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STATE REGULATION OF CAPITATED REIMBURSEMENT FOR PHYSICIAN-HOSPITAL ORGANIZATIONS

Robert C. Feightner, J.D.[†]

WANTED - Self-Funded Employer Health Benefit Plans Seek PHOs and Other Integrated Delivery Systems to Manage Their Employees' Healthcare, Restrain Costs. Good Capitated Rates Paid. State Insurance Commissioners Need Not Apply. Call 29-ERISA.

THE CONFLUENCE OF TWO DEVELOPMENTS in the financing and delivery of employer-paid healthcare services — capitated provider reimbursement and the increase in the number of self-funded health plans — has drawn the rapt attention of insurance regulators. Numerous state insurance commissioners,¹ as well as the National Association of Insurance Commissioners (NAIC),² have taken the position that medical providers who accept full or partial capitated payments directly from self-funded employer groups are engaging in the “business of insurance,” and thus, must be licensed as a health insurer or health maintenance organization (HMO). Some states have even taken the position that physician-hospital organiza-

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1. *See generally Georgia, Virginia Clamps Down on IDSs Taking Financial Risk*, *MANAGED CARE WEEK*, July 10, 1995, at 4. *See also infra* notes 22 to 42 and accompanying text.

2. *See* Memorandum from Kenney Shipley, Chair, Health Plan Accountability Working Group, National Association of Insurance Commissioners to All Commissioners', Directors and Superintendents (Aug. 10, 1995) (on file with author) [hereinafter NAIC Draft Bulletin]. The NAIC Draft Bulletin outlines the National Association of Insurance Commissioner's position that unless PHOs are licensed as HMOs or health insurers, they may not accept capitated payments directly from self-funded payors, or accept risk in the form of a provider withhold. The NAIC Draft Bulletin also contains a proposed letter that the state insurance commissioners may send to PHOs and other medical providers advising them of the insurance commissioner's position upon the unlicensed acceptance of risk.

tions (PHOs) which accept pre-paid capitation, even from a licensed HMO, must themselves become a licensed entity.³ PHOs, and other healthcare provider networks (sometimes referred to as integrated delivery systems (IDSs))⁴ are increasingly contracting directly with self-funded employer health plans or alliances of employer plans for healthcare services for their workers. These employer-sponsored plans sometimes incorporate managed healthcare delivery features, such as gate-keeper primary care physicians (physicians who limit the member's ability to self-refer to a specialist) and utilization management services. As these self-funded plans look increasingly more like HMOs, likewise, the compensation mechanism is changing to capitated reimbursement. Instead paying providers under a traditional fee-for-service method, the employer pays a predetermined monthly amount to the provider in exchange for healthcare services for the employer's plan members.⁵

This Article will address the issue of PHO regulations and will advance the position that PHOs and other IDSs should be permitted to directly contract with self-funded employer groups and receive capitated compensation. It will begin with a brief discussion of PHOs and their expanding role in the healthcare delivery system. The Article will then examine the positions of the NAIC and insurance commissioners with regard to PHOs accepting capitated risk, and will examine the legal and factual

3. See *infra* notes 30-31 and accompanying text.

4. IDS is a protean term, and like the term "health reform," what is and what is not an IDS is in the eye of the beholder (or the beholden). Clearly, a PHO is a form of IDS in that it integrates (to various degrees) the physician and hospital components of the healthcare delivery continuum. An IDS can incorporate more than a PHO by adding ancillary services, allied health providers, neighboring hospitals, and neighboring physician groups. However, a PHO can still retain the appellation PHO and add additional healthcare services. This Article will use the term PHO to refer to the general type of entities which are the subject of insurance regulators' scrutiny, recognizing that many PHOs integrate more components of healthcare delivery than a physician group and a hospital. The term IDS will be used when specifically referred to in cited material, or when necessary to describe an organizational model or entity which is far more extensive than the paradigmatic PHO.

5. There are different methods of paying capitated rates. The HMO or other payor may pay the primary care physician a capitated rate, and pay the specialist physicians on another basis such as a discounted fee-for-service. The hospital could be paid on a "per diem" rate or by a DRG (diagnostic-related group) method. An increasingly alternative method of compensation is to pay a global capitated rate to the PHO. The PHO can then divide the compensation among its constituent providers in a manner which it deems appropriate.

basis for the position that PHOs which accept capitation are improperly engaged in the "business of insurance." Close analysis demonstrates that the acceptance of capitation by PHOs is *not* the unlicensed "business of insurance." Further, these employer-provider relationships may be free of state interference because of the broad preemption provisions of the Employment Retirement Income Security Act of 1974 (ERISA).⁶ Finally, the position of the NAIC and certain state insurance commissioners conflict diametrically with current changes in the healthcare delivery marketplace.

I. THE EVOLUTION OF PHYSICIAN-HOSPITAL ORGANIZATIONS IN THE HEALTHCARE DELIVERY MARKET

Important changes are occurring in the healthcare delivery system. Managed care is becoming a dominant mode of healthcare financing and delivery. It is increasingly demanded by employers, and likewise, is being encouraged at the state and federal level.⁷ To offer a broader range of services, hospitals and physician groups are aligning themselves in PHOs. These PHOs stand alone as business entities distinct from either the hospital or a multi-specialty physician group, and they contract directly with HMOs, health plans, and other payors. The growth of PHOs has been exponential. From an estimated fifty PHOs in 1990, the number increased to two thousand in 1994,⁸ and currently totals approximately three thousand.⁹ There are two trade organizations for PHOs, the American Association of Physician Hospital Organizations/Integrated Healthcare Delivery Systems, which is located in Glen Allen, Virginia, and the National Association of Physician-Hospital/Integrated Health Organizations, which is locat-

6. See 29 U.S.C. § 1144 (1988 & Supp. V. 1993) (exempting certain employee benefit plans from state laws).

7. See Health Law Center, *Hospital Physician Organizations*, in IIB HOSPITAL LAW MANUAL ¶5-3 (Cynthia Conner et al. eds., 1993) (explaining that the development of integrated service networks at the state level is a means of providing quality and cost-effective care).

8. See David Azevedo, *PHOs: Castles in the Sand?*, MED. ECON., Oct. 24, 1994, at 71, 72 (remarking on the explosion of PHOs in the healthcare delivery market).

