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Ericka L. Rutenberg

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MANAGED CARE AND THE BUSINESS OF INSURANCE: WHEN IS A PROVIDER GROUP CONSIDERED TO BE AT RISK?

*Ericka L. Rutenberg**

INTRODUCTION

In August 1995, the Health Plan Accountability Working Group (HPAWG) of the National Association of Insurance Commissioners (NAIC) issued a "Suggested Bulletin Regarding Certain Types of Compensation Reimbursement Arrangements Between Health Care Providers and Individuals, Employers and Other Groups" (Bulletin). HPAWG was charged with developing a single model health care licensing act for all "health carriers." This act was referred to as CLEAR, or the Consolidated Licensure of Entities Accepting Risk Model Act, and was intended to cover Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), point-of-service plans, fee-for-service plans, Blue Cross/Blue Shield Plans, commercial plans and all other entities that finance and deliver health care services on a risk-sharing or risk assuming basis.

During a series of public hearings to better determine the types of risk-bearing arrangements engaged in the business of insurance, the HPAWG became aware of group health providers, such as Integrated Provider Organizations (IPOs), Integrated Provider Associations (IPAs), Physician Health Organizations (PHOs), and Provider Sponsored Networks (PSNs) entering into compensation, reimbursement, and risk sharing arrangements. It was the overwhelming opinion of members of the HPAWG that entities that accept risk on a prepaid basis are engaged in the business of insurance and need to be concerned about existing

*Managing Editor, JOURNAL OF HEALTH CARE LAW. B.S., Skidmore College, 1993; J.D., DePaul University College of Law, 1996; LL.M. (Cand.) DePaul University College of Law, 1997.

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insurance licensure laws. Entities that only accept downstream risk from licensed health carriers are excepted from the NAIC opinion.

This article addresses issues raised by the NAIC's bulletin and reviews the pertinent legal decisions on the issue of insurance. In addition, this article examines the opinion and concerns of the American Medical Association regarding licensure of provider organizations and networks.

THE DEFINITION OF INSURANCE BASED ON CASE LAW AND STATE STATUTE

Although there are many sources for the definition of the "business of insurance," none provide a definitive explanation of what the term actually means. When Congress passed the Federal McCarran-Ferguson Act (Act) in 1945, it was partly to give states exclusive province in the area of insurance regulation, and also to exempt the business of insurance from federal antitrust laws.¹ The Act clearly states: "no Act 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."² As a result, the primary jurisdiction for insurance lies within the individual state, and every state has enacted legislation designed to define and regulate insurance in a slightly different manner.

In the Bulletin, the NAIC relies upon the definition of insurance presented in *Guaranteed Warranty Corp. v. State ex rel. Humphrey*.³ The court in *Guaranteed*, in fact, was citing the Arizona insurance statute,⁴ that defines insurance as "a contract whereby one undertakes to indemnify

¹ 15 U.S.C. §§ 1011-1015 (1994). The McCarran Ferguson Act was passed in reaction to the Court's decision in *United States v. South-Eastern Underwriter's Ass'n*, 322 U.S. 533 (1944) in which the Court held that insurance transactions were subject to federal regulation under the commerce clause, and that antitrust laws were applicable to them. In response, Congress passed the McCarran Ferguson Act. Its purpose was stated in its first section as, "the continued regulation and taxation by the several States of the business of insurance is in the public interest." *See also* *Proctor v. State Farm Mutual Automobile Ins. Co.*, 561 F.2d 262, 266 (1976) (providing a more extensive discussion of the history of the Act and interpretation by the courts).

² *Id.*

³ *Guaranteed Warranty Co. v. State ex rel. Humphrey*, 533 P.2d 87 (1975).

⁴ ARIZ. REV. STAT. ANN. § 20-103(A) (1996).

another or pay a specified amount upon determinable contingencies."⁵ The Arizona definition also includes five elements generally present in an insurance contract, including:

- (1) an insurable interest;
- (2) a risk of loss;
- (3) an assumption of risk by the insurer;
- (4) a general scheme to distribute loss among a larger group of persons bearing similar risks; and
- (5) payment of a premium for assumption of risk.

Although the NAIC chose to focus on Arizona law, the definition of insurance varies from state to state. For example, in North Carolina insurance is defined as: "an agreement by which the insurer is bound to pay money or its equivalent, or to do some act of value to the insured upon, and as indemnity or reimbursement for the destruction, loss or injury, of something in which the other party has an interest."⁶ In Florida, insurance applies to a contract "whereby one undertakes to indemnify another or pay or allow a specified amount or a determinable benefit upon determinable contingencies."⁷ Finally, in the District of Columbia the insurance code defines insurance companies as:

Every corporation, joint stock company, or association not exempt herein, transacting business in the District of Columbia, which collects premiums, dues or assessments from its members or from holders of its certificates or policies, and which provides for the payment of indemnity on account of sickness or accident, or a benefit in case of death shall be known as 'health, accident, and life insurance companies or associations.'⁸

While every state has a slightly different provision regarding insurance, all definitions of insurance seem to share the common element

⁵ *Id.*

⁶ N.C. GEN. STAT. § 58-1-10 (1995).

⁷ FLA. STAT. ANN. § 624.02 (1995).

⁸ D.C. CODE ANN. § 35-202 (1996).

of spreading or shifting of risk.⁹ Indeed, the United States Supreme Court has even recognized that if no underwriting or risk exists in a contractual agreement, then no policy of insurance exists.¹⁰ This factor was highlighted by the United States Supreme Court in its interpretation of insurance in *Group Health & Life Ins. Co. v. Royal Drug Co.*,¹¹ where the Supreme Court found "the underwriting or spreading of risk as an indispensable characteristic of insurance."¹² Thus, to determine whether a contract is one of insurance or of indemnity, "there must be a risk of loss to which one party may be subjected by contingent or future events and an assumption that it be a legally binding arrangement by another. Even the most loosely stated conception of insurance ... requires these elements."¹³

The *Group Health & Life Ins. Co.* decision involved an antitrust action in which the court examined whether an arrangement between a Texas insurance company and a group of pharmacies constituted the business of insurance under the McCarran-Ferguson Act.¹⁴ In this case, the pharmacies entered into an agreement with an insurer to provide prescriptions to policyholders for two dollars per filled prescription, the remainder of the cost to be paid to the participating pharmacy by the insurer. If the prescription was filled at a non-participating pharmacy, the price would not be discounted.¹⁵ The Court found this arrangement did not constitute risk spreading, but merely risk reduction of the underwriting obligations for the insurer who had negotiated a maximum price the insurer would pay for the purchase of prescription drugs. In addition, since the agreement was between the insurer and a party involved in the sale of

⁹ Allison Overbay & Mark Hall, *Insurance Regulation of Providers that Bear Risk*, 22 AM. J. L. & MED. 361, 369 (1996).

¹⁰ S.E.C. v. Variable Annuity Co., 359 U.S. 65, 73 (1959).

¹¹ *Group Health & Life Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), *reh'g denied*, 441 U.S. 917 (1979), *appeal after remand*, 737 F.2d 1433 (5th Cir. 1984), *cert denied*, 469 U.S. 1160 (1985).

¹² *Id.*, 440 U.S. at 212.

¹³ *Id.* at 214.

¹⁴ *Id.* at 212.

¹⁵ *Id.* at 209.

goods and services, rather than between the insurer and insured, the Court denied that any risk spreading had occurred.¹⁶

Another antitrust case that focused upon the spreading of risk was *Union Labor Life Ins. Co. v. Pireno*¹⁷ in which the United States Supreme Court examined an insurance company's use of a professional medical association's peer review committee, which was devised of ten licensed chiropractors. The committee was employed to provide advice on the necessity of treatment and the reasonableness of fees charged by other practicing chiropractors. Upon review, the Court found the insurance company's use of the peer review committee in such a manner did not constitute the business of insurance as contemplated by the McCarran-Ferguson Act. Since the use of the peer review group was unrelated to the relationship between insurer and insured and the spreading of risk involved in that contract, the Court found the arrangement between insurer and committee "play[ed] no part in the spreading and underwriting of a policyholder's risk."¹⁸ Furthermore, the Court summarized the requirements for insurance as the following:

[F]irst, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.¹⁹

In reaching its conclusion in *Union Labor Life*, the court relied upon three of the factors of insurance as set forth in *Group Health & Life Ins. Co.*²⁰ These factors were whether the activity:

- (1) involved the underwriting and spreading of risk;
- (2) involved an integral part of the insurer-insured relationship; and

¹⁶ *Group Health & Life Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), *reh'g denied*, 441 U.S. 917 (1979), *appeal after remand*, 737 F.2d 1433 (5th Cir. 1984), *cert denied*, 469 U.S. 1160 (1985).

¹⁷ *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982).

¹⁸ *Id.* at 130.

¹⁹ *Id.* at 129.

²⁰ *Group Health & Life Ins. Co.*, 440 U.S. at 205.

(3) was limited to entities within the insurance industry.

Even after closely examining these elements, the Court concluded that the peer review committee did not involve the spreading and underwriting of risk since the arrangement between the insurer and the committee was "logically and temporally unconnected to the transfer of risk accomplished by Union Labor Life's insurance policies."²¹ In addition, the Court found the peer review group was not an integral part of the insurer-insured relationship and the mere involvement of parties who were traditionally outside the insurer-insured relationship was not dispositive in determining whether an arrangement involved insurance.²²

Finally, the *Group Health & Life Ins. Co.* analysis was also applied by the United States Supreme Court in *Metropolitan Life Ins. Co. v. Massachusetts*²³ in order to discern whether a state mandated mental health benefits statute regulated insurance within the meaning of the Employee Retirement Income Security Act (ERISA).²⁴ The Court found the statute regulated the business of insurance since the intent of the legislature was to spread the risk of providing mental health care services, and the state statute directly limited the type of insurance the insurer might sell.

THE DISTINCTION BETWEEN INSURANCE RISK, BUSINESS RISK AND SERVICE RISK

Courts addressing the issue of insurance have recognized that not all risks are insurance, and the mere existence of risk does not establish an insurance relationship. Since nearly every business venture entails some assumption of risk, "sound jurisprudence does not suggest the extension, by judicial construction, of the insurance laws to govern every contract involving an assumption of risk or indemnification of loss that when the question arises each contract must be tested by its own terms"²⁵ Thus,

²¹ *Union Labor Life Ins. Co.*, 458 U.S. at 130.

²² *Id.* at 133.

²³ *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).

²⁴ 29 U.S.C. § 1001 (1996).

²⁵ *Transportation Guarantee Co., Ltd., v. Jellins*, 174 P.2d 625, 629 (1946).

in examining the relationship between two entities, courts have held that the element of assumption of risk or indemnification of loss is not controlling, and should not outweigh all other factors.²⁶ As explained in *California Physician's Servs. v. Garrison*,²⁷ the question is not the absence or presence of assumption of risk, but whether by looking at the plan of operation as a whole, "it is service rather than indemnity that is the principle purpose."²⁸

The NAIC also has recognized this distinction between insurance risk, business risk, and service risk,²⁹ and has created a general outline focused on what is *not* considered insurance risk, including discounted fee-for-service, per diem, per case, diagnosis related groups (DRG)/ambulatory patient groups (APG), and global and bundled fee arrangements.³⁰ According to the NAIC, these payment methodologies involve risk shifting rather than the distribution of risk, that is necessary for an insurance contract. Conversely, the NAIC believes that an insurance contract does involve payment methodologies including capitation, percentage of premium, bonus and penalty schemes, withholds and risk pools, and the assumption of a corridor of risk associated with stop-loss plans.³¹ Because none of these reimbursement methods are tied directly to the utilization of a specific employee, the NAIC considers them to be analogous to traditional indemnity insurance.³²

Ultimately, the NAIC definition of insurance is of limited use, since it fails to take into account alternative definitions of insurance, including those which focus on issues of taxes or legal precedent involving the issue of insurance. In fact, the United States Supreme Court which has clearly

²⁶ *Jordan v. Group Health Ass'n*, 107 F.2d 239, 245 (1939).

²⁷ *California Physicians' Servs. v. Garrison*, 172 P.2d 4 (Cal. 1946)

²⁸ *Id.* at 16.

²⁹ Memorandum from the APGA, *Response to the NAIC Memo on "Issues Relating to Risk-Bearing Entities in the Health Insurance Market,"* Mar. 15, 1996 (quoting letter written by David Randall from the Ohio Department of Insurance).

³⁰ Memorandum from Stephanie Lewis of the NAIC to State & Federal Health Insurance Legislative Policy (B) Task Force, *NAIC Memorandum on Issues Relating to Risk Bearing Entities in the Health Insurance Market*, Mar. 15, 1996, at 9.

³¹ *Id.* at 10.

³² *Id.*

distinguished between insurance risk and service risk,³³ has never utilized payment methodology as a criterion for classifying such contracts. Instead, the distinction between service risk and indemnity risk is perhaps best illustrated by imagining a contract to maintain property, such as a fleet of vans or a photocopier.³⁴ Although the value of repair is promised upon injury of the vans or photocopier, courts and regulators have held that the "authority to regulate does not exist where the risk is incidental to a contract whose main purpose is the delivery of some services."³⁵

Directly on point is the case of *Transportation Guarantee Co., Ltd. v. Jellins*,³⁶ where the Supreme Court of California examined two guaranteed maintenance contracts under which the plaintiff agreed to perform periodic maintenance, to repair and replace parts, and to garage and fuel the defendant's vehicle for a fixed monthly sum.³⁷ The court in *Transportation Guarantee Co.*, found these obligations did not place the plaintiff in the position of an insurer, since his duties were merely those of any lessor of vehicles and, "unless we are prepared to hold that any lessor of such vehicles, entering into such a contract, is in the business of insurance then we should not hold that plaintiff is."³⁸ In reaching this conclusion, the court focused upon the fact that the truck maintenance corporation agreed to provide its labor and services should damage or loss occur, but never agreed merely to reimburse the defendant for loss relating to the vehicle.

