not from those covered by Blue Cross or Blue Shield plans.[132](#co_footnote_F132115542113_1) Travelers Insurance Company, among other plaintiffs, claimed that ERISA preempted the state law to the extent that the surcharge system would limit employee benefits plans by increasing the cost of health insurance alternatives to the Blues.[133](#co_footnote_F133115542113_1) The Supreme Court held that ERISA did not preempt the law because it did not relate to ERISA benefit plans.[134](#co_footnote_F134115542113_1) The Court adjudged laws that have merely an “indirect economic influence” on ERISA benefit plans not subject to ERISA preemption.[135](#co_footnote_F135115542113_1) The Court qualified its holding, however, adding that a state law producing indirect economic effects acute enough to “effectively restrict” ERISA plans in their choice of insurers may legitimately remain subject to preemption.[136](#co_footnote_F136115542113_1)

**2. ERISA’s “Saving” and “Deemer” Clauses**

ERISA’s “saving” and “deemer” provisions are integrated into the statute such that even state laws that “relate to” employee benefit plans may not be vulnerable to **\*464** preemption.[137](#co_footnote_F137115542113_1) The saving clause of ERISA exempts from preemption “any law of any State which regulates insurance….”[138](#co_footnote_F138115542113_1) However, ERISA’s deemer clause provides an exception to the saving clause, effectively preventing a state insurance law from deeming a self-insured employer to be in the business of insurance so to fall within the insurance saving clause, thereby avoiding ERISA preemption.[139](#co_footnote_F139115542113_1)

Reading the saving and deemer clauses in unison with the “relate to” provision, the scope of ERISA preemption will often depend on how one defines the business of insurance.[140](#co_footnote_F140115542113_1) This was precisely the issue the Court dealt with both in *Metropolitan Life Insurance Co. v. Massachusetts*[141](#co_footnote_F141115542113_1) and *Pilot Life Insurance Co. v. Dedeaux.*[142](#co_footnote_F142115542113_1) Demarcating certain arrangements as the business of insurance plays a crucial role in determining whether states can justifiably regulate those arrangements, hence, having a reliable means of drawing distinctions necessary for making such determinations becomes important. Defining the breadth of the business of insurance, though, has proved a Herculean task.[143](#co_footnote_F143115542113_1) Furthermore, as will be noted, this challenge confounds states seeking to regulate PSOs that contract with ERISA employers.[144](#co_footnote_F144115542113_1)

**C. APPLYING ERISA PREEMPTION TO PSOS ENGAGED IN DOWNSTREAM AND DIRECT CONTRACTING**

**1. Downstream Risk Contracting**

In downstream arrangements, PSOs enter into contractual agreements with licensed entities, such as indemnity insurers and HMOs, so that the PSOs assume part of the licensed entities’ risk.[145](#co_footnote_F145115542113_1) The licensed entities in these instances function as intermediaries between the PSOs and consumers such as employer groups.[146](#co_footnote_F146115542113_1) Because, in these situations, there is a licensed entity upstream from the PSO which is **\*465** subject to state insurance regulation, the question becomes whether the downstream PSO should be subject to additional regulation. In other words, because these arrangements involve entities licensed and regulated by the state, the question remains: Is the downstream PSO engaged in the business of insurance and subject to regulation?[147](#co_footnote_F147115542113_1)

State regulators are disturbed by these downstream contracting arrangements involving PSOs because they feel the nature of the risk sharing involved calls into question “whether having a licensed entity involved … is enough to address consumer protection concerns.”[148](#co_footnote_F148115542113_1) Regulators fear that when PSOs assume downstream risk, they may fail to account adequately for the nature or amount of risk undertaken and subsequently wind up with insufficient funds with which to pay for the health care services they are obligated to deliver.[149](#co_footnote_F149115542113_1) In these scenarios, the apprehension is that, if a PSO should miscalculate its expenses to the point that it is forced into insolvency, the entities with which it contracted could also become insolvent and, ultimately, patients would be left without medical coverage.[150](#co_footnote_F150115542113_1) Although enlisting health care market forces and relying on licensing and regulating upstream entities seems to protect consumers adequately, some states have begun to take further measures toward more directly regulating PSOs involved in these arrangements.[151](#co_footnote_F151115542113_1) Despite heightened concern among regulators and some movement by the states in this area, regulating PSOs involved in downstream arrangements is neither quite as confounding nor as debatable as is regulating PSOs participating in direct contracting situations.

**2. Direct Risk Contracting**

PSOs create direct contracting arrangements with individuals, self-insured employers or other similar groups to provide covered health care services.[152](#co_footnote_F152115542113_1) The nature of the resulting contractual relationships has led PSOs to tinker with the notion that they can, through direct contracts with, most pertinently, self-insured employers, replace the insurers that typically serve as intermediaries in these arrangements. Theoretically, if PSOs could eliminate insurance companies and HMOs from the transaction, providers could concentrate their efforts on providing quality medical care rather than watching insurers usurp control of health care delivery along with potential profits that wind up in the hands of executives and shareholders.[153](#co_footnote_F153115542113_1)

**\*466** In addition to some practical concerns that arise from PSOs’ capacity to eliminate insurers,[154](#co_footnote_F154115542113_1) regulatory barriers must often be hurdled, as well.[155](#co_footnote_F155115542113_1) Direct contracting creates situations in which PSOs assume risks of various degrees and types that, depending on the state, may or may not be considered participation in the business of insurance, thus triggering regulation.[156](#co_footnote_F156115542113_1) Unlike downstream arrangements, where the state may typically assert only indirect oversight of risk-bearing PSOs through regulating upstream entities, state regulators may charge PSOs contracting directly with employers with acting as unlicensed insurers or HMOs if these PSOs fail to comply with their respective state insurance laws.[157](#co_footnote_F157115542113_1) A heated controversy continues, though, regarding states’ ability to regulate PSOs that assume risk directly from self-insured employers that maintain benefit plans covered by ERISA.

Whether states can regulate risk-bearing PSOs contracting directly with employers boils down to the following question: Are the risk-bearing PSOs acting as insurers and thus subject to state regulation?; or, Are they free of potentially applicable licensing and regulatory requirements because of ERISA’s preemptive effect on state laws? The answer to this question is crucial for two reasons. First, licensing is costly, and such costs may limit providers’ ability to pursue innovations in the marketplace for health care insurance and delivery.[158](#co_footnote_F158115542113_1) Second, costs may limit self-insured employers’ flexibility in designing their own benefits plans.[159](#co_footnote_F159115542113_1) Furthermore, risk-bearing PSOs able to circumvent effectively state insurance laws raise regulators’ concerns regarding consumer protections from insolvency, inadequate care and the need for a level playing field.[160](#co_footnote_F160115542113_1)

**IV. STATE RESPONSES TO PSO MARKET INNOVATIONS: REGULATING TO PROTECT CONSUMERS AND TO LEVEL THE PLAYING FIELD**

Any attempt to achieve regulatory equilibrium will have to address several issues. Among them are the movements of the dynamic health care marketplace, the nature of insurance regulation, ERISA’s effect on the states’ abilities to oversee the business of insurance, and the overarching public policy concerns inherent in financing and delivering health care. The fact that risk-assuming PSOs exist in such a variety of contractual arrangements, and that most states have ill-suited regulatory **\*467** schemes to monitor these arrangements, has resulted in “haphazard” and “erratic” state oversight and in a scramble for alternative means of supervising the activities of the new breeds of PSOs.[161](#co_footnote_F161115542113_1)

Although states are looking to the NAIC for guidance, some states have also begun taking their own regulatory initiatives.

**A. STATE REGULATORY APPROACHES: AN OVERVIEW**

Before analyzing the various courses of action that states may have at their disposal for regulating risk-assuming PSOs, it is first helpful to get a sense of state insurance regulators’ attitudes toward such regulation. In this regard, a fifty-state telephone survey undertaken by the GHAA, is a useful starting point.[162](#co_footnote_F162115542113_1) The survey data provides a benchmark by which to measure and evaluate further developments.

**1. Regulators’ Views: The GHAA Survey**

The GHAA Legal Affairs Department conducted a telephone survey in 1995 that focused on risk transfer to PHOs and the extent to which states regulate the respective risk-transferring arrangements.[163](#co_footnote_F163115542113_1) After examining each state’s regulations on HMOs and insurance companies, the GHAA questioned insurance departments and health departments in the fifty states and the District of Columbia, asking about different contracting arrangements representing varying degrees of risk transfer.[164](#co_footnote_F164115542113_1) With inquiries into how state regulators would analyze four types of PSO risk-sharing arrangements,[165](#co_footnote_F165115542113_1) the GHAA sought to explore the rapid changes in the health care marketplace that “have led to a blurring of traditional product lines raising questions as to the adequacy of the existing regulatory system.”[166](#co_footnote_F166115542113_1) The survey concluded that gaps exist in state oversight of PHOs, especially when PHOs contract directly with employers and accept full or partial risk for providing health care to **\*468** covered employees.[167](#co_footnote_F167115542113_1) Of the three risk-transferring options about which state regulators were questioned, two concerned direct contracting, and the other downstream contracting.[168](#co_footnote_F168115542113_1) As has been suggested, these contractual arrangements comprise the forms of risk-sharing arrangements generating the most controversy surrounding PSO regulation.[169](#co_footnote_F169115542113_1)

When asked about downstream risk, regulators in two states reported that they have affirmative policies that could require licensing PHOs engaging in such practices. Twenty-two states were unclear about their policies toward PHOs involved in downstream contracting, and twenty-seven states indicated they would not require oversight in those instances.[170](#co_footnote_F170115542113_1) The consensus among states that did not require PHO licensure for downstream contracting was that, because the upstream entities involved in the arrangements were regulated, no further regulation of the downstream PHOs was necessary.[171](#co_footnote_F171115542113_1)

State regulators were also asked to comment on their policies toward PHOs involved in direct contracting either on a full risk or a partial risk basis.[172](#co_footnote_F172115542113_1) When PHOs accept full insurance risk on a prepaid, capitated basis, forty-one states reported that they would require licensure.[173](#co_footnote_F173115542113_1) Many regulators’ responses expressed the sentiment that PHOs that assume risk and function like HMOs should be licensed as such.[174](#co_footnote_F174115542113_1) The tests for requiring regulation in most states seemed to turn on the amount of risk assumed by the PHOs. Despite lacking bright-line thresholds beyond which licensure would be required, the state regulators seemed simply “to know how much [risk] is too much.”[175](#co_footnote_F175115542113_1) Finally, when asked to comment on PHOs engaging in transactions that involve accepting only partial risk, regulators in twenty-five states said they would require licensure; twenty-five states were unclear as to their licensure requirements; and the District of Columbia reported no oversight.[176](#co_footnote_F176115542113_1) Clearly, these data indicate widespread uncertainty among states as to proper regulation of PHOs assuming varying degrees of risk.

**\*469** A key point in the GHAA survey is that a state’s indication that a certain form of PHO arrangement should fall within its regulatory authority is not tantamount to a commitment to enforce the appropriate HMO act or insurance statute with respect to that arrangement.[177](#co_footnote_F177115542113_1) Perhaps because regulatory enforcers are unaware of the PHOs operating within their jurisdiction, lack resources or are unwilling to act without legislative imprimatur, the GHAA study revealed that enforcement is “often passive or nonexistent.”[178](#co_footnote_F178115542113_1) The resulting inconsistencies create confusion and cause for concern.[179](#co_footnote_F179115542113_1) Fortunately, however, states are actively reconsidering their respective regulatory schemes and exploring alternative approaches.[180](#co_footnote_F180115542113_1)

**2. State Regulatory Approaches**

Generally, state insurance departments are moving from an entity-based to a function-based regulatory focus to keep pace with the health care market’s rapid evolution.[181](#co_footnote_F181115542113_1) This shift is in response to disintegrating distinctions between health insurance entities and providers that, in turn, precipitate reevaluation of the utility of existing regulatory frameworks.[182](#co_footnote_F182115542113_1) Thus, the challenge for state regulators is: (1) to ensure entities engaging in similar activities, offering similar products, and having similar functional and risk-sharing characteristics are subject to similar regulation; (2) to streamline the regulatory process where possible; (3) to ensure that regulation is consistent with the nature and risk level of each regulated entity; (4) to recognize and allow for new types of risk-sharing arrangements and entities; (5) to promote the use of common definitions regarding entities, products and risk-transferring mechanisms; and (6) to ensure adequate consumer protections exist.[183](#co_footnote_F183115542113_1) To attain these goals, insurance regulators must bear in mind the aforementioned critical health care policy considerations.[184](#co_footnote_F184115542113_1)

**\*470** Before looking more specifically at individual states’ approaches to regulating downstream and direct risk-contracting activities of PSOs, some general observations are necessary. First, providers and insurers seem to agree that PSOs contracting downstream from licensed entities, at the very least, should not need to meet licensure requirements as strict as those met by upstream entities.[185](#co_footnote_F185115542113_1) Second, the emerging trend among states is toward regulating PSOs involved in risk-transferring direct contracts.[186](#co_footnote_F186115542113_1) States are implementing several approaches, including: (1) applying the existing state regulatory requirements to all entities participating in the health insurance market, with such requirements varying in proportion to the level of risk assumed; (2) creating a separate regulatory category for PSOs, reflecting solvency and consumer protection standards similar to those applicable to HMOs; and (3) creating a separate category for PSOs that imposes solvency and consumer protection standards different from those imposed on HMOs.[187](#co_footnote_F187115542113_1) Although most states have not created distinct legal requirements applicable to PSOs, they often license, as HMOs, PSOs that are in the business of insurance.[188](#co_footnote_F188115542113_1)

**B. STATE REGULATORY APPROACHES: A CLOSER VIEW**

While perhaps all states are striving for the same ends; to protect consumers and to enhance competition; emerging policies illustrate distinctive means by which states strike the balance between imposing marketplace restraints and permitting innovative freedom. A fifty-state survey of policy approaches is beyond the scope of this Article, but providing a sketch of some of the more interesting state legislative and regulatory developments involving risk-bearing PSOs is helpful.[189](#co_footnote_F189115542113_1)

All states regulate insurance companies and HMOs.[190](#co_footnote_F190115542113_1) Just thirteen states, however, have statutes or regulations that target PSOs, and many of these apply only to one type of health care service.[191](#co_footnote_F191115542113_1) Most states, contrariwise, either have no pronounced policy addressing risk-bearing PSOs or have issued position statements on the subject.[192](#co_footnote_F192115542113_1) The proceeding three examples of state regulations illustrate various positions along the spectrum of regulatory approaches.

**1. Minnesota**

Minnesota has enacted legislation targeting PSO networks. The Minnesota Integrated Service Network Act[193](#co_footnote_F193115542113_1) provides for the creation of integrated provider networks that have deposit, reserve and solvency requirements expressly applicable to **\*471** those types of networks.[194](#co_footnote_F194115542113_1) Minnesota also has laws regarding “health care cooperatives” and, specifically, “health provider cooperatives.”[195](#co_footnote_F195115542113_1) The Act’s goals include “containing health care costs, improving the quality of health care, and increasing the access of Minnesota citizens to health care services….”[196](#co_footnote_F196115542113_1) The state promotes health care cooperatives among local entities, which act as sellers and buyers of health care, by channeling through providers and consumers.[197](#co_footnote_F197115542113_1)

An interesting facet of the Minnesota health care cooperative act is that it permits direct contracting with certain employers.[198](#co_footnote_F198115542113_1) Provider co-ops may contract for risk in a way that brings them within the statute’s definition of insurance,[199](#co_footnote_F199115542113_1) thus requiring the co-ops to obtain insurance licenses. In limited cases, however, the co-ops may contract on a capitated basis with certain large self-insured employers and remain free from insurance licensure requirements.[200](#co_footnote_F200115542113_1) Provider cooperative contracts with purchasers also require that they are structured to “provide for payment by the purchaser to the health provider cooperative on a substantially capitated or similar risk-sharing basis.”[201](#co_footnote_F201115542113_1)

**2. Ohio**

The Ohio Department of Insurance (DOI) has a conservative, limiting approach toward regulating PSOs. In 1996 the department drafted legislation intended to treat all risk-assuming entities under the same regulatory scheme.[202](#co_footnote_F202115542113_1) The “Managed Care **\*472** Uniform Licensure Act,” which Ohio recently enacted, requires all risk-assuming “health insuring corporations” (HICs), including providers involved in direct contracting with employers, to comply with the same solvency and consumer protection requirements.[203](#co_footnote_F203115542113_1) Thus, PSOs will not be subject to less stringent oversight in terms of capital and operating standards than would large health plans such as HMOs. Provider groups such as the Ohio Hospital Association and the Ohio State Medical Association resisted the proposal as being detrimental to their efforts, whereas the Ohio HMO Association lauded the goals of consumer protection and leveling the regulatory playing field.[204](#co_footnote_F204115542113_1) This recent legislation seemingly seeks to achieve equivalent regulation of risk-bearing entities.[205](#co_footnote_F205115542113_1)

Although Ohio did not previously have any PSO legislation other than its general HMO statutes,[206](#co_footnote_F206115542113_1) a letter from the Ohio DOI provides greater insight into the state’s regulatory approach.[207](#co_footnote_F207115542113_1) After answering questions regarding the business of insurance and insurance risk,[208](#co_footnote_F208115542113_1) the letter discusses various PHO contracting arrangements and certain permissible risk transfers. Of particular interest is a portion of the letter dealing with a capitated arrangement between a PHO and a self-insured employer. After stating that PHOs may enter into such capitated arrangements with licensed HMOs and indemnity insurers, the letter concluded that a PHO accepting capitation directly from an employer is impermissible because that scenario involves an unlicensed entity operating as an insurer.[209](#co_footnote_F209115542113_1)

The Ohio DOI letter contains another small section that perhaps typifies its approach toward PSO regulation. When asked whether there was any degree of risk that a provider could assume that would not require insurance licensure, the department answered emphatically: “There is no ‘degree’ of risk assumption that would be considered *de minimis* to the prohibition … [against the unauthorized practice of insurance]…. It is like being ‘a little bit pregnant.”DD”’[210](#co_footnote_F210115542113_1) The Ohio DOI has determined, as the previous response suggests that restricting PSOs’ ability to bear risk is **\*473** necessary to reach the oft reiterated mandates of protecting consumers and providing a level playing field.

