Memorandum

To: All Commissioners, Directors and Superintendents

From: Glenn Pomeroy, President and Chair of the Special Committee on Health Insurance

Date: January 22, 1998

Re: Suggested Bulletin Regarding Provider Sponsored Organizations

For the past several years, the NAIC has been concerned that Provider Sponsored Organizations (PSOs) and similar risk-bearing entities are operating in the commercial marketplace without state licensure. These entities often perform the same or similar functions as state regulated entities such as HMOs and other health plans. The NAIC through its members believes that consumers should have the same solvency and consumer protections afforded by state insurance laws, irrespective of the ownership of their health plan. The NAIC encourages states to continue to exercise their regulatory authority over these entities.

During 1998 the states will need to address the fact that PSOs may obtain a federal waiver of state license requirements due to provisions in the recently enacted Balanced Budget Act of 1997 (BBA). In addition, states will continue to explore issues relating to the regulation of PSOs in the commercial market. Based on this, the NAIC Special Committee on Health Insurance has formed a PSO Implementation Working Group, which has been charged with providing assistance to states in dealing with these issues. At the 1997 Winter National Meeting, the PSO Implementation Working Group decided to revise and redistribute a memorandum and bulletin on the regulation of PSOs that were originally distributed to state insurance departments by the NAIC on August 10, 1995.

The purpose of this memorandum is to reaffirm the NAIC’s position with respect to the regulation of PSOs at the state level and to provide direction to states as they address this issue in 1998 for both the commercial and Medicare populations. Additionally, attached to this memorandum is a suggested bulletin that you can use to alert such entities of your state’s laws and regulations with respect to PSOs and other similar risk-bearing entities.
Commercial Market
The NAIC through its members strongly recommends that states provide the same solvency and consumer protections available to HMO members to individuals receiving their health care from other health risk-bearing entities in the commercial market unless your state has adopted specific legislation regarding these types of risk bearing entities. Applying the provisions of your HMO statute (based upon the NAIC HMO Model Act) to these entities is a necessary and immediate step that should be taken.

Such action is consistent with the NAIC’s position on the regulation of PSOs. Both the NAIC’s “Risk-Bearing Entities White Paper,” adopted by Plenary at the 1997 Winter National Meeting, and the Health Plan Accountability Standards Working Group’s “Unregulated Entities Bulletin,” sent to insurance departments in August of 1995, state the position that consumers insured by or enrolled in similarly functioning plans deserve the same essential regulatory protections that ensure health plans are financially sound and provide quality care.

As a natural extension of this position, the NAIC has begun the development of consistent licensure standards for all health risk-bearing entities through the Consolidated Licensure for Entities Assuming Risk (CLEAR) initiative. CLEAR is a comprehensive, long-term effort that will allow states to ensure consistent regulatory protections for consumers insured by or enrolled in all types of health carriers. In the short-term, however, it is important that states undertake efforts to ensure that health risk-bearing entities performing the same or similar functions as HMOs are subject to the same state licensure and regulatory requirements.

In addition, the NAIC through its members has adopted a new tool for setting solvency standards for managed care organizations called the Managed Care Organizations Risk-Based Capital (MCORBC) formula.\(^1\) A model act is also nearing completion that will allow states to implement the MCORBC formula. The formula and the model act form the basis of flexible capital standards for use with all types of managed care organizations, including PSOs.

With the completion of the model act, MCORBC will be available for state legislatures to review and adopt. The NAIC strongly encourages states to review and consider the NAIC’s MCORBC standards as an additional solvency tool for the regulation of all health risk-bearing entities, including PSOs.

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\(^1\) This memorandum assumes that MCORBC will be adopted by the NAIC Plenary at either the 1998 Spring or Summer National Meeting.
**Options for States**
Applying existing HMO laws to PSOs is the most direct actions states can take to ensure that consumers have consistent and appropriate regulatory protections. Applying the MCORBC formula to manage care risk-bearing entities is an additional step states can take to protect consumers.