The recognition of service contracts in *Transportation Guarantee Co.* has been widely followed. In *Jim Click Ford, Inc. v. City of Tuscon*,³⁹ the Arizona Supreme Court examined vehicle service contracts sold to customers purchasing a vehicle from the dealership. The service contracts covered the repair and replacement of various parts of the automobile in the event they were defective or malfunctioned, and the dealer maintained

³³ Group Health & Life Ins. Co. v Royal Drug Co., 440 U.S. 205 (1979), *reh'g denied*, 441 U.S. 917 (1979), *appeal after remand*, 737 F.2d 1433 (5th Cir. 1984), *cert denied*, 469 U.S. 1160 (1985).

³⁴ This example is borrowed from Overbay & Hall, *supra* note 9, at 370.

³⁵ *Id.* (quoting Griffin Systems v. Ohio Dep't of Ins., 575 N.E.2d 803 (Ohio 1991)).

³⁶ *Transportation Guarantee Co., Ltd., v. Jellins*, 174 P.2d 625, 629 (Cal. 1945).

³⁷ *Id.* at 626.

³⁸ *Id.* at 631-32.

³⁹ *Jim Click Ford, Inc. v. City of Tuscon*, 739 P.2d 1365 (Ariz. Ct. App. 1987).

an insurance policy to guarantee performance of its obligations.⁴⁰ Under the contract, the purchaser would pay a one time fee to cover parts and labor for replacement during the period of time until the manufacturer's warranty expired, thus indemnifying the purchaser with regard to malfunction of listed parts.⁴¹ The Arizona court in *Transportation Guarantee, Co.*, found the dealership had presented a business contract rather than a service risk, and thus distinguished this contract from the service contract in *Transportation Guarantee* had included incurring costs under the contract and performing such services as providing gas, oil, grease, tires, repairs, paint jobs, and garage space.⁴²

This distinction between service risk and insurance risk has also been maintained by other courts that have carefully examined each case to determine whether a service risk or insurance risk was involved. For example, a Texas court could find no service risk in an association that obligated itself in consideration of yearly dues to pay for damage within a stated amount to the owner's vehicle,⁴³ or in a contract that indemnified the owner of automobile tires against all road hazards caused by defects or collisions.⁴⁴ In addition, New York courts have held that where a contractor for stipulated consideration agrees to replace plate glass windows regardless of the cause of breakage, he was providing insurance,⁴⁵ as was a watchmaker who agreed to replace a watch if lost within one year from the date of purchase.⁴⁵

Numerous other courts have also acknowledged this distinction between service and business contracts. In *Griffin Systems, Inc. v. Ohio Department of Insurance*,⁴⁷ for example, a New York court found that a motor service repair agreement that promised to compensate the promisee for repairs necessitated exclusively from defects in the motor vehicle parts, did not constitute insurance.⁴⁸ In another case focused on by the

⁴⁰ *Id.* at 1365.

⁴¹ *Id.* at 1366.

⁴² *Id.* at 1367-68.

⁴³ *National Auto Serv. Corp. v. State*, 55 S.W.2d 209 (Tex. Civ. App. 1932).

⁴⁴ *State v. Western Auto Supply Co.*, 16 N.E.2d 256, 259 (Ohio 1938).

⁴⁵ *People v. Roschli*, 9 N.E.2d 763 (N.Y. 1937); *People v. Standard Plate & Glass Salvage Co.*, 174 A.2d 501 (N.Y. 1916).

⁴⁶ *Ollendorff Watch Co. v. Pink*, 17 N.E.2d 676 (N.Y. 1938).

⁴⁷ *Griffin Systems Inc. v. Ohio Dep't Ins.*, 575 N.E.2d 803 (Ohio 1991).

⁴⁸ *Id.*

NAIC, *Professional Lens Plan, Inc. v. Department of Insurance*,⁴⁹ the Court of Appeals of Florida examined a plan under which participating optometrists agreed, for a fixed annual fee, to furnish as many replacement contact lenses as a patient desired due to loss, damage, prescription change or cosmetic reasons.⁵⁰ The court concluded that the annual fee acted merely as consideration for an option to purchase lenses at a fixed price, and that Professional Lens Plans, Inc. was not in the business of insurance, but merely involved in a "service contract" or provider agreement to provide the services of optometrists. Such provider agreements do not constitute the business of insurance.⁵¹

Similarly in *California Physicians' Servs. v. Garrison*,⁵² a non-profit physician-owned corporation organized by the medical profession to meet the medical and surgical needs of persons in the lower income groups, sued for declaratory judgment that it was not engaged in the business of insurance under California law. California Physicians' Services (CPS) argued that the Insurance Commissioner was mistaken when he found them to be engaged in the business of insurance, and instead, contended it was rendering personal services to its patients. The California Supreme Court sided with CPS concluding that in order for a contract to be one of indemnity, there must be a risk of loss and an assumption of that risk by a contract. Thus, the court felt that upon looking at the operations as a whole, CPS had assumed no risk and had provided service, rather than indemnity as its principal object and purpose. Therefore, the corporation was not in the business of insurance.⁵³

A distinction between the functions of service and insurance can also be found in *McCarty v. King County Medical Serv. Corporation*,⁵⁴ where a medical corporation was held to be involved in the business of insurance even though it called itself a "service" corporation. According to the court, the corporation was actually involved in the business of insurance because

⁴⁹ *Professional Lens Plan, Inc. v. Dep't of Ins.*, 387 So. 2d 548 (Fla. Dist. Ct. App. 1980).

⁵⁰ *Id.* at 550.

⁵¹ *Id.* at 551.

⁵² *California Physicians' Servs. v. Garrison*, 172 P.2d 4 (Cal. 1946).

⁵³ *Id.* at 12.

⁵⁴ *McCarty v. King County Medical Serv. Corp.*, 175 P.2d 653 (Wash. 1946).

it [sold] medical protection to working people against the hazard of injury or illness. It release[d] the employer from the care and expense of medical and health aid to his employees. It collect[ed] a fixed premium from each employee and reduce[d] the respective rights and obligations of all the interested parties to a written contract [policy]. Through its medical director it determine[d] when coverage applies to the employee -- when it d[id]s not apply. All of this br[ought] the business of the service corporation within the spirit and purpose of the statute.⁵⁵

Finally, the issue is almost put to rest in the notable case of *Jordan v. Group Health Association*,⁵⁶ which held that provider groups who accept capitation payment are merely selling their services for a fee and do not constitute the business of insurance. In *Jordan*, the court was asked to hear an appeal of a declaratory decree finding the defendant Group Health, not to be engaged in the business of insurance. Group Health was a nonprofit corporation that provided physician services, medical attention, and various kinds of medical, surgical and hospital treatment to its members and dependents, similar to a modern HMO.

The *Jordan* court found that a contract should not be classified as insurance if the primary purpose of its formation was the rendition of services,⁵⁷ and admitted that the identical plan and services rendered by Group Health would be considered neither "insurance" nor "indemnity" if offered by an organization owned, operated, and controlled by physicians. Instead, it would be a contract for service on contingency, though the same elements of risk and avoidance of possible consequences would be present.⁵⁸ The court's decision focused not on whether risk was involved or assumed, "but on whether that or something else to which it is related in the particular plan is its principal object and purpose."⁵⁹ Consequently, the court concluded that Group Health could not be subject

⁵⁵ *Id.* at 666.

⁵⁶ *Jordan v. Group Health Ass'n*, 107 F.2d 239, 245 (D.C. Ct. App. 1939).

⁵⁷ *Id.* at 248.

⁵⁸ *Id.*

⁵⁹ *Id.*

to insurance regulation since it was created primarily to distribute health care services to patients, rather than to assume any insurance risk.⁶⁰

The *Jordan* court's distinction between insurance and service contracts was later independently recognized by the Supreme Court of New Jersey in *State v. Community Health Serv. Inc.*, in which a corporation unlicensed to transact insurance contracted with licensed physicians who agreed to render professional services for a stipulated compensation to members of the general public who contracted with the defendant for the services of a physician.⁶¹ The court reviewed several similar decisions⁶² and found the defendant's obligation to pay for services was not contingent upon any risk, and that the business of the defendant could not be construed as insurance.⁶³

Another decision that followed the *Jordan* decision was that of *Michigan Podiatric Medical Association v. National Foot Care Program, Inc.*,⁶⁴ involving a challenge by eleven individual podiatrists who, as part of Michigan Podiatric Association, participated in Blue Cross and Blue Shield of Michigan's health care program. Chrysler Corporation provided podiatric services to its employees through the Blue Cross & Blue Shield Program until July 1986, when Chrysler began to cover full podiatric services for only those employees who used the services of National Foot Care Program.⁶⁵ The podiatrists displaced by Chrysler's decision filed a complaint alleging loss of patients, income and damages to reputation, as well as accusing the defendant of operating as insurers in violation of state statute. The court held that although the health care contracts called for the defendant to partially reimburse a subscriber for treatment received from a non-designated podiatrist, this did not make the defendant an insurer.⁶⁶ In addition, based on *Jordan*, the Michigan appeals court determined "the primary service offered by defendant is the provision of

⁶⁰ *Id.*

⁶¹ *State v. Community Health Serv. Inc.*, 30 A.2d 44 (N.J. 1943).

⁶² *See e.g., Stern v. Rosenthal*, 128 N.Y.S. 711 (1911).

⁶³ *Community Health Serv. Inc.*, 30 A.2d at 44.

⁶⁴ 438 N.W.2d 350, 354 (Mich. Ct. App. 1989).

⁶⁵ *Id.* at 350.

⁶⁶ *Id.* at 354.

podiatric services to subscribers in consideration of prepayment for such services. Defendant is not an insurer as defined in the Insurance Code."⁶⁷

The logic of *Jordan* is also clearly adhered to in *New Mexico Life Ins. Guaranty Ass'n v. Moore*, a case involving a non-profit health care plan organized and operated under the Nonprofit Health Care Plan Act.⁶⁸ The Act provided for reasonable regulation of membership of corporations organized for the purpose of making health care expense payments on a service benefit basis, or on an indemnity basis for persons who become subscribers under contracts with such corporations.⁶⁹ The plaintiffs brought suit alleging that the defendants were subject to the Guaranty Act.⁷⁰ The *Moore* court concluded that the defendants did not write any kind of "insurance" to which the Guaranty Act applied, and that the defendants were not "member insurers" within the meaning of the Act, nor liable for any assessments levied by the Association.⁷¹ The New Mexico Supreme Court looked to *Jordan* in reaching its decision holding that like the defendants in *Moore*, Group Health was a non-profit corporation organized to provide paying members with various medical services and supplies. The New Mexico Supreme Court also borrowed logic from *California Physicians' Services v. Garrison*,⁷² and agreed that assumption of risk was not the sole factor to be regarded, but whether services or indemnity was the principal objective and purpose. As a result, the New Mexico Supreme Court concluded the defendants were not engaged in insurance based on the fact that "defendant health plans are service benefit organizations, as distinguished from the indemnity benefit nature of commercial insurers."⁷³

Finally, another notable case that recognized the distinction between service corporations and the business of insurance as put forth by *Jordan*,

⁶⁷ *Id.*

⁶⁸ *New Mexico Life Ins. Guaranty Assoc. v. Moore*, 596 P.2d 260 (N.M. 1979).

⁶⁹ *Id.* at 261-62.

⁷⁰ *Id.* at 260.

⁷¹ *Id.* See also Guaranty Act, N.M. STAT. ANN. §§ 59-22-1 to 17 (Michie 1978) (explaining that "association" refers to the mechanism created by the Guaranty Act to facilitate coverage, payment of claims, etc.)

⁷² *California Physicians' Servs. v. Garrison*, 172 P.2d 4, 16 (Cal. 1946).

⁷³ *New Mexico Life Ins. Guaranty Ass'n v. Moore*, 596 P.2d 260, 264 (N.M. 1979).

was *Oracare D.P.O. Inc., v. Merin*⁷⁴ in which the state insurance commissioner challenged a dental plan organization that had contracted under an employee-benefit plan to provide dental services. In *Oracare* the Third Circuit pointed out that the basic distinction between service corporations and ordinary health and accident insurers is that while the former undertakes to provide prepaid medical services through participating providers, the latter only indemnifies an insured for medical expenses up to a certain schedule of rates stated in the policy.⁷⁵ The primary purpose of the medical service corporation is to provide physicians who will render services to subscribers. Thus, *Oracare* neither acted as an insurer nor competed directly with insurance companies, providing "a reasonable basis exists for [its] separate classification and the different legislative treatment given [it]."⁷⁶

Although these decisions vary in their logic and outcome, overall it could be said that one of the key factors used to identify whether an entity is involved in insurance risk or service risk, is to determine what party makes the capitation payment to the contract. If the contract calls for payment to a provider who directly contracts with an employer or other direct consumer, the insurance regulators will likely find that the contract constitutes insurance. On the other hand, if the capitation payment is made to a provider from an insurance company, HMO or other regulated entity, it will likely be considered a service contract.⁷⁷

MANAGED CARE ORGANIZATIONS: WHEN DO THEY CONSTITUTE THE BUSINESS OF INSURANCE?

Managed Care Organizations (MCOs) are systems composed of physicians and secondary health care service providers organized to

⁷⁴ *Oracare D.P.O., Inc. v. Merin*, 972 F. 2d 519 (3d Cir. 1992) (cited for court's reasoning, although vacated by settlement).

⁷⁵ *Id.* at 2726.

⁷⁶ *Id.* (referring to the New Jersey State Supreme Court decision in *New Jersey Assoc. of Ins. Agents v. Hosp. Serv. Plan*, 128 N. J. Super 472 (App. Div. 1974), *rev'd on other grounds*, 68 N.J. 213, 220 (1975)).