**3. Illinois**

Illinois’s more liberal regulatory schemes provides a stark contrast with the Ohio approach. The Illinois DOI’s stance toward PSO regulation reflects a commitment to promoting innovation in the health care marketplace. Illinois has legislation governing HMOs, “limited health service organizations” and plans providing limited services.[211](#co_footnote_F211115542113_1) The statutes notwithstanding, a 1996 newsletter issued by the DOI provides significant insight into Illinois’s regulatory philosophy.[212](#co_footnote_F212115542113_1)

The Illinois DOI has indicated that it is not inclined to regulate certain PSO arrangements, such as when a contracting “employer, insurer or HMO is still on risk to either provide or pay for health care services.”[213](#co_footnote_F213115542113_1) Only PSOs that become the “ultimate risk bearer,” and are “directly obligated to individuals to provide, arrange or pay for medical services,” fall within the department’s regulatory jurisdiction.[214](#co_footnote_F214115542113_1) Determining the point at which a PSO arrangement may be regulated as insurance turns on which party bears ultimate responsibility for providing health care services to the individuals covered under such arrangement.[215](#co_footnote_F215115542113_1)

The Illinois DOI approach is laudable in that it permits self-insured employers to continue to seek “innovative and cost effective methods of financing health care for their employees.”[216](#co_footnote_F216115542113_1) Although Illinois is one of a handful of states indicating it will not regulate certain types of PSO arrangements,[217](#co_footnote_F217115542113_1) its readiness to allow PSOs and employers to contract freely for risk-sharing presents a provocative alternative to other, more narrow approaches.[218](#co_footnote_F218115542113_1) This demonstrates that the Illinois DOI perceives its regulatory role as more laissez faire, believing that PSOs and the entities with which they contract are capable of responsibly distributing risk among themselves without intrusion from regulators. Furthermore, this approach dovetails nicely with a generous view of ERISA’s preemptive scope.[219](#co_footnote_F219115542113_1)

**\*474** From the more sophisticated policy in Minnesota, to the restrictive approach taken in Ohio, to the more liberal and enterprising philosophical view espoused in Illinois, a spectrum of great breadth emerges. As PSOs continue to proliferate and more states inevitably become forced to take a stance on the proper level of regulatory intervention on risk-bearing PSOs, it will take a concerted effort to gain something resembling uniformity in state insurance regulation.[220](#co_footnote_F220115542113_1) The quest for uniformity is part of the overall mission of the NAIC, an organization offering one of the potential solutions to the present regulatory muddle.

**V. THE SEARCH FOR UNIFORMITY: CRITIQUING THE NAIC AND ITS CRITICS**

Most states have not made much headway on a viable solution to enigmatic health care market evolution regulating PSOs involved in risk contracting arrangements. Despite the regulators’ fairly limited activity, as risk-assuming PSOs become more common, they will necessarily reach some regulatory equipoise. Because state regulators are faced with a virtual *tabula rasa* on which to craft their approaches, states seek guidance in moving toward more coherent regulatory schemes.[221](#co_footnote_F221115542113_1) Given **\*475** the novelty of these regulatory issues, members of the health care and insurance industries are presenting policy-based arguments. Ideally, sifting through the various policy positions and determining how best to advance the combined interests of providers, insurers, employers and individuals will result in PSO policies that encourage the development of a more effective market for health care services.

**A. THE NAIC, ITS POLICIES AND POSITIONS**

**1. NAIC: Background**

The NAIC drafts nonbinding insurance model laws and regulations to assist state policymakers.[222](#co_footnote_F222115542113_1) NAIC members consist of insurance commissioners from each state, the District of Columbia and four United States territories.[223](#co_footnote_F223115542113_1) NAIC models are extremely influential, whether they are actually adopted as law or serve as authoritative guidance for the states.[224](#co_footnote_F224115542113_1) Working groups within the NAIC develop and circulate the models, which may eventually be approved in quarterly plenary sessions, and thereafter left to the states to adopt the models in whole or in part.[225](#co_footnote_F225115542113_1) NAIC managed care efforts are premised on achieving goals that echo the “consumer protection” and “level playing field” mantras so frequently cited by insurance regulators.[226](#co_footnote_F226115542113_1)

Several NAIC working groups and task forces will presumably influence states’ regulation of health insurance organizations. Among the most prominent groups are the Regulatory Framework Task Force and its Health Plan Accountability Working Group (HPAWG), as well as the Risk-Based Capital (EX4) Task Force and its Health **\*476** Organizations Risk-Based Capital Working Group.[227](#co_footnote_F227115542113_1) These bodies are making observable advances on a framework for regulating PSOs.[228](#co_footnote_F228115542113_1)

A significant initiative undertaken by the NAIC is called the Consolidated Licensure for Entities Assuming Risk (CLEAR).[229](#co_footnote_F229115542113_1) CLEAR is meant to “promote a more competitive marketplace by ensuring that entities that perform the same or similar functions are subject to a level regulatory playing field.”[230](#co_footnote_F230115542113_1) Through this initiative, NAIC members seek to develop a single body of law to govern the range of health care entities involved in risk-sharing arrangements, whether they are HMOs, PSOs, Blue Cross and Blue Shield plans, commercial plans or others engaged in the finance and delivery of health care.[231](#co_footnote_F231115542113_1) In addition, the NAIC believes that CLEAR will clarify that these various plans all fall within the scope of state regulation.[232](#co_footnote_F232115542113_1)

The CLEAR process will include a review of financial standards and reporting requirements, along with incorporating health plan accountability standards.[233](#co_footnote_F233115542113_1) The NAIC has adopted the Quality Assessment and Improvement Model Act, which establishes certain quality assessment and quality improvement standards, as well as the Health Care Professional Credentialing Verification Act, both produced by the NAIC’s HPAWG.[234](#co_footnote_F234115542113_1) Even more recently, the NAIC adopted three other models: the Managed Care Plan Network Adequacy Model Act, the Health Carrier Grievance Procedure Model Act, and the Utilization Review Model Act.[235](#co_footnote_F235115542113_1)

A significant development by the NAIC’s Health Organizations Risk-Based Capital Working Group of the Risk-Based Capital (EX4) Task Force is a risk-based capital formula for health care organizations.[236](#co_footnote_F236115542113_1) Designed with assistance from the American Academy of Actuaries, the Working Group’s capital standards are being designed to apply to all risk-assuming health organizations, including PSOs, a set of capital requirements based on each organization’s risk profile.[237](#co_footnote_F237115542113_1) The risk-based **\*477** capital standards, applicable to *all* entities bearing insurance risk, reflect the NAIC focus on a level playing field and the notion that function is more important than form for the purposes of health insurance regulation.

As the NAIC continues to push toward a single regulatory scheme that would apply to health care organizations assuming insurance risk, it is important also to anticipate the contracting arrangements in which the NAIC would suggest PSOs are bearing such risk. The NAIC’s stance is indicated most clearly within a 1995 memorandum of the HPAWG.

**2. HPAWG Memorandum and Model Bulletin**

In August 1995, the HPAWG formulated a recommendation considering the CLEAR initiative toward developing a single model health care licensing act.[238](#co_footnote_F238115542113_1) The HPAWG Memorandum specifically addresses regulating risk-bearing PSOs pursuant to CLEAR’s charge by outlining the issues and attaching a “““suggested bulletin” that the commissioners could disseminate to organizations within their respective states.[239](#co_footnote_F239115542113_1)

The HPAWG Memorandum indicates that the Working Group feels those entities accepting capitated risk are in the business of insurance and must concern themselves with insurance licensure laws.[240](#co_footnote_F240115542113_1) The HPAWG’s position is that a provider group entering an arrangement with an individual or employer, whereby the provider assumes all or part of the risk for health care expenses or for delivery of health care services, is in the business of insurance.[241](#co_footnote_F241115542113_1) Thus the PSOs involved in the business of insurance must obtain the necessary license to do so, either as a health insurer or as an HMO.[242](#co_footnote_F242115542113_1) The risk assumption contemplated in the memorandum encompasses full or partial capitation, risk corridors, withhold arrangements or pooling arrangements, all of which may trigger regulation as the business of insurance.[243](#co_footnote_F243115542113_1)

The HPAWG Memorandum further expounds the Working Group’s views in a “““Memorandum Addendum,” which analyzes a hypothetical situation involving direct contracting between providers and an employer.[244](#co_footnote_F244115542113_1) The addendum concludes that **\*478** the employer contracting directly with providers is a “““consumer” with an insurable interest and risk of loss; the providers accepting capitation are “insurers” who have accepted the risk of providing health care benefits on a prepaid basis; the providers are involved in a general scheme to distribute the risk of loss across a larger group; and that the capitation payments to the providers function as premiums paid for the assumption of risk.[245](#co_footnote_F245115542113_1) Although concluding that any PSO is involved in the business of insurance when it directly contracts with an employer for providing health care services on a capitated basis, the addendum also cautions that “varying fact situations must be individually reviewed and analyzed in a similar fashion before the same general conclusion can be reached.”[246](#co_footnote_F246115542113_1)

**3. NAIC White Paper**

A more recent document, produced by the Risk-Bearing Entities Working Group of the State and Federal Health Insurance Legislative Policy (B) Task Force, provides an excellent overview of the issues engulfing the regulation of risk-bearing entities as well as further insight into the NAIC’s position on PSO regulation.[247](#co_footnote_F247115542113_1) The White Paper was drafted with the expectation that states would adopt its recommendations as part of the CLEAR reform initiative. Thus, the White Paper does not include specific guidance on how states should regulate risk-bearing PSOs.[248](#co_footnote_F248115542113_1) The White Paper includes nothing, however, to indicate the NAIC has changed its stance since the release of the 1995 HPAWG Memorandum.[249](#co_footnote_F249115542113_1)

The White Paper makes additional notable observations. In addressing direct contracting arrangements transferring risk to PSOs, it suggests that states attempt to regulate these entities as if the business of insurance would not be preempted by ERISA.[250](#co_footnote_F250115542113_1) This conclusion is significant in light of the controversy over ERISA’s **\*479** preemptive scope.[251](#co_footnote_F251115542113_1) Furthermore, despite acknowledging that the 1995 HPAWG Memorandum did not recommend that state insurers require licensure of PSOs engaged in downstream contracting, the White Paper refers to the continuing concerns state regulators are expressing in this area.[252](#co_footnote_F252115542113_1) In support of these concerns, the White Paper examines the few state initiatives to regulate certain downstream arrangements.[253](#co_footnote_F253115542113_1)

The White Paper, although reflecting a recent attempt by the NAIC to encapsulate the difficulties in regulating risk-assuming PSOs, provides more questions than answers. Interpreting the White Paper requires understanding the NAIC’s approach to navigating state regulators toward the elusive consumer protection and level playing field ideals. Examining the goals of the NAIC, the CLEAR initiative, and the HPAWG Memorandum sheds additional light on approaches that state regulators may choose to adopt. The NAIC and its members represent the views of the insurance industry, and, naturally, these groups are intricately involved in developing PSOs whose views insurance regulators do not typically share.

**B. EMPLOYEE HEALTH CARE INNOVATION PROJECT: AN ALTERNATIVE**

Providers and the self-insured employers with whom they directly contract see things differently from the NAIC. We must, however, bear in mind that NAIC members’ viewpoints are shaped by the positions they hold and by their interests in preserving state bureaucracies.[254](#co_footnote_F254115542113_1) Not surprisingly, providers and employer groups, whose efforts to create practical, innovative PSO arrangements would be hindered by excessive state demands, are not entirely swayed by the NAIC policies. Net worth requirements, reporting requirements and other forms of regulatory oversight can create barriers for PSOs that eliminate their cost-effectiveness or even viability.

Provider and employer arguments break down into the familiar categories of downstream contracting and direct contracting. As has been shown, downstream contracting, though it raises some questions among state regulators, is not quite as controversial at this point as direct contracting.[255](#co_footnote_F255115542113_1) Few of the states have been inclined to regulate downstream contracting arrangements, and the NAIC policies affecting PSO regulation similarly devote little attention to downstream contracting. The NAIC as well as similar state positions have drawn the ire of providers and employers alike.

The Employer Health Care Innovation Project (EHCIP) recently expressed its views on the NAIC White Paper and its approach for regulating risk-bearing PSOs contracting directly with self-insured employers.[256](#co_footnote_F256115542113_1) EHCIP is a collaborative effort of several prominent companies that self-insure their health plans.[257](#co_footnote_F257115542113_1) Those corporations, which have been using the flexibility afforded to them by ERISA in designing quality, innovative health plans, organized the EHCIP to inform state insurance **\*480** commissions and legislatures of their need to retain flexibility to design creative health plans.[258](#co_footnote_F258115542113_1)

The EHCIP’s primary concern with the NAIC White Paper seems to be that its justification for state regulation is based largely on the transfer of insurance risk.[259](#co_footnote_F259115542113_1) According to the EHCIP letter, the White Paper does not adequately distinguish insurance risk from either “business risk” or “““service risk,” but merely defines it in terms of the compensation and payment structures that allocate the risk.[260](#co_footnote_F260115542113_1) The EHCIP believes the focus on provider compensation is misplaced, noting that the “consumer protection question--who ultimately bears the responsibility when one of the parties becomes insolvent--is defined through contractual obligations rather than compensation terms.”[261](#co_footnote_F261115542113_1)

The EHCIP letter presents the very clever argument that an employer providing health benefits to employees and their families is not the business of insurance and thus should not be regulated as such. The letter first sets out the factors listed in *Pireno*[262](#co_footnote_F262115542113_1) for determining when an arrangement involves the business of insurance.[263](#co_footnote_F263115542113_1) After pointing out that risk-spreading is the insurance characteristic that spawns the consumer protection concerns emphasized by the NAIC, the EHCIP maintains that “the argument for regulation to protect consumers purchasing insurance products does not extend” to employer self-insurance plans.[264](#co_footnote_F264115542113_1)

In contrast to insurer risk-spreading pools, which can be subject to unpredictable economic costs, employee groups are formed naturally, not for the sole purpose of purchasing health benefits, and therefore are not steeped in the same issues.[265](#co_footnote_F265115542113_1) Although employers spread risks across their employee groups, the employers are not in the *business* of insurance because they do not market this service and individuals do not choose membership in the groups based on their health care needs.[266](#co_footnote_F266115542113_1) The EHCIP letter substantiates this point by arguing that employers who self-insure on large scales are simply not exposed to underwriting risks that require state regulatory oversight.