**Medicare Market**
Medicare requires that PSOs be state-licensed in order to participate in the Medicare+Choice program. However, under BBA, PSOs are allowed to seek a federal waiver of state licensure requirements if a state denies a license for reasons related to solvency and the state’s solvency standards are different than federal Medicare PSO solvency standards, or if the state does not act on the application within 90 days, or if the state imposes requirements on PSOs that it does not apply to similar risk-bearing entities. Federal solvency standards will be developed either through a negotiated rulemaking process, which is underway, or by the Secretary of Health and Human Services, if no agreement is reached through negotiated rulemaking. These standards will be published in the *Federal Register* April 1, 1998. However, even if PSOs receive waivers from the state licensure requirement, the Secretary of Health and Human Services, who is charged with overseeing the waiver process, will require these PSOs to comply with state consumer protection standards not related to solvency. Moreover, the waiver is effective only for a period of three years and is applicable for PSOs that engage only in Medicare+Choice business.

Medicare PSOs will be able to apply for participation in the Medicare+Choice program upon publication of standards on June 1, 1998. Medicare PSOs will also have the opportunity to begin the application process prior to that time under rules the Health Care Financing Administration is currently developing. Therefore, states wishing to avoid federal waiver for Medicare only PSOs will have a brief period of time in early 1998 to enact legislation which conforms to the newly promulgated PSO solvency standards.

**Options for States**
Because all Medicare PSOs, even those with a federal waiver, must comply with state consumer protections not related to solvency, states should ensure that the same protections currently in place for consumers in HMOs are also provided for consumers receiving health care through other entities performing the same or similar functions as HMOs. States can accomplish this by applying the non-solvency provisions of existing HMO laws to federally waived PSOs. States may wish to compare the non-solvency provisions of the NAIC HMO Model Act to determine whether their existing law is adequate.
To maintain regulatory authority over solvency standards for Medicare PSOs, there are several options states can consider, including:

1.) Adopt Medicare PSO standards for Medicare PSOs only, while requiring PSOs seeking entry into the commercial market to comply with state HMO laws.

2.) Give the insurance commissioner, director or superintendent the authority necessary to adopt regulations to enforce the federal Medicare PSO standards; or

3.) Adopt the federal Medicare PSO solvency standards for all health risk-bearing entities for both the commercial and Medicare markets. This option would not be consistent with the NAIC’s position on the regulation of PSOs.

Finally, depending on the nature of the federal PSO solvency standards promulgated, a state may wish to consider whether it is appropriate to modify state standards to conform to the federal standards. The final federal standards may be either so close to state standards that it is unlikely the federal waiver will be utilized in your state, or alternatively, the federal standards might be viewed as comparably so weak as to be unacceptable. The NAIC PSO Implementation Working Group will give you its views regarding this topic once the Department of Health and Human Services has acted.

**Conclusion**
As outlined above, the regulation of PSOs is an issue that will receive attention in the states in 1998. It is important that consumers receiving health care in both commercial and Medicare markets have confidence that their health plans are financially stable and provide quality care. For this reason, the NAIC through its members believes that states should ensure that all health risk-bearing entities performing same or similar functions should be licensed and regulated in the same way. The NAIC suggests that you use the attached bulletin to help ensure that this regulatory goal is achieved.
Memorandum

To: All Commissioners, Directors and Superintendents

From: Kenney Shipley (Florida), Chair
Health Plan Accountability Working Group

Date: August 10, 1995

Re: Suggested Bulletin Regarding Certain Types of Compensation and Reimbursement Arrangements Between Health Care Providers and Individuals, Employers and Other Groups

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

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

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

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

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

KS:dkk
Enclosures
Draft Bulletin

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

If a health care provider enters into an arrangement with an individual, employer or other group that results in the provider assuming all or part of the risk for health care expenses or service delivery, the provider is engaged in the business of insurance. Providers wishing to engage in the business of insurance must obtain the appropriate license [certificate of authority] (e.g., health insurer or HMO, etc.) from the Department of Insurance [insert Division, Bureau, etc., as appropriate].