⁷⁷ Overbay & Hall, *supra* note 9, at 371.

manage costs directly affecting the delivery of health care services.⁷⁸ MCOs generally assume the costs associated with providing health care services for a fee charged to the individual subscriber. The risk of loss in excess of the premiums is then typically shifted by reinsurance arrangements⁷⁹ through a capitated payment system that establishes a fee per member that does not vary, regardless of how much each member requires. In exchange, the MCO agrees to provide the care needed by that member during the payment period; at the same time, the MCO is motivated to economize in order to provide the required care at a profit.⁸⁰ Although only 6 percent of the population is currently fully capitated, it is estimated that more than 50 percent of the nation's population will be capitated by the year 2005.⁸¹

HMOs

Health Maintenance Organizations (HMOs), are a type of managed care organization regulated separately from ordinary health insurers. Typical state statutes define HMOs as "any person who undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis except for copayments and deductible."⁸² The Federal HMO Act, which was passed in 1972 by the Nixon Administration, was created particularly to promote the development of capitated health care delivery for the non-elderly population.⁸³ The Act was largely a response to health care cost inflation precipitated by the enactment of the Medicare Act five years earlier, under Presidents Kennedy and Johnson. Medicare was designed to look and function like a private health insurance program, so as to gain the cooperation of providers and to minimize disruption in the

⁷⁸ John R. Washlick, *Nonprofit Healthcare Organizations: Federal Income Tax Issues, Managed Care Organizations*, BNA TAX MANAGEMENT PORTFOLIO, 873 T.M. 1, A55-A65 (1995).

⁷⁹ *Id.*

⁸⁰ Overbay & Hall, *supra* note 9, at 363.

⁸¹ Julie Johnsson & Mike Mitka, *Showdown at Capitation Corral*, A.M. MED. NEWS, Aug. 15, 1994, at 1.

⁸² Overbay & Hall, *supra* note 9, at 372 (quoting Daniel W. Krane, *Uniform Approach To Risk-Assuming Entities Could Avoid Insolvencies, Federal Regulations*, 4 BNA HEALTH REP. 42, 1636 (Oct. 26, 1995)).

⁸³ Federal Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914 (codified as amended at 42 U.S.C. § 300(e) (1994)).

private market for health care services. However, increased demand and utilization of services quickly precipitated health care cost inflation,⁸⁴ and HMOs were thought to be a way to control health costs through non-regulatory means.⁸⁵

In 1973, Congress inaugurated a federal program to promote the development of HMOs in the private market,⁸⁶ and began requiring employers with over twenty-five employees who sought to receive favorable income tax treatment, to offer an HMO option where federally-qualified HMOs were available.⁸⁷ Both Congress and Medicare managers were nervous about taking this step, even though research had demonstrated that HMOs were a more efficient and cost-effective vehicle for providing medical care.⁸⁸ Mostly, Congress and Medicare managers feared that incentives for HMOs administrators to curtail services, would result in under service to Medicare beneficiaries, and enrollment of only healthy beneficiaries.⁸⁹

Ultimately, the development of the HMOs came only after much litigation challenging the new "health care organizations" as well as attempts to restrain these organizations from carrying on business as an "insurer" without a certificate of authority. A perfect example of this problem was presented in *Roddis v. California Mutual Association*, which involved a nonprofit unincorporated association created to make payments in limited amounts for medical and hospital services rendered to its members using funds derived from periodic dues.⁹⁰ In *Roddis*, the

⁸⁴ Randall R. Bovbjerg, *U.S. Health Care Coverage and Costs: Historical Development and Choices For The 1990s*, 21 J. L. MED & ETHICS 141, 151 (1993) (citing U.S. Dep't of Commerce data and explaining that by 1990 medical prices rose to 800 percent of their 1960 level, and national health expenditures moved from less than 5 percent of the GNP in 1960 to 13.9 percent in 1990).

⁸⁵ Eleanor D. Kinney, *Procedural Protections for Patients in Opiated Health Plans*, 22 AM. J.L. and Med. 301, 305 (1996).

⁸⁶ Federal Health Maintenance Organization Act of 1973, *supra* note 83.

⁸⁷ Kinney, *supra* note 85, at 305.

⁸⁸ Eleanor D. Kinney, *Medicare Managed Care: Symposium of Consumer Protection in Managed Care, Mechanisms of Consumer Protection -- The Marketplace and Regulation: Medicare Managed Care From the Beneficiary's Perspective*, 26 SETON HALL L. REV. 1163, 1173 (1996).

⁸⁹ *Id.* at 1174.

⁹⁰ *Roddis v. California Mutual Ass'n*, 441 P.2d 97 (Cal. 1968).

Supreme Court of California looked to *Jordan* in determining the nature of the health plan, and was cognizant of two policy considerations: indemnity features that force the member to bear risk of personal liability for medical services, and a strong social policy to encourage the services that health plans provide the public. While the court did find the defendant to be in the business of insurance, they noted that "care must be taken to always make it possible for new plans to enter the stage, for health is a commodity which has too few purveyors."⁹¹

Today, most states have developed a regulatory approach toward HMOs that recognize their unique attributes, since HMOs do not fit into the "insurance mold."⁹² HMOs are also recognized under the Federal Health Maintenance Act of 1973 (Act),⁹³ which defines an HMO and the manner in which it must be organized in order to be qualified under the Act. These requirements include that the HMO:

- (1) assumes a contractual responsibility to provide or insure the delivery of a stated range of health services, including at least physician and hospital services;
- (2) services a voluntary enrolled, defined population, broadly representative of the various age, social and income groups in the area which it serves;
- (3) requires a fixed periodic payment to the organization that is independent of its use of services;
- (4) may not expel or refuse to enroll any member because of his or her health status or his or her requirements of health services;
- (5) assumes at least part of the financial risk and or gain on a prospective basis for the provision of basic health care services and makes adequate provisions against the risk of insolvency; and
- (6) has established internal procedures for hearing and resolving grievances, and ongoing quality controls for monitoring quality assurance and utilization.⁹⁴

⁹¹ *Id.* at 588 (quoting 15 ASSEMBLY INTERIM REPORT 26, Finance and Insurance (1961-1963), at 36).

⁹² Overbay & Hall, *supra* note 9, at 375.

⁹³ Federal Health Maintenance Organization Act of 1973, *supra* note 83.

⁹⁴ Washlick, *supra* note 78, at A-55. See also 42 U.S.C. § 300(c) (1994).

When HMOs were first developed in the 1970s, there was no clear law under which they were to be regulated. Although required to meet certain standards under the Federal HMO Act,⁹⁵ in terms of receiving federal financial support, regulation of HMOs was left largely to the states by insurance regulators. Since HMOs were not purely insurance, but incorporated a service function as well, the states determined that they needed to look to the individual HMOs' financial solvency, along with the quality of service delivery. Today, HMOs are strictly regulated in every state, usually by both the state insurance department and the state department of health,⁹⁶ who usually regulate financial solvency requirements, quality assurance, utilization management, delivery networks, and such financial details as the type of investments HMOs can make.⁹⁷

An HMO typically contracts with physicians and health care providers for the provision of basic health care services in exchange for a fixed fee. These fees may be established by paying a fixed salary, combination of salary and bonuses, a fixed fee per member, or a fee-for-service (FFS) if the provider is a hospital, specialist, or an out-of-area emergency care provider.⁹⁸ In return for the HMO agreeing to provide these medical services, members contractually agree to make certain periodic payments.⁹⁹

Although there is no universal HMO model, the IRS has characterized HMOs into four basic models based on the relationship between the HMO and the physicians contracting to provide the actual medical services to the HMO's members. These models include:¹⁰⁰

Staff Model HMOs- In these type of HMOs, health care services are provided by physicians and other health care professionals, who are

⁹⁵ Federal Health Maintenance Organization Act of 1973, *supra* note 83.

⁹⁶ Overbay & Hall, *supra* note 9, at 375 (quoting *Physician Hospital Organization: State Regulators Play Catch-up*, at 1 (1994) (unpublished report available from Ernst & Young by calling Sondra Klimacek at 212. 773.5164)).

⁹⁷ *Id.* (Quoting MICHELE GARVIN, HEALTH MAINTENANCE ORGANIZATIONS, 4 HEALTH CARE CORPORATE LAW: MANAGED CARE, ch. 1, § 1.5 (Mark A. Hall & William S. Brewbaker eds. (1996))).

⁹⁸ Washlick, *supra* note 78, at A-55. See also 42 U.S.C. § 300(c) (1994).

⁹⁹ *Id.*

¹⁰⁰ GCM 39829 (8/30/90).

salaried employees of the HMO. Services are provided at one or more locations directly to members who have contracted for services. HMO members cannot seek medical care outside the HMO, and the salaried physicians who are employees of the HMO, cannot practice outside the HMO. In addition, staff bonuses are offered to physicians based on HMO performance as a means of encouraging cost-containment and utilization.

Group Model- In a group model HMO, care is provided in a central location by physicians already practicing in a group practice. The group receives a fixed dollar amount payable per month to service all the health care needs of a certain number of the HMO patients for a specified time period. Thus, the number of enrollees determines the group's income, and only by keeping its costs lower than the capitated fees will the practice be able to realize a profit.

Independent Practice Associations (IPA) Model- An IPA itself is usually a separate, related or unrelated, physician-controlled association which negotiates managed care contracts on behalf of its physician members and performs administrative services required by the HMO contract. Physicians practicing independently in their own offices contract with the IPA which, in turn, contracts with an HMO. The HMO compensates the IPA for services on a capitated basis, and the IPA then compensates the physicians for their medical services on a fee-for-service basis.

Network Model- A network model provides medical care through two or more medical practices.

Whether HMOs should be considered insurance is debatable. By analogy, perhaps the HMO could be considered to be within the business of insurance since other prepaid plans, which are similar in function and purpose, have been found to constitute insurance.¹⁰¹ In addition, insurance

¹⁰¹ See e.g., *Cleveland Hosp. Ass'n v. Elbright*, 45 N.E. 2d 157 (1942) (discussing nonprofit hospital selling prepaid care contracts found to be involved in the business of insurance); *Bloom v. Northern Pacific Beneficial Ass'n*, 193 N.W.2d 244 (1971) (finding an unincorporated

companies also meet the requirements set forth in *Group Health & Life Insurance Company*.¹⁰² At least for tax purposes, an association must involve both risk shifting and risk distribution to be labeled as insurance.¹⁰³

The Internal Revenue Service (IRS) defines an insurance company as a company whose primary and predominant business, is the issuing of insurance or annuity contracts or the reinsuring risks underwritten by insurance companies.¹⁰⁴ However, not all HMOs are considered to be insurance companies. For example, in *Jordan*, discussed above, the court found an HMO type organization that furnished services in its own facilities through contracts with physicians who received a fixed annual compensation not to be engaged in the business of insurance.¹⁰⁵ In addition, the IRS ruled in Rev. Ruling 68-27 that an organization structured similarly to a staff model HMO, which issues medical service contracts to groups or individuals and provides direct medical services to its subscribers through salaried physicians and nurses, is not an insurance company for federal income tax purposes since it lacks any shifting of risk.¹⁰⁶ The factors the IRS examines in making a conclusion about whether a company is providing commercial-type insurance are whether:

association of railway employees who provided medical, surgical and hospital care to its members who payed premiums under a payment plan was in the business of insurance); *McCarty v. King County Medical Serv. Corp.*, 175 P.2d 653, 666 (1946) (declaring company selling prepaid medical protection against hazard of injury or illness to which each employee paid a fixed premium based upon a written contract in the business of insurance); *Maloney v. American Indep. Medical and Health Ass'n*, 259 P.2d 503 (1953) (finding that a corporation that entered into contracts with licensed physicians, surgeons and hospitals to make available services to its members based upon prepayment of a fee assumed insurance risk); *Mansen v. California Dental Servs.*, 424 F. Supp. 657 (N.D. Cal. 1976) (stating that a corporation that contracted to provide dental services or prepaid premiums and underwrote actuarial risks that payments would be sufficient took on insurance risk).

¹⁰² *Group Health & Life Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), *reh'g denied*, 441 U.S. 917 (1979), *cert. denied*, 469 U.S. 1160 (1985).

¹⁰³ *Helvering v. Le Giese*, 312 U.S. 531 (1941); *Commissioner v. Treganowan*, 183 F.2d 188 (2d Cir. 1950); Rev. Rul. 68-27, 1968-1 C.B. 315; GCM 33144 (12/2/65); Rev. Rul. 60-275, 1960-2 C.B. 43.

¹⁰⁴ Treas. Reg. § 1.801-3(n) (1996) (The primary and predominant test is satisfied if income from insurance contracts exceed 33 percent total income).

¹⁰⁵ *Jordan v. Group Health Ass'n*, 107 F.2d 239, 245 (D.C. Ct. App. 1939).

¹⁰⁶ Rev. Rul. 68-27, 1968-1 C.B. 315.

- (1) a risk is being transferred and distributed;
- (2) to what extent the entity is operating in a manner similar to for-profit insurers;
- (3) to what extent the entity is marketing a product similar to for-profit insurers;
- (4) to what extent the entity provides health care services directly; and
- (5) to what extent the entity has shifted a risk of loss to the service providers through salary or fixed fee compensation agreements.¹⁰⁷

The IRS has, however, found some HMOs to be insurance companies for tax purposes, including for profit IPA-model HMOs.¹⁰³ An IPA, is an organization established and controlled by physicians who negotiate with an HMO on behalf of its member physicians.¹⁰⁹ The courts have distinguished the IPA from the staff-model HMO analyzed in Rev. Rul. 68-27, since the IPA-model HMO did not hire physicians or medical staff for its subscribers, but merely contracted with physicians in private practice to provide services on a fee-for-service basis.¹¹⁰ The IRS determined that since staff-model HMOs do not typically issue annuity contracts or reinsure risks underwritten by insurance companies, in order to determine whether an HMO qualifies as an insurance company for federal income tax purposes, its primary and predominant business activity during the taxable year must be the issuance of insurance contracts.¹¹¹

PPOs

Preferred Provider Organizations (PPOs), contract with a network of providers who deliver services to enrollees in accordance with a negotiated fee schedule. This usually occurs through discounts, per diem rates or payments based on DRGs (Diagnosis Related Groups). The PPO sells to insurers and self-funded employer plans; and, while enrollees pay

¹⁰⁷ *Id.*; See also GCM 39703 (Feb. 26, 1988).

