

Insurance Departments May Regulate Some Managed Care Arrangements

BY CHARLES S. GILHAM, JD

With the healthcare ministry moving toward managed care, hospitals are becoming increasingly involved in alternative arrangements with other hospitals, physicians, insurers, and employers looking for cost-efficient healthcare services. There are many alternative arrangements, integrated delivery networks (IDNs), integrated provider organizations (IPOs), integrated provider arrangements (IPAs), physician-hospital organizations (PHOs), and provider-sponsored networks (PSNs).

This alphabet soup of alternative arrangements creates opportunities, as well as hazards, for hospitals. In this article I focus on one hazard in particular: how a hospital's acceptance of risk may subject it to regulation by state insurance departments, which consider such involvement tantamount to being in the insurance business.¹

INSURANCE BUSINESS DEFINED

Although the exact definition of "insurance" varies by statute from state to state, courts generally rely on five elements when determining whether an agreement is a contract for insurance:

- The insured possesses an interest of some kind susceptible to pecuniary estimation, known as an insurable interest.
- The insured is subject to a risk of loss through the destruction or impairment of that interest by the occurrence of designated perils.
- The insurer assumes that risk of loss.
- Such assumption is part of a general scheme to distribute actual losses among a large group of persons bearing somewhat similar risks.
- As consideration for the insurer's promise, the insured makes a ratable contribution, called a premium, to a general insurance fund.²

The underlying theme of the five elements of insurance is the requirement that a definable risk of loss be passed from the insured to the insurer in return for the payment of a premium. Although these elements are clearly not applicable in the fee-for-service context, several may come



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into play in some current managed care arrangements. For example, providers that accept capitation and participate in a bonus program (also called "risk pools") could arguably be assuming a portion of the risk for the care and treatment of participants in the capitated healthcare plan if the claims for the plan greatly exceed the levels projected. The unpaid bonus may be viewed as the provider's "risk of loss" caused by higher-than-expected claims utilization.

NAIC's POSITION

The idea that participation in a healthcare provider's capitation and bonus pools involves a risk of loss is precisely the view taken by the National Association of Insurance Commissioners (NAIC), which is made up of the top officials of state insurance departments. NAIC's goal is to bring some uniformity to the patchwork of state laws and regulations regarding insurance. NAIC regularly publishes model statutes and regulations for use by state insurance commissioners. These NAIC model laws are not binding on the states, but can be used as written or modified to address special requirements of a particular state.

In 1995 an NAIC task force called the Health Plan Accountability Working Group of the Regulatory Framework Task Force (HPAWG) was given the job of developing a model healthcare licensing act for all "health carriers," including HMOs and insurance companies, as well as any other entities that finance and deliver healthcare services on a risk-sharing or risk-assuming basis. The act developed by HPAWG was referred to as the Consolidated Licensure of Entities Accepting Risk Model Act (CLEAR).

During the formulation of CLEAR, HPAWG held a series of public meetings to find out what types of entities are engaging in risk sharing. The group used the information gathered to better define what is meant by the phrase "business of insurance." HPAWG learned that healthcare providers are entering arrangements in which they may be considered to be insurers.

Consequently, on August 10, 1995, HPAWG sent a draft bulletin to all state insurance department commissioners, directors, and superintendents.³ This included a draft bulletin for use by state insurance department officials. It notes:

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. . . . 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.

When a provider is deemed to be in the business of insurance, it must obtain either an insurance license or an HMO license from its state insurance department.⁴ When a healthcare provider agrees to assume all or part of the risk for healthcare expenses or service delivery under a contract with a duly licensed health insurer or HMO, it is exempt from the licensing requirement. In this situation the insurer or HMO—not the healthcare provider—is considered to be the entity taking on the risk, which it can do under its license from the state insurance department.

State insurance departments are not required to follow the advice in the NAIC bulletin. However, since the top officers of state insurance departments are the NAIC's members, it is likely that the departments will act on the bulletin's recommendation.

GROUP HEALTH STUDY

The possibility of state insurance departments increasing their scrutiny of healthcare provider arrangements is reflected in a study by Group Health Association of America (GHAA). In July 1995, just before HPAWG released its bulletin, GHAA published the results of a survey of each state's insurance department. GHAA wanted to discover state insurance departments' attitudes toward PHOs and risk assumption.⁵ The study divided PHOs into four categories, depending on the relative amount of risk they

States have far to go in deciding how to regulate cases in which providers assume partial risk or downstream risk in physician-hospital organizations.

assumed in the arrangement:

- *No risk:* PHO is paid on a fee-for-service basis, with the employer retaining all insurance risk.