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

The Department of Insurance invites health care providers who have entered into an arrangement, or who are considering doing so, to ask for clarification if they are uncertain whether the arrangement violates state law. The Department will be pleased to work with providers to bring any arrangements into compliance with state insurance law or other laws applicable to health carriers.
August 10, 1995, Memorandum Addendum
Thoughts and analysis on groups of health care providers engaging in the business of insurance.

A. Bulletin Fact Situation:

“For example, if a group of doctors or a hospital enters into an arrangement with an employer to provide future health care services to its employees for a fixed prepayment (i.e., full or partial capitation) the doctors or hospital are engaged in the business of insurance.”

B. Various Definitions for “Insurance”:

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

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

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

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

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

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

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

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

For purposes of this scenario, assume Florida’s definition of insurance, namely, “a contract whereby one undertakes to indemnify another or pay or allow a specified amount or a determinable benefit upon determinable contingencies.” Apply the five elements normally present in an insurance contract as set forth in the Florida case cited above:
1. **An insurable interest.** The employer in this example is a consumer and has an insurable interest in the health and welfare of its employees (and importantly their dependents) especially where it has established a health benefit plan that obligates it to pay for or provide health care benefits to its employees.

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

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

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

As another aside, some providers have argued that since the employer remains primarily obligated (i.e., stays at risk) to pay or provide for the benefits of the health benefit plan even if the provider group goes insolvent that somehow, magically, this fact removes these transactions from being the business of insurance. This is not the case. Here the employer is seeking to remove all or part of its determinable contingent risk arising from its obligations under the health benefit plan it established for its employees. Employers know that they stay ultimately obligated under the plan to their employees.
However, the employer has an expectation that when it prepays a fixed amount to someone to take over a variable obligation belonging to them, that the person or entity will be there when the time comes to perform. Insurance laws are designed to protect all consumers. Employers are consumers. Employers purchase all types of insurance to help cover risks that they are primarily liable for.

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

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

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

**E. General Discussion of the Marketplace:**

Typically, when an employer chooses to establish a health benefit plan for its employees, it first decides how to fund or fulfill its obligations under the plan. It can choose to self-insure (also referred to as “self-funding”) or to purchase insurance. The plan itself is usually designed by the employer in consultation with a health benefits consultant or with a licensed insurer, which ultimately will either “administer the self-insured plan” or “fully insure it.” Either way, the plan is an employee benefit plan under ERISA. It is important to keep in mind that few employers pay 100% of the cost of a health benefit plan. Employees are regularly subject to co-payments and deductibles and in many instances are required to contribute monthly “premiums” towards the cost of the plan. Unfortunately, most employees are not privy to whether their plan is self-insured or fully insured. The NAIC’s White Paper entitled *ERISA: A Call for Reform* points out the lack of protections for employees under a self-insured plan.
If the employer chooses to self-insure, the amount of money it must pay each month varies depending on how often its employees receive treatment (i.e., it depends on claims experience). Self-insured employers will often hire an actuary to determine its theoretical monthly financial obligation in order to set a global budget for the amount at risk and the statistical odds of exceeding this budget. The larger the number of covered lives in the group, the more predictable the risk.

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

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

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

This scenario also places the employees at risk since most providers will look to them for full payment for the services they have individually received in a situation where the employer falls on hard times and becomes in arrears for payment of the fixed prepayment.
Since no privity of contract exists between the providers and the employees, the providers can look for payment from the person who personally received the treatment. It has been reported that few of these risk-sharing agreements have hold-harmless provisions to protect the employees if the employer were to become insolvent.
July 28, 1994

John E. Callender, Senior Vice President
Ohio Hospital Association
155 E Broad St
Columbus OH 43215-3620

Re: O.H.A. Questions at Managed Care Seminar

Dear John:

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

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

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

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

a. The insured must have an insurable interest,

b. The insured's interest is subject to a risk of loss upon the happening of some outlined peril or contingency.