9. See Mary Jaklevic, *PHOs Fall Short of Expectations*, MOD. HEALTHCARE, Oct. 9, 1995, at 77 (estimating that 3,000 PHOs have formed since the early 1980s).

ed in Oklahoma City, Oklahoma. The often-cited benefits of forming a PHO are to create leverage in negotiations with managed care companies by combining the hospital and physician care components into one unified entity, to develop more control of practice standards and data management, and to align incentives to allow the PHO to prosper from capitation contracts with payors.¹⁰ PHOs are sometimes viewed as interim steps on the vertical integration ladder—the penultimate step before becoming a fully integrated delivery system that can contract directly with self-funded payors and third-party administrators for a full continuum of healthcare delivery.¹¹ To compete effectively with HMOs and other managed care delivery systems (such as tightly managed preferred provider organizations (PPOs)), PHOs will need to accept full or partial risk in the form of global or limited capitated payments.¹² It is this acceptance of full or partial capitated risk, the next logical step in PHO evolution, that draws the ire of insurance regulators.

10. *See id.*

11. *See id.* *See also* Azevedo, *supra* note 8, at 71 (describing the ultimate goals of PHOs).

12. *Cf.* Azevedo, *supra* note 8, at 78. Some commentators question whether PHOs are cost-effective providers of medical services, and whether they can control utilization effectively enough to prosper under capitated payment reimbursement. Although a discussion of the pros and cons of PHOs from a business and cost perspective would be an interesting undertaking, it is regretfully beyond the scope of this Article. For a discussion of the business merits of PHOs as healthcare delivery systems, refer to Azevedo, *supra* note 8 and, Jaklevic, *supra* note 9.

II. THE NATURE OF THE "RISK" THE PHO INCURS

The amount and nature of the "risk"¹³ the PHO incurs will change according to the way the compensation is structured. If the PHO's internal economic incentives are not properly aligned, then savings gained in one component of care can be lost through the shifting of utilization to another. For example, if only the primary care physicians are capitated, and the specialist physicians and hospital in the PHO are paid on a fee-for-service basis, there can still be overutilization of services. Unless there is a method to link the utilization of the specialists and the hospital to the primary care physician's referral and hospital admission patterns, the primary care physician's incentive will be to rely more on the services of the specialist and the hospital, and conserve her time and resources for other activities. Conversely, the PHO's internal incentives could be misaligned to provide incentives for the hospital to shift utilization to the physicians and ancillary providers. In either case, these would not be compensation arrangements which maximized the healthcare plan's capital.¹⁴ Further, if members were hospitalized more frequently or incurred greater waiting time to see specialist physicians, such members would incur higher opportunity costs because of the less-than-efficient de-

13. This Article will frequently use the term "risk," but not in the same context that an insurance regulator would use the term. One of the main premises of this Article is that the "risk" the PHO incurs under capitation is not an impermissible "insurance risk," but risk of a type which any contracting party can assume in a transaction, i.e., "business risk." For the definition of "insurance risk," refer *infra* note 46 and accompanying text.

The PHO does not accept "insurance risk" because it is the employer who incurs the "risk" of ultimately providing healthcare services to the employer. The funds "at risk" to pay for the employee's healthcare services are the general assets of the company. The employer will often pay the HMO or the PHO a monthly capitated amount per member (usually expressed as "per member, per month," or "PMPM"). If the employer group fails to pay the premiums, the PHO would not be obligated to continue to provide healthcare services to the employer group's members. The employer would, however, remain obligated to provide healthcare benefits to its employees and the employees' dependents.

14. The Author suggests that the analogy of squeezing a balloon is instructive when considering achieving the maximum value of PHO capitation. If one can wrap one's hands around the entire balloon, the balloon can be compressed. However, if the balloon can squirt through between one's fingers, or in other places where the hands do not completely clasp, the balloon escapes compression. Similarly, squeezing only some, but not all, of the utilization vectors in the PHO can result in inefficient care delivery as incentives and utilization patterns are misaligned.

livery of healthcare. The more risk the PHO takes, the greater the chance it can more efficiently deliver healthcare to the plan's members because the risk of inappropriate utilization will fall upon all providers in the PHO. The greater the risk the PHO assumes, however, the more suspect it becomes in the eyes of insurance department bureaucrats. The nature and amount of risk accepted by the PHO is taken into consideration by many insurance commissioners when considering whether to consider the PHO's risk assumption to be the "business of insurance." The NAIC, however, considers any acceptance of what it deems "insurance risk" by the provider who is contracting with a self-funded payor to be the "business of insurance."¹⁵ The only permissible provider risk in the NAIC Draft Bulletin is a PHO accepting capitated payments from a licensed HMO or other health insurer.¹⁶

The Group Health Association of America (GHAA) prepared a survey of state insurance regulator's positions regarding PHO assumption of risk.¹⁷ The GHAA developed a paradigm to describe the types and nature of risk accepted by PHOs, and used the paradigm in querying the regulators of all fifty states and the District of Columbia. The GHAA paradigm will be adopted in this Article when discussing the types of PHO risk, with only a few clarification points added. This paradigm is set out below:

Option One (No Risk): The PHO contracts directly with the employer, and the PHO is paid on a fee-for-service basis for all medical services. The employer retains the full insurance risk for the cost of employee medical services.

Option Two (Full Risk): The PHO contracts directly with the employer, and the PHO is paid on a prepaid, capitated basis for all medical services.

Option Three (Partial Risk): The PHO contracts directly with the employer and a budget is established, usually on an annual basis, to pay for all medical services. At the end of the contract

15. See NAIC Draft Bulletin, *supra* note 2, at 3.

16. See *id.*

17. See GROUP HEALTH ASSOCIATION OF AMERICA (GHAA), PHOS AND THE ASSUMPTION OF INSURANCE RISK: A 50-STATE SURVEY OF REGULATORS' ATTITUDES TOWARD PHO LICENSURE 1, 4 (July 10, 1995). The findings of this survey are discussed *infra* notes 22 to 30 and accompanying text, as well as in Appendix A.

period, the PHO is liable for any services above the budgeted amount up to 110 percent of the budget. If the cap is not reached, the PHO splits the savings with the employer.¹⁸

Option Four (Downstream Risk): The PHO contracts with a licensed health plan to provide medical coverage pursuant to a group policy, and the PHO is paid on a prepaid, capitated basis. The licensed health plan contracts with one or more employer groups.¹⁹

This paradigm will be used in this Article to describe the degree to which PHOs assume risk in reimbursement relationships with employer health plans. However, Option Two may be further broken down into situations where the PHO itself is paid a global capitalization rate, and where only some PHO services are capitated, and some are paid in another manner.