- *Full risk:* PHO contracts directly with employer and is paid on a prepaid, capitated basis.

- *Partial risk:* PHO contracts directly with employer. A budget cap is established, where the PHO is liable for expenses up to a maximum of 110 percent of the cap.

- *Downstream risk:* PHO contracts with an insurance company or HMO to provide medical coverage under a group policy on a prepaid, capitated basis.

See the **Table** for survey results. An overwhelming majority of states (41) said no license would be required for the no-risk option. The same number of states said they would require a license for the full-risk option. These options represented the opposite ends of the risk spectrum, so the responses are not too surprising. The respondents' opinions were less conclusive, however, regarding licensure for the partial-risk and downstream-risk options. Unfortunately, the majority of arrangements that healthcare providers are entering into under the guise of managed care are partial-risk and downstream-risk arrangements. Obviously, states have far to go in deciding how to regulate such cases.

EFFECT OF INSURANCE REGULATION

What are the ramifications for a healthcare provider that comes under the jurisdiction of the state insurance department? If the provider ignores

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STATE REGULATORS' ATTITUDES TOWARD PHO LICENSURE

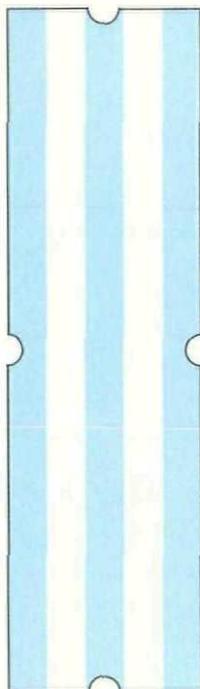
Degree of Hospitals' Risk	License Required	License Requirement Uncertain	No License Required
No risk	2	8	41
Full risk	41	9	1
Partial risk	25	25	1
Downstream risk	2	22	27

From Group Health Association of America, *Summary of State Regulators' Attitudes toward PHO Licensure*, Washington, DC, 1995.

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its state's insurance commissioner, it will be charged with carrying on an unlicensed insurance business. Penalties for this vary from state to state. At the very least, a state insurance department can force the provider to cease the arrangement. Worse, the state's insurance department could forbid the provider from holding an insurance license for a period of time (e.g., 5 or 10 years) in that state. Consequently, any arrangements the provider had would be void, and it could not enter into new risk-sharing arrangements. Assuming a provider would not want to face such a penalty, what are the costs of insurance licensure?

First is the cost of going through the licensure process itself. In some states a provider can obtain licensure merely by filing the proper documents; in others, the insurance department is highly political, and outside counsel familiar with the internal workings of the department will be necessary for approval.

Second, if a healthcare provider is in the business of insurance, the state insurance department will require it to carry a pool of money (i.e., a reserve), which is generally a fixed percentage of the amount of insurance business written in the state. The amount of reserve that must be held can pose a substantial burden on the healthcare provider.

Third, since the financial accounting requirements of insurance companies are complex and unique to the industry, healthcare providers will need to hire additional accounting and financial staff who are familiar with these requirements.

Finally, providers shoulder the burden of ongoing cost of compliance, as insurance laws are revised regularly. Compliance is even more difficult for multi-institutional systems with facilities in more than one state, since laws regarding licensing, reserve level, and

financial reporting are not uniform throughout the country.

PROCEED WITH CAUTION

Healthcare providers are increasingly entering into risk-assuming arrangements with employers, physicians, and insurers that stretch the meaning of the business of insurance. State insurance departments, fearing healthcare providers will be accepting risk without regulation, may soon become more vigilant in enforcing their insurance laws and regulations. The costs of holding an insurance license can be staggering, especially when the reserves are factored in.

Readers are urged to talk with their counsel to determine whether the state insurance department considers any arrangements they have entered into as the business of insurance. In some cases, state regulators might assist in determining whether the state's insurance laws apply to a particular managed care risk-sharing arrangement. □

For more information, call Charles S. Gilham, 314-253-3412.

NOTES

1. Some states require licensing from the state insurance department; others require licensing from the state corporation commission. A few states require licensing from both the department and the commission. In addition, healthcare providers are regulated by the state department of health. For simplicity, I will only refer to state insurance departments, but readers should be aware that the requirements differ from state to state.
2. Vance, Law of Insurance, section 1 (3d ed., 1951).
3. A copy of the bulletin may be obtained from NAIC, 120 W. 12th St., Suite 1100, Kansas City, MO 64105-1925, or by calling 816-842-3600.
4. See Note 1 above.
5. A copy of the survey may be obtained from GHAA, 1129 20th St., NW, Suite 600, Washington, DC 20036, or by calling 202-778-3200.