The EHCIP’s most clever line of reasoning is that self-insured employers are not involved in the business of insurance and they do not transfer to PSOs with whom they contract sufficient insurance risk to trigger state regulation. The letter notes that self-insured employers who contract with PSOs to deliver health care to their employees maintain the risk-spreading function that constitutes insurance.[267](#co_footnote_F267115542113_1) Because the PSOs’ risks are “neither purely actuarial, nor backed solely by financial assets,” financial risk transfer is not tantamount to transferring the risk-spreading **\*481** function of insurance.[268](#co_footnote_F268115542113_1) The inescapable conclusion is that an “arrangement between a risk-bearing provider group is neither the business of insurance, nor should it be subject to state regulation.”[269](#co_footnote_F269115542113_1)

The EHCIP’s arguments against state regulation of PSO arrangements with self-insured employers go to the heart of insurance regulation. As the EHCIP letter intimates, evaluating the wisdom of regulation requires reverting to the tenets of consumer protection and leveling the playing field. These buzzwords are repeatedly spun out in defending PSO regulation, yet their existence within the regulatory framework is not readily apparent. In reaching a regulatory solution, these goals of insurance regulation must be kept close for easy reference.

**C. COROLLARY**

Ultimately, the question remains: What is the best route to regulating risk-bearing PSO arrangements? Presently, using the NAIC policies as a yardstick, states apparently are shying away from regulating PSOs accepting risk downstream from licensed entities while leaning toward regulating PSOs bearing risk directly from self-insured employers. Does this dualistic approach make sense in light of health care market trends, the premises of insurance regulation, and ERISA? How can a regulatory policy achieve the proper balance among the competing interests at stake? The latter question pertains to any law and to states when struggling to accommodate interests in regulating risk-assuming providers. There are some conclusions to be derived from the continuing debate.

Generally, the NAIC’s effort to create a regulatory scheme that applies to risk-bearing entities equally, focusing on function over form, makes sense. Creating separate regulatory categories for each type of health care entity would be short-sighted and not practicable in a swift-paced, dynamic marketplace.[270](#co_footnote_F270115542113_1) Providers are pushing for tailored standards that would recognize that PSOs need not be held to the same requirements as other insurers, for fear that the distinct nature of the risks they assume will not be accommodated by “off-the-rack” regulations.[271](#co_footnote_F271115542113_1) Although defining risk will continue to be a point of contention, creating risk-based capital standards and a framework that accounts for different types of risk within a flexible formula seems the most reasonable prospect for progress. Due to the unpredictable nature of future hybrid entities, a regulatory scheme that applies based on overall risk assumption is preferable, in theory, to one that attempts to create separate categories for different “types” of health care entities.[272](#co_footnote_F272115542113_1) Unfortunately, a set of risk-based standards that does not specifically account for the unique characteristics of PSOs will, at least in the short term, fail to capture fully the nature of PSO risk-assumption.

**\*482** The preceding paragraph comments on *how* health insurance regulation should operate; there remains, however, the challenge of determining to which entities the regulations should apply. Determining the proper manner in which regulations should apply is quite a separate issue from determining which health care organizations properly fall within the realm of entities subject to such regulation. To evaluate the propriety of regulating PSOs assuming risk, therefore, we return to the dichotomy between downstream contracting and direct contracting.

First, it seems the states are proceeding correctly in their treatment of PSOs engaged in downstream contracting arrangements. The states have at least indirect control over the downstream PSOs through their ability to monitor the upstream licensed entities in those arrangements. Requiring downstream PSOs to obtain licenses would necessarily assume that somehow total risk increases when licensed entities contract with PSOs to provide health care services. Further regulation, even when PSOs assume risk, seems duplicative and unwise. Besides the fact that the upstream HMOs or insurers have every incentive to avoid PSOs that are financially unstable, the upstream entities can also contract for remedies with the PSOs.[273](#co_footnote_F273115542113_1) Regulating the upstream entities, not the downstream provider groups seeking to impress change on the health care market, will do more for the consumer than unnecessary regulation that prevents innovation from coming to the market.[274](#co_footnote_F274115542113_1) The commercial HMOs and insurers involved in contracting with PSOs in today’s marketplace are primarily businesses seeking to make profits. Engaging in contracts with PSOs that risk becoming insolvent is not in the best interests of either the executives or the shareholders of these companies. Perhaps regulators are determined to avoid the HMO bankruptcies of the 1980s, and rightfully so; but the marketplace is much different in 1997.[275](#co_footnote_F275115542113_1) The fears of cascading insolvencies do not seem well founded among the regulatory, legal and market-induced safeguards currently in place.

Second, many more troubling issues remain as to the proper treatment of PSOs’ direct contracting arrangements with self-insured employers. The NAIC takes the position that PSOs involved in direct contracting relationships with consumers, including employers, should fall under state insurance regulation.[276](#co_footnote_F276115542113_1) The NAIC’s stance raises several issues concerning the interpretation of ERISA, internal inconsistencies within NAIC downstream and direct contracting policies, and conflicting regulatory ideals.

The NAIC’s conclusion that states may regulate PSO arrangements involving direct contracting with self-insured employers necessarily assumes that ERISA preemption does not override their regulatory efforts. This proposition is somewhat troubling, especially considering the perfunctory treatment the NAIC gives to its **\*483** defense. Surely, ERISA’s preemptive scope is not clearly circumscribed, even in the wake of the recent *Travelers*[277](#co_footnote_F277115542113_1) decision. Inevitably, concluding that self-insured employers may not contract directly with unlicensed provider groups encroaches on employers’ freedom to design their own cost-saving health benefit plans. One ambiguity exists in defining the business of insurance and insurance risk, a task that has proven to be an exercise in futility, particularly within the health care market’s lexicon of multi-faceted risk-sharing arrangements.[278](#co_footnote_F278115542113_1) Risk-bearing PSOs’ activities do not comfortably fit within these concepts, because the most oft-cited cases confronting the span of the business of insurance are a product of antitrust decisions interpreting the federal McCarran-Ferguson Act.[279](#co_footnote_F279115542113_1)

The persistent complications that hinder courts and insurance seeking to define the business of insurance in the context of complex PSO arrangements indicates that perhaps a different tack is required. Doctors practicing within PSOs are engaged in risks that are neither purely “business” nor “service” nor “““insurance.” Court-driven definitions of the business of insurance are sufficiently obscure so that they necessitate case-by-case analysis of complex arrangements and difficult to decipher demarcations, resulting in the absence of clear or meaningful guidelines. Nevertheless, even a PSO that would readily admit it engages in the business of insurance would not be operating just like any other insurance company. Because these hybrid entities that combine the functions of both health care service provider and health care insurer are unlike health plans that have existed, attempts to analyze PSOs within the common business of insurance paradigm may be as unenlightening as they are laborious.

On a related note, arguing that unlicensed PSOs may engage in downstream contracting but may not directly contract with self-insured employers requires making certain disputable assumptions regarding the regulation of self-insured employers and upstream entities. To hold simultaneously that unlicensed PSOs assuming risk from licensed upstream entities is acceptable but that PSOs doing the same from self-insured employers is unacceptable, one must also deduce that self-insurance arrangements with PSOs unregulated by the state unavoidably put consumers at risk. That is, one would have to conclude that requiring regulation of PSO direct contracting arrangements but not of PSO downstream arrangements effectively disregards the impact of ERISA oversight of self-insured plans treating former arrangements as if they were unregulated.[280](#co_footnote_F280115542113_1) This conclusion may be the result of an expansive reading of what is properly considered the transfer of insurance risk and the business of insurance.

Alternatively, it may be that because ERISA provides no substantive funding requirements for health benefits, such as it imposes on employee pension plans, indicates that Congress left a void to permit state-imposed regulatory requirements on PSO contracts with self-insured employers.[281](#co_footnote_F281115542113_1) Conceivably, state regulation of risk- **\*484** bearing PSOs contracting with self-insured employers would serve to protect employees from poorly run benefit plans.[282](#co_footnote_F282115542113_1) Employers and provider networks counter this hypothesis, however, by referring to the nature of the contractual relationships between self-insured employers and PSOs, noting that in these instances self-insured plans remain the ultimate risk-bearers with concomitant responsibility owed to covered employees.[283](#co_footnote_F283115542113_1)

The provisions of ERISA and its preemptive effect, amid current jurisprudence, are not enlightening in terms of guiding state regulation of self-funded health plans. Application of the “saving” and “deemer” clauses of ERISA, once again, hinges on defining more precisely what the business of insurance is in the context of PSO arrangements with self-insured employers. As PSOs continue to evolve and engage in varying levels of risk transfer, crafting such precise definitions will become increasingly difficult. Applying insurance-related ERISA provisions to the new breed of PSOs involved in direct contracting arrangements is like endeavoring to force square pegs into round holes.

ERISA’s preemptive scope affecting PSO contractual relationships with self-insured employers is sufficiently complex and uncertain that drawing any reliable conclusion in this area is futile without further congressional action.[284](#co_footnote_F284115542113_1) Perhaps the combination of managed care covering more Medicare and Medicaid enrollees and increasing pressure from employers and employer coalitions will spur congressional action.[285](#co_footnote_F285115542113_1) The ERISA Targeted Health Insurance Reform Act, introduced in 1995, would have allowed unregulated PSOs to engage in direct contracting with self-insured employers and permitted small employers to join into self-insured coalitions to similarly contract directly with PSOs.[286](#co_footnote_F286115542113_1) However, as Congress continues to stir about the need to enact federal regulation covering health-insuring organizations, state insurance regulators deride any suggestion that they should treat PSO direct contracting arrangements differently than similarly situated insurance organizations.[287](#co_footnote_F287115542113_1) Evaluating the foregoing policy arguments requires revisiting the inceptive rationales underlying health insurance regulatory philosophy.

The primary justifications for regulating health insurance--consumer protection and the need for the level playing field--are of uncertain relevance in the ongoing debate over regulating PSOs contracting with self-insured employers. First, the traditional consumer protection argument is not particularly convincing when the targeted consumers are self-insured companies. The suggestion, if based on the traditional notion that consumers need protection because of imperfect information or **\*485** insufficient product knowledge, seems misplaced.[288](#co_footnote_F288115542113_1) These employers are capable of contracting with PSOs to provide employees with health benefits to the extent that they may be in even better bargaining positions than those provider groups with whom they contract. The consumer protection ideal could be perceived as the need to ensure that employees will have access to health care. Even in the case of insolvency, through the contractual relationships between employers and PSOs, employers will still be responsible for providing health care to their employees.[289](#co_footnote_F289115542113_1) Perhaps consumers as well as health care delivery and insurance availability will ultimately be best situated by unbridling the forces of the health care market that are shaping the future.

In the end, an ingenuous justification for state regulation of risk-bearing PSO arrangements must be based on the need to create the evanescent level playing field. The notion that a regulatory framework should not favor “the development or maintenance of any particular organizational form assuming insurance risk”[290](#co_footnote_F290115542113_1) seems reasonable on its face. The quest for a level playing field, however, must be aborted when it stifles employers’ and providers’ own pursuits to bring cost-effective, deviceful health care products to the market. State insurance regulators cannot sacrifice potential innovations in the provision of health care for the benefit of protecting established methods of insuring such care. Until Congress takes the initiative to clarify the ERISA preemption clauses and expound the scope of that statute’s preemptive effect, the states should take an open-minded, yet watchful, approach toward regulating PSO direct contracting arrangements.

Congress should be commended for facilitating further PSO development by crafting legislation to eliminate, in some instances, state regulatory measures that serve as barriers to provider-controlled delivery of health care. Enacting the Balanced Budget Act[291](#co_footnote_F291115542113_1) is a welcome start, but its effect on PSO development is uncertain pending PSO participation levels in the Medicare+Choice plan and, most significantly, the development of realistic solvency standards. Only by clarifying ERISA’s preemptive effect will Congress ultimately promote the best public policy.

**VI. CONCLUSION**

Capitation is about creating appropriate incentives to induce an optimal level of health care delivery. It is also about power, money and control. These are the realities of today’s health care marketplace. However, once market competitors accept that capitation and the progeny of the managed care revolution are real and here for at least the immediate future, the forces of human nature and the marketplace coalesce to produce innovation and progress. Regulation and its underlying postulates--the quest for consumer protection and a level playing field--should not stand as a barrier to advancement. Regulation should not reach out to protect consumers not in need of further protection, nor should it “level” market competition by penalizing competitors who attempt to rise in challenging the status quo.

Although regulation of PSOs bearing downstream risk seems to be running its proper course, congressional intervention would be welcome in sorting out the confusion that exists regarding the states’ role in regulating PSOs involved in direct **\*486** contracting with self-insured employers. The initiatives undertaken by some of the states, as well as the discourse among the states that continues to take place through the NAIC, are to be commended because they call attention to the issues arising as providers and the organizations they sponsor seek to become more intricately involved in the payment mechanisms that drive the market. One can only hope that Congress will take the baton being extended to it and facilitate further development of provider-sponsored endeavors to pioneer the evolution of health care insurance and delivery.