III. THE POSITIONS OF STATE INSURANCE REGULATORS REGARDING PHO ASSUMPTION OF RISK

In addition to the GHAA survey referred to above, another study has been prepared by the national accounting firm of Ernst & Young.²⁰ The Ernst & Young study used different categories than the GHAA paradigm categories to query regulators.²¹ Although the results were not coterminous because of differences in the querying methodology, both studies found that most regulators believed that PHOs must be licensed as HMOs if they wished to accept full or partial capitated risk.²²

18. This ten percent loss below or above the budgeted amount is often called a "risk corridor." This ten percent "risk corridor" is usually funded with "withhold" or a reserve pool, or perhaps a combination of both. "Withholds" are amounts withheld from the fees paid to providers. For example, if the budgeted amount for a service is one hundred dollars, the provider would be paid only ninety dollars with ten dollars being held by the payor as a withhold. At the end of the contract year, if the group's claims healthcare experience is equivalent to the budgeted claims amount, the withhold is returned to the provider. If the claims experience is worse than estimated, part or all of the withhold is retained by the payor to recoup the claims loss. The cost of services which exceed the withhold of the budgeted amount will be borne by the payor. Similarly, reserve pools are amounts withheld from the capitated payment to fund losses within the "risk corridor." Losses outside this risk corridor are absorbed by the payor, or sometimes shared through other mechanisms between the provider and payor.

19. See GHAA, *supra* note 17, at 4.

20. ERNST & YOUNG, LLP, PHYSICIAN HOSPITAL ORGANIZATIONS: STATE REGULATORS PLAY CATCH-UP (Ernst & Young ed. 1994).

21. See *id.* at 4-5.

22. See *id.* at 4. This Article will not reproduce the positions of all fifty states. However, a

For Option Two (Full Risk), the GHAA study found that forty-one states would require PHO licensure, nine had not formally developed a position but would not permit full risk taking by a PHO, and only the District of Columbia would permit a PHO to accept full risk capitation from self-insured payors without licensure.²³ The Ernst & Young study apparently did not query the District of Columbia.²⁴ However, this study found that none of the states would permit full risk capitation from multiple employer groups contracting with a PHO, but Illinois and Kansas had unwritten policies permitting a PHO to accept full capitated risk from a single employer.²⁵ Subsequent to the completion of the 1994 Ernst & Young study, in April of 1996, the Illinois Department of Insurance announced in a written bulletin that it would permit PHOs and other IDSs to accept capitated payments directly from self-funded employer plans.²⁶ The Ernst & Young study did not break their risk categories down between full and partial risk, however. Regarding Option Three, limited insurance risk, the GHAA study found that twenty-five state insurance commissioners would not permit PHOs to accept such risk without licensure, and again, only the District of Columbia categorically would permit such partial risk assumption.²⁷ The other twenty-five states were categorized as "unclear," meaning that the state's policy was either "uncertain" or "undecided."²⁸ The GHAA survey noted that many of the regulators in the states categorized as "unclear" stated they would have to look at each arrangement individually.²⁹

Option Three, condemned by many insurance regulators as an improper assumption of "insurance risk," is a fairly common relationship. The ten percent "risk corridor"³⁰ is in effect

simulation of the GHAA survey matrix is attached as Appendix A.

23. See GHAA *supra* note 17, at 5, 11-12.

24. See ERNST & YOUNG, *supra* note 20, at 1.

25. See *id.* at 5.

26. See David Grant, *Provider Based Market Systems - When to Regulate*, 2 ILL. INS. BULL., Apr. 1, 1996, at 1.

27. See GHAA *supra* note 17, at 5, 11-17.

28. See *id.* at 5.

29. See *id.* at 7 (discussing that states are unsure whether or not to make risk assumption part of their licensing process).

30. See *supra* note 18 for a discussion of "risk corridor."

“pre-funded” by the PHO agreeing to the withhold. If the risk corridor is ten percent, and there is a ten percent withhold, the risk is prefunded. If the total cost of healthcare services provided to plan members totals 110 percent of the budgeted amount, the withhold is consumed. If the PHO successfully manages utilization, it may keep some or all of the withhold.

Option Four is the “downstream” transfer of risk. This is the relatively common scenario where a licensed HMO pays a capitated payment to a PHO or other provider for members of the HMO. Two states, California and Nevada, told the GHAA that they would require that PHOs which accept capitated payments, even from licensed entities, must themselves become licensed.³¹ Texas also does not permit PHOs to accept global capitation for both physician and hospital services.³² This Article will not seek to reproduce the results of the GHAA and Ernst & Young surveys. However, a review of correspondence and statements from various state insurance regulators provides an illustration of a general condemnation of the acceptance of capitation from a non-regulated entity or a self-funded employer plan.

A 1990 Maryland Attorney General Opinion addressed a health plan marketed to employee groups by a third-party administrator.³³ The health plan was called “Healthnet.” Healthnet accepted capitated fees from employer groups and deducted an administrative fee from the capitated payment.³⁴ Healthnet then contracted with some licensed HMOs, other health plans, and directly with some providers.³⁵ The Maryland Attorney General found that while Healthnet was not subject to the insurance commissioner’s jurisdiction, the providers of healthcare under direct contract with Healthnet were

31. See GHAA, *supra* note 17, at 8 (discussing the policies of California and Nevada which require PHO licensing). California does not permit providers to capitate for healthcare services that such provider renders unless such provider is licensed as an HMO. However, the physician component of a PHO could capitate for physician services and the hospital component could capitate for the hospital services. See *id.*

32. Letter from Leah Rummel, Director, *HMO/URA*, to Texas Medical Providers (Summer 1995) (on file with author).

33. Insurance - Jurisdiction of Ins. Comm’r. - Health Benefits Program, 1990 Md. Att’y Gen. LEXIS 30, at *1 (1990) (concluding that the health benefits program, known as “Healthnet,” is subject to the jurisdiction of the Insurance Commission).

34. See *id.* at *1-*2.

35. See *id.* at *2-*3.

engaged in the "business of insurance."³⁶ The Maryland Attorney General addressed the question of whether the self-funded employer plan arrangement with Healthnet and the provider triggered ERISA preemption.³⁷ The Maryland Attorney General did not engage in any analysis to determine whether the healthcare providers were engaged in the unlicensed "business of insurance." Rather, the Attorney General merely assumed that the providers were engaged in the business of insurance, and cursorily noted that while ERISA preempts state regulation of employee benefit plans, ERISA still allows states to continue to regulate the sale of insurance.³⁸ The cases cited by the Maryland Attorney General, however, did not stand for the cited propositions.³⁹ The subject employee benefit vehicles in the cases cited by the Maryland Attorney General⁴⁰ were somewhat crude variants of multiple employer welfare benefit plans. These courts found that the instant plans were not employee welfare benefit plans which are favored with ERISA preemption.