¹⁰⁸ Tech. Adv. Mem. 94-12-002.

¹⁰⁹ *Id.*

¹¹⁰ Washlick, *supra* note 78, at A-65 (discussing Rev. Rul. 68-27).

¹¹¹ *Id.*

according to the fee schedule for physician services, if enrollees go to a provider who is not part of the PPO, the costs of care is higher.¹¹² PPOs usually do not take on insurance risk for arranging the network.¹¹³

PSOs

Reform of health care is flourishing in the private marketplace, a sector that has long understood the benefits of managed care contracting. Consequently, a variety of new managed care approaches have been introduced to address both quality and cost-control of health care. One of the newest additions to the market is the Provider Sponsored Organization (PSO), a health care delivery network owned and operated by providers.¹¹⁴ The mission of the PSO is to contract with licensed plans, self-insured employers, and other group purchasers to deliver health care services. PSOs themselves can be clinics, medical groups, hospitals, skilled nursing facilities, home health agencies and other licensed health care providers that contract with third party payors, including self-funded ERISA plans.

PSOs are a restructured delivery system in which provider networks contract directly with employers in order to more directly address patients' needs. They are distinguishable from other kinds of health plans, because PSOs are health care providers as opposed to financial intermediaries. Whereas HMOs and insurance companies typically concentrate operating assets in their administrative capacity to collect premiums and buy medical services for their plan members, providers who own and operate PSOs have their investments concentrated in health care delivery.¹¹⁵

¹¹² PATRICIA YOUNGER, *LEGAL ANSWER BOOK FOR MANAGED CARE*, at 10 (Aspen Publishers 1995).

¹¹³ A survey conducted by the American Managed Care Review Association in October 1994 found only 4 percent of PPOs were at risk, while 16 percent of hospitals and 7 percent of physicians were at financial risk. *AMCRA, 1994 - 95 Managed Health Care Overview*, at 20 (1995).

¹¹⁴ The term PSO refers to a full spectrum of health plans and networks, including IPAs, PHOs, MSOs, and PPOs.

¹¹⁵ Edward B. Hirshfeld, *Provider Sponsored Organizations and Provider Service Networks—Rationale and Regulation*, 22 *AM. J. L. & M ED.* 263, 267 (1996). (One way for providers to create PSOs is to create a new corporation owned by the providers).

Creating PSOs also increases opportunity for providers to regain control over decision making and to enter more favorable economic arrangements, especially for those physicians who want to keep their practices and are wary of more tightly integrated organizations. Employers also benefit when they contract with PSOs by being able to eliminate an unnecessary layer of administrative costs, since they currently pay for two management structures to manage risk -- the one developed by the HMO to manage the risk it takes on from the employer, and the one created by the provider network to assume risk from the HMO (downstream contracting). These administrative costs represent 23 percent of U.S. health care spending.¹¹⁶ By contracting directly, the employer can eliminate the management costs and profit of the HMO since PSOs are not intermediaries or network arrangers.

Finally, because the employer works directly with the provider, direct contracting can yield better service and quality for the self-funded employer. This is also appealing to employees who would prefer to have their physicians decide where to draw the line on individual treatment, rather than allow limits to be set by their insurer or HMO.

A survey of provider organizations taken by Ernst & Young L.L.P. in 1994, found that most were created for the following purposes:

- (a) contracting with managed care organizations;
- (b) collaborating with medical staff;
- (c) improving relationships with community physicians;
- (d) sharing financial risk among provider participants; and
- (e) enhancing quality of care.¹¹⁷

Many PSOs and provider service networks (PSNs) have been successful in reducing the rate of increased health care costs¹¹⁸ because they control expenses more effectively, while maintaining or enhancing the quality of

¹¹⁶ Louise Kertesz & Joanne Wojcik, *Risky PHOs Winning Bet: Some Integrated Delivery Systems Are Pulling The Strings Under Capitation, But many Will Find It Too Big Of A Gamble*, MODERN HEALTHCARE 46 (1996).

¹¹⁷ Ernst & Young, LLP, *Physician-Hospital Organizations: Profile 1995*, at 8 (Feb. 1995) (For information on getting copies of this report you can contact a local Ernst & Young professional).

¹¹⁸ GAIL HARRIS & EDWARD B. HIRSHFELD, *MANAGED CARE AND THE MARKET, A SUMMARY OF NATIONAL TRENDS AFFECTING PHYSICIANS*, at 12-13 (2d ed. 1995).

care. This is largely the case because "changes occurring [in the medical field] are those in the application of medical science and can best be managed by organizations led and operated by providers."¹¹⁹

Delivery systems that have significant physician system integration, have also been found to perform better than those that do not.¹²⁰ This is largely because it is not possible to "achieve any measurable level of clinical integration for patients without a close relationship of physicians with an organized delivery system."¹²¹ A study published in the *New England Journal of Medicine*, conducted by James C. Robinson and Lawrence P. Casalino, reported on the cost performance of six California physician owned medical groups paid primarily by capitation.¹²² The study found that hospitals used by these six physician groups showed use from 120 to 149 days per 1000 non-Medicare members and from 643 days per Medicare members in 1994. Conversely, in 1993, the mean number of hospital days per 1000 non-Medicare members for Commercial HMOs in California was 232 days and 1337 for Medicare members.¹²³

Do PSOs Take On Insurance Risk Or Service Risk?

Undeniably, in many respects the risk-bearing PSO is very similar to the staff model HMO concept. For example, both forms are established as provider networks, both provide service delivery, and both operate on prepaid revenues. However, while PSOs assume the risk that a population of patients will need health care services, their main function is the selling of health care services and the risk assumption is merely incidental to the primary objective.¹²⁴ This function of PSOs resembles a service contract or provider agreement, under which the PSO physicians provide medical services to the employer's workers for a fixed amount.¹²⁵ The self-funded

¹¹⁹ Hirshfeld, *supra* note 115, at 274.

¹²⁰ Stephen M. Shortell, *New World of Managed Care: Creating Organized Delivery System*, 13 HEALTH AFF'L 52-53 (1994).

¹²¹ *Id.* at 53.

¹²² James C. Robinson & Lawrence P. Casalino, *The Growth of Medical Groups Paid Through Capitation In California*, 333 NEW. ENG. J. M ed 1684 (1995).

¹²³ *Id.*

¹²⁴ Not all PSO are alike, and there are some forms of PSOs which resemble insurance more than others.

¹²⁵ Professional Lens Plan, Inc. v. Department of Ins., 387 So. 2d 548 (Fla. Dist. Ct. App. 1980).

employer, however, remains responsible for delivering health care benefits to its employees, so if the provider fails the employer must purchase health care elsewhere. Courts have found similar arrangements not to constitute insurance.

Although the United States Supreme Court has never directly addressed the issue of whether PSOs constitute insurance, an analogy could be made to a PSO based on the Supreme Court decision in *Group Health Health & Ins. Co.* where the Court found that acceptance by pharmacies of two dollars from subscribers with the difference to be covered by the insurer did not constitute the business of insurance. Instead, the Court found it merely “minimized the costs Blue Shield insures in fulfilling its underwriting obligations.”¹²⁶ This arrangement was labeled by the Court as an agreement for the “purchase of goods and services,” a description also applicable to PSOs that contract with self-funded employer plans to provide services at a price that may minimize the employer’s risk. Employers do not shift their responsibility to pay for the health services promised to their employees in their employee benefit plan; rather, they arrange for the purchase of goods and services at a price that allows them to control their costs. In *Group Health & Life Ins. Co.*, the Supreme Court found that pharmacies who believe that they might not be able to acquire drugs for the agreed upon price and may then have to take a loss, are not involved in the business of insurance. It is reasonable then to conclude that for the purpose of the McCarren-Ferguson Act, agreements between insurers and health care providers also do not constitute the business of insurance.

There are however, different types of PSOs and some may be involved in arrangements that do resemble insurance more than others. The characteristics to be considered in evaluating this differentiation include whether the PSO offers:

- (a) global fees, where the PSO promises to provide all care needed to treat a specific injury or illness for a fixed fee, regardless of the amount of resources necessary to care for any given patient;

¹²⁶ *Group Health & Life Ins. Co. v. Royal Drug Co.*, 440 U.S. 20S (1979), *reh’g denied*, 441 U.S. 917 (1979), *appeal after remand*, 737 F.2d 1433 (5th Cir. 1984), *cert denied*, 469 U.S. 1160 (1985). (This analogy is borrowed from Memorandum from the AGPA, *supra* note 29).

- (b) fee withhold arrangements, where part of each fee charged by a PSO is withheld and paid only if utilization goals for the PSO are met;
- (c) capitation, where the PSO provides its services in return for a fixed payment per month for each patient assigned to it;
- (d) global capitation, where the PSO provides its services and the services of providers outside the PSO for care that it cannot deliver in return for a fixed payment per patient per month; or
- (e) percentage of the premium arrangements, which resemble global capitation except that the PSO is paid a fixed percentage of the premium paid to the HMO.

These arrangements fall on a continuum with respect to the amount of risk assumed by PSOs. As PSOs assume greater risk for items in the benefits package, the risk is pooled and spread among covered lives pursuant to capitation agreements, and risk is assumed for larger amounts of services until the PSO cannot deliver without obtaining services from other providers. It is at this point that PSOs resemble insurance; however, to designate all PSOs as insurance is both arbitrary and inaccurate since the differences among them are significant.

Although PSOs can subcontract with insurance companies or HMOs, called downstream capitation,¹²⁷ many PSOs have bypassed insurance companies and HMOs completely by contracting directly with employers on a fully or partially capitated basis -- so called upstream capitation.¹²⁸ It is this activity that has lead licensed health plans and the NAIC to demand that PSOs accepting "upstream" risk be directly licensed as insurance companies. A recent study of PSOs, however, indicated that at present most PSOs enter into contractual agreements with PPOs (41 percent), HMOs (18 percent) Blue Cross and Blue Shield Plans (16 percent) and commercial plans (11 percent). Only 14 percent of enrollees served by PSOs were pursuant to a direct contract with employers.¹²⁹

¹²⁷ Overbay & Hall, *supra* note 9, at 362.

¹²⁸ *Id.*

¹²⁹ Ernst & Young, LLP, *supra* note 117, at 8.

Are PSOs Actually HMOs?

The PSO looks very similar to the staff-model HMO. For example, both organizational forms are established as provider networks, both integrate service and delivery functions, and both operate on prepaid revenue to provide managed care.¹³⁰ However, there are many significant differences between HMOs and PSOs. For instance, HMOs are typically larger, operate nationally with millions of subscribers, and provide access to both hospitals and physicians (general practitioners and specialists). PSOs, on the other hand, generally operate in a single or a few small cities, with more than half having contracts covering fewer than 25,000 lives.¹³¹ PSOs are especially effective in smaller towns and rural areas that cannot support a large health care organization.¹³² And while a large health care organization might be able to serve smaller areas on a fee-for-service basis only, a PSO can operate profitably on a capitated basis in a smaller market.¹³³ Unfortunately, because proposed PSO regulations favor highly organized and financially powerful institutions over smaller ones newly associated to the market, PSOs serving smaller markets will most likely be quickly stifled.

Additionally, provider group physicians are predominantly specialists, with three-quarters of the provider groups having physician panels of more than 50 percent specialists.¹³⁴ Often provider owned, PSOs typically contract for fewer services than the physicians themselves provide, and simply work more hours for less pay when they fail to accurately estimate risk.¹³⁵ This differs significantly from HMOs who become financially liable for poor risk estimations — the very reason why HMOs need to be regulated.

While HMOs are regulated by the HMO Act, state regulation of PSOs has been erratic at best. In the early 1990s, state regulators began to focus their oversight on the newly integrated delivery systems with

¹³⁰ Memorandum from Stephanie Lewis, *supra* note 30, at 9.

¹³¹ Ernst & Young, LLP, *supra* note 117, at 1.

¹³² Overbay & Hall, *supra* note 9, at 366.

¹³³ *Id.*

¹³⁴ Ernst & Young, LLP, *supra* note 117, at 2. (The numbers used are based on the 189 provider groups and management service organizations included in this survey).

¹³⁵ Overbay & Hall, *supra* note 9, at 377.

which providers contracted. But even today, many state regulators are uncertain about how to deal with these creatures and are awaiting direction from their legislatures.¹³⁶ Many states have treated PSOs as HMOs, others have required them to be licensed as insurance.¹³⁷ Some states have not asserted jurisdiction at all, others have only in certain circumstances.¹³⁸

Currently, the majority of states have not enacted PSO-specific regulations and there is clearly discord among the states, as well as within the states, on the issue of how provider organizations should be regulated. A survey by the Group Health Association of America¹³⁹ asked state regulators how provider groups, under four different arrangements, would be regulated under their current state law. The four arrangements considered, included when the provider group contracts:

- (1) directly with the employer on a fee-for service basis and the employer retains full risk for cost of employee medical services;
- (2) directly with the employer on a capitated basis;
- (3) directly with the employer and a budget is established to pay for medical services. While any savings are split with the employer, additional expenses at the end of the contract period up to 110 percent of the budget must be borne by the provider organization; and
- (4) on a capitated basis with a licensed health plan, which has contracts with employers to provide medical coverage pursuant to a group policy.¹⁴⁰

The survey results revealed that under the fee-for-service option, regulators in forty states did not feel they had jurisdiction to require licensure of the PSO. Under the capitated basis option, however, more than 80 percent of regulators thought that PSOs would be required to be licensed. The manner in which they should be licensed was uncertain,

¹³⁶ Laura Kaufman & Susan Webster, *GHAA Survey Finds States are Erratic in Oversight and Regulation of PHOs*, 4 BNA HEALTHL. REP. 28, 1063 (July 13, 1995).