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| Footnotes | |
| [a1](#co_footnoteReference_Fa1115542113_ID0EBQ) | Associate, Health Care Team, Long Aldridge & Norman LLP, Atlanta, Ga.; B.B.A., Emory University; J.D., New York University School of Law; LL.M., University of Houston Law Center.  The author wishes to thank the faculty and staff at the University of Houston Law Center Health Law & Policy Institute, especially Professors William J. Winslade and Mary Anne Bobinski, for their assistance. |
| [1](#co_footnoteReference_F1115542113_ID0EIRA) | Capitation refers to an arrangement by which a fixed amount of money is prepaid to health care organizations for delivering health care services to plan enrollees. *See* William S. Painter, *Provider-Sponsored Managed Care Organizations: A Compendium of Key Legal Issues, in* QUALIFIED PLANS, PROFESSIONAL ORGANIZATIONS, HEALTH CARE, AND WELFARE BENEFITS 1997, at 1069 (ALI-ABA Course of Study Materials No. 2, 1997). This payment system is customarily based on a fee “per member, per month” (PMPM) that does not vary with the amount of monthly care each member should require. *See id.* at 1076. In exchange for the PMPM fee, the organizations provide either all or a defined portion of the care needed by each member during the coverage period, thus creating the profit incentive in economizing. *See* Allison Overbay & Mark Hall, *Insurance Regulation of Providers That Bear Risk,* 22 AM. J.L. & MED. 361, 363 (1996). |
| [2](#co_footnoteReference_F2115542113_ID0ENRA) | *See* Steven Findlay, *Can Capitation Save the World?,* BUS. & HEALTH, June 1996, at 45, 45. |
| [3](#co_footnoteReference_F3115542113_ID0ESRA) | *See* Roger Taylor & Leeba Lessin, *Restructuring the Health Care Delivery System in the United States,* J. HEALTH CARE FIN., June 1, 1996, [*available in* 1996 WL 10931984](http://www.westlaw.com/Link/Document/FullText?findType=Y&pubNum=999&cite=1996WESTLAW10931984&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)). |
| [4](#co_footnoteReference_F4115542113_ID0ELSA) | This may even be understating the importance of the capitated dollar amounts. “Whoever controls the capitated revenue stream will be poised to dominate the emerging health care delivery system--and to reap an enormous windfall that could total hundreds of billions of dollars.” Overbay & Hall, *supra* note 1, at 361 n.1. |
| [5](#co_footnoteReference_F5115542113_ID0EITA) | *See* Greg Jaffe, *Start-Ups in Health Care are Booming: Change in Nation’s Medical Care Provides Openings,* WALL ST. J., May 23, 1997, at A9A (noting the entrepreneurs rushing to fill gaps in the health care industry and the increasing number of doctors assuming more risk through capitation). |
| [6](#co_footnoteReference_F6115542113_ID0EGUA) | [29 U.S.C. §§ 1001](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000546&cite=29USCAS1001&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=LQ&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search))-[1461 (1994)](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000546&cite=29USCAS1461&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=LQ&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)). |
| [7](#co_footnoteReference_F7115542113_ID0EJUA) | *See* [29 U.S.C. §§ 1144(a)](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000546&cite=29USCAS1144&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RB&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)#co_pp_8b3b0000958a4), [1144(b)(2)(A)](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000546&cite=29USCAS1144&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RB&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)#co_pp_1eca000045f07)-(B). |
| [8](#co_footnoteReference_F8115542113_ID0ESUA) | *See* RISK-BEARING ENTITIES WORKING GROUP, NAT’L ASS’N OF INS. COMM’RS, THE REGULATION OF HEALTH RISK-BEARING ENTITIES (1996) [hereinafter NAIC White Paper]. |
| [9](#co_footnoteReference_F9115542113_ID0EUWA) | *See id.* at 8. |
| [10](#co_footnoteReference_F10115542113_ID0EXW) | Health maintenance organizations (HMOs) are health care delivery systems that offer comprehensive health coverage for hospital and physician services for a capitated fee. *See* PATRICIA YOUNGER ET AL., LEGAL ANSWER BOOK FOR MANAGED CARE 2 (1995). HMOs exist in various forms; the five basic types are the staff model, the group model, the network model, the direct contract model and the individual practice association. *See id.* at 3. |
| [11](#co_footnoteReference_F11115542113_ID0E3W) | *See* Laura Johannes, *Doctor Networks Campaign to Offer Health Insurance,* WALL ST. J., Jan. 8, 1996, at B1. |
| [12](#co_footnoteReference_F12115542113_ID0EBX) | *See id.;* James J. Unland, *The Emergence of Providers as Health Insurers,* J. HEALTH CARE FIN., Fall 1996, at 57, 60. |
| [13](#co_footnoteReference_F13115542113_ID0EGX) | *See* Johannes, *supra* note 11, at B1. |
| [14](#co_footnoteReference_F14115542113_ID0EKX) | Provider-sponsored organizations (PSOs) deliver “a range of services including hospital, physician, and ancillary care.” *Two Bills in Congress Would Create Opportunities for PSOs: Provider Groups Support Legislation; State Regulators, HMOs Oppose It,* PHYSICIAN PRAC. OPTIONS, May 1997, at 1, 1. PSOs may contract with HMOs, Blue Cross and Blue Shield plans, traditional indemnity insurers, employers or employer groups. *See id.* This Article uses the term *PSOs* to encompass both provider-sponsored organizations and provider-sponsored networks, although some may distinguish between the two based on whether risk is accepted. *See id.* Additionally, the term PSOs will be used to refer to the most commonly discussed forms of PSOs including physician-hospital organizations (PHOs), individual or independent practice associations and group practices. *See* NAIC White Paper, *supra* note 8, at 11. |
| [15](#co_footnoteReference_F15115542113_ID0EZX) | *See id.* |
| [16](#co_footnoteReference_F16115542113_ID0E5X) | *See* Painter, *supra* note 1, at 1070. |
| [17](#co_footnoteReference_F17115542113_ID0EDY) | *See* Overbay & Hall, *supra* note 1, at 361-62. |
| [18](#co_footnoteReference_F18115542113_ID0EIY) | *See* Memorandum from Professor J.D. Epstein to the Seminar in Health Care Law and Policy at the University of Houston Law Center 17 (Fall 1996) [[[hereinafter Epstein] (on file with author). The text points out that although PHOs vary greatly in structure, they typically provide: (1) a unified entity through which hospitals and physicians may negotiate contracts with third-party payors; (2) a joint structure for marketing provider services; (3) utilization and quality control; (4) incentives for controlling costs; and (5) assistance in increasing operational efficiency. *See id.* at 17-18. |
| [19](#co_footnoteReference_F19115542113_ID0ESY) | *See* NAIC White Paper, *supra* note 8, at 11. |
| [20](#co_footnoteReference_F20115542113_ID0EXY) | *See* Painter, *supra* note 1, at 1070. |
| [21](#co_footnoteReference_F21115542113_ID0E3Y) | *See* Epstein, *supra* note 18, at 16; Painter, *supra* note 1, at 1070. |
| [22](#co_footnoteReference_F22115542113_ID0EBZ) | *See* Epstein, *supra* note 18, at 17. |
| [23](#co_footnoteReference_F23115542113_ID0EFZ) | *See id.* |
| [24](#co_footnoteReference_F24115542113_ID0EXZ) | *See* NAIC White Paper, *supra* note 8, at 11. |
| [25](#co_footnoteReference_F25115542113_ID0E3Z) | *See* YOUNGER ET AL., *supra* note 10, at 10; Painter, *supra* note 1, at 1070. |
| [26](#co_footnoteReference_F26115542113_ID0E6Z) | Recent estimates suggest that approximately 15% of existing HMOs are PSOs. *See* Terese Hudson, *The Great Debate: Resolved, PSOs are Going to be Regulated. The Question Is, Will They Get What They Want?,* MED. & HEALTH J., Jan. 20, 1996, *available in* LEXIS, Health Library, Rxmega File. |
| [27](#co_footnoteReference_F27115542113_ID0EC1) | *See* [IOWA CODE § 513C.10 (1995)](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000256&cite=IASTS513C.10&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=LQ&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)). |
| [28](#co_footnoteReference_F28115542113_ID0EF1) | *See* Ernst & Young, *Navigating Through the Changing Currents* (visited Nov. 7, 1997) ‹http://www.businessmonitor.co.uk/docs/proc/203/104CURR.html› (PSO survey). |
| [29](#co_footnoteReference_F29115542113_ID0EI1) | *See* GA. COMP. R. & REGS. r. 33-20-1 (1996); Ericka L. Rutenberg, Note, [*Managed Care and the Business of Insurance: When is a Provider Group Considered to be at Risk?,* 1 DEPAUL J. HEALTH CARE L. 267, 302](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=0107782242&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=LR&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) (1996). |
| [30](#co_footnoteReference_F30115542113_ID0EL1) | *See* [MICH. COMP. LAWS ANN. §§ 331.1303](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000043&cite=MIST331.1303&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=LQ&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)), [333.21042 (West 1997)](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000043&cite=MIST333.21042&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=LQ&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)). |
| [31](#co_footnoteReference_F31115542113_ID0EP1) | *See* MINN. STAT. ANN. § 331.1303 (West 1992). |
| [32](#co_footnoteReference_F32115542113_ID0EB2) | *See* Ernst & Young, *supra* note 28. |
| [33](#co_footnoteReference_F33115542113_ID0EG2) | *See id.* |
| [34](#co_footnoteReference_F34115542113_ID0EL2) | Just 30% of the surveyed PSOs reported a profit in 1995. *See id.* |
| [35](#co_footnoteReference_F35115542113_ID0EU2) | *See id.* PSOs “are taking on many of the characteristics that will allow them to compete with existing managed care companies.” *Id.* |
| [36](#co_footnoteReference_F36115542113_ID0EB3) | *See* Mary Chris Jaklevic, *Doc-Owned Health Plans Struggle to Go It Alone,* MOD. HEALTHCARE, May 12, 1997, at 3, 14. Significantly, access to capital, including reserve amounts needed to acquire an HMO license, is cited as a major impediment that prevents PSOs from competing with sizable HMOs. *See id.* |
| [37](#co_footnoteReference_F37115542113_ID0EJ3) | *See* Stephen M. Shortell et al., *The New World of Managed Care: Creating Organized Delivery Systems,* 13 HEALTH AFF. 46, 52-53 (1994). |
| [38](#co_footnoteReference_F38115542113_ID0EO3) | *See* CENTER FOR HEALTH POLICY RESEARCH, AM. MED. ASS’N, HEALTH SYSTEM CONVERSION TO MANAGED CARE: WORKFORCE IMPLICATIONS POLICY RESEARCH PERSPECTIVES 1 (1994). |
| [39](#co_footnoteReference_F39115542113_ID0ES3) | *See generally infra* Part V.C (discussing various forms of regulation applicable to PSOs). |
| [40](#co_footnoteReference_F40115542113_ID0EW4) | *See* Unland, *supra* note 12, at 57. |
| [41](#co_footnoteReference_F41115542113_ID0E24) | *See id.* Generally, three factors are motivating providers to offer services more akin to insurance: (1) desire to reduce the 20-30% of health insurance proceeds that the insurance industry takes for overhead and profit; (2) resentment of insurers’ intrusion into the practice of medicine and the physician-patient relationship; and (3) strong negative public perception surrounding HMOs, managed care and poor health care treatment. *See id.* at 58. |
| [42](#co_footnoteReference_F42115542113_ID0EC5) | *See id.* The importance of distinguishing between insurers and providers will become more apparent as this Article proceeds. *See infra* notes 142-57 and accompanying text. |
| [43](#co_footnoteReference_F43115542113_ID0ER5) | *See* NAIC White Paper, *supra* note 8, at 13-14. |
| [44](#co_footnoteReference_F44115542113_ID0EW5) | *See id.* at 14; *infra* Part II.B.2-3. |
| [45](#co_footnoteReference_F45115542113_ID0EL6) | *See* Kathrin E. Kudner, Study presented at the National Health Lawyers Association Conference 1 (Dec. 11-13, 1996) (on file with author). |
| [46](#co_footnoteReference_F46115542113_ID0EP6) | *See id.* |
| [47](#co_footnoteReference_F47115542113_ID0E56) | *See* NAIC White Paper, *supra* note 8, at 11. |
| [48](#co_footnoteReference_F48115542113_ID0EEA) | *See id.* at 14. |
| [49](#co_footnoteReference_F49115542113_ID0EJA) | *See id.* Global fee arrangements involve the payment of a flat fee for services rendered throughout the entire course of an enrollee’s treatment for a certain type of medical condition or procedure. *See id.* at 15. To utilize “withholds” and “risk pools,” designed to place providers at partial risk for the costs of an individual’s care, managed care entities add to a fund for referrals to specialists. *See id.* The pooled funds may be either lost to the providers or distributed back to them, depending on whether the cost of delivered services exceeds the managed care entity’s budget. *See id.* |
| [50](#co_footnoteReference_F50115542113_ID0ENA) | *See id.* |
| [51](#co_footnoteReference_F51115542113_ID0EFB) | *See id.* |
| [52](#co_footnoteReference_F52115542113_ID0EYB) | Group Health Association of America, *PHOs and the Assumption of Insurance Risk: A 50-State Survey of Regulator’s Attitudes Toward PHO Licensure, in* HEALTH CARE M&A: COMMERCIALIZATION OF THE MEDICAL INDUSTRY 1996 (Commercial Law and Practice Course Handbook Series No. A-741, 1996) [[[hereinafter GHAA Survey]. GHAA, now known as the American Association of Health Plans, is an HMO trade group that generally advocates greater state PHO oversight. *See infra* Part IV.A.1. |
| [53](#co_footnoteReference_F53115542113_ID0E4B) | Because PHOs represent a type of PSO, examining PHO payment methods is applicable in the PSO context. *See generally infra* Part III.A.1 (examining risk-sharing arrangements applicable to PHOs). |
| [54](#co_footnoteReference_F54115542113_ID0EHC) | *See* GHAA Survey, *supra* note 52, at 825. The surveyors acknowledged that although the four categories developed in their study represent several ways PHOs may contract to provide health care services, they do not encompass all of the arrangements that can exist. *See id.* |
| [55](#co_footnoteReference_F55115542113_ID0EMC) | *See id.* |
| [56](#co_footnoteReference_F56115542113_ID0EWC) | *See id.* |
| [57](#co_footnoteReference_F57115542113_ID0E2C) | *See id.* |
| [58](#co_footnoteReference_F58115542113_ID0EAD) | *See id.* |
| [59](#co_footnoteReference_F59115542113_ID0EED) | *See id.* |
| [60](#co_footnoteReference_F60115542113_ID0EAE) | *See id.* |
| [61](#co_footnoteReference_F61115542113_ID0EEE) | *See id.* |
| [62](#co_footnoteReference_F62115542113_ID0EWE) | *See* NAIC White Paper, *supra* note 8, at 27; Unland, *supra* note 12, at 57. |
| [63](#co_footnoteReference_F63115542113_ID0E2E) | *See* NAIC White Paper, *supra* note 8, at 27. |
| [64](#co_footnoteReference_F64115542113_ID0EAF) | *See* Taylor & Lessin, *supra* note 3. |
| [65](#co_footnoteReference_F65115542113_ID0EEF) | *See generally infra* Part V.C (addressing the problem of determining which regulations are best applicable to PSOs). Although the regulatory issues related to state insurance licensure requirements are the focus of this Article, PSO capital requirements depend on several additional factors. *See* Unland, *supra* note 12, at 63. Other considerations include: (1) start-up organization expenses; (2) start-up management and infrastructure expenses; (3) capital reserves based on actuarial data, including premiums for reinsurance and stop-loss coverage; (4) amounts that vary according to the scope of coverage of self-insured employers; (5) working capital; and (6) capital for marketing and promotion. *See id.* |
| [66](#co_footnoteReference_F66115542113_ID0ERF) | *See* GHAA Survey, *supra* note 52, at 825; *infra* Part IV.A.2. |
| [67](#co_footnoteReference_F67115542113_ID0EWF) | *See* NAIC White Paper, *supra* note 8, at 18. |
| [68](#co_footnoteReference_F68115542113_ID0E2F) | *See* Painter, *supra* note 1, at 1077. An example of a no risk arrangement is one in which payment is made to a PSO on a discount fee-for-service basis (FFS), such that the amount paid represents a discount from regular charges and payment is only made for services actually delivered. *See id.* Full risk arrangements are typically those in which capitated payments are made. *See id.* A “risk corridor” is a mechanism by which a PSO would assume risk and simultaneously purchase stop-loss insurance to cover costs that are greater than planned. *See* NAIC White Paper, *supra* note 8, at 15. |
| [69](#co_footnoteReference_F69115542113_ID0EEG) | *See infra* Part III.C.2. Because no risk arrangements do not raise the specter of unauthorized insurance risk assumption, these agreements are not of much concern to insurance regulators and, likewise, are not of much concern in this Article. |
| [70](#co_footnoteReference_F70115542113_ID0EWG) | *See* Unland, *supra* note 12, at 57-58. |
| [71](#co_footnoteReference_F71115542113_ID0E1G) | *See id.* at 58. |
| [72](#co_footnoteReference_F72115542113_ID0EPH) | *See* Louise Kertesz & Joanne Wojcik, *Risky PHO’s Winning Bet,* MOD. HEALTHCARE, July 25, 1994, at 44, 44. |
| [73](#co_footnoteReference_F73115542113_ID0EKI) | *See* McCarran-Ferguson Act, [15 U.S.C. §§ 1011](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000546&cite=15USCAS1011&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=LQ&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search))-[1015 (1994)](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000546&cite=15USCAS1015&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=LQ&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)). The Act provides in relevant part that:  (a) The business of insurance and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.  (b) No act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, … unless such Act specifically relates to the business of insurance….  *Id.* § 1012. |
| [74](#co_footnoteReference_F74115542113_ID0EPI) | *See* NAIC White Paper, *supra* note 8, at 1. |
| [75](#co_footnoteReference_F75115542113_ID0EUI) | *See id.* |
| [76](#co_footnoteReference_F76115542113_ID0E5I) | *See generally infra* Parts III.A-B, IV.C (discussing the complexity of health insurance systems and the difficulties in instituting regulations). |
| [77](#co_footnoteReference_F77115542113_ID0EWK) | *See* [15 U.S.C. §§ 1011](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000546&cite=15USCAS1011&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=LQ&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search))-[1015](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000546&cite=15USCAS1015&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=LQ&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)). The McCarran-Ferguson Act, among other things, provides an exemption from federal antitrust laws for the business of insurance. *See id.* at §§ 1012-1013. |