Similarly, the Ohio Department of Insurance, in a letter to the Ohio Hospital Association, stated that a capitated arrangement between a PHO and a self-insured employer transfers all of the risk from the employer to the PHO.⁴¹ The letter goes on to state that no degree of risk acceptance by an unlicensed

36. *See id.* at *13.

37. *See id.*

38. *See id.*

39. *See id.*, citing *Taggart Corp. v. Efos*, 475 F. Supp. 124 (S.D. Tex. 1979) (describing that the subject plan was not established by employer(s) as defined in 29 U.S.C. § 1003(a)), *aff'd*, 617 F.2d 1208 (1980); *Matthew 25 Ministries, Inc. v. Corcoran*, 771 F.2d 21 (2d Cir. 1985) (concluding that instant plan operator was not a bonafide employer or employee organization pursuant to 29 U.S.C. § 1003(a)); *Bell v. Employee Sec. Benefit Ass'n.*, 437 F. Supp. 382 (D. Kan. 1977) (holding that the ESBA plan was not an "employee benefit plan"). However, *Metropolitan Life Insurance Company v. Massachusetts Travelers Insurance Company*, would generally support the Attorney General's position. 471 U.S. 724 (1985) (holding that a state statute that regulates insurance is not preempted by ERISA).

40. "Multiple Employee Welfare Arrangements" is defined in 29 U.S.C. § 1002 (40)(A) (West 1985) as benefit plans that are established or maintained for the employees of two or more employers. These arrangements are subject to state insurance insolvency laws. *See* 29 U.S.C. § 1144(b)(6)(A) (1988 & Supp. V. 1993) (providing that fully insured multiple employer welfare arrangements are subject to state insurance insolvency laws).

41. Letter from David J. Randall, Deputy Director, *Ohio Department of Insurance*, to John E. Callender, Senior Vice President, Ohio Hospital Association 3 (July 28, 1994) (on file with author).

entity is permissible under Ohio law without licensure.⁴² The positions of Ohio and Maryland represent the position of the NAIC Draft Bulletin. The flaws in the assumptions of the Maryland Attorney General and the Ohio Deputy Insurance Director's claim that the PHO/self-funded employer capitated arrangement is the unlicensed business of insurance will be addressed in the next section.

IV. THE NAIC DRAFT BULLETIN

The NAIC Draft Bulletin was a by-product of the Health Plan Accountability Working Group of the Regulating Framework Task Force.⁴³ This working group was established to examine the existing rules regarding healthcare plan legislation. The group was also formed to consider the development of a single model healthcare licensing act for all "health carriers." This model act, which has since been drafted, 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 healthcare services on a risk basis.⁴⁴ In the course of conducting public hearings to prepare this model act, the working group discovered self-funded employer groups were bypassing HMOs and insurers, and going directly to the source of healthcare, mainly, PHOs and other IDSs. This belated discovery of marketplace reality prompted the NAIC Draft Bulletin.⁴⁵

The NAIC takes the position that *any* assumption of risk by healthcare providers who contract directly with an employer constitutes the "business of insurance" and requires licensure as an HMO or other health insurer.⁴⁶ This includes not only full or partial capitation, but also arrangements which "include risk corridors, withold [sic] or pooling arrangements."⁴⁷ In reaching the conclusion that the foregoing arrangements amount to the "business of insurance," the NAIC sets out the following

42. *Id.*

43. *See* NAIC Draft Bulletin, *supra* note 2, at 1.

44. *See id.*

45. *See id.*

46. *See id.* at 3.

47. *Id.*

definition from the Florida District Court of Appeals case of *Professional Lens Plan, Incorporated v. Department of Insurance*.⁴⁸ The elements of an "insurance contract" are:

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

However, in applying this definition to PHO/self-funded employer arrangements, the NAIC misconstrues the nature of the relationship. The NAIC is correct when it asserts that the first two elements enumerated above are satisfied. Clearly, an employer has an insurable interest in the health of its employees through the terms of a health-benefit plan.⁴⁹ Also, the employer does incur the risk of loss when it establishes a direct contractual relationship with its employees through a self-funded plan. The assets at risk are the general assets of the employer's company.⁵⁰ However, the NAIC, just as some of its constituent insurance commissioner members had earlier done, incorrectly draws the conclusion that the PHO provider is the party who assumes the risk as an "insurer."

The third element of the "business of insurance" test is an assumption of risk by the party deemed to be the insurer.⁵¹ The NAIC discounts the essential element that differentiates the PHO-employer transaction from the insured-insurer transaction. It is the employer who is directly obligated to provide healthcare services to the employee, not the PHO. This lack of direct and contracted obligation between the employee and the PHO was cited by the Illinois Department of Insurance in its April 1996 bulletin which permits PHOs and other IDSs to contract directly with self-funded employee groups on a capitated basis and upon other risk-sharing bases.⁵² There is

48. 387 So. 2d 548 (Fla. 1980). It is interesting to note that the Florida District Court of Appeals in this case found that the arrangement did not constitute the "business of insurance." *Id.* at 551.

49. See NAIC Draft Bulletin, *supra* note 2, at 5.

50. See *id.*

51. See *id.* See also *Professional Lens*, 387 So. 2d at 550.

52. See Grant, *supra* note 26, at 1.

no contractual relationship between the employee and the PHO. Every operative term which obligates the employer to provide healthcare to the employee is contained in the health benefit plan document.⁵³ The PHO only appears in the directory of participating providers. If the PHO facilities (for example, hospital and provider group offices) were bombed by terrorists or destroyed by a natural disaster, the employer would still be forced to go down the street to another provider for the benefit plan services. The "force majeure" clause, which is probably contained in the healthcare provider contract between the employer group and the PHO, or the agreement between the PHO and a third-party administrator who is acting on behalf of the employer, will excuse the PHO from performance. But more realistically, if the PHO does become insolvent, cease operation, or defaults on its contractual obligations, the primary employer-employee health benefit contract still exists and must be discharged through other healthcare service providers.

