REPORT OF THE
STATE CORPORATION COMMISSION BUREAU OF INSURANCE IN COOPERATION WITH THE STATE DEPARTMENT OF HEALTH

REVIEW OF STATUTES AND REGULATIONS GOVERNING HEALTH MAINTENANCE ORGANIZATIONS AND DETERMINATION AS TO THE FEASIBILITY OF THEIR APPLICATION TO OTHER FORMS OF MANAGED CARE PURSUANT TO HJR 611

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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COMMONWEALTH OF VIRGINIA

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STATE CORPORATION COMMISSION
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To: The Honorable George Allen
Governor of Virginia,
The General Assembly of Virginia
and
The Joint Commission on Health Care

I am pleased to transmit this Report of the State Corporation Commission Bureau of Insurance in Cooperation with the State Department of Health: A Review of Statutes and Regulations Governing Health Maintenance Organizations and Determination as to the Feasibility of their Application to Other Forms of Managed Care Pursuant to HJR 611.

Respectfully submitted,

Alfred W. Gross
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I.
Authority for Study

House Joint Resolution (HJR) 611 of the 1997 Session of the General Assembly requested that the State Corporation Commission's Bureau of Insurance (BOI), in cooperation with the Virginia Department of Health (VDH), identify the types of health insurance plans that should be considered managed care plans, review statutes and regulations governing health maintenance organizations (HMOs), and determine the feasibility of their application to other forms of managed care health insurance plans. A copy of HJR 611 is provided as Appendix A.

II.
Background

Background for HJR 611

As can be evidenced by looking at the number of recent studies authorized by the General Assembly, managed care is a topic of current importance. Managed care has evolved over the years from a basic pre-payment plan for health services, into many varieties of complex plans combining healthcare delivery and insurance. HJR 611 flows from two earlier studies of the 1996 General Assembly: Senate Document No. 7, published in 1997, which resulted from SJR 67 (1996), and House Document No. 79, also published in 1997, the result of Chapter 776 of the 1996 Acts of Assembly (HB 1393) and HJR 231 (1996). SJR 67 directed the Joint Commission on Health Care (JCHC) and the BOI to study in 1996 the appropriate roles for various agencies of the Commonwealth to assume in the monitoring, policing and regulation of the managed care

industry. Option VII of Senate Document No. 7 subsequently suggested that legislation be introduced in the General Assembly to extend health maintenance organization provisions included in Chapter 43 of Title 38.2 to other managed care products. Rather than introducing legislation, the 1997 General Assembly passed HJR 611 requesting a report which would "... (i) identify the types of health insurance plans that should be considered as managed care plans, (ii) review the provisions of Chapter 43 of Title 38.2 and evaluate which provisions, if any, should apply to other forms of managed care health plans, and (iii) identify any other appropriate provisions of the Code of Virginia or regulations promulgated by the BOI that should apply to the types of health plans identified as managed care plans." Option III of House Document No. 79 called for the introduction of a resolution directing the BOI to review the advisability of revising current HMO/insurer licensing laws to reflect more accurately the changing health care delivery system and to report its findings to the JCHC and the General Assembly.

Since Senate Document No. 7 and House Document No. 79 of the 1996 General Assembly are the starting points for HJR 611, a review of their findings may provide an appropriate introduction to this study.

The Managed Care Marketplace

Senate Document No. 7 of the 1996 Session of the General Assembly reported that managed care can be defined in many ways and can involve different levels of care management. In its simplest form, managed care includes such basic mechanisms as pre-certification of hospital stays or utilization review to ensure that services received by patients are medically necessary. Such

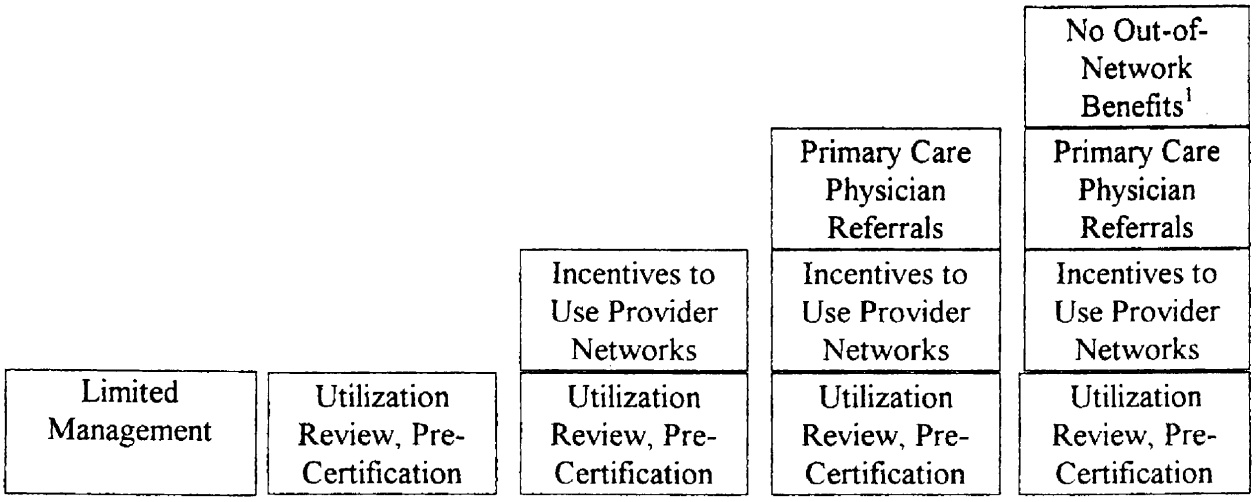
"managed care" processes exist in many different types of health insurance, including indemnity plans.

More advanced forms of managed care, such as those often referred to as preferred provider organizations (PPOs) and point of service (POS) plans, not only require utilization review and medical necessity determinations, but also provide incentives for enrollees to receive care from selected network providers in order to obtain the highest level of the plan's benefits. Some PPOs and most POS plans also require an enrollee to select and use a primary care physician (PCP) who provides primary care and coordinates access to other health care services. The highest form of managed care is provided by HMOs which are the only entities that must provide statutorily defined "basic health care services." Most HMOs require enrollees to select a PCP; require use of network physicians, unless a POS option is included; and generally have more limited networks of specialty providers than PPOs and POS plans. Figure 1 provides a generalized continuum of the managed care plans that are available in the marketplace starting with the simplest and progressing to today's more complex forms of managed care plans.