| [78](#co_footnoteReference_F78115542113_ID0EZK) | Market regulations include, most prominently, rates and policy form regulation and market practice regulation. *See* Robert W. Klein, *Structural Change and Regulatory Response in the Insurance Industry* (visited Sept. 17, 1997) ‹http://www.naic.org/geninfo/about/regutra3.htm›. The rationales for these regulations reflect concern for “destructive competition” and market implosion, high consumer search costs, imperfect information and unequal bargaining power. *See id.* (citing Paul L. Joskow, *Cartels, Competition and Regulation in the Property-Liability Insurance Industry,* 4 BELL J. OF ECON. 375 (1973)). *See generally* Scott E. Harrington, *Rate Suppression,* 59 J. RISK & INS. 185 (1992) (providing background on trends in rate regulation). |
| [79](#co_footnoteReference_F79115542113_ID0E5K) | *See* Klein, *supra* note 78. |
| [80](#co_footnoteReference_F80115542113_ID0EDL) | *See id.* |
| [81](#co_footnoteReference_F81115542113_ID0EIL) | *See id.* Solvency regulation is designed “to limit the degree of insolvency risk in accordance with society’s preference for safety.” *Id.* Solvency regulation covers insurers with regard to: “(1) capitalization; (2) pricing and products; (3) investments; (4) reinsurance; (5) reserves; (6) asset-liability matching; (7) transactions with affiliates; and (8) management.” *Id.* Over the last decade or so, states have been involved in a significant effort to “rebuild the framework for insurance regulation,” and much of this effort has focused upon “strengthening solvency regulation by establishing more stringent capital standards, expanding financial reporting, improving monitoring tools, and certifying insurance departments.” *Id.* |
| [82](#co_footnoteReference_F82115542113_ID0ELL) | *See id.* These standards aim to create a cushion against an insurer’s unexpected losses by requiring insurers to set aside funds that may be used to help protect policyholders and claimants in the event of subsequent insolvency. *See id.* |
| [83](#co_footnoteReference_F83115542113_ID0EAM) | The National Association of Insurance Commisioners (NAIC) states these elements as follows: “1. All entities which assume health insurance risk must be subject to solvency and other appropriate consumer protection standards, irrespective of the name and form 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.” NAIC White Paper, *supra* note 8, at 2. These concerns, of course, must be considered in light of factors that affect insurance regulation more generally, including: industry structure, conduct and performance; public opinion; interdependence among states; state fiscal pressures; and state/federal tensions. *See* Klein, *supra* note 78. |
| [84](#co_footnoteReference_F84115542113_ID0EFM) | *See* NAIC White Paper, *supra* note 8, at 2. |
| [85](#co_footnoteReference_F85115542113_ID0EKM) | Regulations that hinder entrepreneurial PSOs by requiring excessive capital requirements, for instance, end up restricting market movements that have the potential to create lower overall health insurance costs, thereby benefiting consumers. *See* Klein, *supra* note 78. Between competitors, furthermore, creating a level playing field necessarily involves taking away from a group or organization some degree of competitive advantage, albeit perhaps originating from a prior regulatory framework. *See* NAIC White Paper, *supra* note 8, at 19. Achieving regulatory objectives requires coordination between solvency and market regulations. *See* Klein, *supra* note 78. However, evaluation of these objectives relative to PSO regulation depends on the interests of whichever group--insurers, providers or employers--one believes to be foremost. *See generally* Overbay & Hall, *supra* note 1, at 362-68 (observing that regulation needs to focus on protecting consumers and fostering market reform instead of preserving insurers and providers). |
| [86](#co_footnoteReference_F86115542113_ID0EOM) | *See* Kudner, *supra* note 45, at 6. A more in-depth look at state health insurance provisions follows later in this Article. *See infra* Parts IV.A.2, IV.B.1-3. |
| [87](#co_footnoteReference_F87115542113_ID0EWN) | For a related discussion, see *infra* notes 95-123 and accompanying text. |
| [88](#co_footnoteReference_F88115542113_ID0E2N) | *See* RANDOM HOUSE WEBSTER’S COLLEGE DICTIONARY 1162 (2d ed. 1992). |
| [89](#co_footnoteReference_F89115542113_ID0EOO) | The scenario described herein is based on material contained in the NAIC White Paper, which provides a thorough background description of insurance risk. Despite discussion, the author acknowledges that distinguishing insurance risk from business risk or service risk remains difficult particularly in the health care context. *See* ED HIRSHFELD & FRANK KOLB, AM. MED. ASS’N, LEGAL ISSUES IN FORMING REGIONAL PHYSICIAN NETWORKS 21 (National Managed Health Care Congress Executive Briefing Series No. 21, 1997). |
| [90](#co_footnoteReference_F90115542113_ID0EYO) | *See* NAIC White Paper, *supra* note 8, at 4. |
| [91](#co_footnoteReference_F91115542113_ID0E4O) | *See id.* |
| [92](#co_footnoteReference_F92115542113_ID0ECP) | *See id.* |
| [93](#co_footnoteReference_F93115542113_ID0EHP) | *See id.* at 4 n.4. |
| [94](#co_footnoteReference_F94115542113_ID0ELP) | *See id.* at 4. Unfortunately, this definition of insurance risk does not sufficiently distinguish this type of risk from other risks, such as financial risk or service risk. These distinctions prove to be critical in regulating capitation arrangements because PSOs involved in such arrangements often assume a combination of risk elements that do not neatly lend themselves to classification. At least one author has noted that a key factor used in identifying whether a risk is appropriately classified as “service” or “““insurance” is which party makes capitation payments. *See* Rutenberg, *supra* note 29, at 280. Because regulators rely so heavily on categorizations based on insurance risk and the business of insurance, regulators would like to define these terms as broadly as possible; PSOs bearing risk are critical of such liberal interpretations. *See* Letter from G. Lawrence Atkins, Project Coordinator, Employer Health Care Innovation Project, to Stephanie Lewis, National Association of Insurance Commissioners 2-3 (Oct. 31, 1996) [[[hereinafter EHCIP Letter] (questioning the NAIC definition of insurance risk). For further discussion of the arguments surrounding the interpretation of regulatory terminology, see *infra* Part V.B. |
| [95](#co_footnoteReference_F95115542113_ID0EMQ) | *See* Kudner, *supra* note 45, at 7. |
| [96](#co_footnoteReference_F96115542113_ID0ERQ) | *See id.* |
| [97](#co_footnoteReference_F97115542113_ID0EVQ) | *See* NAIC White Paper, *supra* note 8, at 5. |
| [98](#co_footnoteReference_F98115542113_ID0ERR) | [440 U.S. 205 (1979)](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1979108037&pubNum=780&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)). |
| [99](#co_footnoteReference_F99115542113_ID0E3R) | [458 U.S. 119 (1982)](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1982129078&pubNum=780&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)). |
| [100](#co_footnoteReference_F100115542113_ID0EZ) | *See generally* [440 U.S. 205 (1979)](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1979108037&pubNum=780&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) (analyzing the language in the McCarran-Ferguson Act). |
| [101](#co_footnoteReference_F101115542113_ID0E5) | *See* [*id.* at 209.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1979108037&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) |
| [102](#co_footnoteReference_F102115542113_ID0ED) | *See* [*id.* at 214.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1979108037&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) |
| [103](#co_footnoteReference_F103115542113_ID0ER) | [*Id.* at 221.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1979108037&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) |
| [104](#co_footnoteReference_F104115542113_ID0EV) | The Court commented that the insurer’s arrangements with the pharmacies “may well be sound business practice, and may well inure ultimately to the benefit of policyholders in the form of lower premiums, but they are not the ‘business of insurance.”DD’ [*Id.* at 214.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1979108037&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) |
| [105](#co_footnoteReference_F105115542113_ID0E6) | *See* [*id.* at 215.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1979108037&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) |
| [106](#co_footnoteReference_F106115542113_ID0EW) | [*Id.* at 215-16](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1979108037&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) (quoting [SEC v. National Sec., Inc., 393 U.S. 453, 460 (1969)](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1969132909&pubNum=780&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&fi=co_pp_sp_780_460&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)#co_pp_sp_780_460)). The Court stated that these concerns were the core of the business of insurance. *See* [*id.* at 216](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1979108037&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) (quoting [*National Sec., Inc.,* 393 U.S. at 460).](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1969132909&pubNum=780&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&fi=co_pp_sp_780_460&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)#co_pp_sp_780_460) |
| [107](#co_footnoteReference_F107115542113_ID0EZ) | The Court rejected a contrary interpretation of the relationship as “plainly contrary to the statutory language, which exempts the ‘business of insurance’ and not the ‘business of insurance companies.”DD’ *Id.* at 217. It is quite plausible to read the opinion as placing great emphasis on the relationship’s effect on the policyholder. *See* Overbay & Hall, *supra* note 1, at 374. Overbay and Hall comment that:  Because the policyholder’s relationship is with the entity that sells the policy, only that entity is properly regulated as an insurer. The method that the insurer chooses to meet its obligation is not irrelevant to the policyholder, but this concern justifies only more intensive regulation of the primary insurer. It does not justify reaching behind or beyond the insurer to regulate every entity with which an insurer does business.  *Id.* This line of reasoning might equally be applied to conclude that PSOs’ downstream risk contracting arrangements do not involve the business of insurance. *See id.* For a related discussion, see *infra* notes 145-52 and accompanying text. |
| [108](#co_footnoteReference_F108115542113_ID0EG) | *See* [*Royal Drug,* 440 U.S. at 224.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1979108037&pubNum=780&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&fi=co_pp_sp_780_224&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)#co_pp_sp_780_224) The Court made this point in the context of reviewing the legislative history of the McCarran-Ferguson Act. *See id.* |
| [109](#co_footnoteReference_F109115542113_ID0E2) | [458 U.S. 119 (1982)](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1982129078&pubNum=780&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)). |
| [110](#co_footnoteReference_F110115542113_ID0EK) | *See* [*id.* at 122.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1982129078&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) The peer review committee consisted of ten practicing chiropractors, who served on a voluntary basis, and was designed primarily to assist insurers in evaluating chiropractic claims. *See* [*id.* at 123.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1982129078&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) |
| [111](#co_footnoteReference_F111115542113_ID0EX) | *See* [*id.* at 126-29.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1982129078&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) None of the three criteria is determinative in deciding whether a particular practice is part of the business of insurance. *See* [*id.* at 129.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1982129078&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) The risk-spreading component, in particular, gives rise to inherent public policy concerns in many insurance risk arrangements. *See* NAIC White Paper, *supra* note 8, at 6. Nevertheless, distinguishing insurance risk from other types of risk remains difficult. *See supra* notes 87-94 and accompanying text. |
| [112](#co_footnoteReference_F112115542113_ID0E2) | *See* [*Pireno,* 458 U.S. at 134.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1982129078&pubNum=780&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&fi=co_pp_sp_780_134&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)#co_pp_sp_780_134) |
| [113](#co_footnoteReference_F113115542113_ID0EW) | *See* [*id.* at 130.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1982129078&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) The Court reasoned that the  transfer of risk from insured to insurer is effected by means of the contract between the parties--the insurance policy--and that transfer is complete at the time the contract is entered. If the policy limits coverage to “necessary” treatments and “reasonable” charges for them, then that limitation is the measure of risk that has actually been transferred to the insurer.  *Id.* |
| [114](#co_footnoteReference_F114115542113_ID0E2) | *See id.* at 131. |
| [115](#co_footnoteReference_F115115542113_ID0E6) | *See id.* at 132. The weight the Court gives to this third factor is somewhat unclear. Although the Court used language indicating the factor is perhaps not dispositive, it refused to depreciate the fact that the provider market potentially affected by the arrangement--the chiropractic services market--was not an insurance market. *See id.* at 132-33. |
| [116](#co_footnoteReference_F116115542113_ID0ET) | *See* [471 U.S. 724, 744 (1985)](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1985127857&pubNum=780&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&fi=co_pp_sp_780_744&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)#co_pp_sp_780_744). With certain exceptions, the Employee Retirement and Income Security Act of 1974 (ERISA) preempts state laws that relate to employee benefit plans. *See* [29 U.S.C. §§ 1001](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000546&cite=29USCAS1001&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=LQ&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search))-[1461 (1994)](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000546&cite=29USCAS1461&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=LQ&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)); *infra* Part III.B. |
| [117](#co_footnoteReference_F117115542113_ID0EA) | [471 U.S. at 743.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1985127857&pubNum=780&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&fi=co_pp_sp_780_743&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)#co_pp_sp_780_743) For an ERISA case where the Court applied these same criteria but concluded that a state law did not regulate the business of insurance, see [*Pilot Life Insurance Co. v. Dedeaux,* 481 U.S. 41, 50-51 (1987)](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1987042953&pubNum=780&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&fi=co_pp_sp_780_50&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)#co_pp_sp_780_50). |
| [118](#co_footnoteReference_F118115542113_ID0EE) | *See* [471 U.S. at 746.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1985127857&pubNum=780&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&fi=co_pp_sp_780_746&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)#co_pp_sp_780_746) |
| [119](#co_footnoteReference_F119115542113_ID0EH) | [107 F.2d 239 (D.C. Cir. 1939)](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1939122670&pubNum=350&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)). One source compares the *Jordan* arrangement to the discount purchase agreement in *Royal Drug. See* Painter, *supra* note 1, at 1074. Other commentators view the activities in *Jordan* to be “identical to the modern-day HMO.” Overbay & Hall, *supra* note 1, at 370. |
| [120](#co_footnoteReference_F120115542113_ID0EU) | *See* [*Jordan,* 107 F.2d at 242.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1939122670&pubNum=350&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&fi=co_pp_sp_350_242&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)#co_pp_sp_350_242) |
| [121](#co_footnoteReference_F121115542113_ID0EZ) | *See* [*id.* at 243.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1939122670&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) |
| [122](#co_footnoteReference_F122115542113_ID0EH) | *See* [*id.* at 247 n.26.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1939122670&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) The court was not concerned with “whether risk is involved or assumed, but … whether that or something else to which it is related in the particular plan is its principal object and purpose.” [*Id.* at 248.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1939122670&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) |
| [123](#co_footnoteReference_F123115542113_ID0EL) | *See id.* The court’s distinctions relating to the types of risk involved in the activities in *Jordan* do not comport with more recent state insurance commission analyses. *See* NAIC White Paper, *supra* note 8, at 7 nn.17-18 and accompanying text; Painter, *supra* note 1, at 1075. For an additional discussion of state insurance commission reports, see *infra* Part V.A. |
| [124](#co_footnoteReference_F124115542113_ID0EN) | *See* [29 U.S.C. §§ 1001(a)](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000546&cite=29USCAS1001&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RB&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)#co_pp_8b3b0000958a4)-[(c)](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000546&cite=29USCAS1001&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RE&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)#co_pp_4b24000003ba5), [1144(a)](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000546&cite=29USCAS1144&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RB&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)#co_pp_8b3b0000958a4), [(b)(1)](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000546&cite=29USCAS1144&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RB&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)#co_pp_3fed000053a85)-(2) (1994). The ERISA provisions indicate that an “employee benefit plan” includes an “employee welfare benefit plan.” *Id.* § 1002(3). “Employee welfare benefit plan,” in turn, includes “any plan, fund, or program which was … established or maintained by an employer or by an employee organization, or by both … for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise … medical, surgical, or hospital care or benefits.” *Id.* § 1002(1). In this context, state law includes all laws, decisions, rules, regulations, or other state action having the effect of law, of any state. *See* [*id.* § 1144(c)(1)](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000546&cite=29USCAS1144&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RB&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)#co_pp_10c0000001331). Furthermore, the term “state” includes a state, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by ERISA. *See* [*id.* § 1144(c)(2)](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000546&cite=29USCAS1144&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RB&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)#co_pp_fcf30000ea9c4). |