The NAIC also likens the employer to a consumer who requires the paternalistic protection of insurance laws. The NAIC Draft Bulletin states that an "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."⁵⁴ This is quite true. However, the employer expects the same performance from any party with whom it contracts, and does not require the department of insurance to regulate the terms and conditions of its contracts with vendors, suppliers, and service providers.

In actuality, the risks to the employee of not receiving healthcare benefits has changed little, if at all, where his employee contracts with a PHO on a capitated basis. Employers fund their self-insured benefit plans with the assistance of benefit-design consultants and actuarial analysis. They often

53. See 29 U.S.C. § 1132(a)(1)(B) (1988 & Sup. V. 1993) which provides that participants or beneficiaries under a plan may bring an action "to recover benefits" due him under the terms of the plan. See also *Bullwinkel v. New Eng. Mut. Life Ins. Co.*, 18 F.3d 429, 430-31 (7th Cir. 1994) (stating that an ERISA health plan is a contract); *N.W. Laundry & Dry Cleaners Health & Welfare Trust Fund v. Burzynski*, 27 F.3d 153, 156 n.8 (5th Cir. 1994) (stating ERISA plan must be interpreted as any other contract), *cert. denied*, 115 S. Ct. 1110 (1995).

54. NAIC Draft Bulletin, *supra* note 2, at 6.

purchase "stop loss" insurance to protect them from large healthcare claims. Moreover, PHOs typically protect themselves with cost outliers that supplement the capitated rate when an employee incurs substantial expense.⁵⁵ Likewise, PHOs typically purchase provider-excess insurance or provider reinsurance to protect them from substantial medical expenses. Additionally, the PHO, unlike an employer (or an insurer) is the *actual* provider of the healthcare, not merely a payor. Thus, it can internally subsidize the cost of uncompensated care, through foregone profits and lost opportunity costs, more efficiently than an entity that can only write checks for the cost of healthcare services provided by others.⁵⁶ But while the risk of nontreatment of an employee's illness has changed little, if at all, the perceived ability of insurance regulators to expand their jurisdiction has. Self-funded employer benefit plans are clearly exempt from state regulation under ERISA when paying fee-for-service reimbursement to providers.⁵⁷ However, when these self-funded plans seek to take advantage of cost-reducing marketplace trends such as provider capitation, these regulators find the entrée that will allow them to retake lost regulating territory.

V. CURRENT STATE PHO/IDS-PAYOR REGULATION

Minnesota and Iowa have rules in place which regulate PHOs/IDSs and Payors. These rules are promulgated, respectively, in the Minnesota Integrated Service Network Act⁵⁸ and

55. A cost outlier is a mechanism where, for example, if the cost of hospital care for an employee-patient exceeds \$50,000 for an incident of illness, the reimbursement mechanism might charge from the monthly capitated premium for such employee up to 80% of the providers' billed charges for such services.

56. See Eric Weissenstein & Jonathan Gardner, *Foiled on PSNs, Hospitals Oppose Budget*, MOD. HEALTHCARE, Nov. 20, 1995, at 4. Provider groups argued to United States House of Representative and Senate Republican leaders that provider networks are "fundamentally different from insurers and should not have to meet the same requirements." For example, "they [provider representatives] say that providers should not have to meet the same solvency requirements as insurers because they are the organizations providing the care, unlike insurers, who must keep adequate cash on hand to pay their claims." *Id.*

57. See 29 U.S.C. § 1144 (1988 & Supp. V. 1993) (providing that only fully funded employer benefit plans are subject to state regulations).

58. MINN. STAT. ANN. § 62N.01 (West 1995).

the Iowa Organized Delivery Systems regulations.⁵⁹ The stated purpose of the Minnesota statute is to:

[A]llow the creation of integrated service networks that will be responsible for arranging for or delivering a full array of healthcare services, from routine primary and preventive care through acute inpatient hospital care, to a defined population for a fixed price from a purchaser.⁶⁰

The statute basically allows for the formation of "mini HMOs" with slimmed-down reserve and reporting requirements. The provisions of the statute are regulated by the Minnesota Healthcare Commission,⁶¹ not the Department of Insurance. The statute sets out two types of networks: Integrated Service Networks (ISNs),⁶² and Community Integrated Service Networks (CISNs).⁶³ ISNs are large networks with *more than* fifty thousand members, and may accept capitated payments or other risk sharing reimbursement formulas from self-insured payors.⁶⁴ CISNs are networks with *less than* fifty thousand members.⁶⁵ It is in regard to CISNs that the Minnesota statutory mechanism lifts significant burdens that are placed on ISNs and HMOs. For example, ISNs are exempt from filing yearly quality assurance plans,⁶⁶ maintaining required statistics,⁶⁷ filing annual marketing plans,⁶⁸ and filing provider contract forms.⁶⁹ The CISN requirements do contain a net worth minimum of one million dollars,⁷⁰ but also provide that

59. IOWA ADMIN. CODE § 641-201 (1996).

60. MINN. STAT. ANN. § 62.01.2 (West 1995).

61. See MINN. STAT. ANN. §§ 62N.02.3, 62N.02.4 (West 1995) (defining "commission" and "commissioner").

62. See MINN. STAT. ANN. § 62N.02.8 (West 1995) (defining "integrated service networks").

63. See MINN. STAT. ANN. § 62N.02.4(a) (West 1995) (defining "community integrated service network").

64. See MINN. STAT. ANN. § 62N.02.8(b) (West 1995) (explaining "integrated service networks").

65. See MINN. STAT. ANN. § 62N.02.4a(a) (West 1995) (describing "community integrated service networks").

66. See MINN. STAT. ANN. § 62N.25.7(2) (West 1995).

67. See MINN. STAT. ANN. § 62N.25.7(3) (West 1995).

68. See MINN. STAT. ANN. § 62N.25.7(6) (West 1995).

69. See MINN. STAT. ANN. § 62N.25.7(4) (West 1995).

70. See MINN. STAT. ANN. § 62N.28.1(1) (West 1995) (describing Minnesota's net worth requirement for HMOs). This net worth requirement may also be phased in. See MINN. STAT. ANN. § 62N.28.4 (West 1995). New Minnesota HMOs, by contrast, must have a net worth of at least \$1,500,000, or 8 1/3% of amount of all expenses to be incurred in the year following the

this amount can be secured by certain "guaranteeing organizations," organizations that obligate themselves to maintain the CISNs financial reserves for the CISNs.⁷¹