House Document No. 79 of the 1996 Session of the General Assembly found that a significant portion of the marketplace was moving toward more advanced forms of managed care in which patients have limited choices of providers and access to care is coordinated and managed by a PCP; however more recent reports show some plans no longer require that a PCP be used.

Figure 1

Variations in Managed Care Plans



[1] except for emergency care and specifically defined circumstances

Note: The plan designs shown here are generalizations; there are variations among these different types of plans

Source: modified from a Joint Commission on Health Care Staff Analysis

The following is an explanatory listing of the basic kinds of entities providing managed care. This is not an all-inclusive list of managed care arrangements. Further, it is important to understand that the current regulatory focus is on the functional aspects of such plans, not on the label attached to the particular entity (e.g. PPO, HMO, POS plan, etc.).

- **Managed Indemnity Plans**: Managed indemnity plans provide limited management of services, and typically include utilization review techniques such as hospital pre-certification and medical necessity determinations.

- **Preferred Provider Organizations (PPOs):** In a PPO, enrollees receive the highest level of benefits if they receive care from providers who participate in the "preferred provider" network. Patients can receive care from providers who are not in the network; however, they receive a lower level of benefits when accessing care outside of the network. Providers in the network generally receive discounted reimbursement from the carrier in return for increased patient flow within the network.

- **Health Maintenance Organizations (HMOs):** HMOs provide the highest form of managed care. In an HMO, the plan generally provides or arranges for all health care services to the members (enrollees) in return for an annual fee. There are generally three distinct features of the traditional HMO:

  (1) PCPs are used to coordinate the enrollee's care;

  (2) enrollees must receive care from providers, including physicians and hospitals, who are in the HMO's provider network; no benefits are provided for out-of-network services, except in specifically defined circumstances; and

  (3) a fixed fee structure, such as capitation, often is used to reimburse providers rather than paying providers for each service rendered.

- **Point of Service (POS) Plans:** POS plans have developed in recent years in response to the marketplace's demand for HMOs to provide enrollees with a greater choice of providers. In traditional "closed-panel" HMOs, enrollees receive no benefits if they receive care outside the HMO's provider network. An HMO benefit plan that includes a POS feature allows enrollees to receive services from providers outside the network for an increased payment. Typically, persons who utilize the POS feature pay a higher premium, greater copayments or higher deductibles, or some combination of these three.

- **Provider Sponsored Organizations (PSO)**: PSOs are formal affiliations of providers, organized and operated to provide an integrated network of health care providers in which third parties, such as insurance companies, HMOs or other health carriers, may contract for health care services to covered individuals.

- **Provider Hospital Organizations (PHO)**: PHOs are joint ventures formed and owned by one or more hospitals and physician groups for the purpose of contracting with health carriers to provide a variety of health care services.

This list, which is not intended to be all-inclusive of the managed care marketplace, illustrates that while each label is different, each listed entity serves the same function because each offers managed care in some form.

Trends in the Regulation of Insurance Risk

Currently, statutory provisions exist in the Code of Virginia which require entities conducting the business of insurance by accepting or transferring insurance risk to be subject to licensure as either an insurance company, health services plan, or HMO. Sections 38.2-1024, 38.2-4222, 38.2-4301, and 38.2-4517 of the Code of Virginia are the primary licensing provisions for insurance companies, health services plans, HMOs, and companies providing only dental or optometric services plans, respectively. In September, 1995, the BOI issued Administrative Letter 1995-10 to clarify for all insurers, HMOs, and interested parties that compensation of health care providers via capitation (i.e., fixed, periodic payments to providers in exchange for services rendered to members) constitutes the business of insurance, and that under such agreements "the health care providers as well as the health plan administrators may be subject to the provisions of Title 38.2 of the Code of Virginia." A copy of Administrative Letter 1995-10 is provided as Appendix B.

Virginia's regulation of managed care may not extend to all managed care activity. Self-funded, single-employer employee welfare benefit plans (29 USC §1002(1)) are exempt from state insurance laws pursuant to the federal Employee Retirement Income Security Act (29 USC §1144). In addition, federal and state benefit programs such as Medicare and Medicaid also may be exempt from some or all state regulation. Therefore, regulating managed care by function will for the most part affect the commercial insurance market only, which according to several previous reports of the JCHC, represents approximately 25% of the overall health care market in Virginia.

Managed Care Market in Virginia

The current composition of the managed care marketplace in Virginia consists primarily of 31 licensed HMOs as well as various PPOs operating through arrangements with licensed insurance companies. The precise nature and extent of the non-HMO market is not clearly identifiable. The BOI maintains records for HMOs, but does not routinely track the number of PPOs, POS plans, PSOs, PHOs, or other managed care entities that operate in Virginia. In preparation for this report the BOI asked the Virginia Hospital and Healthcare Association (VHHA) and The Medical Society of Virginia (MSV) to provide information regarding the number and/or types of managed care plans operating in the state. Specifically, the BOI requested:

1. Information on the types of managed care plans currently active in the Virginia market; e.g., PPOs, PHOs, POS plans, PSOs, etc.
2. A narrative describing the organization of each type plan as well as a summary of the manner in which each plan operates; i.e., how each contracts with providers, employers, and other health carriers.
3. An estimate as to the number of managed care plans, excluding HMOs, currently operating in Virginia.
4. An estimate as to the number of individuals covered by these managed care plans.

Neither the VHHA nor the MSV were able to provide the requested information. See Appendix C.

Trend Toward Functional Regulation

With the emergence of increasingly complex managed care plans, traditional regulatory distinctions have become blurred. As a result, and as concluded by the Risk-Bearing Entities Working Group of the State and Federal Health Insurance Legislative Policy (B) Task Force of the National Association of Insurance Commissioners (NAIC), the trend among state regulators is towards "...pursuing initiatives to eliminate artificial distinctions that are irrelevant in today's marketplace." This can be achieved in part by ensuring that plans which engage in similar activities and share similar functional and risk-sharing or risk-transferring characteristics are subject to the same regulatory oversight. In this connection, the aforementioned NAIC working group concluded the following:

> (1) All entities which assume health insurance risk must be subject to solvency and other appropriate consumer protection standards, irrespective of the name and form of the entity; and
>
> (2) Any regulatory framework should foster a level playing field among risk-bearing entities which engage in similar insurance arrangements as opposed to a regulatory framework that favors the development or maintenance of any particular organizational form assuming insurance risk.