| [125](#co_footnoteReference_F125115542113_ID0ES) | *See* [*id.* § 1144(b)(2)(A)](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000546&cite=29USCAS1144&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RB&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)#co_pp_1eca000045f07). This clause is qualified, however, by the “““deemer clause.” *See* [*id.* § 1144(b)(2)(B)](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000546&cite=29USCAS1144&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RB&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)#co_pp_424e0000ad683). As such, these provisions must be read in tandem, but to do so is not so easy. *See infra* Part III.B.2. |
| [126](#co_footnoteReference_F126115542113_ID0EX) | The purpose of ERISA’s preemptive clauses is to give large employers whose retirement and welfare benefit plans would be subject to federal regulation “some assurance that they would face uniform requirements.” CLARK C. HAVIGHURST, HEALTH CARE LAW AND POLICY 1197 (1990). The entanglement of the statute’s provisions, however, prohibits a smooth transition from succinct objective to facile translation and application of the language employed. *See* Mary Anne Bobinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured,* 24 U.C. DAVIS L. REV. 255, 274-78 (1990) (observing that nebulous interrelation of ERISA’s provisions leads to extensive litigation). |
| [127](#co_footnoteReference_F127115542113_ID0E6) | [463 U.S. 85 (1983)](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1983129663&pubNum=780&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)). |
| [128](#co_footnoteReference_F128115542113_ID0EE) | *See* [*id.* at 96-99.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1983129663&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) |
| [129](#co_footnoteReference_F129115542113_ID0ES) | [*Id.* at 96-97.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1983129663&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) |
| [130](#co_footnoteReference_F130115542113_ID0EV) | The Court commented that “some state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law ‘relates to’ the plan.” [*Id.* at 100 n.21.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1983129663&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) For an example of other Supreme Court cases reading ERISA’s scope expansively, see *FMC Corp. v. Holliday,* 498 U.S. 50 (1990); [*Ingersoll-Rand Co. v. McClendon,* 498 U.S. 133 (1990)](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1990169468&pubNum=780&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)); [*Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41 (1987)](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1987042953&pubNum=780&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)). The Court finally limited the effect of the relate to clause in [*New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.,* 514 U.S. 645 (1995)](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1995096310&pubNum=780&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)). |
| [131](#co_footnoteReference_F131115542113_ID0EM) | [514 U.S. 645 (1995)](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1995096310&pubNum=780&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)). |
| [132](#co_footnoteReference_F132115542113_ID0ER) | *See* [*id.* at 649.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1995096310&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) The law was constructed to promote the coverage of Medicaid recipients. *See* [*id.* at 658.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1995096310&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) |
| [133](#co_footnoteReference_F133115542113_ID0EW) | *See* [*id.* at 651-52.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1995096310&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) |
| [134](#co_footnoteReference_F134115542113_ID0E2) | *See* [*id.* at 668.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1995096310&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) |
| [135](#co_footnoteReference_F135115542113_ID0EA) | *See* [*id.* at 659, 668.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1995096310&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) The Court reasoned that laws with only “““indirect economic influence” fail, with respect to employee benefits, to either “bind plan administrators to [a] particular choice and thus function as a regulation of an ERISA plan itself … [or] preclude uniform administrative practice or the provision of a uniform interstate benefit package.” [*Id.* at 659-60.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1995096310&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) |
| [136](#co_footnoteReference_F136115542113_ID0EE) | *See* [*id.* at 668.](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1995096310&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) |
| [137](#co_footnoteReference_F137115542113_ID0EC) | *See* Torin A. Dorros & T. Howard Stone, *Implications of Negligent Selection and Retention of Physicians in the Age of ERISA,* 22 AM. J.L. & MED. 383, 406 (1995). |
| [138](#co_footnoteReference_F138115542113_ID0ER) | [29 U.S.C. § 1144(b)(2)(A)](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000546&cite=29USCAS1144&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RB&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)#co_pp_1eca000045f07) (1994). The provision “saves” insurance acts to minimize federal encroachment on the state’s traditional role as insurance regulator. *See* Overbay & Hall, *supra* note 1, at 379-80. |
| [139](#co_footnoteReference_F139115542113_ID0EV) | *See* [29 U.S.C. § 1144(b)(2)(B)](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000546&cite=29USCAS1144&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RB&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)#co_pp_424e0000ad683). Thus, the deemer clause effectively overrides the insurance saving clause and reinstates ERISA preemption for employers who self-insure their own employee benefits. *See* Overbay & Hall, *supra* note 1, at 380. |
| [140](#co_footnoteReference_F140115542113_ID0EE) | *See supra* note 87 and accompanying text. Notably, courts have ruled differently on the issue of whether HMO laws regulate the “business of insurance” and are subject to preemption. Compare, for example, [*Travelers Insurance Co. v. Cuomo,* 14 F.3d 708 (2d Cir. 1993)](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1994029989&pubNum=506&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) (holding that ERISA preempted a New York statute imposing surcharges on hospital rate assessments made against certain HMOs) with [*Physician’s Health Plan, Inc. v. Citizens Insurance Co. of America,* 673 F. Supp. 903 (W.D. Mich. 1987)](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1987144860&pubNum=345&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) (finding that the Health Maintenance Organization Act did not preempt a section of Michigan’s insurance code). |
| [141](#co_footnoteReference_F141115542113_ID0EJ) | [471 U.S. 724 (1985)](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1985127857&pubNum=780&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)). *See supra* notes 116-19 (discussing the definition of the “business of insurance”). |
| [142](#co_footnoteReference_F142115542113_ID0EW) | [481 U.S. 41 (1987)](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1987042953&pubNum=780&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)). |
| [143](#co_footnoteReference_F143115542113_ID0E5) | *See supra* Part III.A.2. |
| [144](#co_footnoteReference_F144115542113_ID0EC) | *See infra* Part III.C.2. |
| [145](#co_footnoteReference_F145115542113_ID0EG) | *See* NAIC White Paper, *supra* note 8, at 27; Painter, *supra* note 1, at 1080. |
| [146](#co_footnoteReference_F146115542113_ID0EL) | *See* Painter, *supra* note 1, at 1080. An illustration may help describe how downstream arrangements operate. Suppose an employer pays an HMO on a capitated basis (i.e., fixed amount, per member, per month) in exchange for that HMO’s obligation to provide health care services as the covered employees may require. The HMO, in turn, can contract downstream with a PSO, for example, and pay the PSO a smaller capitated amount for assuming responsibility for providing health care as the employees require. In this manner, the HMO transfers a portion of its risk to the PSO and, in doing so, it raises significant regulatory issues. For a more detailed illustration, see Overbay & Hall, *supra* note 1, at 371-72. |
| [147](#co_footnoteReference_F147115542113_ID0EX) | *See* Overbay & Hall, *supra* note 1, at 372. |
| [148](#co_footnoteReference_F148115542113_ID0EP) | NAIC White Paper, *supra* note 8, at 28. |
| [149](#co_footnoteReference_F149115542113_ID0EU) | *See* HIRSHFELD & KOLB, *supra* note 89, at 18. |
| [150](#co_footnoteReference_F150115542113_ID0EZ) | *See id.* The NAIC White Paper echoes these concerns, observing that “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.” NAIC White Paper, *supra* note 8, at 28. |
| [151](#co_footnoteReference_F151115542113_ID0E5) | *See* NAIC White Paper, *supra* note 8, at 28. Some of the state initiatives in this area are discussed at *infra* Part IV.A-B. The comments of Overbay and Hall reflect, however, the view that regulation of PSOs which contract for risk downstream “provides little additional protection of the consumer and may in fact harm the consumer by hampering this innovation in health care delivery.” Overbay & Hall, *supra* note 1, at 373. |
| [152](#co_footnoteReference_F152115542113_ID0EZ) | *See* Painter, *supra* note 1, at 1077. Although these arrangements may in some situations involve no risk (e.g., FFS), this Article deals only with the more controversial realm of risk contracting. |
| [153](#co_footnoteReference_F153115542113_ID0EA) | *See* Unland, *supra* note 12, at 60. There are a number of related reasons for PSOs’ heightened interest in bearing risk. These include the following: increased interest by HMOs and purchasers to share risk with providers; providers’ increased desire to control medical management decisions; “excess supply of beds and physicians; declining premiums; opportunities for Medicaid and Medicare risk contracting; and the emergence of for-profit hospitals.” NAIC White Paper, *supra* note 8, at 18-19. |
| [154](#co_footnoteReference_F154115542113_ID0ER) | *See supra* note 65 and accompanying text. |
| [155](#co_footnoteReference_F155115542113_ID0EW) | *See* Kate Bowen, *The “Other” Risk in Provider Contracting* (visited Nov. 7, 1997) ‹http://www.jenkens.com/hf96\_3.htm›. |
| [156](#co_footnoteReference_F156115542113_ID0E2) | *See Regulation of Risk-Bearing Networks Described as “All Over the Board”,* 4 Health Care Pol. Rep. (BNA) No. 9 (Feb. 26, 1996), *available in* 1997 WL BNA-HCP [hereinafter *Regulation of Risk-Bearing Networks*]. |
| [157](#co_footnoteReference_F157115542113_ID0EA) | *See id.* |
| [158](#co_footnoteReference_F158115542113_ID0EX) | *See* HIRSHFELD & KOLB, *supra* note 89, at 18-19. The high cost of licensure is a result of solvency standards, reporting requirements and other regulatory requirements. *See id.* at 18. The flexibility that would be lost by self-insured employers includes the ability to save money by designing their own health benefits plans rather than purchasing these plans from insurers who themselves must comply with licensing requirements. *See id.* at 19. |
| [159](#co_footnoteReference_F159115542113_ID0E3) | *See id.* |
| [160](#co_footnoteReference_F160115542113_ID0EA) | *See* NAIC White Paper, *supra* note 8, at 19. The consumer protection and level playing field credos serve as buzzwords littering insurance industry-speak. *See* Jeannine Mjoseth, *NAIC Creates Body of Regulation to Address Managed Care Entities,* 3 Health Care Pol. Rep. (BNA) No. 40, 1665 (Oct. 9, 1995); *NAIC Gives States Guidance for Regulating IDSs, PHOs,* 5 Managed Care Wk. No. 30 (Aug. 21, 1995), [*available in* 1995 WL 2409108;](http://www.westlaw.com/Link/Document/FullText?findType=Y&pubNum=999&cite=1995WESTLAW2409108&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) *NAIC Urges State Oversight of Non-Regulated Providers,* 3 Wash. Health Wk. (Atl. Info. Serv.) No. 18 (Aug. 21, 1995), [*available in* 1995 WL 7731224](http://www.westlaw.com/Link/Document/FullText?findType=Y&pubNum=999&cite=1995WESTLAW7731224&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)). |
| [161](#co_footnoteReference_F161115542113_ID0ED) | *See State Regulation of PHOs Depends on How Provider At-Risk Contracts are Structured,* 5 Managed Care Wk. (Atl. Info. Serv.) No. 19 (May 22, 1995), [*available in* 1995 WL 2408963](http://www.westlaw.com/Link/Document/FullText?findType=Y&pubNum=999&cite=1995WESTLAW2408963&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) (noting that “state oversight of PHOs and other provider linkages is haphazard”). To sum up the confounding regulatory environment, one can simply say, “It’s just kind of a mess.” *Id.* (quoting Doug Chaet, President of New York City’s Lenox Hill PHO and Chairman of the American Association of PHOs); *see also* GHAA Survey, *supra* note 52, at 822 (observing that regulatory oversight of PHOs is erratic). Alternatively, one could describe the state regulation of risk-bearing PSOs as “all over the board.” *See Regulation of Risk-Bearing Networks, supra* note 156. |
| [162](#co_footnoteReference_F162115542113_ID0EM) | *See generally* GHAA Survey, *supra* note 52 (discussing the states’ regulation of risk transfer to PHOs). |
| [163](#co_footnoteReference_F163115542113_ID0EH) | *See id.* at 824. The survey results provide insight into how states regulate one particular type of PSO (namely, the PHO); thus, the regulators’ opinions are relevant not only in terms of regulating PHOs specifically, but also PSOs generally. *See supra* Part II.B.2. |
| [164](#co_footnoteReference_F164115542113_ID0EM) | *See* GHAA Survey, *supra* note 52, at 824. |
| [165](#co_footnoteReference_F165115542113_ID0EP) | One of these four options describes an arrangement where no risk is transferred to the PHO, which is of little consequence here beyond confirming that, as could have been expected, 40 states and the District of Columbia reported that they had no licensure requirements for PHOs in these situations. *See id.* at 827. |
| [166](#co_footnoteReference_F166115542113_ID0E4) | *Id.* at 823. Introductory materials to the survey results recognize the goal of state licensure requirements as “ensur[ing] that consumers receive the medical coverage they have been promised.” *Id.* The materials continue to list a number of typical solvency requirements states impose on risk-bearing health plans, as well as quality of care regulations that may be imposed. *See id.* The materials also make reference to regulators’ concern with “maintaining a level regulatory playing field,” as well as to the observation of the “NAIC and others” that PHOs “frequently operate in states as unauthorized insurers or health plans … [assuming] insurance risk without applying for state licensure.” *Id.* Additionally, conclusory remarks express concern the “adequacy of consumer protections and the fairness of the competitive environment” and with fostering “a more level regulatory playing field.” *Id.* at 831. |
| [167](#co_footnoteReference_F167115542113_ID0EH) | *See id.* at 822. |
| [168](#co_footnoteReference_F168115542113_ID0EM) | The survey denoted direct contracting arrangements as “Full Risk” and “Partial Risk,” distinguishing based on the level of risk transferred to the PHO through the payment mechanism. *See id.* at 825. Full Risk options were defined as those in which “the PHO is paid on a prepaid, capitated basis for all medical services.” *Id.* Partial Risk contracts were described as those where the PHO and the employer establish a budget within which the PHO must stay, providing that the PHO will be liable for expenses beyond the budgeted amount and any savings below the budget will be split between the PHO and the employer. *See id.* The downstream contracting option was aptly titled “““Downstream Risk,” wherein a PHO contracts with a licensed health plan on a prepaid, capitated basis for providing medical services. *See id.* See *supra* Part II.B.2 for additional discussion of the options presented to state regulators. |
| [169](#co_footnoteReference_F169115542113_ID0EQ) | *See supra* Part II.B.3. |
| [170](#co_footnoteReference_F170115542113_ID0EC) | *See* GHAA Survey, *supra* note 52, at 829. |
| [171](#co_footnoteReference_F171115542113_ID0EG) | *See id.* Most of the states indicating that they would not regulate downstream PHOs also conveyed that significant transfers of risk could raise the possibility that such organizations would be subject to regulation. *See id.* |
| [172](#co_footnoteReference_F172115542113_ID0EV) | *See id.* at 825. |
| [173](#co_footnoteReference_F173115542113_ID0E1) | *See id.* at 827. |
| [174](#co_footnoteReference_F174115542113_ID0E6) | *See id.* |
| [175](#co_footnoteReference_F175115542113_ID0EQ) | *Id.* Interestingly, regulators representing different agencies within the same state even expressed disparate views regarding arrangements that would trigger oversight. This may be attributed to the fact that “[t] ypically, state insurance departments focus on solvency issues, while state health departments focus on the delivery system.” *Id.* at 828. While locating a plausible cause of confusion is fascinating enough, it cannot be particularly reassuring for those PHOs needing guidance as to state regulatory requirements. |
| [176](#co_footnoteReference_F176115542113_ID0EV) | *See id.* |