Also, the ISN/CISN statute has a mechanism for accrediting providers who want to provide capitated services to ISNs/CISNs. These providers, called "Accredited Capitated Providers,"⁷² must demonstrate to the Minnesota Commissioner of Health that they have the operational and financial capacity to provide services to the network on an on-going basis, and for a period of 120 days after the insolvency of the network, a period of time in which the provider would not receive payment from the CISN for its services.⁷³ Additionally, the CISN can reduce its net worth requirement by up to the amount by which its net worth exceeds one million dollars by "ceding" financial risk to accredited capitated providers.⁷⁴ This "risk-ceding" mechanism permits the CISN to allocate capitated risk to providers, and permits it to lower its net worth requirement to one million dollars.⁷⁵ The amount of risk ceded is the percentage that all capitated rate payments made by the CISN bears to all premium revenue received by the CISN in a contract year.⁷⁶ This risk-ceding mechanism could greatly lessen the burden upon CISNs, and could assist in forming economic "partnerships" between the providers who serve the CISNs. At a minimum, the Minnesota law represents an attempt to recognize smaller community provider-payor relationships which do not require all of the regulatory burdens placed upon traditional HMOs.

issuance of certificate of authority, whichever is greater. *See* MINN. STAT. ANN. § 62D.042.1(a) & 62D.042.2(a)-(b) (West 1995) (describing net worth and working capital requirements for Minnesota HMOs). Also, Minnesota HMOs must deposit the greater of \$500,000 or 33% of their uncovered expenses from the previous year. *See* MINN. STAT. ANN. § 62D.041.3-4 (West 1995).

71. *See also* MINN. STAT. ANN. § 62N29 (West 1995). *See also* MINN. STAT. ANN. § 62D.043 (West 1995).

72. *See* MINN. STAT. ANN. § 62N31 (West 1995) (stating the standards for capitated provider accreditation).

73. *See* MINN. STAT. ANN. § 62N27 (West 1995) (defining the period of time for which the capitated provider is accredited).

74. *See* MINN. STAT. ANN. §§ 62N27(5), 62N27(6) (West 1995) (allowing service networks to cede their financial risk to their accredited capitated providers).

75. *See* MINN. STAT. ANN. § 62N27.5 (West 1995) (allowing service networks to allocate the risk through providers).

76. *See id.* (explaining that premium revenue can be received by the service network during any contract year).

The Iowa "Organized Delivery System" (ODS) rules, in contrast to the Minnesota CISN⁷⁷ mechanism, place burdensome reporting, structural, and member relations requirements upon ODSs. While these regulations may be necessary for statewide or regional ODSs, they do not reflect the lesser requirements of smaller community ODSs which the Minnesota CISN laws recognizes. The application process and requirements are those typically required by other states for HMO applications, such as a detailed complaint resolution and recordation system,⁷⁸ service area descriptions, coverage requirements,⁷⁹ and reporting requirements⁸⁰ which mandate detailed profiling of membership and utilization.⁸¹ The financial reserve requirement in the ODS rules is one million dollars, or three times the ODS's average monthly claims amount, whichever is larger.⁸² This is equivalent to the Minnesota CISN rule.⁸³ However, Iowa ODSs must post a surety bond with the Iowa Insurance Commissioner, and the rules contain investment limitations on the ODS's assets⁸⁴ which are analogous to the limits that states place on insurance company assets. One area the ODS rules provide for is antitrust exemptions,⁸⁵ a mechanism not present in the Minnesota CISN and ISN rules.

In comparing the Minnesota statute and the Iowa rules, it is apparent that Minnesota legislators have given CISN's relief from HMO-type regulation to serve local needs, while Iowa's regulators have maintained bureaucratic "HMO-like" controls over ODSs. While these statutes do reflect at least some recognition that full HMO or insurance licensure is not necessary for IDSs to operate, they still represent government intervention in an area where state regulation may not be permitted, the relationship between self-funded employer groups and providers.⁸⁶

77. See MINN. STAT. ANN. § 62N.02.4(a) (West 1995).

78. See IOWA ADMIN. CODE § 641-201.7 (1996).

79. See IOWA ADMIN. CODE § 641-201.5 (1996).

80. See IOWA ADMIN. CODE § 641-201.8 (1996).

81. See IOWA ADMIN. CODE § 642-201.8 (4) (1996).

82. See IOWA ADMIN. CODE § 641-201.12(2) (1996).

83. See MINN. STAT. ANN. § 62N28.4 (West 1995).

84. See IOWA ADMIN. CODE § 201.13 (1996).

85. See IOWA ADMIN. CODE § 641-201.20 (1996).

86. Self-funded plans' relations with PHOs and other providers and IDSs should be free of state regulation, both because of ERISA and the sophisticated nature of the purchaser. However, state regulation should still be involved when individuals, very small employers, and small

VI. ERISA PREEMPTION OF STATE REGULATION OF SELF-FUNDED HEALTH BENEFIT PLANS

The potential “trump card” that an employer self-funded health benefit plan can play in disputes with state laws and state regulators is the broad preemption provisions of 29 U.S.C. § 1144. The preemption provision, and its limits, are set out below.

(a) Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

(b)(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(b)(2)(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.⁸⁷

Basically, Section 1144(a) preempts “any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.”⁸⁸ However, Section 1144(b)(2)(a), the “savings clause,” goes on to state that “nothing . . . shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking or securities.” At this juncture, it appears that the preemption provisions that Congress gave with one hand to employer-sponsored benefit plans,

associations purchase coverage. In this regard, HMO-like protection should be in place when such purchasers buy coverage directly from community PHOs and IDSs. Perhaps Minnesota's CISN rules could serve as a template for other states' operation of community IDSs.

87. 29 U.S.C. § 1144(a)-(b) (1988 & Supp. V. 1993) (enumerating preemption, construction, and application of section 1144).

88. U.S.C. § 1144(b)(2)(B) (1988 & Supp. V. 1993).

it took back with the other. However, the "deemer" clause comes to the rescue and provides that "an employer benefit plan . . . shall [not] be deemed to be an insurance company . . . or engaged in the business of insurance . . . for purposes of any law of any state purporting to regulate insurance."⁸⁹ The interplay of the "deemer" and "savings" clauses establishes a bifurcated mode of analysis of state benefit law regulation. If the state law regulates the insurance-benefit product offered by the employer plan, it is saved from preemption.⁹⁰ Thus, Utah could require that underwritten employee-group health plans contain benefits for birth control drugs and devices, or North Carolina could mandate group health plan benefits for cigarette smoking cessation. However, if the employer plan is self-funded, these hypothetical state laws would be preempted.⁹¹ State insurance laws, because they "relate to" the employer's self-funded capitated payment of health benefit plans, and are inapplicable to such plans because of the "deemer" clause, are preempted by ERISA.