Recognition of Quality of Care Issues

As noted earlier, the review authorized by HJR 611 is not the sole General Assembly study dealing with health care issues. Chapter 688 of the 1997 Acts of Assembly (HB 2785) authorized a study of the quality of health care services provided by HMOs. One aspect of this study, a joint effort between the VDH, BOI, and Department of Health Professions, is to "...determine the

extent to which such quality of care mechanisms currently exist for forms of managed care other than HMOs...and whether any or all of such mechanisms should be expanded to entities other than HMOs..."

Quality of care should be an essential element in the regulation of managed care, regardless of the form the managed care takes. Recognizing the work being done by the HB 2785 study and the importance of adequately addressing quality of care issues, the HJR 611 study, along with this resulting report defer to the HB 2785 study group regarding the determination of which specific aspects of quality of health care regulation should extend to all managed care entities. As a result, details regarding quality of care regulation, as it relates to managed care, are not addressed in this study.

Defining a Managed Care Health Insurance Plan

The following proposed definition for "managed care health insurance plan" can be used to determine whether a given plan is a managed care plan which warrants regulatory oversight as an HMO, health services plan, or insurance company pursuant to the provisions of Title 38.2 of the Code of Virginia. It is important to note that the definition does not look to acronyms (e.g., PPO, PSO) to define what constitutes a managed care plan; rather, consistent with approaches in other states, the definition looks to the managed care *functions* being performed. At a minimum, a *pre-paid* managed care plan requires regulatory approval; also a responsible entity must be licensed. The definition for "managed care health insurance plan" as set forth below is based in part on the definition of "managed care plan" found in the NAIC's Health Care Professional Credentialing

Verification Model Act. Proposed definitions for the essential terms used in the definition of "managed care health insurance plan" are provided also.

> *"Managed care health insurance plan"* means any arrangement in which a person undertakes to provide, arrange for, pay for, or reimburse any of the cost of health care services on a prepaid or insured basis, and either requires an enrollee or member to use, or creates incentives, including financial incentives, for an enrollee or member to use providers, managed, owned, under contract with or employed by the health carrier. Such person must be licensed as an insurance company, health maintenance organization, health services plan, or, if providing only dental or optometric services, as a dental or optometric services plan pursuant to the appropriate provisions of Title 38.2 of the Code of Virginia.

Related definitions which should also be considered when defining a "managed care health insurance plan" include:

> *"Enrollee" or "member"* means an individual who is enrolled in a managed care health insurance plan (adapted from definition in § 38.2-4300 of the Code of Virginia).

> *"Provider"* means a hospital, physician, or any type of provider licensed, certified or authorized by statute to provide a covered service under the managed care health insurance plan (adapted from definition in § 38.2-3407.10 of the Code of Virginia).

"Health carrier" means an entity that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including any entity providing a plan of health insurance, health benefits or health services, an accident and sickness insurance company, a health maintenance organization, a nonprofit hospital or a health service corporation (adapted from definition in NAIC's Health Care Professional Credentialing Verification Model Act).

"Health care services" means the furnishing of services to any individual for the purpose of preventing, alleviating, curing or healing human illness, injury or physical disability (as defined in § 38.2-4300 of the Code of Virginia).

III.
Provisions of the Code of Virginia and Regulations Promulgated by the BOI Which Should Be Considered for Managed Care Health Insurance Plans

If consistent regulatory oversight among managed care health insurance plans is desired, it will be necessary to make selected regulatory provisions in the HMO statutes applicable to all managed care health insurance plans. Currently, the primary regulatory requirements for HMOs are found in Chapter 43 of Title 38.2 of the Code of Virginia, and further detailed under 14 VAC 5-210-10 *et seq.*, the Commission's Rules Governing Health Maintenance Organizations. The following paragraphs describe provisions from Chapter 43 of Title 38.2 and 14 VAC 5-210-10 *et seq.* that, if applied to all managed care health insurance plans, would facilitate the creation of a level playing field with regard to the regulation of such entities. It is assumed that managed care cannot be regulated unless responsible entities are subject to basic licensing and financial solvency

provisions which can be consistently and similarly applied by a recognized regulatory authority such as the BOI.

§ 38.2-4300 and 14 VAC 5-210-40 - Definition of "emergency services"

Various managed care health insurance plans may have similar incentives to question the provision of emergency services. A common definition for emergency services would ensure that all managed care health insurance plans provide such coverage on a consistent basis. As a result, emergency services could be no more restrictive than that required by this definition for all managed care health insurance plans.

§§ 38.2-4301 B 9 through 38.2-4301 B 11 and § 38.2-4301 C, 14 VAC 5-210-50 B 3 l through 14 VAC 5-210-50 B 3 n and 14 VAC 5-210-50 C

These statutory and regulatory cites identify material information an HMO is required to disclose in its license application and, thereafter, file with the BOI as such items are amended. The purpose of such submissions is to ensure that the managed care health insurance plan (i) operates only in an approved service area, (ii) provides members with readily available and accessible services, (iii) assesses the quality of health care services through approved programs and procedures, (iv) establishes a system for resolution of grievances, and (v) reports plan modifications to the Commission in a timely manner. Each concern is a consideration for all managed care health insurance plans in order to ensure similar disclosure and regulatory requirements; however, the specific manner and the degree to which each of the concerns should be scrutinized requires further study. Quality of care and grievance issues will be discussed as

part of the report issued pursuant to the second enactment of HB 2785 from the 1997 General Assembly.

§ 38.2-4308, 14 VAC 5-210-70 H, and 14 VAC 5-210-100 B 7

In order to ensure that the grievances of members of all managed care health insurance plans are appropriately considered and processed in a timely manner, the captioned sections, currently applicable only to HMOs, would need to be applied to all managed care health insurance plans. Details regarding grievance procedure issues are to be discussed as part of the report issued pursuant to the second enactment of HB 2785 from the 1997 General Assembly.