¹³⁷ *Id.*

¹³⁸ *Id.*

¹³⁹ Group Health Ass'n of Am., *Survey: PHOs and the Assumption of Insurance Risk: A 50-State Survey of Regulators Attitudes Toward PHO Licensure*, July 10, 1995.

¹⁴⁰ *Id.*

although some states suggested that HMO or insurance regulations would be adequate. Still other states were unsure, unclear, or disputed the issue among administering agencies within the state. In the third option, where risk is transferred on an annual predetermined budget, exactly one-half of the states responded they would require licensure, while the remaining half remained unclear. Finally, in the fourth option, an example of downstream transfer of insurance risk, two states reported they already regulate such activities,¹⁴¹ twenty-two states were still unclear, and twenty-seven regulators stated they would require no oversight.

As indicated by this survey, because most states lack specific regulations that address PSOs, provider groups have been regulated across the country under a variety of different schemes. An NAIC draft compilation of *State Activity Related to the Regulation of Risk Bearing Entities*¹⁴² reveals, for example, that Alabama, Alaska, Arizona, District of Columbia, Kansas, Indiana, South Dakota, Louisiana, Maine, Massachusetts, Montana, Nebraska, Nevada, New Mexico, and West Virginia, have no proposed regulations to treat PSOs any differently than non-provider based entities.¹⁴³ Arkansas, Michigan, Missouri, Connecticut, Hawaii, Idaho, Delaware, New York, North Carolina, North Dakota, Oregon, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, and Wyoming appear to have regulated or plan to regulate some or all of their provider-base organizations as HMOs or other managed care service contractors.¹⁴⁴ In California, New Hampshire and Maryland, the issue is being studied and regulation is pending, while in Ohio and Oklahoma, proposed regulations specific to PSOs are being reviewed.

As this survey demonstrates, regulation by the states has been inconsistent and erratic. In April of 1996, New Jersey's Department of Health released for comment final proposed regulations permitting the assumption of risk by an authorized payer, defined by state statute as one who actually provides health services within the scope of his/her license. In contrast, the South Carolina Department of Insurance believes it may

¹⁴¹ California and Nevada.

¹⁴² See NAIC Survey Respondent, Draft No. 2, May 1996.

¹⁴³ Memorandum from Stephanie Lewis, *supra* note 30 at 9.

¹⁴⁴ *Id.*

not even have the authority to license PSOs that contract only with self-insured, single employer health plans.¹⁴⁵

Regulators in at least two states, Illinois and North Carolina, have expressed the belief that the risk of using PSOs remains on the employer. In a recent advisory opinion, the Attorney General of North Carolina opined that a health care provider organization that contracts directly with a self-insured employer to provide specified health care services, is not subject to state regulation as an HMO.¹⁴⁶

In its opinion, the attorney general of North Carolina was issuing advice to a hospital considering a theoretical provider organization arrangement involving a direct contract between a provider group and an employer that sponsored a self-funded health insurance plan¹⁴⁷ for a specified set of services to a set of employees and dependents. The attorney general stated that while payment could include risk for services provided within the provider's scope of practice, it could not include financial risk for services outside the scope of practice, due to medical emergencies, out-of-network services or referrals beyond the extent that the provider can manage the care, or tertiary or catastrophic care, unless directly provided within the network. If the providers cannot provide the required care, it remains the employer's responsibility to protect against catastrophic claims by taking other measures, including obtaining stop-loss coverage. Thus any risk borne by the network is not an insurance risk, but rather a risk of utilization over that is relatively minimal.¹⁴⁸

In analyzing whether ERISA preempted state regulation of provider groups as HMOs, the attorney general of North Carolina found that licensure provisions of the HMO Act are subject to preemption when they "relate" to ERISA plans by restricting their choice of providers to licensed entities. The attorney general found this restriction to be comparable to state mandated benefit laws and "any willing provider laws," which several courts have ruled as preempted by ERISA, because they directly

¹⁴⁵ *Id.*

¹⁴⁶ *State Agencies Disagree on Regulating Provider Networks Direct Contracting*, BNA HEALTH CARE DAILY, Oct. 16, 1996, at 1.

¹⁴⁷ "Provider" was defined by the attorney general as a network or other integrated system of physicians, hospitals, clinics and other health care providers or facilities, or any combination thereof, duly licensed as providers.

¹⁴⁸ BNA HEALTHCARE DAILY, *supra* note 146, at 2.

impact plan structure and administration of benefits.¹⁴⁹ Finally, the attorney general determined the state HMO Act's licensure requirements are not saved from preemption, because the purpose of the hypothetical contract was to obtain health services, rather to protect against a financial risk, and thus there existed no insurance contract that could be subject to state regulation.

A similar conclusion was reached by the Illinois Department of Insurance (Department), which issued a bulletin in April 1996 stating that a contracting provider group is not subject to regulation by the state, whether it assumes no risk, full risk, potential risk or downstream risk. Instead, the employer or licensed entity remains at risk.¹⁵⁰ The Department reached its conclusion upon finding there was no direct contractual obligation made by PSOs to employees covered under self-insured agreements. Since, the contractual agreement is "only between the provider group and the self-funded employer, licensed insurer or HMO, who continues to have full and direct responsibility to the individual if the provider group fails to perform, the employer, insurer or HMO is still at risk to either provide or pay for health services."¹⁵¹ According to the Department, only when a health care provider group becomes the ultimate risk bearer and is directly obligated to individuals to provide, arrange for, or pay for medical services, the provider group must be appropriately licensed as an HMO, limited health service organization, or insurance company.¹⁵²

¹⁴⁹ See *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985); *Stuart Circle Hospital Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993), *cert denied*, 510 U.S. 1003 (1993); *Blue Cross & Blue Shield of Kansas City v. Bell*, 798 F.2d 1331 (10th Cir. 1986); *CIGNA Healthplan of Louisiana v. State*, 82 F.3d 642 (5th Cir. 1996), *reh'g denied*, 1996 U.S. App. LEXIS 17707 (5th Cir., June 4, 1996), *cert denied*, 1996 U.S. LEXIS 6613 (Nov. 4, 1996); *Blue Cross & Blue Shield of Alabama v. Neilson*, 917 F. Supp. 1532, 1538 (N.D. Ala. 1996).

¹⁵⁰ David Grant, *Provider based Market Systems — When to Regulate*, Illinois Department of Insurance, Apr. 1996.

¹⁵¹ *Id.*

¹⁵² *Id.*

Proposed Federal Regulation of PSOs and PSNs

There are currently no federal regulations that specifically apply to PSOs or PSNs. The federal government, however, did consider legislation¹⁵³ that would facilitate the development of health plans owned and operated by providers, including PSOs¹⁵⁴ and PSNs.¹⁵⁵ Although the legislation that included rule making for PSOs and PSNs never became law, the issue is sure to be the subject of future proposals and debates. What is significant, however, is that the proposed legislation recognized both the distinct characteristics of PSOs and recommended that unique standards be applied to these provider groups.

The proposed federal legislation would also have created a new Part C option for Medicare patients as an alternative to Parts A and B of the Medicare program and the existing part C.¹⁵⁶ Presently, Part A covers fee-for-service hospital services, while Part B covers fee-for-service physician services. Patients pay a premium to receive services under part B, and both sections are subject to copayments, deductibles, and limits on coverage.¹⁵⁷ Part C of the Medicare statute allows a patient to choose a qualified HMO or competitive medical plan¹⁵⁸ that underwrites the entire Medicare benefits package, but also restricts the choice of available providers to Medicare patients.¹⁵⁹

¹⁵³ See The Balanced Budget Act of 1995, H.R. 2491, 104th Congress, 1st Sess. (1995) (passed by Congress and vetoed by President Clinton, Dec. 7, 1995); Common Sense Balance Budget Act of 1995, H.R. 2530, 104th Cong., 1st Sess. (1995) (also known as Blue Dog Bill, introduced to the House of Representatives on Oct. 25, 1995); Budget reconciliation legislation for fiscal year 1997 (not submitted to Congress).

¹⁵⁴ The term "provider sponsored organization" is used in all bills to refer to a health plan owned and operated by providers that would underwrite the Medicare benefit package for Medicare eligible patients.

¹⁵⁵ The term "provider sponsored network" is used in H.R. 2530 to refer to a health care delivery network owned and operated by providers.

¹⁵⁶ Hirshfeld, *supra* note 115, at 264 (referring to Republican bill, *supra* note 153, § 8001; Blue Dog bill, *supra* note 153, § 8002, Clinton bill, *supra* note 153, § 11201).

¹⁵⁷ *Id.* at 264.

¹⁵⁸ 42 U.S.C. § 1395k (1994).

¹⁵⁹ Hirshfeld, *supra* note 115, at 265 (explaining that Part C is informally known as the Medicare Risk Contract Program, because the HMOs and CMPs assume the risk that Medicare patients will need Medical Services. Medicare pays a fixed premium to the selected HMO or CMP who in turn must provide the full Medicare package to patients. "To the extent that HMOs can provide the package (including a reasonable profit) for less than the premium, they must provide

The proposed part C would have expanded the types of health plans currently available to Medicare patients to include PPOs, PSOs and other plans that could even choose to offer greater benefits to Medicare patients for an additional premium. Although health plans that could be used under part C would require licensing under state law, according to both the proposed Republican and Blue Dog bills, the state licensing requirements would be preempted if they failed to meet standards developed for Part C by the federal government.¹⁶⁰ The standards would include requirements for coverage of services, quality assurance, credentialing and retention of provider, utilization review, solvency, and more.¹⁶¹

An example of the federal government's recognition of the unique characteristics of PSO's as compared to other managed care plans, is that the proposed regulation included requirements for PSOs that differed from other part C health plans. In fact, all three bills would have required separate solvency standards be set for PSOs,¹⁶² thus recognizing that PSOs are able to meet solvency requirements with smaller amounts of liquid financial resources.¹⁶³ This is largely because PSOs have the capacity to deliver care, they are able to weather unexpected patient needs, and require fewer assets to pay for unexpected health care demands. Conversely, because most health insurers are financial intermediaries, they must purchase any unexpected amounts of health care services needed by their beneficiaries.¹⁶⁴

The ability of providers to deliver care without large financial reserves is an opinion that was shared by the New Jersey Supreme Court

additional benefits to the patients." 42 U.S.C. § 1395mm(g) (West 1992)). Consequently, an HMO or CMP may provide more benefits to patients than the FFS program under parts A and B).

¹⁶⁰ Republican bill, *supra* note 153, §8001 (a)/ S.S.R. §§ 1853(a)(2)-(6), 1856(c); Blue Dog bill, *supra* note 153, § 8002(a)/S.S.R. §§ 1854(b), 1856(e).

¹⁶¹ These sections are found throughout the bills.

¹⁶² Republican bill, *supra* note 153, § 8001/ S.S.R. §§ 1853(d)(2), 1856(b); Blue Dog bill, *supra* note 153, § 8002/S.S.R. §§ 1854(b), 1856(c); Clinton bill, *supra* note 153, §11202/S.S.R. §§ 1851A(e)(1)(E), 11203(a)(2).

¹⁶³ See Hirshfeld, *supra* note 115, at 268. Liquid financial resources usually include cash or other assets easily turned into cash. Because PSOs generally concentrate in the area of health care delivery, much of their assets are land, buildings, equipment and personnel, which are often not recognized as assets for conventional solvency standards since they cannot be really turned into cash. However, these types of assets do enable PSOs to respond to unexpected demands for service.

¹⁶⁴ *Id.*

in *New Jersey Ass'n of Indepen. Ins. Agents v. Hospital Serv. Plan of New Jersey*¹⁶⁵ where the court examined a student accident insurance plan that provided fifteen specified benefits,¹⁶⁶ allegedly in violation of Federal and State constitutions by not complying with insurance statutes. Although the Appellate Division found the plan to be a typical insurance policy, the Supreme Court of New Jersey held that while any coverage offered by the plans must essentially be in the form of service benefits in order to avoid being labeled as insurance since, "where certain services and items are incidental to service benefits, indemnification may be permissible."¹⁶⁷ The New Jersey Court found the Student Accident Insurance Coverage to be a legitimate activity, but proposed it be reviewed to ensure it was in fact restricted essentially to service benefits. The court concluded by stating that:

Rather than require them to maintain large financial reserves, thereby increasing the cost of benefits provided, the Legislature provided for the financial integrity of the Plans by requiring that they contract with an adequate number of providers of health care. These providers serve as a substitute for the capital and assets required of regular insurance companies.¹⁶⁸

Specific Regulation of PSOs Currently Employed by States

Several states have already come up with their own licensing mechanism for provider based plans such as PSOs, although individual states' approaches vary from week to week. The uncertainty among the states concerning how to classify PSOs is evidence they do not fit easily into the

¹⁶⁵ *New Jersey Ass'n of Indepen. Ins. Agents v. Hospital Serv. Plan of New Jersey*, 343 A.2d 739 (N.J. 1975).

¹⁶⁶ *Id.* at 742. The benefits included hospital services, drugs, professional ambulance service, private duty nursing services, prosthetic devices, physiotherapist services, orthopedic appliances, blood processing and dental services. These services are provided on a reimbursement or indemnity basis: services by a physician, surgical services, administration of anesthesia, x-ray and laboratory examinations by a physician, physical therapy by a physician, and drugs, medicine or medical supplies administered or used in a physician's office or by a physician. Payment for these benefits is made to the student's parent or guardian on an indemnity basis or directly to the physician if he is a participant in Blue Cross and Blue Shield.

¹⁶⁷ *Id.*

¹⁶⁸ *Id.* at 743.

insurance or HMO category.¹⁶⁹ States such as: California,¹⁷⁰ Colorado,¹⁷¹ Iowa,¹⁷² Georgia,¹⁷³ Maryland,¹⁷⁴ Minnesota,¹⁷⁵ Ohio,¹⁷⁶ Kentucky,¹⁷⁷ and Pennsylvania¹⁷⁸ have all enacted regulations, or will be enacting regulations, that apply directly to provider networks and set forth compliance criteria and solvency requirements.