| [177](#co_footnoteReference_F177115542113_ID0EK) | *See id.* at 829; *see also* Laura Kaufman & Susan Webster, *GHAA Survey Finds States Erratic in Oversight, Regulation of PHOs,* 3 Health Care Pol. Rep. (BNA) No. 29, 1142 (July 17, 1995) (discussing the GHAA survey results and observing the discrepancy between what regulators say and how they act). |
| [178](#co_footnoteReference_F178115542113_ID0EP) | GHAA Survey, *supra* note 52, at 829. |
| [179](#co_footnoteReference_F179115542113_ID0EU) | *Id.* at 831. In summary,  [t]he immediate challenge for most regulators … is whether they will shift from a passive to active paradigm by aggressively seeking out those arrangements or plans that improperly assume risk and subject them to licensure … to ensure a more level regulatory playing field and to assure that health care consumers are protected.  *Id.* |
| [180](#co_footnoteReference_F180115542113_ID0EY) | *See* Painter, *supra* note 1, at 1080 (noting that since the GHAA survey, states have revised their approaches or requirements regarding risk-bearing PSOs). |
| [181](#co_footnoteReference_F181115542113_ID0ER) | *See* Klein, *supra* note 78. |
| [182](#co_footnoteReference_F182115542113_ID0EW) | *See* NAIC White Paper, *supra* note 8, at 18. |
| [183](#co_footnoteReference_F183115542113_ID0E2) | *See id.* at 17-18. The NAIC White Paper underscores that regulators must target these resolves as they strive to address consumer protection and solvency issues, to create a level playing field, and to allow for development of new delivery and financing systems. *See id.* at 18. As commendable as this sounds, one must bear in mind that the White Paper “does not include a recommendation on the specific manner in which states should regulate risk-bearing entities.” *Id.* at 2. |
| [184](#co_footnoteReference_F184115542113_ID0E6) | *See id.* at 17. By way of review, it is worth citing some of the critical considerations facing insurance regulators in the process of shaping policies regarding risk-bearing PSOs. These include: (1) identifying the scope of the business of insurance; (2) distinguishing (to the extent appropriate) provider risk from insurance risk, as well as the significance of drawing distinctions for purposes of licensing requirements; (3) determining the level of oversight befitting downstream risk-contracting arrangements; and (4) what effect ERISA preemption has on state regulatory initiatives. *See* Unland, *supra* note 12, at 64-65.  A backdrop to these issues is the ever present concerns of consumer protection from both insolvency and incentives to limit care, as well as for maintaining a level playing field and permitting the development of innovative organizational arrangements. *See* NAIC White Paper, *supra* note 8, at 18. |
| [185](#co_footnoteReference_F185115542113_ID0EV) | *See id.* at 27. |
| [186](#co_footnoteReference_F186115542113_ID0E1) | *See id.* at 21. |
| [187](#co_footnoteReference_F187115542113_ID0E6) | *See id.* |
| [188](#co_footnoteReference_F188115542113_ID0ED) | *See id.* The White Paper points out that more than half of the states have passed laws based on the NAIC Health Maintenance Organization Model Act (model 430), which governs persons who provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis.. *See id.* The NAIC HMO Model Act contains initial and minimum net worth requirements and, for contracts between HMOs and providers, requires that a “hold harmless” provision prevent providers from collecting from subscribers or enrollees in case of HMO nonpayment. *See id.* |
| [189](#co_footnoteReference_F189115542113_ID0E6) | *See generally* Kudner, *supra* note 45 (outlining the current statutes and regulations that may apply to PSOs in risk-sharing arrangements). |
| [190](#co_footnoteReference_F190115542113_ID0EO) | *See id.* at 8. Hawaii was the last state to regulate HMOs. *See* HAW. REV. STAT. ANN. § 432D (Michie Supp. 1996). |
| [191](#co_footnoteReference_F191115542113_ID0ET) | *See* Kudner, *supra* note 45, at 8. |
| [192](#co_footnoteReference_F192115542113_ID0EY) | *See id.* |
| [193](#co_footnoteReference_F193115542113_ID0EU) | [MINN. STAT. ANN. § 62N.01](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000044&cite=MNSTS62N.01&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=LQ&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search))-.40 (West 1996). |
| [194](#co_footnoteReference_F194115542113_ID0E5) | Incidentally, the capital requirements for the provider networks are not significantly different from the requirements applicable to HMOs licensed in Minnesota. *Compare id.* § 62N.28 (requiring a provider network to maintain a minimum net worth equal to the greater of: (1) $1 million; (2) 2% of the first $150 million of annual premium revenue plus 1% thereafter; (3) 8% of the annual health service costs, excluding capitated or managed hospital payments, plus 4% of the annual capitation and managed hospital payments costs; or (4) 4 months uncovered health services cost) *with* § 62D.042 (requiring an HMO to maintain a net worth equal to the greater of: (1) 8-1/3% of the sum of all expenses expected to be incurred; (2) $1.5 million for the first year of operation and the greater of $1 million; or (3) 8-1/3% of the sum of all expenses incurred during the most recent calendar year thereafter). |
| [195](#co_footnoteReference_F195115542113_ID0ED) | *See id.* § 62R.03. A health provider cooperative is defined as a “corporation organized under this chapter and operated on a cooperative plan to market health care services to purchasers of those services.” *Id.* § 62R.04.4. |
| [196](#co_footnoteReference_F196115542113_ID0ES) | *Id.* § 62R.01. |
| [197](#co_footnoteReference_F197115542113_ID0EW) | *See id.* |
| [198](#co_footnoteReference_F198115542113_ID0EF) | *See id.* § 62R.17. The provision sunsets December 31, 1999. *See id.* § 62R.26. |
| [199](#co_footnoteReference_F199115542113_ID0EI) | *See* Joint Bulletin # 94-3 from the State of Minnesota Department of Health 2 (Sept. 26, 1994) [hereinafter Minnesota Joint Bulletin] (on file with the State of Minnesota Department of Health). Insurance is defined as “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.” MINN. STAT. ANN. § 60A.02.3(a). |
| [200](#co_footnoteReference_F200115542113_ID0EQ) | *See* Minnesota Joint Bulletin, *supra* note 199, at 2. Recently, Minnesota regulators have recommended that they limit PSOs in their ability to contract directly with employers, noting the potential threat to consumers when PSOs act as insurers. *See* Lisa Scott, *Providers Overruled: Minnesota Regulators Recommend Treating PSOs as Insurers,* MOD. HEALTHCARE, Mar. 10, 1997, at 28, 28. The March final report followed a draft released in January which, as was anticipated, drew concern particularly from providers who object to being held to capital standards approaching those imposed on HMOs. *See Minnesota: Urges Regulations for Risk-Bearing Networks,* AM. HEALTH LINE, Jan. 8, 1997, *available in* 1997 WL APN-HE7. |
| [201](#co_footnoteReference_F201115542113_ID0E4) | MINN. STAT. ANN. § 62R.06.1. The Health Care Cooperative Act does not define substantially capitated or similar risk-sharing basis, thus, whether an arrangement satisfies this requirement depends on the totality of the circumstances. *See* Minnesota Joint Bulletin, *supra* note 199, at 3. |
| [202](#co_footnoteReference_F202115542113_ID0EZ) | *See* Mary Chris Jaklevic, *Ohio Weighs Rules for Risk Bearers,* MOD. HEALTHCARE, Apr. 15, 1996, at 26, 26; Sharon McIlrath, *Who Will Regulate Provider-Run Plans?: States Jockey to Limit Federal Oversight Role,* AM. MED. NEWS, Apr. 1, 1996, at 3, 23; *Ohio: Bill Would Standardize Managed Care Regulation,* AM. HEALTH LINE, Feb. 28, 1996, *available in* 1997 WL APN-HE11 [[[hereinafter *Ohio Bill*]. |
| [203](#co_footnoteReference_F203115542113_ID0ED) | Solvency requirements, based on the types of services provided, range from $1.2-1.7 million. *See* Ohio S.B. 67, 122d Gen. Ass. (1997) (enacted); *see also* Jaklevic, *supra* note 202, at 26; *PHOs Regulated Under Ohio Law,* MOD. HEALTHCARE, June 30, 1997, at 78, 78; Diane West, *Ohio’s Uniform Licensure Act Moves,* NAT’L UNDERWRITER LIFE & HEALTH/FIN. SERVICES, Mar. 31, 1997, [*available in* 1997 WL 9319046](http://www.westlaw.com/Link/Document/FullText?findType=Y&pubNum=999&cite=1997WESTLAW9319046&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)). |
| [204](#co_footnoteReference_F204115542113_ID0EL) | *See* Jaklevic, *supra* note 202, at 26. |
| [205](#co_footnoteReference_F205115542113_ID0EP) | PSOs not assuming risks, such as certain preferred provider organizations (PPOs), would nonetheless have to register with the state even though they are not subject to other HIC standards. *See Ohio Bill, supra* note 202. |
| [206](#co_footnoteReference_F206115542113_ID0E3) | *See* [OHIO REV. CODE ANN. §§ 1736.01](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000279&cite=OHSTS1736.01&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=LQ&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search))-.28, [1742.01](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000279&cite=OHSTS1742.01&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=LQ&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search))-.41 (Anderson 1992). |
| [207](#co_footnoteReference_F207115542113_ID0EB) | *See* Letter from David J. Randall, Deputy Director, *State of Ohio Department of Insurance,* to John E. Callender, Senior Vice President, *Ohio Hospital Association* (July 28, 1994) [hereinafter Ohio Department of Insurance Letter] (on file with the State of Ohio Department of Insurance). |
| [208](#co_footnoteReference_F208115542113_ID0EE) | *See id.* at 1-4. In clarifying the difference between an insurance risk and a business risk, the Ohio Department of Insurance (DOI) indicates that the former involves a risk transference (spreading), while the latter does not. *See id.* By example, the letter illustrates that a capitated payment arrangement consists of insurance risk, while a discounted FFS represents mere business risk. *See id.* The distinction made here is difficult to decipher and adds little more than providing a somewhat rhetorical attempt to differentiate among risk types based on accepted state attitudes toward insurance regulation. |
| [209](#co_footnoteReference_F209115542113_ID0EO) | *See id.* at 3. |
| [210](#co_footnoteReference_F210115542113_ID0EP) | *See id.* The reference to a possible *de minimis* exception was made in the context of a capitated arrangement that was limited to services only provided by a particular provider, or alternatively, if the contract was reinsured via stop-loss coverage. *See id.* |
| [211](#co_footnoteReference_F211115542113_ID0EV) | *See* [215 ILL. COMP. STAT. 110/1](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000008&cite=IL215S110%2f1&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=LQ&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search))-/47; 125/1-1 to 6-15; 130/1001-/4008 (West 1993). A limited health service organization is defined as “any organization formed under the laws of this or another state to provide or arrange for one or more limited health care plans under a system which causes any part of the risk of limited health care delivery to be borne by the organization or its providers.” *Id.* 130/1002. “Limited health care plan[s]” provide, arrange and pay for the cost of any limited health services given on a capitated basis. *Id.* (listing ambulance, clinical laboratory, dental, pharmaceutical, podiatric and vision care services as limited health services). |
| [212](#co_footnoteReference_F212115542113_ID0EZ) | *See* David Grant, *Provider Based Market Systems--When to Regulate,* St. of Ill. Dep’t of Ins. Newsl., Feb. 1996 (St. of Ill. Dep’t of Ins., Springfield, Ill.) [hereinafter Ill. Dep’t of Ins. Newsl.]. |
| [213](#co_footnoteReference_F213115542113_ID0ER) | *Id.* |
| [214](#co_footnoteReference_F214115542113_ID0E6) | *Id.* |
| [215](#co_footnoteReference_F215115542113_ID0ED) | *See id.* |
| [216](#co_footnoteReference_F216115542113_ID0E2) | *Id.* |
| [217](#co_footnoteReference_F217115542113_ID0E5) | *See* NAIC White Paper, *supra* note 8, at 26. In Idaho, the DOI has apparently indicated it would not require licensure of a PSO contracting either downstream or directly such that responsibility to the covered individuals remains with the licensed entity or the self-insured employer. *See id.* Furthermore, in South Carolina, the DOI notes that its attempts to regulate provider networks contracting only with self-insured, single-employer health plans might be subject to ERISA preemption. *See id.* |
| [218](#co_footnoteReference_F218115542113_ID0EE) | In contrast to Ohio’s approach that it would not tolerate any degree of PSO risk assumption, for instance, the Illinois DOI focuses on whether a contracting employer or upstream entity “remains on risk for health care costs … should the provider group fail to perform.” Ill. Dep’t of Ins. Newsl., *supra* note 212. Arguably, this approach more nearly achieves goals of ensuring a level of consumer protection and promoting innovation in the health care marketplace. |
| [219](#co_footnoteReference_F219115542113_ID0EL) | *See generally supra* Part III.C.1-2 (discussing the recent risk involvement of PSOs). |
| [220](#co_footnoteReference_F220115542113_ID0EB) | To this point, only a small fraction of states have indicated clear policies regarding their tack on these issues, a reality largely attributable to the relative dearth of past PSO involvement in bearing risk. This is not to say that other states are not making headlines as they grope for common ground and endeavor to locate the proper place for PSOs within existing regulatory frameworks. *See Georgia, Virginia Clamp Down on IDSs Taking Financial Risk,* 5 Managed Care Wk. (Atl. Info. Serv.) No. 25 (July 10, 1995), [*available in* 1995 WL 2409040;](http://www.westlaw.com/Link/Document/FullText?findType=Y&pubNum=999&cite=1995WESTLAW2409040&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) *NAIC Committee Sees Delay in PSO Rules as Members Await Congressional Action,* 4 Health Care Pol. Rep. (BNA) No. 14 (Apr. 1, 1996), *available in* 1997 WL BNA-HCP (discussing the various stages of state regulation of risk-assuming PSOs); *N.C. Insurance Department, Attorney General Clash on PSNs,* 6 Managed Care Wk. (Atl. Info. Serv.) No. 40 (Nov. 4, 1996), [*available in* 1996 WL 13126993;](http://www.westlaw.com/Link/Document/FullText?findType=Y&pubNum=999&cite=1996WESTLAW13126993&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) *Regulation of Risk-Bearing Networks, supra* note 156 (discussing the status of state regulations in California, Colorado, Iowa, Maine and Minnesota); *States Creating Provider-Sponsored Organization Chapters in Insurance Codes as Congress Gears up for Renewed Debate for Medicare, Medicaid PSO Contractors,* 8 Health News Daily (FDC) No. 249 (Dec. 30, 1996), *available in* 1997 WL HND (discussing Georgia, Kentucky and Ohio); *State Health Week,* 4 Wash. Health Wk. (Atl. Info. Serv.) No. 40 (Nov. 4, 1996), [*available in* 1996 WL 14375904 (discussing efforts in North Carolina)](http://www.westlaw.com/Link/Document/FullText?findType=Y&pubNum=999&cite=1996WESTLAW14375904&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)). |
| [221](#co_footnoteReference_F221115542113_ID0EE) | Despite the lack of comprehensive federal legislative guidance for PSO risk contracting, Congress recently enacted legislation permitting PSO participation in Medicare. The Balanced Budget Act of 1997 (BBA), signed into law by President Clinton on August 5, enacted some of the most significant changes to the structure of the Medicare and Medicaid programs that have been made since their inception. [Pub. L. No. 105-33, 111 Stat. 251 (1997).](http://www.westlaw.com/Link/Document/FullText?findType=l&pubNum=1077005&cite=UUID(I5A19510DA2-EC4F7F9E8C2-6D05F7D07A4)&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=SL&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)) The BBA creates a new Medicare Part C program called Medicare+Choice, through which Medicare beneficiaries can elect to receive benefits from HMOs, point-of-service plans, PPOs, MSA plans, private FFS plans and, significantly, plans offered by PSOs. *See id.* § 4001. The BBA promotes PSO formation by allowing them, under certain conditions, to contract directly with Medicare to offer health care services to Medicare-eligible patients.  The BBA requires that “a Medicare+Choice organization shall be organized and licensed under state law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each state in which it offers a Medicare+Choice plan.” *Id.* § 1855(a)(1). A special exception applies, however, to PSOs. In general, a PSO seeking to offer a Medicare+Choice plan can apply to the Secretary of HHS for a waiver of the state licensing requirement by filing an application no later than November 1, 2002. *See id.* § 1855(a)(2)(A). Such a waiver, though, is available only if certain conditions are met and grants limited benefits. *See id.* § 1855(a)(2)(A)-(D). A PSO that seeks to offer a Medicare+Choice plan in a state will be able to apply for a federal waiver of that state’s licensure requirements if the state has denied the PSO a license based on solvency, discriminatory reasons, or if the state fails to approve the license within ninety days of the PSO’s application. *See id.* The waiver would be effective for three years, would not apply to any other state and would not be renewable. *See id.* § 1855(a)(2)(E). By December 31, 2001, the Secretary must submit to Congress a report regarding whether HHS should continue the waiver process after December 31, 2002. *See id.* § 1855(a)(2)(H).  The BBA also requires that the Secretary establish, using a negotiated rulemaking task force, solvency requirements for organizations seeking to qualify as PSOs participating in the Medicare+Choice program. *See id.* § 1856(a)(1)(A). The Secretary recently issued a Notice of [Intent to establish a negotiated rulemaking committee to develop the solvency standards for PSOs. *See* 62 Fed. Reg. 49,649 (1997)](http://www.westlaw.com/Link/Document/FullText?findType=Y&pubNum=1037&cite=62FR49649&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=FR&fi=co_pp_sp_1037_49649&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)#co_pp_sp_1037_49649). In establishing PSO solvency standards, the Secretary must take into consideration any standards the NAIC develops specifically for risk-based health care delivery organizations. *See* Balanced Budget Act § 1856(a)(1)(B)(iii).  Because the BBA Medicare+Choice provisions will likely enhance PSO formation, PSO licensure requirements are now, more than ever, under a microscope. The extent to which PSOs choose to offer Medicare+Choice plans, thereby obligating themselves to abide by minimum enrollment and other requirements placed on providers offering such plans, will reveal itself only with the passage of time. Because waiver of state licensure is an option under only limited circumstances, the impact of the new BBA provisions is another unknown. *See id.* § 1857. State licensure continues as an impediment to PSOs not participating in Medicare+Choice, including, vitally, all nonparticipating PSOs that contract directly with self-insured employers. Furthermore, because establishing solvency standards for PSOs, as mandated in the BBA, explicitly requires the Secretary to take into account the risk-based capital formula that the NAIC develops, the NAIC’s approach toward the regulation of PSOs remains a crucial determining factor. *See id.* § 1856(a)(1)(B)(iii). If the NAIC continues to fail to recognize the unique properties and operating characteristics of PSOs, risk-based capital standards, as well as the Medicare+Choice program with which they are now linked, will leave unresolved barriers to PSOs seeking to compete with traditional indemnity plans and HMOs. *See* D. Ward Pimley, *HMOs Report Solvency Problems on Test of Revised Risk-Based Capital,* 6 Health Law Rep. (BNA) No. 38 (Sept. 25, 1997), *available in* LEXIS, Bna Library, Bnahlt File. |