§ 38.2-4311, 14 VAC 5-210-60 H 1, 14 VAC 5-210-60 H 2, 14 VAC 5-210-70 D, 14 VAC 5-210-100 B 8, and 14 VAC 5-210-110 C

As currently required of all licensed HMOs, the application of the referenced sections to all managed care health insurance plans would ensure that the provider contracts of such plans contain "hold harmless" language as well as a 60-day termination provision. Hold harmless language protects an enrollee from balance billing by a participating provider. Sixty-day termination provisions protect an enrollee from a sudden interruption of care by requiring participating providers to give at least 60-days advanced notice of termination.

§§ 38.2-4312 C, 38.2-4312 F and 38.2-4312 G, and 14 VAC 5-210-80 C 2

All managed care health insurance plans would need to institute similar provisions regarding cancellation of coverages in order to ensure a uniform and competitive marketplace. In addition,

the inability for any managed care health insurance plans to discriminate against physicians as a class would further serve to level the playing field. Also, similar application of § 38.2-4312 G of the Code of Virginia would levy equal requirements on managed care health insurance plans regarding Medicare-eligible members of the plan who are also residents of a continuing care retirement community.

§ 38.2-4312.3

The referenced section requires HMOs to provide 24-hour access to medical care or access via telephone to a physician or licensed health care professional on a 24-hour basis. Managed care health insurance plans' members would be assured similar access to emergency services with uniform application of this section.

§§ 38.2-4315 B, 38.2-4315 C, and 32.1-122.10:01

These sections of Title 38.2 authorize the State Health Commissioner to examine quality assurance programs and quality of health care services issues for licensed HMOs. Quality of health care services and quality assurance issues are recognized as important elements in any managed care setting. As such, the application of §§ 38.2-4315 B and 38.2-4315 C to all managed care health insurance plans is necessary.

Also, those sections of Title 38.2 dealing with examinations that were relocated to Title 32.1 by HB 2785 (§ 32.1-122.10:01) should also be considered when reviewing the application of managed care statutes since they provide the authority to examine essential quality assurance issues. The report issued pursuant to the second enactment of HB 2785 from the 1997 General

Assembly should be considered also because it is expected to contain further findings regarding quality assurance programs, quality of health care issues, and the State Health Commissioner's review of such programs, as such relate to managed care entities.

§§ 38.2-4316 A 4 and 38.2-4316 A 7

The State Corporation Commission is authorized to suspend the license of any HMO that fails to implement a complaint system or procedures for furnishing quality health care services. Application of this section to managed care health insurance plans in addition to licensed HMOs would serve to ensure further the existence of quality of care and grievance procedures for all managed care health insurance plans.

§§ 38.2-4319 C and 38.2-4319 D

The referenced section contains provisions regarding statutory construction and relationship to other laws that are applicable to all managed care health insurance plans. Specifically, the cited subsections provide that an HMO shall not be deemed to be engaged in the unlawful practice of medicine nor be required to offer coverage to employees residing outside the approved service area.

14 VAC 5-210-40 - Definition of "out-of-area services" and "service area"

HMOs are restricted to providing health care services only in approved service areas. Service areas consist of geographic counties and independent cities. In order for a requested service area to be approved, the HMO must demonstrate that the provider network it has contracted with in the requested area is sufficient to provide generally available and readily accessible services. The

degree to which service areas should be reviewed and approved for managed care health insurance plans may require further study. The degree to which the service area of a managed care health insurance plan should be subject to this type of regulatory oversight may vary. Strict scrutiny may not be appropriate for non-basic health services involving nominal financial incentives and limited case management. Nevertheless, some type of service area regulation seems appropriate for managed care plans to ensure availability of and accessibility to health care services.

14 VAC 5-210-70 E

Application of this section to all managed care health insurance plans would ensure that such plans' members are provided with a description of the service area at the time of enrollment or at the time the contract is issued.

14 VAC 5-210-70 G

This section allows enrollees to select their own primary care physician. The members' right to select their own primary care physician should be consistent for all managed care health insurance plans.

14 VAC 5-210-90 A 1 and 14 VAC 5-210-90 A 2

The referenced section requires HMOs to establish and maintain certain reasonable standards regarding access to care. In order to ensure a level playing field these requirements must be applicable to all managed care health insurance plans.

14 VAC 5-210-140 and 14 VAC 5-210-150

Standard provisions regarding controversies involving contracts and the severability of 14 VAC 5-210-10 *et seq.* are contained in the referenced sections and should be applicable to all managed care health insurance plans.

Statutory and Regulatory Provisions Which Should Be Considered for Managed Care Health Insurance Plans

Statutory or Regulatory Cite	Description
38.2-4300	Definitions
emergency services	
38.2-4301	Establishment of HMO
B	
9	
10	
11	
C	
38.2-4308	Complaint system
A	
B	
C	
38.2-4311	Provider contracts
A	
B	
C	
D	
38.2-4312	Prohibited practices
C	
F	
G	
38.2-4312.3	Patient access to emergency services
38.2-4315	Examinations
B	
C	
38.2-4316	Suspension or revocation of license
A	
4	
7	

38.2-4319	Statutory construction and relationship to other laws
C	
D	
32.1-122.10:01	Review of health maintenance organizations
14 VAC 5-210-40	Definitions
emergency services	
out-of-area services	
service area	
14 VAC 5-210-50	Licensing requirements
B	
3	
l	
m	
n	
C	
1	
2	
3	
14 VAC 5-210-60	Financial condition requirements
H	
1	
2	
14 VAC 5-210-70	General requirements
D	
E	
G	
1	
2	
H	
1	
2	
3	
4	
5	
14 VAC 5-210-80	Prohibited practices
C	
2	
14 VAC 5-210-90	Services
A	
1	
a	

b	
c	
d	
2	
14 VAC 5-210-100	Disclosure requirements
B	
7	
8	
14 VAC 5-210-110	Filing requirements
C	
1	
2	
3	
14 VAC 5-210-140	Controversies involving contracts
14 VAC 5-210-150	Severability

IV.
NAIC Initiatives for Managed Care Plans

The NAIC has been active on several fronts regarding health carriers, including managed care entities. In August, 1995, a "Suggested Bulletin Regarding Types of Compensation and Reimbursement Arrangements Between Health Care Providers and Individuals, Employers and Other Groups" (bulletin) was issued by the Health Plan Accountability Working Group of the Regulatory Framework Task Force. This bulletin addressed the issue of various types of health care providers that are delivering health care services on a risk-sharing basis. The bulletin was developed following public hearings held by the NAIC working group during which it was determined that there are many variations of associated health care providers operating in states and assuming insurance risk without first obtaining a license or certificate of authority from the insurance regulatory agency. The bulletin, sent to all state insurance commissioners, alerted regulators in each state to the existence of these unlicensed health care providers, and

recommended that communication be made to the marketplace in each state reiterating that risk-sharing arrangements often are insurance, and may need to be regulated as such.