- (a) In California, the state Department of Corporations recently required a provider-group medical center to obtain a limited HMO-type license under the Knox-Keene Act in order to operate fully at-risk and accept global capitation. While the PSO could bear risk from licensed HMOs, it would not be permitted to enter into direct capitation agreements with employers or other unlicensed payors. In addition, the PSO license was identical to those granted HMOs except for variation in the areas of marketing, advertising, access, and group contracts.¹⁷⁹
- (b) In Colorado, recent health form legislation, including the state HMO Act and a 1995 Division of Insurance Bulletin, appear to

¹⁶⁹ *Id.* The Iowa legislature created a statute that allows an integrated delivery system to become a risk-bearing entity without becoming either an insurer or an HMO. IOWA CODE ANN. § 96.3 (West 1994). Solvency oversight may be conducted by the Department of Insurance to make sure the delivery system will deliver the promised services. The entities must provide information for a state-sponsored annual report and meet a minimum balance of \$1,000,000, or three times the average monthly claims for third party providers.

¹⁷⁰ Kathleen M. Illes, James M. Jacobson, *The Risk in Bearing Risk; Insurance and Tax Regulators Confront Health Care Providers' New Arrangements*, THE INSURANCE TAX REVIEW, Nov. 1996, at 914-915

¹⁷¹ COLO. REV. STAT. ANN. § 10-16-102 (HMO Act); Division of Insurance, Bulletin 8-95 (issued Nov. 13, 1995).

¹⁷² IOWA CODE ANN. § 96.3 (West 1994).

¹⁷³ GA. CODE ANN. § 33-20-1 (1996).

¹⁷⁴ See Md. Health General §19-7.13.2 (applicable to Administrative Service providers); Md. Op. Att'y Gen 90-020 (1990).

¹⁷⁵ Minnesota Integrated Services Network Act of 1994. The Minnesota statutes create two types of licensed entities: the integrated service network and the community integrated service network. The Minnesota regulatory requirements include net worth, insolvency protection and provider risk-sharing.

¹⁷⁶ The law will be codified as OHIO CODE § 1760.01 (Anderson 1997).

¹⁷⁷ KRS § 304.17A-300 (Michie 1996).

¹⁷⁸ 26 Pa. Bull. 1629.

¹⁷⁹ See *supra* note 169.

require any organization accepting risk to meet minimum solvency standards and obtain a license as an HMO, nonprofit hospital, or traditional insurer.¹⁸⁰ The most significant difference in the treatment of PSOs may be found in a recently released draft regulation governing the assumption of risk by the Colorado Division of Insurance. The regulations affect organizational criteria in the areas of paperwork by requiring GAAP rather than NAIC Blank, and setting solvency standards that employ a risk-based approach with minimum net worth as low as \$100,000.¹⁸¹

- (c) In Iowa, the state licenses provider groups as Organized Delivery Systems (ODS) and requires a net worth of \$1 million or three times the average monthly claims for third party providers.¹⁸² The ODS is exempted from state and federal antitrust laws and is encouraged to contract with essential community providers through hold harmless language.¹⁸³
- (d) In July 1996, the Insurance Commissioner of Georgia adopted regulations governing PSOs that added a new chapter to the Department's rules, making Provider Sponsored Health Care Corporations insurers who must obtain a certificate of authority in order to operate a health plan. These corporations are subject to designated insolvency standards and are required to include hold-harmless provisions in all contracts. Although the regulations require a net worth of \$1 million, which is one-quarter the amount required of HMOs, the PSO can offer only limited services.¹⁸⁴
- (e) In Minnesota, provider organizations are licensed as Community Integrated Service Networks (CISNs), and are required to have a net worth of at least \$1 million, reduced by the percentage of risk ceded to accredited capitated providers. A secured deposit of \$500,000 is required and the CISN is prohibited from entering exclusive provider contracts. In all

¹⁸⁰ COLO. REV. STAT. ANN. § 10-16-102 (HMO Act); Division of Insurance, Bulletin 8-95 (issued Nov. 13, 1995).

¹⁸¹ See Yondorf, Director of Policy and Research, *Regulation of PHOs: Why the States are Concerned*, American Association of Health Plan Conference Materials for the 7th Annual Managed Care Law Conference, Washington, Apr. 26, 1996.

¹⁸² IOWA CODE ANN. § 96.3 (West 1994).

¹⁸³ *Id.*

¹⁸⁴ GA. COMP. R. & REGS. § 33-20-1 (1996).

other details, the CISN must meet state HMO regulations except for the reporting requirements.

- (f) In Kentucky, a statute was enacted recently that regulates Provider-Sponsored Integrated Health Delivery Networks¹⁸⁵ by requiring these entities to obtain a certificate of filing from the Insurance Commissioner relating to the entity's capacity to administer aspects of the health plan. The law imposes financial requirements including an initial net worth or a surety bond of \$1,500,000 and the entities must maintain a minimum net worth of at least \$1,000,000.¹⁸⁶
- (g) In Pennsylvania, instead of a separate regulatory framework for PSOs, the state enacted regulations that impose requirements on HMOs that enter into downstream risk arrangements with PSOs.

On April 6, 1996, pursuant to authority granted under the HMO Act, the Pennsylvania Department of Insurance issued a *Statement of Policy on Contractual Arrangements between HMOs and IDSs*¹⁸⁷ and the State Department of Health issued a *Statement on Approval of Provider Contracting Arrangements Between HMOs and PHOs, POs and IDSs*.¹⁸⁸ The Departments' policies allow physician developed "integrated delivery systems" (IDS) to accept financial risk from HMOs, and included in the definition are physician organizations, physician hospitals organizations and super-PHOs. Risk-sharing on a capitated basis is allowed as long as the contracts contain hold-harmless provisions and are reviewed to ensure the HMOs have provided for the financial viability of the IDS. All of the entities may accept a percentage of the premium and a bonus or withhold arrangement for meeting utilization targets without being licensed as an HMO or insurance company, but the Insurance Department can challenge the contract if 75 percent or more of the premium is transferred to one or more IDS.¹⁸⁹ In all other ways, the standards used by the provider groups must

¹⁸⁵ KRS § 304.17A-300 (Michie 1996).

¹⁸⁶ See NAIC Survey Respondent, Draft No. 2, May 1996.

¹⁸⁷ 31 PA. CODE § 301 (1995). IDSs include PSOs, PHOs and other provider groups.

¹⁸⁸ 28 PA CODE § 9 (1995).

¹⁸⁹ Maureen E. Corcoran, Pillsbury, Madison & Sutro, *Provider Financial Risk: Assumption: Regulatory Issues and Product Design*, PA. DEP'T OF HEALTH AND INS., Apr. 6, 1996 (quoting Statement of Policy, 26 PA. BULL. 14, 1629-1639).

be submitted to, approved by, and considered the same as standards of HMOs.

- (h) In Maryland, on March 25, 1996 the state senate approved legislation that would permit PSOs to bypass managed care organizations and form their own 'community health networks.' The PSO would not be treated as an insurer or HMO, but would enjoy relaxed consumer protection requirements, reduced benefit mandates, and lower solvency requirements. The bill is strongly opposed by the HMO industry.¹⁹⁰

This medley of approaches to the regulation of PSOs is an indication that no consensus has been reached concerning their regulation. Consequently, the regulatory gaps in state oversight of risk bearing PSOs leaves much to be addressed. In order to assure a level regulatory playing field and protect health care consumers, it is time that regulators identify PSOs as unique integration products in the managed care industry. If insurance regulators find it necessary to formulate regulations for PSOs, the rules must be better focused upon the particular characteristics of PSOs so that provider groups that negotiate an occasional managed care agreement are not treated as insurers, and confined by an inflexible definition, when it is clear they do not provide or function as insurance. As summed up by an attorney for the North Carolina Insurance Department's General Counsel's office: "there are so many variations in the managed care area that each arrangement must be examined individually to determine if it involves the business of insurance."¹⁹¹

SELF-FUNDED EMPLOYERS & ERISA

Concern regarding the regulation of PSOs as insurance companies is focused largely on provider groups who contract directly with self-funded employers (upstreaming). In 1992, self-funded plans were used by 65 percent of employers nationwide.¹⁹² This amount may be expected to

¹⁹⁰ Illes & Jacobson, *supra* note 169, at 917.

¹⁹¹ BNA HEALTH CARE DAILY, *supra* note 146, at 2.

¹⁹² Marybeth Burke, *The Growth of Self-funded Plans Sets Hurdles For State Reform Efforts*, HOSPITALS., June 20, 1992, at 34.

increase especially among medium-sized employers who are having difficulty coping with current health care market forces and rising costs.¹⁹³ The critical difference between self-funded plans and state regulated plans is whether employers or insurance companies bear the risk of paying for claims.¹⁹⁴ Employers retain the risk of paying for benefits in the self-funded approach, while the insurance companies bear the risk in the other approaches.¹⁹⁵ As a result, self-funded employers often purchase stop-loss insurance, where the employer self-insures its plan expenses up to a certain dollar amount for each claim, or up to a specific level of aggregate expenses during the year. The employer then insures the balance of liabilities over this amount with an independent insurer.¹⁹⁵ The debate, therefore, is whether the contract between the provider and the employer is considered to be an agreement related to the administration of the ERISA health benefits, and thus exempt from state insurance regulation.¹⁹⁷

Employee health care benefit plans are regulated by a federal employee benefit regulation known as the Employee Retirement Income Security Act of 1974 (ERISA).¹⁹⁸ Section 1144(a) declares that ERISA "shall supersede any and all state laws insofar as they ... relate to ... any employee benefit plan."¹⁹⁹ ERISA not only regulates the administration of employee health care benefits,²⁰⁰ but also provides a regulatory framework for administration of employee benefit plans among the

¹⁹³ Susan Nanovic Flannery, 12 HOFSTRA L. REV., note 77, at 38 (quoting Leo Uzycz, *Commentary, ERISA Erects Health Care Reform Barriers*, 16 PENN. L. J. 2 (1993)).

¹⁹⁴ See *NGS AM, Inc. v. Barnes*, 998 F.2d 296 (5th Cir. 1993) (holding administrators serve no risk bearing function); See also Roger C. Siskse & Joni L. Andrioff, *ALI-ABA Course of Study: Advanced Law of Pensions and Deferred Compensation, Selected Topics in ERISA Preemption*, C758 ALI-ABA 45, 47 (1992).

¹⁹⁵ *Longoria v. Cearly*, 796 F. Supp. 997, 1003 (W.D. Tex. 1992).

¹⁹⁶ See Eric C. Sohlgrén, Note, *Group Health Benefits Discrimination Against AIDS Victims: Falling through the Gaps of Federal Law — ERISA, The Rehabilitation Act and the Americans With Disabilities Act*, 24 LOYOLA L. REV. 1247, 1251, n. 10 (1991).

¹⁹⁷ Corcoran, *supra* note 189, at 5.

¹⁹⁸ 29 U.S.C. § 1001-1461 (1988 & Supp. IV 1992).

¹⁹⁹ 29 U.S.C. § 1144 (a) (1988 & Supp. III 1991).

²⁰⁰ 29 U.S.C. § 1001(a) (1988 & Supp. IV 1992).

states.²⁰¹ This framework has resulted in the invalidation of much state law and public policy by both Congress and the Supreme Court.²⁰²

To maintain uniform and consistent regulation, the preemption clause of ERISA supersedes all state laws that may relate to employee benefit plans,²⁰³ and the Supreme Court has given a broad interpretation to ERISA's preemption clause allowing federal courts to invalidate much state common law relating to health care and public policy.²⁰⁴

Although insurance regulation is explicitly exempted from section 1144(a) of ERISA, limiting the statute's preemptive ability, health care law is a nontraditional or lesser area of state interest and regulations pertaining to provision of health care fall under ERISA, and are thus preempted by the federal regulation.²⁰⁵ Section 1144(b)(2)(a), the insurance saving clause, provides that nothing in ERISA shall be construed to exempt or relieve any person from the law of any state that regulates insurance, banking or securities. However, the deemer clause provision, which overrides the insurance clause and reinstates the ERISA preemption, also clearly asserts that states cannot declare employee benefit plans to be insurance or insurance-related and thus avoid preemption under ERISA.²⁰⁶ Specifically, the clause provides that no employee benefit plan "shall be deemed to be an insurance company or

²⁰¹ 29 U.S.C. § 1002 (1)(2) (1988 & Supp. III 1991).

²⁰² James E. Holloway, *ERISA, Preemption And Comprehensive Federal Health Care: A Call For "Cooperative Federalism" To Preserve The State's Role In Formulating Health Care Policy*, 16 CAMPBELL L. REV. 405, 410 (1994).

²⁰³ See 29 U.S.C. § 1004. (1988 & Supp. III 1991). An exception to preemption is made for laws addressed in §§ 1144(c)(2) and 1003(b)(3).

²⁰⁴ Holloway, *supra* note 202, at 417 (referring to *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985)). However, ERISA still prohibits states from making laws that would directly or indirectly regulate the contents of employee benefit plans. See also *Van Camp v. AT&T*, 963 F.2d 119, 122-123 (6th Cir. 1992); *Arkansas Blue Cross & Blue Shield v. St. Mary's Hosp., Inc.*, 947 F.2d 1341, 1344-45 (8th Cir. 1991); *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers*, 115 S.Ct. 1671 (1995); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992); *CIGNA Healthplan of Louisiana, Inc. v. Louisiana*, 82 F.3d 642 (5th Cir. 1996).

²⁰⁵ Holloway, *supra* note 202, at 418 - 419. For a more recent decision see *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 115 S.Ct. 1671 (1995) (upholding a statute that required hospitals to collect surcharges from insurers in order to fund a pool for uninsured patients).