The most recent pronouncement regarding ERISA preemption is the U.S. Supreme Court case of *New York Conference of Blue Cross v. Travelers Insurance Company*⁹² which was decided on April 26, 1995. This case involved a New York statute which requires hospitals to collect surcharges from patients whose services were reimbursed by commercial health insurance, and also requires HMOs to pay varying surcharges based on their number of Medicaid members.⁹³ The purpose of this statute was to raise the cost of commercial insurance for carriers other than Blue Cross and Blue Shield, and to shift market share back to the economically threatened Blue Cross and Blue Shield plan.⁹⁴ The Court, after discussing its prior

89. *Id.*

90. *See Metro. Life Ins. Co. v. Ma. Travelers Ins. Co.*, 471 U.S. 724, 746 (1985). For additional discussion of ERISA preemption, refer to the following: *Tex. Pharmacy Ass'n v. Prudential Ins. Co.*, 907 F. Supp. 1019, 1025-26 (W.D. Tex. 1995) (stating that ERISA preempts "any willing provider laws"), *aff'd, modified*, 1997 U.S. App. LEXIS 2723 (5th Cir. Feb. 14, 1997); *Prudential Ins. Co. v. Nat'l Park Med. Ctr., Inc.*, No. LR-C-95-514 (Jan. 14, 1997 E.D. Ark.) (holding that the Arkansas Patient Protection Act was preempted by ERISA).

91. *See Metro. Life Ins. Co. v. Travelers Ins.*, 471 U.S. at 747.

92. 115 S. Ct. 1671 (1995).

93. *See id.* at 1673.

94. *See id.* at 1678-79.

ERISA decisions and discussing the purpose of the preemption clause, held that the surcharges were not preempted because they only had an indirect economic effect on the cost of health insurance, and, therefore, did not "relate to" employee benefit plans within the meaning of 29 U.S.C. § 1144.⁹⁵ Although the Court held that state laws that have only an indirect economic effect, such as New York's surcharges, do not have a great enough nexus with employee health benefit plans to "relate to" them for ERISA preemption purposes, it did restate holdings which should still trigger preemption of state limitations on PHO/self-funded employer plan capitation reimbursement.

The Court's discussion of the New York surcharges differentiates the surcharges from state laws which affect benefit plan design or administration. It cited *Shaw v. Delta Airlines*⁹⁶ which held that a New York law that prohibited benefit discrimination on the basis of pregnancy and required specific pregnancy benefits "related to" employee benefit plans, was preempted.⁹⁷ Similarly, the Court distinguished the surcharges from the preempted Pennsylvania law in *FMC Corporation v. Holliday*⁹⁸ which purported to prevent plans from pursuing subrogation rights on behalf of their members against tortfeasors.⁹⁹ Additionally, the Court reiterated its decision in *Alessi v. Raybestos-Manhattan, Incorporated*,¹⁰⁰ where it held that a New Jersey law that purported to prohibit pension plans from offsetting workers' compensation awards against employees' pension was preempted by ERISA.¹⁰¹ Differentiating those cases from the instant case, the Court relied on the fact that the preempted state laws in those cases mandated employee benefit structures or their administration.¹⁰² These laws would force the employer to adopt a different benefit structure or administrative mechanism in the states where the offending laws were in effect. With the Supreme Court's reiter-

95. *See id.* at 1680.

96. 463 U.S. 85 (1983).

97. *See Blue Cross v. Travelers Ins.*, 115 S. Ct. at 1678.

98. 498 U.S. 52 (1990).

99. *See Blue Cross v. Travelers Ins.*, 115 S. Ct. at 1678.

100. 451 U.S. 504 (1981).

101. *See Blue Cross v. Travelers Ins.*, 115 S. Ct. at 1678.

102. *See id.*

ation of ERISA preemption with regard to laws¹⁰³ which mandate benefit structures or administration in hand, a template for a preemption attack on state PHO capitation proscriptions may be developed.

There are many reasons why self-funded employer plans might choose to contract directly with PHOs on a capitated basis. Some examples are as follows:

A. Lower cost of benefit plan: By circumventing an HMO, the employer cuts out the middle man's administrative fees and profits.

B. Self-administered plans could save claim administration fees and greatly streamline administrative procedures nationwide by capitating their providers, instead of paying claims individually on a fee-for-service basis.

C. Benefit compensation structures with capitated providers give providers the incentive to manage the health and "wellness" of employees, not merely treat the conditions.¹⁰⁴

Direct capitation contracts with PHOs will allow employers to tailor their own plans to achieve this end.

Under the *Travelers* rationale, however, Example A would not in and of itself support preemption. If the only benefit to the plan, if freed from the state PHO regulation, were the lower cost of its healthcare services, a preemption claim would fail.¹⁰⁵ However, if the burdens of state PHO regulation would impact a plan's interest in promoting Example B or C (mandating administrative burdens or plan structures), the law

103. The "laws" which ERISA preempts are not limited only to state statutes. For example, 29 U.S.C. § 1144(c)(1) (1988 & Supp. V. 1993) provides that state actions, such as issuing "cease and desist orders," could be preempted by ERISA, just as a state statute attempting to achieve the same effect would be. The definition of "state law" for the purposes of section 1144 includes "all laws, decisions, rules, regulations or other state action having the effect of law, of any state." *Id.*

104. Under a capitated-reimbursement methodology, providers have incentives to keep patients well. Under a fee-for-service methodology, the providers' economic incentives lead them to treat patients for symptoms and conditions in order to maximize revenue. The Author concedes that at mercenary extremes, some capitation providers could skimp on treatment to maximize profits. However, by failing to treat conditions in their nascent stages, providers may incur greater costs later when the member's condition has needlessly advanced. Conversely, a fee-for-service reimbursement mechanism incentivizes providers to over-treat in the costliest settings. The Author believes, however, that medical ethics, and personal and corporate integrity, reign in providers who would consciously over-treat or under-treat to maximize profits. Still, the Author believes that close treatment decisions made by providers may be subtly swayed by economic motives. By incentivizing providers to keep patients well, economic motives will drive the greater personal and public health needs of the country, not steer the providers to over-treat, and thereby, raise healthcare expenditures.

