INSURANCE LICENSURE FOR ADMINISTRATIVE SERVICE ORGANIZATIONS AND PROVIDER NETWORKS: BUREAU OF INSURANCE ADMINISTRATIVE LETTER 1995-10

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Introduction. In its September 11, 1995, Administrative Letter, a copy of which is attached, the Virginia State Corporation Commission's Bureau of Insurance has taken the position that capitated administrative services agreements with self-insured employers and union funds are insurance for all purposes under Title 38.2 of the Virginia Code. If that analysis is correct, the parties to such arrangements will be subject to licensing, contract, mandatory benefit, tax, assessment and reserve requirements applicable to all insurers in Virginia.

Insurance Issues. Providers have increasingly begun to respond to consolidation and other changes in the health care industry by banding together in single or multi-specialty networks, physician-hospital organizations ("PHOs") or other formats to attempt to contract directly with self-insured employers, union funds and other payors for the delivery of health care services.

The Administrative Letter concludes that if those arrangements involve capitation, the administrative services organization arranging the program or the provider network accepting capitation must be licensed as an insurance company, health maintenance organization or health services plan. If, instead, the providers are paid on a discounted fee-for-service basis, possibly with a fee withhold tied to utilization and quality measures, the Bureau's current position is that insurance regulation would not apply to the arrangement.

The reserve and other financial constraints on complying with insurance regulations likely would be prohibitive for many small or newly formed provider networks. For example, the financial requirements for HMOs licensed in Virginia include: (a) a net worth equal to three months of all uncovered expenses (with a minimum net worth of $300,000 and a maximum of $2,000,000), (b) a $300,000 deposit, (c) an additional deposit equal to three months of uncovered health care expenses and (d) an actuarial report certifying that the HMO's reserve for accrued but unpaid claims liability is adequate.

If the network instead qualifies as a health (or medical or hospital) services plan, the capitalization requirements include: (a) 45 days of anticipated operating expenses, (b) 45 days of anticipated claims expenses, and (c) an actuarial report certifying that appropriate provision has been made for accrued but unpaid claims.

According to a spokesperson for the Bureau, the Administrative Letter does not preclude a provider network or independent practice association ("IPA") from contracting with an HMO or other regulated entity on a capitated basis to provide services to employers, even though the network or IPA is assuming capitation risk. The Bureau advises that such capitation is not to be treated as insurance because of the existence of statutory hold harmless provisions in HMO provider agreements and because the licensed HMO assumes the ultimate risk of loss for patient care.

Antitrust Issues. The position of the Bureau raises important antitrust issues, in addition to

the obvious financial and regulatory concerns. The Department of Justice and the Federal Trade Commission issued Policy Statements in 1993 and 1994 which created certain antitrust safety zones for joint ventures among competing providers. Although failure to satisfy a safety zone does not necessarily mean that an arrangement is in violation of federal antitrust laws, it is generally recommended that a network or provider organization which is controlled by otherwise competing providers attempt to comply with a safety zone.

Often, a provider controlled network will retain a third-party "broker" which is specifically authorized to negotiate and contract on behalf of the participating providers within certain predetermined parameters. The broker's authority instantly to bind the providers on matters of price and other terms makes it an attractive vehicle for payors from a business perspective because they are dealing with a single decision maker.

Since the broker model arguably presents an opportunity for improper joint action among otherwise competing providers, the safety zones require (in addition to other elements) that the broker model network's participants be "integrated" by assuming substantial financial risk. The safety zones provide only two examples of acceptable "risk" or "integration," i.e., (a) capitation and (b) substantial fee withholds.

While fee-for-service reimbursement with significant fee withholds may supply the "risk" element of the antitrust safety zones, payors prefer to contract with networks or PHOs which are willing to accept capitation because it permits the payor to budget more accurately its health care expenditures. Thus, if the Bureau's positon is correct, provider networks, PHOs and integrated delivery systems which are willing to accept capitation in order to satisfy the antitrust safety zones and to meet their customers' risk sharing demands may inadvertantly subject themselves to Virginia insurance regulation.

Conclusion. The Administrative Letter raises many unanswered questions. First, the Bureau advises that it has not considered generally whether withhold arrangements (the other avenue for achieving financial risk integration under the Policy Statements) constitute "risk" for insurance regulatory purposes. Currently, a spokesperson for the Bureau advises that it is not actively focusing on that issue.

Second, it is unclear whether Medicare reform will preempt certain state insurance licensing laws which limit the capacity of provider networks to compete with HMOs in the delivery of managed health care to beneficiaries or whether the Virginia General Assembly will address the issue in 1996. Further, the issues of ERISA preemption and whether capitation alone constitutes insurance may yet be tested in the courts.

Finally, the scope and nature of the Bureau's enforcement activities have not yet been fully defined, although the Administrative Letter and the advice of a Bureau spokesperson indicate that complaints will be actively pursued.