²⁰⁶ *Id.* at 419 (discussing 29 U.S.C. § 1144(b)(2)(A) (1988 & Supp. III 1991); See also *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985)).

other insurer ... or to be engaged in the business of insurance ... for the purposes of any law of any state purporting to regulate insurance companies or insurance contracts."²⁰⁷ Under this ERISA preemption, self-insured employers have been able to design their own health benefits rather than purchasing them, and have realized further savings from avoiding costs of state regulation that licensed insurers pass on to their customers. In addition, it is significant that Congress has included no minimum level of capital reserves for employer-funded health benefits to comply with ERISA.

Although the states have asked Congress to amend the ERISA preemption clause for state health care law, ERISA has not been altered. As a result, states continue to be denied the right to experiment with novel legislation to further their own public interests.²⁰⁸ In *Metropolitan Life Ins. Co. v. Massachusetts*,²⁰⁹ the United States Supreme Court held that states may enact insurance regulations to implement health care policy but that such regulations were not to regulate the content of employee benefit plans or apply to self-funded employee benefit plans.

Recently, in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*,²¹⁰ the court looked at a statute that required hospitals to collect a surcharge from certain employers to fund a pool for uninsured patients. Although Travelers argued that ERISA preempted any charges imposed on patients whose insurance was purchased through an ERISA plan, the Court rejected the argument but concluded that:

[an] indirect economic influence ... does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself... Nor does the indirect influence of the surcharges preclude uniform administrative practice or the provision of a uniform interstate benefit package.... It simply bears on the cost of the benefits and the relative costs of

²⁰⁷ 29 U.S.C. § 1144 (b)(2)(B); (1988 & Supp. III 1991); See also *Metropolitan Life Ins. Co.*, 471 U.S. at 724 (1985).

²⁰⁸ Holloway, *supra* note 202, at 425 (quoting Michael S. Ackerman, *ERISA: Preemption of State Health Care Law and Worker Well-Being*, 1981 U. IL. L. REV. 825 (1981)).

²⁰⁹ *Metropolitan Life Ins. Co.*, 471 U.S. at 738 (1985).

²¹⁰ *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers*, 115 S. Ct. 1671, 1679 (1995) (This discussion is borrowed from an article by Overbay & Hall, *supra* note 9, at 381).

competing insurance to provide them. It is an influence that can affect a plan's shopping decisions, but does not affect the fact that any plan will shop for the best deal it can get, surcharges or no surcharges.

Although the Court maintained it would not recognize preemption for every indirect impact on ERISA, state laws that create acute indirect effects and restrict employers' choices of insurers would likely be considered preempted under ERISA.²¹¹ Because federal regulation of self-funded employers has been so lenient, not approaching the rigor of state insurance licensing laws, the NAIC has become concerned about direct contracting. Under ERISA, the NAIC cannot regulate employers, who are the ultimate risk-holders for delivering benefits to their employees. In addition, The NAIC cannot subject self-funded plans to minimum net worth, reserve, deposit, reporting or other solvency requirements. In addition, it also seems that the NAIC, which has chosen to focus its regulation on provider groups instead, may also be foreclosed from imposing such regulation under ERISA which, if it does preempt state regulation of agreements between PSOs and self-insured employers, would allow a self-funded employer to enter into a risk sharing agreement with a PSO in order to fully cover the health care costs needs of the employees.

One specific decisions that clearly address this issue is *Oracare D.P.O., Inc. v. Merin*²¹² which involved a contract that a hospital sought to purchase from Oracare D.P.O., based on submitted bids, to provide dental benefits to hospital employees through its employee benefit plan. The Commissioner of Insurance asserted that Oracare's dental plan did not satisfy the definition of an Employee Benefit Plan, because the dental plan was not established or maintained by the employer or participants. In addition, the Commissioner asserted the State Dental Plan Organization Act (the Dental Act) required Oracare D.P.O. to have a Certificate of Authority issued by the State Department of Insurance.

²¹¹ Overbay & Hall, *supra* note 9, at 382 (quoting *New York State Conference of Blue Cross & Blue Shield Plans v. Travelors*, 115 S. Ct. 1671, 1683 (1995)).

²¹² *Oracare D.P.O., Inc. v. Merin*, 13 EBC [Employee Benefits Cases] 2720 (D.N.J. 1991), *vacated*, 972 F.2d 519 (3d Cir. 1992) (*vacated* due to a settlement agreement; cited for court's compelling reasoning).

The *Oracare* court first determined that by buying group insurance, an employer establishes a benefit plan even if the participants are not employed by the insurance company; therefore, the contract with Oracare established a benefit plan.²¹³ Next, the court examined the Dental Act in light of the ERISA preemption and concluded that the phrase "relate to" should be "given its common sense meaning such that a state law relates to a benefit plan in the normal sense of the phrase, if it has a connection with or reference to such a plan."²¹⁴ The court in *Oracare* agreed with case precedent by holding that a statute need not conflict with one of the subjects covered by ERISA in order to relate to benefit plans,²¹⁵ and cited the Supreme Court decision in *Metropolitan Life Ins. Co. v. Massachusetts* as standing for the proposition that a law need not directly regulate employee benefit plans to be subject to preemption.²¹⁶ In addition, the *Oracare* court emphasized the Supreme Court's holding from *Pilot Life Ins. Co. v. Dedeaux*, reaffirming the expansive sweep of the preemption clause in ERISA and confirming that the phrase 'relate to' has been given the broadest common-sense meaning such that state law 'relates to' a benefit plan if it has a connection with, or reference to, such a plan.²¹⁷

Finally, the New Jersey court concluded that the state Dental Act was neither too remote nor too tenuous in its regulation of the Oracare plan. In fact, the court recognized that the state was trying to directly regulate Oracare, the effect of which would invalidate the proposed arrangement under the hospital's employee benefit plan.²¹⁸ Consequently, the court held that any regulation of Oracare by the state was preempted by ERISA.

An opinion by the North Carolina Attorney Generals' office concurs with the Supreme Court's decision in *Oracare* and has held that ERISA's state insurance regulation exception does not apply to PSOs, by recognizing the purpose of the parties' contract in a PSO is not to shift insurance risk, but to obtain health care services for benefit plan

²¹³ *Id.* at 2724.

²¹⁴ *Id.* at 2725 (quoting *Shaw v. Delta Airlines*, 463 U.S. 85 (1983)).

²¹⁵ *Id.*

²¹⁶ *Id.* (referring to *Metropolitan Life Ins. Co. v. Massachusetts*, 105 S.Ct 2380 (1985)).

²¹⁷ *Oracare D.P.O., Inc. v. Merin*, 13 EBC [Employee Benefits Cases] 2720, 2725 (D.N.J. 1991), *vacated*, 972 F.2d 519 (3d Cir. 1992) (citing *Pilot Life Ins. Co. v. DeDeaux*, 107 S.Ct. 1549, 1553 (1987)).

²¹⁸ *Id.*

enrollees.²¹⁹ The North Carolina HMO statute specifically defines an HMO as “any person who undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis except for enrollees’ responsibility for copayments and deductibles.” Because the term “person” does not include professional associations or individuals, the attorney general’s letter suggests that the HMO statute allows physician practice groups to contract directly with an ERISA employer to provide services under a health benefit plan. The attorney general concluded that the statutory licensure requirements for HMOs are similar to benefit mandates that are preempted by ERISA, because they directly affect plan structure and administration by limiting the plan’s choice of provider. However, the letter noted, state laws indirectly affecting a plan’s cost of providing benefits are not preempted.²²⁰

ANTITRUST CONSIDERATIONS

On August 28, 1996, the United States Department of Justice (DOJ) and the Federal Trade Commission issued a *Statement of Antitrust Enforcement Policy in Health Care*.²²¹ The statement, which is referred to as the “new guidelines,” replaces older guidelines issued in September 1994.²²² The older guidelines restricted the size of physician networks and limited the applicability of the guidelines to networks where the physician assumed substantial financial risk similar to insurance risk.²²³ This limitation made it difficult for physicians to organize networks since they lacked both the necessary capital and management experience to build the infrastructure required for capitation. In addition, alternative arrangements, such as agreeing to offer discounted rates, were considered to be illegal.

²¹⁹ BNA HEALTH CARE DAILY, *supra* note 146, at 2 (discussing opinion by North Carolina Attorney General’s Office).

²²⁰ *Id.*

²²¹ Statement Of Antitrust Enforcement Policy In Health Care, August 1996, statement 9, pp. 106-110.

²²² Statement of Enforcement Policy and Analytical Principles Relation To Health Care And Antitrust, September 27, 1994, statement 9, pp. 91-92.

²²³ “Financial risk” was defined as including capitation arrangements, and fee withhold arrangements where the amount withheld was substantial enough to influence physician practice patterns.

The new guidelines expand the options available to physicians and make it possible for physicians to organize legal fee-for-service networks that can serve self-insured employers. Physicians are now permitted to become involved in networks where there is adequate clinical and functional integration of the physicians, and where physicians are paid on a fee-for-service basis by payors according a fee schedule to which the physicians have agreed. The integration may include means of monitoring and controlling utilization of health services in order to control costs and assure quality of care. Additionally, network physicians may be chosen for their ability to further these goals. These functions are largely intended to encourage a high degree of interdependence and cooperation among physicians in order to control costs and assure quality. Under the new guidelines, other forms of integration involving agreements on price which are reasonably necessary to achieve integration may also be legal.

These networks can also qualify for a safety zone even if they fall outside size limits set by the antitrust guidelines. Like the old guidelines, the new guidelines maintain that in exclusive networks, the physicians may deal with health plans through the network that are limited to no more than 20 percent of the physicians in any given specialty in a market. Nonexclusive networks, where physicians can participate in more than one network or deal freely with health plans, are limited to involving 30 percent of physicians in any given specialty. Although the size requirements under the new guidelines have not changed, the guidelines clarify that networks may in fact be larger than the safety zones.

The new guidelines refer to business review letters and advisory opinions where networks as large as 50 percent of the specialty of practitioners involved were approved by the DOJ or the FTC. The clarification states that merely because a physician network joint venture does not come within a safety zone, it in no way indicates that it is unlawful under the antitrust laws. On the contrary, these kinds of arrangements may be procompetitive and lawful, and such arrangements can expect to receive favorable business review letters or advisory opinions from the agencies.

Under the new guidelines, two scenarios are provided in order to give guidance as to the conditions under which larger networks may be legal. The first involves nonexclusive networks in a competitive market that are unlikely to violate antitrust laws. In fact, the guidelines state that if in the

relevant market there are many other networks or physicians who would be available to form competing networks or to contract directly with health plans, the formation of such a joint venture would not create any significant competitive concerns.

A second scenario that the guidelines suggest would not violate antitrust regulation, is a network in which physicians have different incentives. This scenario takes into account that some physicians merely invest substantial amounts of money in the network and look to its success as a business, as opposed to the physicians whom are contracted with to provide medical services. The guidelines state that agencies will consider not only the proportion of physicians in any relevant market who are in the network, but also the incentives faced by physicians in the networks, and whether different groups of physicians within the network have significantly different incentives. This would reduce the likelihood of anticompetitive conduct.

Finally, while the old guidelines provided that physician networks accepting insurance risk through capitation arrangements could not negotiate with the same payors as fee-for-service arrangements, under the new guidelines the network can negotiate both types of arrangements, as long as management tools such as utilization review are applied to both types of arrangements.

Application of New Guidelines to Networks That Accept Capitation

The new guidelines also expand the number of arrangements considered to involve "substantial risk" to include percentage of premium arrangements, global fees and utilization targets that employ substantial rewards or penalties. Percentage of premium arrangements include networks that agree to provide designated services or classes of services to a health plan for a predetermined percentage of premium revenue from the plan. Global fees are more complex arrangements in which the venture agrees to provide substantial coordination of care by physicians in different specialties offering complementary services for a fixed, predetermined payment, though costs can vary among individuals. Finally, utilization targets involve giving substantial rewards or penalties to physicians depending upon whether they meet utilization standards.

Networks whose members may share these substantial risks and fall within the size limitations described in detail above, qualify for safety zones and will not be in violation of antitrust regulations.

To illustrate how these guidelines would apply, consider a physician network that accepts capitation and has the physicians agree on the per member per month amount they will accept. Panel size is restricted to 30 percent, in aggregate and by specialty, and the plan is marketed to HMOs and self-insured employers. The physicians also contract with other payers. This type of network would fall within the safety zone; because the network accepts capitation, the members share substantial financial risk, and the network falls within size limits for a nonexclusive network. Alternatively, if the network accepted both capitation and fee-for service arrangements with the same payor, the network would not qualify for a safety zone. With the addition of the fee for service aspects, it must be demonstrated that the networks involve the generation of substantial efficiencies. This may be done by demonstrating that the cost control mechanisms used for capitation are also applied to the fee for service business.

Because the new guidelines are lengthy and complex, physicians should seek legal counsel experienced in forming such networks. In addition, under the new guidelines, opinions from the DOJ and FTC about the legality of specific network proposals are available by sending a letter containing information about the proposed network. Both agencies will answer letter within ninety days of receipt of all information.

PROPOSED REGULATION OF PROVIDER SPONSORED ORGANIZATIONS

In August 1995, The Health Plan Accountability Working Group of the National Association of Insurance Commissioners (NAIC) issued a bulletin to all state insurance commissioners, directors and superintendents declaring that the acceptance of risk by provider networks such as IPAs, PHOs, and others, constituted insurance. The NAIC stated that any providers involved in risk sharing arrangements with employers must have an insurance license.

However, regulation of PSOs as insurance companies may have severe ramifications on new managed care entities struggling to enter the

market and would delay much needed market reform, a goal that seeks to include as many competitors as possible in order to lower the price of health care. Currently, only a small percentage of employers, about 9 percent, engage in direct contracting with provider networks, and even fewer participate on any sort of risk-sharing basis. The negative side-effects of insurance regulation may be considerable, including foreclosing the entry of new organizations into the health care market and stifling market reform, and other innovative managed care approaches to the health care crisis.