Accredited by the National Association of Insurance Commissioners (NAIC)
c. The insurer assumes the risk of loss,

d. The assumption is part of a scheme to distribute the losses among a group with similar risks, and

e. The insured pays a premium as consideration for the insurer's promise to pay.

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

a. Is the risk transferred and spread,

b. Is the practice an integral part of the policy relationship between the insurer and the insured, and

c. Is the practice limited to entities in the insurance industry?


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

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

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

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3. Can a fully integrated Physician Hospital Organization (PHO) enter into a capitated arrangement with any of the following:
a. HMO?
b. Indemnity insurer?
c. Self-insured employer?

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

* * *

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

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

* * *

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

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

* * *

6. Our reading of Chapter 1742 appears to allow a local political subdivision to create an HMO without creating a separate corporation. Do you agree? If yes, what financial reserve requirements must these entities meet?
No. The Department's view is that political subdivisions do not fall within the definition of "person" contained in Ohio Revised Code §1742.01(K). The term "political subdivision" is often included in various sections of the Ohio Revised Code where the intent is to specifically include them. As the term is not included in §1742.01(K), the Department believes they are not permitted to operate an HMO without creating a separate entity.

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

Sincerely,

[Signature]

David J. Randall
Deputy Director
TO: Interested Persons

FROM: John Gross, Supervisor
Life and Health Analysis
Minnesota Department of Commerce

Nanette M. Schroeder, Director
Occupational and Systems Compliance Division
Minnesota Department of Health

DATE: September 26, 1994

RE: Issues in Implementing Health Care Provider Cooperatives

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

I. Direct Contracting with Self-Insured Plans

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

Section 6, subdivision 1 of the Co-op Act requires contracts between provider co-ops and purchasers to provide for payment on a "substantially capitated or similar risk-sharing basis." The transfer of risk that is inherent in such contracts makes them "insurance" as defined in Minnesota Statute §60A.02, subdivision 3:
Administrative Bulletin 94-3
Issues in Implementing Health Care Provider Cooperatives

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

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

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

An exception to the general rules stated above was provided in the MinnesotaCare Act of 1994. Under a series of provisions (including, among others, Article 1, Sections 3 and 4, and Article 8, section 1), a narrow exception was crafted under which certain large self-insured purchasers may purchase health care on a capitated basis, through a CISN, Integrated Service Network (ISN), HMO, or preferred provider organization (PPO), subject to certain specified state insurance regulations, without otherwise becoming subject to state insurance regulation. Pursuant to these provisions, a provider co-op may provide capitated services to some self-insured purchasers, through a CISN, ISN, HMO or PPO.

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

Please contact Terry Desmond of the Department of Commerce at (612) 296-9429 if you have any questions concerning this issue.
II. Enforcement of the Requirement that Provider Co-ops Contract with Purchasers on "Substantially Capitated or Similar Risk-Sharing Basis."

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

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

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

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

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


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

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

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I. The Healthnet Plan

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

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

In order to have medical services available for covered persons, Willse also enters into contracts with various “health plans,” some of which are licensed health maintenance organizations (“HMOs”) and some of which are not. Indeed, we understand that at least one and possibly more of the health plans participating in Healthnet do not provide health

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1 These conclusions apply only to the Healthnet program and others that might be structured similarly. An assessment of whether an entity is engaged in the provision of “insurance” can only be made case-by-case, after close analysis of the particular facts.

We also note that if a program were to be structured so as to be a “preferred provider insurance policy,” it would be subject to regulation under newly enacted Chapter 578 (House Bill 558), Laws of Maryland 1990 (effective July 1, 1990).
care benefits at all. Rather, these plans themselves enter into contracts with physicians or physician groups, and sometimes with HMOs, to render the necessary care.