| [222](#co_footnoteReference_F222115542113_ID0ES) | *See* Mjoseth, *supra* note 160, at 1665. |
| [223](#co_footnoteReference_F223115542113_ID0EX) | *See id.* |
| [224](#co_footnoteReference_F224115542113_ID0E3) | *See id.* (quoting Jason B. Adkins, President of the Center for Insurance Research, Cambridge, Massachusetts). An illustration of this point is that the NAIC Health Maintenance Organization Model Act (model 430) has provided great input toward state-based HMO regulation. *See id.* |
| [225](#co_footnoteReference_F225115542113_ID0EB) | *See id.* |
| [226](#co_footnoteReference_F226115542113_ID0EF) | In sum, NAIC efforts in this area are crafted to “enhance efficiency of licensing and oversight of various forms of health insurance providers, aid the insurance industry in creating a level playing field, and help consumers in disputes with health insurance carriers.” *Id.* (quoting Gregory B. Stites, NAIC official). |
| [227](#co_footnoteReference_F227115542113_ID0E3) | *See* NAIC White Paper, *supra* note 8, at 32. |
| [228](#co_footnoteReference_F228115542113_ID0EA) | *See id.* |
| [229](#co_footnoteReference_F229115542113_ID0EQ) | *See id.* |
| [230](#co_footnoteReference_F230115542113_ID0E5) | *Id.* |
| [231](#co_footnoteReference_F231115542113_ID0ED) | *See* Mjoseth, *supra* note 160, at 1665. |
| [232](#co_footnoteReference_F232115542113_ID0EH) | *See* NAIC White Paper, *supra* note 8, at 33. This, of course, is debatable, particularly in light of the questionable effect of ERISA preemption on states’ abilities to regulate certain self-insured employers. *See supra* Part III.C.1-2. The NAIC cites with approval the Ohio DOI’s efforts in developing its Managed Care Uniform Licensure Act for Health Insuring Corporations and creating a single regulated entity. *See supra* Part IV.B.2. |
| [233](#co_footnoteReference_F233115542113_ID0EW) | *See* NAIC White Paper, *supra* note 8, at 33. |
| [234](#co_footnoteReference_F234115542113_ID0E2) | *See id.* |
| [235](#co_footnoteReference_F235115542113_ID0E6) | *See id.* These models, respectively, establish standards for health carriers’ creation and maintenance of provider networks; health carriers’ establishment of procedures to resolve enrollee grievances; and for the structure and application of utilization review services. *See id.* at 33-34. The NAIC is currently reviewing related issues, including the confidentiality and reporting of health information and health care consumer disclosure. *See id.* at 34. |
| [236](#co_footnoteReference_F236115542113_ID0EO) | *See* Mjoseth, *supra* note 160, at 1666. |
| [237](#co_footnoteReference_F237115542113_ID0ET) | *See* NAIC White Paper, *supra* note 8, at 34. In principle, arguing about the logic and wisdom behind risk-based capital standards is difficult. These standards already apply in the contexts of life, health, property and casualty insurance companies. *See id.* The debate will rage, however, concerning to which entities these risk-based formulas should apply. The same difficulties--determining what is the business of insurance, the scope of ERISA preemption and the precise nature of downstream and direct contracting--will remain debate topics, even if the ontological underpinnings of risk-based capital standards are accepted. In addition, crafting risk criteria acceptable to all types of risk-bearing entities with competing interests, including HMOs, insurers and providers is itself a monumental challenge. *See* Mjoseth, *supra* note 160, at 1666 (noting some of the concerns of Ellen Pryga, Director of Policy Development for the American Hospital Association). |
| [238](#co_footnoteReference_F238115542113_ID0EE) | *See* Memorandum from Kenney Shipley, Chair (Florida), Health Plan Accountability Working Group, to the Insurance Commissioners, Directors and Superintendents 1 (Aug. 10, 1995) (on file with the NAIC) [hereinafter HPAWG Memorandum]. |
| [239](#co_footnoteReference_F239115542113_ID0EN) | *See id.* |
| [240](#co_footnoteReference_F240115542113_ID0E6) | *See id.* The HPAWG Memorandum notes that “[t]he only exception to this opinion is where the entity is accepting ‘downstream risk’ from a duly licensed health carrier.” *Id.* at 2. Kenney Shipley indicated elsewhere, however, that because the memorandum fails to deal with downstream risk does not mean that the NAIC is not interested in downstream arrangements; on the contrary, the HPAWG Memorandum was simply focused elsewhere. *See Health Attorneys Very Supportive of NAIC Risk Bearing Entities Bulletin,* 3 Health Care Pol. Rep. (BNA) No. 37 (Sept. 18, 1995), *available in* LEXIS, Bna Library, Bnahcp File. Interestingly, though, the “draft bulletin” portion of the memorandum reads in relevant part: “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 insurer, for that insurer’s policyholders, certificate-holders or enrollees.” HPAWG Memorandum, *supra* note 238, at 3. The most plausible interpretation of this sentence is that the memorandum exempts downstream PSOs from any suggestion that they need to fulfill state licensing requirements as bearers of insurance risk. |
| [241](#co_footnoteReference_F241115542113_ID0EE) | *See* HPAWG Memorandum, *supra* note 238, at 3. |
| [242](#co_footnoteReference_F242115542113_ID0EJ) | *See id.* |
| [243](#co_footnoteReference_F243115542113_ID0EN) | *See id.* |
| [244](#co_footnoteReference_F244115542113_ID0EB) | The hypothetical fact situation reads as follows: “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.” HPAWG Memorandum, *supra* note 238, at 4. The analysis used Florida’s definition of insurance and referred to Florida case law construing this definition. *See* [Professional Lens Plan v. Department of Ins., 387 So. 2d 548, 550 (Fla. Dist. Ct. App. 1980)](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1980136922&pubNum=735&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&fi=co_pp_sp_735_550&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)#co_pp_sp_735_550). |
| [245](#co_footnoteReference_F245115542113_ID0EL) | *See* HPAWG Memorandum, *supra* note 238, at 5-6. The analysis makes some interesting, if not puzzling, observations. In evaluating the providers’ assumption of risk, the HPAWG Memorandum notes that “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).” *Id.* at 5. What this statement proves is far from clear. Furthermore, the memorandum rejects the idea that arrangements in which the employer remains obligated to provide health benefits, even if the provider group goes bankrupt, are not the business of insurance. *See id.* at 5-6. Instead, the memorandum holds that employers are consumers who themselves are purchasing insurance to protect against risks for which they are primarily obligated. *See id.* This holding seems to miss entirely the point that ERISA serves to preempt state regulations that would cover these activities, even if such activities were correctly classified as the business of insurance. |
| [246](#co_footnoteReference_F246115542113_ID0EP) | *Id.* |
| [247](#co_footnoteReference_F247115542113_ID0EL) | *See generally* NAIC White Paper, *supra* note 8 (addressing insurance risk, forms of risk-bearing entities operating in the health insurance market and state regulation of risk-bearing entities). |
| [248](#co_footnoteReference_F248115542113_ID0ET) | *See id.* at 2. |
| [249](#co_footnoteReference_F249115542113_ID0EX) | *See supra* notes 237-47 and accompanying text. |
| [250](#co_footnoteReference_F250115542113_ID0EJ) | *See* NAIC White Paper, *supra* note 8, at 26. This is because:  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.  *Id.* |
| [251](#co_footnoteReference_F251115542113_ID0ET) | *See supra* Part III.B.1-2. Although the White Paper does refer, in this context, to an NAIC document dealing specifically with ERISA, the absence of further discussion of ERISA preemption and direct contracting arrangements is somewhat conspicuous here. Apparently other readers have made this observation as well. *See* Meeting Minutes from Risk-Bearing Entities Working Group of the State and Federal Health Insurance Legislative Policy (B) Task Force 1 (Dec. 16, 1996) (on file with the NAIC). |
| [252](#co_footnoteReference_F252115542113_ID0EY) | *See* NAIC White Paper, *supra* note 8, at 27-28. |
| [253](#co_footnoteReference_F253115542113_ID0E3) | *See id.* at 28-32. |
| [254](#co_footnoteReference_F254115542113_ID0EO) | *See* Unland, *supra* note 12, at 65. |
| [255](#co_footnoteReference_F255115542113_ID0EF) | *See supra* Part IV.A.1-2. |
| [256](#co_footnoteReference_F256115542113_ID0EZ) | *See generally* EHCIP Letter, *supra* note 94 (discussing the EHCIP’s views on the NAIC White Paper). |
| [257](#co_footnoteReference_F257115542113_ID0E5) | *See id.* |
| [258](#co_footnoteReference_F258115542113_ID0EH) | *See id.* |
| [259](#co_footnoteReference_F259115542113_ID0EW) | *See id.* |
| [260](#co_footnoteReference_F260115542113_ID0EA) | *See id.* |
| [261](#co_footnoteReference_F261115542113_ID0EE) | *Id.* The Employer Health Care Innovation Project (EHCIP) extends this argument to downstream arrangements as follows: “The risk to a consumer whose HMO contracts with an independent medical group to provide medical services for a capitation payment is defined by the capacity of the HMO to deliver promised benefits, and not by the financial condition of the medical group.” *Id.* |
| [262](#co_footnoteReference_F262115542113_ID0E6) | See *supra* notes 113-15 and accompanying text for the factors in *Pireno.* |
| [263](#co_footnoteReference_F263115542113_ID0EE) | *See* EHCIP Letter, *supra* note 94, at 2. |
| [264](#co_footnoteReference_F264115542113_ID0ER) | *See id.* |
| [265](#co_footnoteReference_F265115542113_ID0EA) | *See id.* |
| [266](#co_footnoteReference_F266115542113_ID0EH) | *See id.* The EHCIP has elaborated on this point elsewhere. *See* Memorandum from the Employer Health Care Innovation Project on Self-Insurance 1 (Mar. 14, 1996) [hereinafter EHCIP Project]. |
| [267](#co_footnoteReference_F267115542113_ID0E2) | *See* EHCIP Letter, *supra* note 94, at 2. However, “[u]nlike an insurance carrier that bears risk with little control over the delivery of services, a provider group will have substantial control over how services are provided.” *Id.* |
| [268](#co_footnoteReference_F268115542113_ID0EO) | *Id.* The letter emphasizes here that the employer remains “““ultimately responsible” for health services for the employee and cites the Illinois DOI as supporting this position. *See id.* For discussion of the Illinois approach, see *supra* Part IV.B.3. |
| [269](#co_footnoteReference_F269115542113_ID0E2) | EHCIP Letter, *supra* note 94, at 3. |
| [270](#co_footnoteReference_F270115542113_ID0EI) | Recent statistics show that provider-sponsored health plans do not need special regulatory breaks to attract investors. *See* American Ass’n of Health Plans, *AAHP Survey of State Regulators Shows Provider-Sponsored Health Plans Don’t Need Special Regulatory Breaks* (visited Nov. 7, 1997) ‹http:// www.aahp.org/servoces/pr\_update/media/pr6\_3\_97.htm›. |
| [271](#co_footnoteReference_F271115542113_ID0EN) | *See* McIlrath, *supra* note 202, at 23. |
| [272](#co_footnoteReference_F272115542113_ID0EV) | Commentators have recognized the validity of each of these approaches. *See, e.g.,* HIRSHFELD & KOLB, *supra* note 89, at 22 (endorsing risk-based regulation); Overbay & Hall, *supra* note 1, at 386 (favoring regulation specific to PSOs). |
| [273](#co_footnoteReference_F273115542113_ID0EK) | *See* Overbay & Hall, *supra* note 1, at 372. |
| [274](#co_footnoteReference_F274115542113_ID0EP) | *See id.* at 372-73. This is particularly true in states requiring that PSOs guarantee their obligations to upstream entities and that the providers agree to “hold harmless” provisions that would prevent them from seeking recourse from plan enrollees in case the upstream entity defaults. *See id.* |
| [275](#co_footnoteReference_F275115542113_ID0E1) | A number of HMOs sought protection under federal bankruptcy laws during the last decade. *See, e.g., In re* [Estate of Medcare HMO, 998 F.2d 436 (7th Cir. 1993)](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1993134114&pubNum=350&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)); *In re* [Beacon Health, Inc., 105 B.R. 178 (Bankr. D. N.H. 1989)](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1989141599&pubNum=164&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)); *In re* [Family Health Servs., Inc., 104 B.R. 279 (Bankr. C.D. Cal. 1989)](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1989121438&pubNum=164&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)); *In re* [Michigan Master Health Plan, Inc., 44 B.R. 642 (Bankr. E.D. Mich. 1984)](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1984160058&pubNum=164&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)); *In re* [Portland Metro Health, Inc., 15 B.R. 102 (Bankr. D. Or. 1981)](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1981147136&pubNum=164&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)). *See generally* Gayle L. Holland, *Health Maintenance Organizations: Member Physicians Assuming the Risk of Loss Under State and Federal Bankruptcy Laws,* 15 J. LEGAL MED. 445 (1994) (exploring the controversy over protecting HMOs under federal bankruptcy laws, and discussing whether HMOs are insurance companies for bankruptcy purposes). |
| [276](#co_footnoteReference_F276115542113_ID0EO) | *See* HPAWG Memorandum, *supra* note 238, at 1; *see also supra* Part V.A.3 (discussing the NAIC’s position in depth). |
| [277](#co_footnoteReference_F277115542113_ID0EQ) | [New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995)](http://www.westlaw.com/Link/Document/FullText?findType=Y&serNum=1995096310&pubNum=780&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=RP&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)). *See supra* notes 137-43 and accompanying text. |
| [278](#co_footnoteReference_F278115542113_ID0E2) | *See generally supra* Part II.A-B.1 (discussing the various entities involved and the risk arrangements that have developed in the health care marketplace). |
| [279](#co_footnoteReference_F279115542113_ID0E6) | [15 U.S.C. §§ 1011](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000546&cite=15USCAS1011&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=LQ&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search))-[1015 (1994)](http://www.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000546&cite=15USCAS1015&originatingDoc=If6c4c3815c9e11dbbe1cf2d29fe2afe6&refType=LQ&originationContext=document&vr=3.0&rs=cblt1.0&transitionType=DocumentItem&contextData=(sc.Search)); *see supra* Part III.A.2. |
| [280](#co_footnoteReference_F280115542113_ID0EU) | This is a point made clear by the EHCIP. *See* EHCIP Project, *supra* note 266, at 1. On the other hand, recognizing the difference between disclosure-oriented ERISA regulations and state-driven solvency regulations may explain such disparate treatment of direct and downstream arrangements. |
| [281](#co_footnoteReference_F281115542113_ID0EF) | *See* Overbay & Hall, *supra* note 1, at 382-83 (citing James E. Holloway, *ERISA, Preemption and Comprehensive Federal Health Care: A Call for “““Cooperative Federalism” to Preserve the States’ Role in Formulating Health Care Policy,* 16 CAMPBELL L. REV. 405, 416 (1994)). |
| [282](#co_footnoteReference_F282115542113_ID0EP) | *See* Overbay & Hall, *supra* note 1, at 383. |
| [283](#co_footnoteReference_F283115542113_ID0ET) | *See* EHCIP Project, *supra* note 266, at 1. |
| [284](#co_footnoteReference_F284115542113_ID0EX) | Some of the commentators’ “clear” conclusions concerning ERISA’s preemptive effect on PSO direct contracting regulation stand in conflict with each other. Although one may conclude “it is clear that states may regulate provider groups that contract directly with employers on a capitated basis,” Overbay & Hall, *supra* note 1, at 380, one may also conclude that it is “uncertain whether ERISA preemption applies” to similar arrangements. HIRSHFELD & KOLB, *supra* note 89, at 25. One could also favor a balancing approach and the notion that regulating employers who are not financially strong would not be inappropriate. *See* Rutenberg, *supra* note 29, at 321-22. |
| [285](#co_footnoteReference_F285115542113_ID0E3) | *See supra* note 221; *see also* Kudner, *supra* note 45, at 5 (discussing Medicare and Medicaid managed care requirements). |
| [286](#co_footnoteReference_F286115542113_ID0EB) | *See* H.R. 995, 104th Cong. (1995). |
| [287](#co_footnoteReference_F287115542113_ID0EG) | *See Testimony of the Nat’l Ass’n of Ins. Comm’rs (EX) Special Comm. on Health Ins. Before the Health Subcomm. of the Comm. on Ways and Means of the United States House of Representatives on Medicare HMO Regulation and Quality,* 105th Cong. (1997), *available in* LEXIS, Legis Library, Cngtst File (testimony of David Randall, Deputy Director of the State of Ohio Department of Insurance); *Level the Playing Field for Health Insuring Organizations, State Insurance Regulators Tell Hill* (visited Nov. 4, 1997) ‹http:// www.naic.org/geninfo/releases/031997hg.htm›. |
| [288](#co_footnoteReference_F288115542113_ID0EC) | *See* EHCIP Project, *supra* note 266, at 1. |
| [289](#co_footnoteReference_F289115542113_ID0EN) | *See id.* The use of “hold harmless” clauses, which prevent employees from being subject to out-of-pocket expenses for health care in the event of PSO insolvency, further enhances protection of employees as consumers and weakens the argument for state regulation. *See id.* |
| [290](#co_footnoteReference_F290115542113_ID0EI) | NAIC White Paper, *supra* note 8, at 2. |
| [291](#co_footnoteReference_F291115542113_ID0ED) | *See supra* note 221. |

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