This bulletin, although focusing on entities that assume risk in a health care arrangement, emphasized that organizations of health care providers can take many forms, and are not limited to health maintenance organizations. Nomenclature, i.e., the name of the entity, is irrelevant. The working group concluded that the nature of the arrangement should be the controlling factor in determining whether there should be regulatory oversight.

Subsequently, in December, 1996, and also in June, 1997, the Risk Bearing Entities Working Group of the State and Federal Health Insurance Legislative Policy (B) Task Force of the NAIC issued drafts of a white paper entitled "The Regulation of Health Risk-Bearing Entities." A statement reiterated throughout the paper is that in many states, "...a primary focus of current regulatory efforts is on creating a regulatory structure that recognizes function as opposed to structure." The report goes on to state that "...a strong consensus exists among state insurance regulators that entities which enter into a contractual arrangement with an individual, employer, or other unlicensed group and assume insurance risk pursuant to that contractual arrangement, should be required to obtain the appropriate regulatory license." Of the few states that have developed specific laws to license provider-sponsored organizations, most impose requirements that are not significantly different from the state's HMO laws. Of seeming significance is the conclusion that "...many states believe that all entities operating in the health insurance marketplace that perform similar functions should be subject to the same or similar regulatory requirements."

A separate study of "Medicaid Managed Care" by the State and Federal Health Insurance Legislative Policy (B) Task Force of the NAIC resulted in a white paper adopted in December, 1995. This study focused on the growing use of managed care as the mechanism by which states provide Medicaid services. Included in the paper were recommendations that "...states may want to require that all plans meet the same specifications as do commercially licensed HMOs." Also provided in the paper was a discussion regarding certain Florida statutes which initially allowed managed care plans that participated in the Medicaid program a three-year exemption from HMO licensing requirements. Because of financial and quality of care problems, these statutes were subsequently revised and, beginning in January, 1996, all pre-paid Medicaid managed care plans must obtain a license from the Florida Department of Insurance. Although the 1995 study focused on Medicaid managed care plans, an argument can be made that many of its concerns are also applicable to a commercial, or mixed commercial and Medicaid plan.

As a result of these and other studies, the NAIC has begun an initiative entitled "Consolidated Licensure for Entities Assuming Risk" (CLEAR), which seeks to "...promote a more competitive marketplace by ensuring that entities performing the same or similar functions are subject to a level regulatory playing field." As part of the CLEAR initiative, the NAIC is developing a "Managed Care Plan Network Adequacy Model Act," a "Health Carrier Grievance Procedure Model Act," and a "Utilization Review Model Act." It is anticipated that these models will "...serve to clarify that the wide array of organizations performing managed care functions, including health maintenance organizations, preferred provider organizations, point of service plans, fee for service plans, Blue Cross and Blue Shield plans, commercial plans, and any other

plans which finance and deliver health care, fall within the scope of state regulation." The CLEAR initiative intends to address financial standards, accountability standards, and licensing standards.

Other NAIC initiatives that are in development include a "Health Organizations Risk-Based Capital" formula, and insolvency protection for enrollees of health care entities. The risk-based capital formula would provide regulatory officials with a method to measure the risk profile of risk-bearing entities.

These activities of the NAIC further support the notion that it is the insurance aspects and functions of a plan that must be regulated and not the specific label attached to the entity. Artificial labels, classifications, and distinctions should not drive the regulation of entities providing health care services; rather, consistent and uniform scrutiny should be applied to all entities which engage in the activities of a managed care health insurance plan.

V.
Regulatory Approaches of Other States

According to the NAIC's "Regulation of Health Risk-Bearing Entities" white paper, there is agreement among state insurance regulators that entities which assume risk should be regulated. However, different states use different regulatory approaches. The NAIC white paper includes examples of approaches from Colorado, Georgia, Iowa, Kentucky, Minnesota, New York, Ohio, Oklahoma, Oregon, Texas, and Wisconsin. In addition, Maryland has recently enacted legislation recognizing managed care plans other than HMOs.

- Colorado has a "limited service licensed provider network" category to license provider networks that provide services related to a single facility or medical specialty. The regulation which created this category of managed care provider organization includes requirements which are similar to HMO regulations, as well as risk-based solvency requirements that are similar to indemnity carriers.

- Georgia issued a regulation in 1996 entitled "Regulation of Provider Sponsored Health Care Corporations." This regulation establishes provider-sponsored organizations as insurers, imposes a net worth minimum of $1 million on the licensee, and clear "hold harmless" language in provider contracts.

- Iowa enacted a statute in 1993 which provides for the licensing of "organized delivery systems." These integrated delivery systems are monitored by the Iowa Department of Public Health, but are subject to financial review by the Iowa Department of Insurance. Capital requirements of an organized delivery system are higher than those for an HMO.

- Kentucky enacted a statute in 1996 which creates "Provider-Sponsored Integrated Health Delivery Networks." These entities are defined as insurers that provide a health benefit plan on a prepaid basis. Included in the requirements are an initial net worth or surety bond of $1.5 million, and maintaining an ongoing net worth of $1 million.

- Minnesota law provides for the establishment of "community integrated service networks," which are provider-sponsored networks that provide prepaid health services to populations of 50,000 or fewer subscribers. The law provides for a minimum net worth which is similar to that of an HMO.