In evaluating the NAIC proposal to regulate providers who contract with self-insured providers, there are many factors which must be examined, including the logic behind solely regulating providers in upstream contracting, and whether under ERISA the NAIC has the right to regulate self-insured employers at all. In addition, issues of solvency, reporting, and other regulatory requirements need to be addressed in light of the NAIC's proposal.

The Logic Behind Regulating Only Upstream Contracting Between Providers and Employers

Although the NAIC believes that risk sharing agreements between providers and employers constitutes insurance (upstreaming), the NAIC has held that risk sharing agreements between providers and HMOs or other licensed insurers do not constitute the business of insurance (downstreaming). An example of the latter may be an employer who pays an HMO or insurer \$300 a month per employee in exchange for all the health services each employee may need. The HMO may contract for \$200 a month to a PHO, to provide most of the health care services required by its members, who then contracts with its own primary physicians for \$100 a month to provide designated services. These physicians may then subcontract for specialty services. This trail of capitated service arrangements leaves it unclear as to which of these provider groups should be regulated for solvency requirements since on each level there is risk shifting.²²⁴ Presently, most states, as well as the NAIC, believe that

²²⁴ Overbay & Hall, *supra* note 9, at 372.

downstream contracting involves mere service contracts and that the primary insurer is already regulated as an HMO. Therefore, as it currently stands, HMOs and insurance companies can transfer downstream risk to provider networks, but providers cannot take on the upstream risk by themselves.

There is no outward logic in allowing an HMO to transfer substantial amounts of risk to an unlicensed provider and simultaneously require transfers of risk to reinsurers to involve licensed entities. Providers are allowed to assume risk from HMOs without a license, because the providers can deliver the care; or in the case of global capitation, they generally have a high degree of control over the extent to which other providers are used. Since many employers who want to engage in direct contracting are large, financially strong organizations that are sophisticated and not vulnerable to exploitation, they are capable of taking care of themselves without protection of the insurance commissioner. Just as HMOs and insurance companies take on the risk of the provider's failure, so does the employer who assumes the same risk as well as the duty to find a new source of health care for its employees should the provider fail.

Alternatively, since not all employers are strong, a balance is required in order to protect some employees' insurance benefits. Thus, while it is unfair to bar capable employers from entering provider agreements, regulation of companies that are not financially strong, or who do not have sophisticated managerial capabilities, would not be inappropriate.

Solvency of the Provider

Capital reserve minimums required of both HMOs and insurance companies are intended to offset possible operating losses which may cause provider groups to go bankrupt, leaving subscribers without a source of treatment. It is argued that PSOs who contract with self-funded employers should be required to meet similar solvency standards. However, such a requirement as applied to all PSOs is unnecessary since, in fact, employers bear the risk of provider insolvency.

Whether an insurance company, HMO, or self-insured employer contracts with a provider group, the PSO's responsibilities to provide health care remain unchanged. The PSO is required to service the

beneficiaries' medical needs during the payment period, regardless of whether the actual hours used or the number of patients who make appointments exceeds the providers' expectations. At no time does the provider face financial risk when they fail to accurately predict the number of patients who will seek services; however, they must continue to provide care to however many patients seek their services, even if this might result in destroying any profit they may have realized. Alternatively, HMOs and insurance companies pay for subscribers to seek medical services from physicians. A poor estimation of patient medical needs may require the HMO or insurance company to suffer financial loss in order to cover the health bills of all its subscribers. Even if a contract exists with a provider group (down streaming), the risk of loss stays with the HMO or insurance company.²²⁵

Similarly, a self-funded employer who contracts with a PSO takes on the same risk as an HMO or insurance company when they promise to pay for the medical needs of their employees. However, the PSO's responsibilities to serve the patient population remain unchanged. In fact, this arrangement is arguably better for the providers since they are generally owed an average of \$2,005,000 whenever an HMO goes insolvent.²²⁶ They can avoid this loss by forming their own contracts with employers and making sure they meet all necessary patient needs.

Requiring a PSO to acquire a license as an insurer would be time consuming, expensive, and would subject the employer to premium taxes. First, solvency typically requires a license holder to have a minimum net worth of \$1.5 million. Start-up costs for more tightly integrated and regulated health care organizations can range from \$7.9 million to \$30 million.²²⁷ Furthermore, only certain kinds of assets can be counted toward meeting these requirements -- usually liquid assets with a low probability of significant loss in value and for which there is a ready

²²⁵ Even the NAIC does not consider down-stream risk to pose a problem.

²²⁶ Jay M. Howard, *The Aftermath of HMO Insolvency: Considerations for Providers*, 4 ANN. HEALTH L. 87, 88 (1995) (describing a survey by the Solvency Working Group of the NAIC).

²²⁷ Overbay & Hall, *supra* note 9, at 366.

market that establishes their worth, such as cash, federal government bonds, or AAA rated corporate bonds.²²⁸

Non-liquid assets, such as real estate, equipment, and goodwill cannot be counted toward contributions. Since PSOs generally have these types of nonliquid assets, they must raise the money necessary to meet solvency requirements. Because hospital and physician groups do not have the liquid capital of large corporate insurance companies and HMOs, and since most of their assets are tied up in physical plant and equipment costs rather than being readily available,²²⁹ PSOs most likely cannot come close to meeting the capital associated with solvency requirements. Currently, however, PSOs are relatively inexpensive to establish and can be created for as little as \$50,000.²³⁰

Although only a few states have independently created statutory requirements for PSOs, the solvency requirements that have been set are high. For example, the Minnesota Care bill signed by Governor Arne Carlson on May 10, 1994 requires community integrated service networks that provide prepaid health services to 50,000 or fewer enrollees to maintain a minimum net worth of at least \$1,000,000.²³¹ Likewise, Washington's Health Services Act requires a minimum of \$1.5 million in capital. Unfortunately, thus far only Illinois and North Carolina have recognized; that employers remain at risk when they contract with PSOs, and that a contracting provider group is not subject to regulation by the Department of Insurance.²³²

Licensing the PSO as an HMO would not be much easier for providers if standards such as those set forth in the NAIC Model HMO

²²⁸The NAIC Model HMO Act requires that an HMO maintain a minimum net worth equal to the greater of \$ 1,000,000 or two percent of annual premium revenues on the first \$ 150,000,000 of premium and one percent of annual premium on the premium in excess of \$150,000,000, or an amount equal to the sum of three months uncovered health care expenditures, or an amount equal to the sum of 8 percent of annual health care expenditures, except those paid on a capitated basis or managed hospital payment basis, plus 4 percent of annual hospital expenditures paid on a managed hospital basis. See NATIONAL ASS'N OF INS. COM'RS, HEALTH MAINTENANCE ORGANIZATION MODEL ACT, NAIC MODEL LAWS, REGULATIONS & GUIDELINES § 13(a)(2)(d)(i)-(ii) (1990).

²²⁹Overbay & Hall, *supra* note 9, at 366.

²³⁰*Id.*

²³¹See Minnesota Integrated Services Network Act, *supra* note 175.

²³²*Id.*

Act are required. The Act requires a minimum net worth of \$1.5 million²³³ and the entity must maintain a minimum net worth equal:

- (1) to the greater of \$1 million or 2 percent of annual premium revenues on the first \$150 million of premium and 1 percent of annual premium on the premium in excess of \$150 million;
- (2) an amount equal to the sum of three months uncovered health care expenditures; or
- (3) an amount equal to the sum of 8 percent of annual health care expenditures,²³⁴ except those paid on a capitated basis or managed hospital payment basis, plus 4 percent of annual hospital expenditures paid on a managed hospital basis.²³⁵

In addition, HMOs are required to deposit cash, securities and other assets with a value of at least \$300,000,²³⁶ at least as well as a benefit plan in the event of insolvency,²³⁷ and an uncovered expenditures deposit in case uncovered expenditures exceed 10 percent of the HMO's total health care expenditures.²³⁸ The amount of funds required far exceeds that which provider groups are able to raise.

A better solution perhaps might be found in a report by the American Academy of Actuaries (AAA) developed for the NAIC that does not set forth a comprehensive scheme of solvency standards for health organizations, but instead creates a formula that can be used to estimate the amount of risk-based capital that different kinds of health plans must retain.²³⁹ Basically, the formula estimates the capital needed by a given organization to account for four kinds of risks: asset risk,²⁴⁰ insurance

²³³*Id.*

²³⁴*Id.* at § 13(A)(2)(a)-(c).

²³⁵*Id.* at § 13(A)(2)(d)(I)-(ii).

²³⁶*Id.* at § 13(B)(1)-(3). This amount is included in the determination of the minimum net worth of the HMO.

²³⁷*Id.* at § 13(E).

²³⁸*Id.* at § 14(A).

²³⁹Hirshfeld, *supra* note 115, at 291.

²⁴⁰"Asset risk" is the risk with respect to the insurer's assets.

risk,²⁴¹ interest rate risk²⁴² and business risk.²⁴³ The formula also applies a statistical technique called the "covariance adjustment" to account for the fact that risk inherent in each of the categories is not necessarily correlated to the risk inherent in other categories.²⁴⁴

In developing the plan, the AAA gathered financial performance and claims data from a number of health plans.²⁴⁵ The resulting formula is much more flexible than solvency standards in the NAIC Model HMO Act, and allows for a greater range of risk-based capital for HMOs and other health plans with different characteristics.²⁴⁶ The formula also recognized four categories of managed care methods that reduce the insurance risk including:

- (1) arrangements with providers where payments are set by contractual agreement (fixed fee per service, inpatient day, or episode of care);
- (2) fee withhold or bonus arrangements with providers;
- (3) capitation payments made to entities directly providing medical care for care directly provided (does not include global capitation); and
- (4) noncontingent salaries or aggregate cost payments when paid directly to persons licensed to provide medical care.²⁴⁷

This type of flexible approach is much more appropriate for PSO regulation since it recognizes the legitimate differences between PSOs and other health plans. Although this proposal currently results in higher capital requirements than the HMO model, which is undesirable; these risk-reducing factors should still be recognized in developing a proper mode of PSO regulation.

²⁴¹ "Insurance risk" is the risk of adverse insurance experience with respect to the health plan's liabilities.

²⁴² "Interest rate risk" is the risk with respect to the insurer's business.

²⁴³ "Business risk" is the risk which includes all other business risks.

²⁴⁴ Hirshfeld, *supra* note 116, at 291.

²⁴⁵ HEALTH ORGS. RISK-BASED CAPITAL TASK FORCE, AMERICAN ACADEMY OF ACTUARIES, REPORT TO THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS HEALTH ORGS. RISK-BASED CAPITAL WORKING GROUP (1994) [hereinafter AAA 1994 Report].

²⁴⁶ *Id.*

²⁴⁷ *Id.*

Reporting and Other Regulatory Requirements

In nearly every state, HMOs and insurance companies are subject to complex and stringent reporting and accounting requirements, in addition to the minimum amounts of net worth and working capital. In 1973, Congress passed the Federal Health Maintenance Organization Act under which HMOs can qualify for federal funds by conforming to federal requirements. For example, some of the requirements include:

- (1) maintenance of a fiscally sound operation and adequate risk against insolvency satisfactory to the Secretary of the Department of Health and Human Services (HHS);²⁴⁸
- (2) assumption of full financial risk on a prospective basis for the provision of health services;²⁴⁹
- (3) open enrollment requirements;²⁵⁰ and other organizational standards; and
- (4) provisions of medical services.²⁵¹

State governments, in their active support of HMOs, have also promulgated their own regulations. For example in Florida, HMOs are required to file an annual financial statement of the organization both on computer diskette and on department forms.²⁵² In addition, the HMOs must submit an audited financial statement of the organization, its balance sheet, statement of operations for the preceding year, certified by an independent certified public accountant,²⁵³ and an actuarial certification. Also, the HMO must file quarterly reports that include unaudited financial statements.²⁵⁴ Failure to file these reports can result in fines up to \$1,000 for each of the first ten days they neglect to file and up to \$2,000 for each day after, to a maximum of \$100,000 for each report.²⁵⁵

²⁴⁸ 42 U.S.C. § 300e(c)(1).

²⁴⁹ 42 U.S.C. § 300e(c)(2).

²⁵⁰ 42 U.S.C. § 300e(c)(4).

²⁵¹ 42 U.S.C. § 300e(c)(1).

²⁵² FLA. STAT. ANN. § 641.26 (1)(a) (West 1995).

²⁵³ *Id.* § 1(c).

²⁵⁴ *Id.* § 2.

²⁵⁵ *Id.* § 3.

States that have already enacted specific PSO provisions have required hold harmless provisions, meaning that providers would have to agree not to attempt to collect any fees or charges from HMO enrollees in the event the HMO becomes insolvent. Hold harmless provisions are also required under the NAIC Model HMO Act.²⁵⁶

CONCLUSION

Regulation of PSOs is currently a high priority concern for both the NAIC and state Insurance Commissioners across the country. But in regulating these provider groups, the NAIC must be cautious to first objectively examine PSOs and other newly integrated managed care organizations in order to control the urge to categorize them immediately as either an "HMO" or "traditional indemnity insurer."

Over the past few decades, Americans have become familiar with HMOs, although when they were first introduced they too created debate and uncertainty, much like that which PSOs have created today. Still, without unique regulations for HMOs both by individual states and the Federal Government, managed care could not have become the sophisticated and comprehensive system it is today. Consequently, by creating regulations that recognize the unique nature of PSOs, including the variable levels of risk they can assume and the benefits they offer both providers and the public, legislators will enhance this new form of managed care as well as encourage future evolution of the health care market.

It is difficult to overcome the powerful influence of HMOs and traditional insurers who hotly contest the creation of PSOs. Recognizing, however, that their bluster derives from fear that PSOs may provide a more efficient system, makes it easier to ignore their protests. Since the NAIC's concern, as they profess it to be, is the well-being of American consumers, only by completing a thorough evaluation of PSNs, while turning a deaf ear toward the HMOs and insurers, can the NAIC

²⁵⁶ NATIONAL ASS'N OF INS. COMM'RS, *supra* note 228.

objectively assess the value of PSOs and find a way to appropriately regulate them without stifling their development.