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

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

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

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

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

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

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

The Healthnet program in some respects resembles a traditional preferred provider organization (“PPO”), in which insureds are offered panels of physicians from which to choose their care. In both types of programs, these panels of physicians work under contract to the plan administrator or insurer. However, it is our understanding that the PPO structure does not contain certain provisions, such as the hospitalization bonus or penalty, contained in the Healthnet contracts. We find this distinction to be significant.
The second group of contracts contains a different approach to annual adjustments. First, an annual projected cost per-employee per-month is developed for each sponsor. The annual projected cost includes not only the capitation fees paid the health plan, but also the projected amount that will be spent for each sponsor’s covered persons for the year for hospital fees, emergency care, and other out-of-health-plan benefits. At the end of the year, a comparison is made between the annual projected cost and the actual cost of services. The actual cost of services equals the cost of services provided by the health plan plus the cost of hospital, emergency, and other out-of-health-plan benefits actually paid. If the actual cost of services exceeds the annual projected cost, a penalty is assessed against the health plan equal to 50% of the difference, with an overall dollar limit. Willse administers the penalty for the sponsor against the health plan by reducing the capitation payments made to the health plan. The sponsor is responsible for the remainder of the loss. If the actual cost of services is less than the annual projected cost, a bonus equal to 50% of the difference is paid to the health plan.

II. Applicability of Insurance Code

A. Introduction

The legal question is whether the Healthnet program, in whole or in part, is “insurance” and thus subject to regulation. 5

“Insurance” is defined in Article 48A, § 2 of the Maryland Code as “a contract whereby one undertakes to indemnify another or pay or provide a specified or determinable amount or benefit upon determinable contingencies.” This definition “includes not only promises of strict indemnity but also promises to pay or provide a specific or determinable amount or benefit upon determinable contingencies. By using the term ‘provide’ the statute includes contracts for the rendition of service.” 63 Opinions of the Attorney General 422, 424 (1978). 6

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6 The “insurance business” is defined as follows in § 8:

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

(b) The “insurance business” does not include the pooling together by public entities for the purpose of self-insuring casualty risks.
The following five elements of an insurance contract have long been applied in determining whether a particular plan falls within the definition of "insurance":

“(a) The insured possesses an interest of some kind susceptible of pecuniary estimation, known as an insurable interest.

(b) The insured is subject to a risk of loss through the destruction or impairment of that interest by the happening of designated perils.

(c) The insurer assumes that risk of loss.

(d) Such assumption is part of a general scheme to distribute actual losses among a large group of persons bearing somewhat similar risks.

(e) As consideration for the insurer’s promise, the insured makes a ratable contribution, called a premium, to a general insurance fund.”


B. Status of Intermediaries

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

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

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

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

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

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

1. The insureds, the “covered persons,” possess an insurable interest in their health.

2. The covered persons face substantial risk of loss through the occurrence of designated perils, such as disease or accident.

3. The health care provider assumes the risk of loss by accepting capitation payments under the contracts described above.

4. The health care provider spreads the cost over a large group of covered persons.

5. The provider accepts a “premium”—the capitation payment.

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

Our conclusion is not changed by the fact that Willse enters into the contract with the provider on behalf of the employer. Willse, in entering into these contracts, is expressly acting as agent for the employer. The ultimate beneficiary of the services remains the employees. Moreover, we do not believe that merely interjecting a claims payment administrator into the relationship alters the provider’s underlying obligation to provide care to those employees who participate in the benefits plan. Simply placing a conduit between insured and provider does not render the provider’s obligation to employees anything other than “insurance.”

Finally, we do not believe that the employer’s creation of a self-funded employee benefits package, protected from state regulation by the Employee Retirement Income Security Act (“ERISA”), 29 U.S.C.A. § 1001 et seq., exempts the providers of those services from state regulation as well. “While ERISA supersedes state law regulation of employee benefits plans, the Act allows the States to continue to regulate the sale of insurance.”


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

IV. Conclusion

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

J. Joseph Curran Jr.
Attorney General

Editor’s Note

1Nor does it matter if Willse contracts with Healthcare 2000 or some other additional administrative intermediary.

8Editor’s Note—No section III per original.
PARALLEL CITATION Opinion No. 90-030
DATE NEW 1990
Georgia Attorney General Opinions

Selected Attorney General’s Opinions

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

August 27, 1982

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

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

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

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

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

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

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

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

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

Michael J. Bowers
Attorney General