- New York statutes provide for the licensing of integrated delivery systems, which may deliver health benefits on a capitated basis. The integrated delivery system is subject to solvency standards which are similar to those for HMOs.

- Ohio has recently enacted SB 67, the Managed Care Uniform Licensing Act. Its enactment makes Ohio the first state to develop a comprehensive licensing system for managed care entities other than indemnity insurance companies. The stated purpose of the bill was to (i) "...assure the financial soundness of health plans, especially those that are engaged in the business of insurance and are currently unregulated, i.e., PPOs, PHOs, etc." (ii) "...allow a single statute to license all managed care entities, while still leaving enough freedom for innovation in the market place" and (iii) "...balance the types of regulation that traditional indemnity carriers and managed care companies are subject to in Ohio." As a result of this legislation, Ohio now licenses one type of managed care entity, the "health insuring corporation." It includes all entities which assume health insurance risk and are not indemnity insurance companies.

- Oklahoma has recently enacted a statute which authorizes the Board of Health to promulgate rules regarding "provider sponsored networks." The statute states that the rules must provide

for financial solvency standards, quality assurance standards equal to those applied to HMOs, and network standards. HMOs are regulated primarily by the Board of Health in Oklahoma.

- Oregon has established certain requirements for health insurers whose plans require designation of a PCP by its members. These requirements consist of establishing utilization review, grievance, and quality assurance programs, as well as mandating the length of maternity hospital stays. All such insurers must also disclose certain information annually with the Department of Consumer and Business Services.

- Texas statutes provide for the certification of "approved nonprofit health corporations," which can provide prepaid health benefit plans. These entities must secure a certificate of authority, and are subject to HMO regulatory standards.

- Wisconsin licenses "limited service health organizations." Within this license category are entities which provide or arrange for health care services on a limited, prepaid basis. Surplus requirements are linked to premium income.

Also recently, Maryland has passed legislation recognizing "managed care organizations" and establishing financial and operational requirements under which the managed care organization must operate. These organizations include HMOs and any other health care entities that are authorized to receive medical assistance capitation payments with regard to Medicaid recipients.

VI.
Federal Initiatives

Over the past few years, there have been several federal proposals in the group health insurance area. These proposals impact significantly the regulation of managed care in Virginia. Of particular importance is the enactment of the Health Insurance Portability and Availability Act of 1996. It prompted the 1997 General Assembly to consider a number of implementation statutes which became law on July 1, 1997. Federal budget provisions passed this year by Congress create provider-sponsored organizations that may not be subject to state regulation when providing Medicare health insurance services. In addition, the Health Care Financing Administration is encouraging Medicare beneficiaries to enroll in HMOs in order to manage costs of the federal program more efficiently. H.R. 1515, which included language that would exempt provider-sponsored organizations from state regulation even if the organization were considered to be in the business of insurance, is another example of federal interest in health insurance. This bill has been withdrawn at the time of the writing of this study but may be considered again at a later date.

VII.
Conclusions

Managed Care Plans Have Become Increasingly Complex

With the emergence of PPOs, PHOs, POS plans, etc., in addition to HMOs, the managed care marketplace has become highly complex. In addition, the distinctions that define such plans are becoming increasingly obscured.

Current Statutory Provisions Require Entities Accepting Insurance Risk to be Licensed

Currently, any entity offering health insurance in the Commonwealth of Virginia must be licensed as an insurance company authorized to write accident and sickness coverages, a health services plan, an HMO, or a dental or optometric services plan if providing only dental or optometric services. The licensing provisions for insurance companies, health services plans, HMOs, and dental or optometric services plan are found in §§ 38.2-1024, 38.2-4222, 38.2-4301 and 38.2-4517 of the Code of Virginia, respectively. Any managed care plans that also accept insurance risk should be subject to such licensing requirements.

Administrative Letter 1995-10 Further Defines Which Entities Need To Be Licensed

BOI issued Administrative Letter 1995-10 in September of 1995. This Administrative Letter clarified for all insurers, HMOs, and interested parties that a transfer of insurance risk occurs when providers of health care services are compensated on a capitated basis. Such a transfer of risk may subject the health care providers, as well as the health plan administrators, to the provisions of Title 38.2 of the Code of Virginia.

Trend Toward Functional Regulation

As a result of the complexity and varieties of managed care plans, regulation of such entities is starting to focus on the functions of plans involved in managed care activities. The pervasive conclusion of the NAIC and individual state regulators appears to be that plans which engage in similar functional activities, especially in the area of risk-sharing or risk-transfer, should be subject to the same type and level of state regulation.

States Have Begun to Adopt Statutes Which Broaden Regulatory Oversight to Include Managed Care Entities Other Than HMOs

Already twelve states have enacted legislation regulating managed care entities other than HMOs, most predominantly for provider-sponsored organizations. Approaches by other states appear aimed at leveling the playing field with regard to regulatory oversight among HMOs and other entities engaged in managed care activities.

VIII.
Options

The following policy options are offered for consideration by the JCHC. They are not intended to represent the entire range of options that the JCHC may wish to pursue. It should also be noted that these options are meant to be mutually exclusive of one another; combinations of the various options should not be considered.

Option I: Maintain the status quo

Under Option I, no specific actions would be recommended by the JCHC to the 1998 General Assembly. Option I recognizes that specific laws and regulations currently in place in Title 38.2 of the Code of Virginia already subject all entities assuming insurance risk, including those defined as managed care health insurance plans in this study, to licensure and regulation as an insurance company, a health services plan, or an HMO.

Option II: Introduce legislation to amend Chapter 34 of Title 38.2 to include provisions applicable to managed care health insurance plans

Option II would amend Chapter 34 of Title 38.2 of the Code of Virginia by adding a new section referencing requirements for managed care health insurance plans. This section would incorporate by reference or restate the cited statutory provisions that should be considered for managed care health insurance plans and would also include the recommended definitions. Applicable provisions of 14 VAC 5-210-10 *et seq.* could be codified as part of the new section of Chapter 34. This new section would be swept into the regulation of health services plans and dental and optometric services plans by additional reference at § 38.2-4214 § 38.2-4509 of the Code of Virginia respectively. Additionally, appropriate provisions of 14 VAC 5-210-10 *et seq.* would have to be codified in Chapter 43 to ensure statutory and regulatory consistency for all managed care health insurance plans. Managed care health insurance plans accepting insurance risk would still be subject to solvency and licensure requirements as currently required by § 38.2-1024, § 38.2-4222, § 38.2-4301 or § 38.2-4517 of the Code of Virginia. Implementation of this option may require fewer statutory changes than Option III.

Option III: Introduce legislation to create a new Chapter in Title 38.2 setting forth requirements to be met by managed care health insurance plans

Under this option, the JCHC would seek to create a new chapter in Title 38.2 of the Code of Virginia setting forth specific requirements for managed care health insurance plans. This chapter would restate the cited statutory provisions that should be considered for managed care health insurance plans and would include also the recommended definitions set out in this report. In addition, applicable provisions of 14 VAC 5-210-10 *et seq.* would have to be codified as part of

the new chapter and also in Chapter 43 to facilitate statutory consistency for all managed care health insurance plans. This new chapter would be swept into the regulation of health services plans and dental and optometric services plans by additional reference at § 38.2-4214 and § 38.2-4509 of the Code of Virginia respectively. Entities accepting insurance risk would still be subject to licensure under § 38.2-1024, § 38.2-4222, § 38.2-4301 or § 38.2-4517 of the Code of Virginia. This option would place provisions from Chapter 43 of Title 38.2 which are peculiarly applicable to managed care health insurance plans in one place. Since the affected provisions would be replicated, they could be modified if necessary to refer specifically to managed care health insurance plans.

If it is the decision of the General Assembly that appropriate provisions of the Code of Virginia be extended to apply to managed care health insurance plans, it is the view of the BOI that Option III represents the most feasible and appropriate method. A new chapter in Title 38.2 would allow consistent regulation between managed care health insurance plans and HMOs to be developed, and would encourage a level playing field in the managed care market in Virginia.

APPENDIX A

GENERAL ASSEMBLY OF VIRGINIA -- 1997 SESSION

HOUSE JOINT RESOLUTION NO. 611

Requesting the State Corporation Commission Bureau of Insurance, in cooperation with the State Department of Health, to review statutes and regulations governing health maintenance organizations and to determine the feasibility of their application to other forms of managed care health insurance plans.

Agreed to by the House of Delegates, February 4, 1997
Agreed to by the Senate, February 19, 1997

WHEREAS, the health insurance marketplace continues to change at a rapid pace in response to market demands for quality health care services at a reasonable cost; and

WHEREAS, managed care has become the dominant form of health insurance coverage in the United States and Virginia as evidenced by the increase in the number of employers offering managed care plans to their employees and the transition of many government-sponsored programs such as Medicare and Medicaid to managed care plans; and

WHEREAS, one of the goals of managed care health insurance plans is to provide quality care and at the same time control health care costs by coordinating the care received by patients and managing patients' access to providers and services; and

WHEREAS, a number of provider groups and consumer advocates have voiced concern regarding the degree to which some managed care insurance plans control patients' access to certain providers and services; and

WHEREAS, managed care originally encompassed only health maintenance organizations but now includes many different types of health insurance plans including preferred provider organizations, point-of-service plans and some managed indemnity benefit plans; and

WHEREAS, market trends indicate there will be a further proliferation of different forms of managed care plans in the near future; and

WHEREAS, a recent study conducted by the Joint Commission on Health Care regarding the Commonwealth's role in overseeing the managed care industry found that there are a number of state insurance laws and regulations contained in Chapter 43 (§ 38.2-4300 et seq.) of Title 38.2 that provide managed care protections which apply only to health maintenance organizations and not to other forms of managed care plans; and

WHEREAS, preferred provider organization and point-of-service plans include many of the same managed care features and requirements as health maintenance organizations; and

WHEREAS, given the changes that have occurred in the health care marketplace and the similarities that exist between health maintenance organizations and other forms of managed care plans, it may now be appropriate to have some provisions of Chapter 43 (§ 38.2-4300 et seq.) of Title 38.2 apply to other managed care insurance plans; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the State Corporation Commission Bureau of Insurance, in cooperation with the State Department of Health, be requested to review statutes and regulations governing health maintenance organizations and to determine the feasibility of their application to other forms of managed care health insurance plans. The Bureau is requested to: (i) identify the types of health insurance plans that should be considered as managed care plans; (ii) review the provisions of Chapter 43 (§ 38.2-4300 et seq.) of Title 38.2 and evaluate which provisions, if any, should apply to other forms of managed care health insurance plans such as preferred provider organizations and point-of-service plans; and (iii) identify any other appropriate provisions of the Code of Virginia or regulations promulgated by the Bureau that should apply to the types of health insurance plans identified as managed care plans.

The Bureau shall submit its findings and recommendations to the Joint Commission on Health Care by October 15, 1997, and to the Governor and the 1998 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B

COMMONWEALTH OF VIRGINIA

STEVEN T. FOSTER
COMMISSIONER OF INSURANCE

BOX 1157
RICHMOND, VIRGINIA 23205
TELEPHONE: (804) 371-9741
TDD/VOICE: (804) 371-9206

STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

September 11, 1995

Administrative Letter 1995-10

TO: All Insurers, Health Maintenance Organizations, and Interested Parties

RE: Capitated Administrative Services Only (ASO) Agreements are insurance and may subject both the provider and administrator to the provisions of Title 38.2 of the Code of Virginia.

The State Corporation Commission's Bureau of Insurance (the "Bureau") has received several inquiries regarding capitated Administrative Services Only (ASO) agreements. A capitated ASO contract is an arrangement that purports to provide only administrative services to a self-funded health plan, but which, in fact, involves a transfer of all or part of the risk of loss for health care claims through capitation, i.e. through a fixed charge per time unit (e.g. month) per member (or other unit) enjoying health care coverage.

It has come to the Bureau's attention that certain insurers, health maintenance organizations, health services plans, third party administrators, health care providers, or other entities may have entered into capitated ASO agreements with several employer groups and others in Virginia. **Capitated ASO agreements are insurance and, under such agreements, the health care providers as well as the health plan administrators may be subject to the provisions of Title 38.2 of the Code of Virginia.**

An employer may self-fund health benefits for its employees and contract with an administrator in an ASO agreement to process claims and provide access to a network of providers. In such cases, the employer bears the ultimate risk of loss for all health care claims incurred by its employees. Furthermore, the employer may self-fund to cover its entire risk of loss, or it may self-fund to a certain dollar cap and purchase stop-loss insurance to cover any health care claims that exceed an individual or aggregate cap.

However, with a capitated ASO agreement, the employer, for a fixed fee per employee, transfers all or a portion of its risk of loss for health care claims of its employees to an administrator, health care provider or other entity. This type of agreement constitutes a contract of insurance under Virginia law. Such contracts are subject to the appropriate provisions of Title 38.2 of the Code of Virginia, including provisions relating

to licensing, contract and benefit requirements, taxes, and assessment for maintenance of the Bureau of Insurance.

No insurer, health maintenance organization, health services plan, third party administrator, health care provider, or other entity should enter into a capitated ASO agreement in Virginia unless the contract as well as the entity are in compliance with all the requirements of Title 38.2 of the Code of Virginia. Furthermore, any capitated ASO agreements currently in effect in Virginia should not be renewed. The Bureau will continue to monitor capitated health care arrangements in the Commonwealth, and will take appropriate regulatory action when it finds violations of Title 38.2 of the Code of Virginia.

Questions concerning this Administrative Letter shall be directed to:

Victoria I. Savoy, CPA
Chief Financial Auditor
Financial Regulation Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23209
(804) 371-9869

Sincerely,

Steven T. Foster
Commissioner of Insurance

APPENDIX C

VIRGINIA HOSPITAL
& HEALTHCARE
ASSOCIATION
An alliance of hospitals and health delivery systems

4200 INNSLAKE DRIVE, GLEN ALLEN, VIRGINIA 23060
P.O. BOX 31394, RICHMOND, VIRGINIA 23294-1394
(804) 747-8600 FAX (804) 965-0475

July 24, 1997

Scot A. Chancy, FLMI
Senior Financial Examiner
Company Licensing and Regulatory Compliance
Bureau of Insurance
State Corporation Commission
Post Office Box 1157
Richmond, Virginia 23218

Dear Mr. Chancy:

Per your request of July 17, 1997, this letter will serve as written notice that this Association does not keep records on the information requested in your July 30th communication regarding HJR611.

Please call if you have questions.

Sincerely,

Katie M. Webb

Katharine M. Webb
Senior Vice President

THE MEDICAL SOCIETY OF VIRGINIA
4205 DOVER ROAD · RICHMOND, VIRGINIA 23221-3267
804-353-2721 · TOLL FREE 1-800-746-6768 · FAX 804-355-6189

Madeline I. Abbitt, Director, Legislative Affairs

August 21, 1997

Mr. Robert L. Wright
Principal Insurance Analyst
Virginia Bureau of Insurance
P. O. Box 1157
Richmond, Virginia 23218

Dear Bob:

Per your request, the Medical Society of Virginia does not seek or maintain information about contractual arrangement(s) that a physician or a physicians' group may have. In light of Virginia's increasing managed care trend, the Medical Society feels that such arrangements are in the process of being developed, but only antidotal information is to be found. Having discussed this issue with several physicians throughout Southwest Virginia, for instance, there was a suggestion that one orthopedic group was developing an "arrangement" with an industry, but that the group had been in contact with the Bureau in order to abide by the code of Virginia in its formation.

On this point, I wish that I could be of more help to you, but the Medical Society has not seen the need to collect this type of information.

Sincerely,

Madeline I. Abbitt

APPENDIX D

Summary of Comments

Comments were received from 3 provider organizations and 2 consumer groups. There was a general consensus that a functional approach toward regulation of managed care plans is appropriate. The consumer groups commented in support of applying HMO provisions to all managed care health insurance plans. Likewise, one of the three provider organizations expressed support for such application. The remaining two provider organization were silent with regard to support of any particular option.

Summary of Individual Public Comments

American Association of Retired Persons (AARP)

William L. Lukhard commented on behalf AARP. AARP strongly supports the concept that organizations performing managed care functions, regardless of what they are called, should be subject to the same laws and regulations. AARP also believes that a basic set of consumer protections should be applicable to all managed care plans. AARP supports the general conclusions of the report and strongly supports Option III.

The Medical Society of Virginia (MSV)

Patrick C. Devine, Jr. commented that MSV supports generally either Option II or III. However, MSV also believes that while the focus of much of the discussion in the Report has been on the increased regulation to which HMOs are subject, it is equally appropriate when leveling the playing field to consider several of the significant advantages which HMOs enjoy. Mr. Devine noted that the Report should specify that entities operating a dental or optometric services plan pursuant to Chapter 45 of Title 38.2 are also considered managed care plans. MSV concludes that the report is headed in the right direction; however, care should be taken to truly level the playing field among all managed care plans and their administrators and to avoid unnecessarily inhibiting innovation, competition and new entry into the managed care market.

Virginia Association of Health Maintenance Organizations (VAHMO)

May Fox, Executive Director, expressed concern that the text of the Report leans too strongly toward government bureaucracies in lieu of private sector incentives and concludes that the Report falls short of preparing Virginia policy makers for legislative or regulatory changes at this time. Absent additional policy analysis of many of the issues, the VAHMO was reluctant to endorse the Report.

Virginia for Patient Choice (VPC)

Mark E. Rubin commented in support of Option II or III. Specifically, VPC appreciated the BOI's recognition of the importance of quality of care and consumer protections in managed care companies. VPC agrees with the NAIC and state regulators that regulation of health care plans should focus on the function performed by the plan rather than what the plan is called. VPC supports the broadening of the definition of managed care health insurance plan to include managed indemnity plans engaging in utilization review or pre-certification.

Virginia Hospital & Healthcare Association (VHHA)

Catherine C. Hammond, Vice President, responded that as a matter of principle, the VHHA supports the functional approach expressed in the Report. The VHHA hopes that in discussing government regulation in this rapidly changing industry, some emphasis is placed on the fact that purchasers of health care benefits, as well as consumers, continue to look for new options that develop in response to market needs. While regulation of insurance risk is essential for protection of the public, the VHHA believes that effective regulation can be achieved without inhibiting the development of new products that respond to health care needs of the public.