105. See *Blue Cross v. Travelers Ins.*, 115 S. Ct. at 1680.

may be preempted. State regulatory enforcement actions, statutes, or regulations prohibiting PHO capitation would mandate an administrative mechanism in that such proscriptions would not permit direct PHO capitation with local or regional providers unless such PHOs incur the unacceptable cost of HMO licensure. In such a regulatory environment, plan administrators would be forced to compensate such a PHO on a fee-for-service basis, and incur the claims costs, utilization management costs, and other expenses necessary to administer a fee-for-service system. Also, under a capitated system, a payor can delegate medical management, utilization review, precertification, and other functions to the PHO. Since a capitated PHO would have substantial incentives to reduce utilization and carefully manage the care of the employer's members, it would usually assume such functions. The employer plan sponsor would then need only to perform oversight functions if it had carefully contracted with a PHO capable of managing its members care. In addition to incurring medical management costs, the plan must either administer the claims itself, or pay a third-party administrator to do so.¹⁰⁶ The purported state proscription upon PHO capitation would limit an employer-plan sponsor's ability to adopt a benefit plan of its liking, and would force it to adopt a fee-for-service plan in a market that is moving toward capitation or contract with a licensed PHO. According to the Court's analysis in *Travelers, Shaw*, and *FMC Corporation*, such laws should be preempted.

Similarly, Example C should provide a basis to support ERISA preemption. Managed care, with gatekeeper physicians, medical management, and a heavy emphasis on preventative care, seeks to lower healthcare costs by alleviating, or at least managing, members' conditions at lower acuity stages. Managed care benefit plans typically have generous preventative care features, such as reduced copayments for physicals and "wellness programs" which promote fitness and health lifestyle choices. Many plans also provide generous benefits for pre-

106. Many payors and plan sponsors still require providers to submit claims or information data even when the provider is paid a capitated amount. This information is sometimes called "encounter data." Encounter data tracks utilization and is useful to determine a group in rate negotiation.

scription drugs. The emphasis is upon improving or maintaining the members' health, not treating conditions under a fee-for-service mechanism. While it is true that plan sponsors would not be precluded from incorporating these preventative and primary care features into a fee-for-service plan (or contracting with a licensed HMO), the effectiveness of these plan features may be obviated by physicians still "incentivized" by a fee-for-service reimbursement mechanism. The incentives of capitated reimbursement, outlined earlier, could be incorporated into the plan design to provide superior health of members at lower costs paid to a PHO that is free from burdensome state regulation. In that regard, state insurance regulators are mandating a benefit structure, an administrative mechanism, and fee-for-service reimbursement. All of these plan design features may be inapposite to the plan sponsor's desired goal.

Another potential basis for ERISA preemption may exist for employers with locations in states which do permit direct PHO capitated contracting, and states which do not. Although few state insurance regulators currently would permit an employer group to contract directly with a PHO on a capitated basis, the District of Columbia would reportedly permit it.¹⁰⁷ Illinois would permit it, and Kansas reportedly has an unwritten policy which permits a self-funded plan to enter into a capitation contract with a PHO.¹⁰⁸ One of the underpinnings of the preemption clause is to avoid conflicting state regulations and allow the uniform national administration of benefit plans.¹⁰⁹ A company with offices in Ohio and Illinois could not administer the same benefit plan if the Illinois office contracted with only one PHO. It must pay fee-for-service in Ohio with no provider risk sharing permitted.¹¹⁰ However, in Illinois, it could administer a capitated plan with a single PHO. In this example, Ohio insurance regulators stymie the uniform administration of this hypothetical company's benefit plan, and may face ERISA preemption of its enforcement activities.

107. See GHAA, *supra* note 17, at 11 (discussing state regulatory oversight of PHOs). See also *supra* note 23 and accompanying text.

108. See GHAA, *supra* note 17, at 11. See also *supra* note 25 and accompanying text.

109. See *Blue Cross v. Travelers Ins.*, 115 S. Ct. at 1677-78.

110. See *supra* notes 41-42 and accompanying text.

The Author's research reveals no case law which advances the position that regulators may enforce state insurance laws against PHOs that accept capitation from a self-funded employer plan. However, analogies drawn from a developing line of ERISA jurisprudence may lend support to ERISA preemption of state insurance PHO capitation proscription. Just as limits upon PHO capitation constrict the benefit structures and administration of employer plans, "any willing provider laws"¹¹¹ (AWP laws) limit a self-funded employer's ability to structure and administer its plan in the most advantageous manner.¹¹² The Fifth Circuit Court of Appeals in the case of *Cigna Healthplan of Louisiana v. State, Ex Rel. Ieyous*,¹¹³ and a Connecticut Superior Court in *Hollis v. Cigna Healthcare of Connecticut*,¹¹⁴ have held that ERISA preempts those states' AWP laws. Also, while the Fourth Circuit Court of Appeals held that Virginia's AWP law was not preempted as it related to an insured PPO in *Stuart Circle Hospital Corporation v. Aetna Health Management*,¹¹⁵ the Court did acknowledge that the Virginia AWP law was preempted as it related to self-funded plans.¹¹⁶

111. AWP laws require insurers and managed care plans to contract with any provider who is willing to meet the terms and conditions of participation in the managed care network. *See, e.g.*, IDAHO CODE § 41-3937 (1996) (discussing healthcare provider contracts and grievance procedures); IND. CODE ANN. § 27-8-11-3 (West 1995) (citing reimbursement agreements and immunity issues); WYO. STAT. § 26-22-503 (1996) (citing policies with incentives or limits on reimbursement authorized and conditions).

112. Managed care plans and managed care networks oppose AWP laws because such laws force them to contract with more providers than their network and membership may require. AWP laws thereby cause managed care entities to lose bargaining leverage with providers, because the provider's incentive to cut the best deal possible is diminished. AWP laws also require managed care entities to incur unwanted administrative costs by credentialing providers, administering additional contracts, and by requiring the education of additional providers in network policies and protocols. Providers generally support AWP laws because it gives them managed care network access that the free market would not.

113. 82 F.3d 642 at 644-45 (5th Cir. 1996).

114. 1994 WL 757530, at *1 (Conn. Super. Ct. Dec. 5, 1994).

115. 995 F.2d 500 (4th Cir. 1993). *See also* Texas Pharmacy Ass'n. v. Prudential Ins. Co., 907 F. Supp. 1019, 1025-26 (W.D. Tex. 1995) (holding that the Texas pharmacy AWP law was "related to" employee benefit plans, but was "saved" by the "insurance clause"), *aff'd, modified*, 1997 U.S. App. LEXIS 2723 (5th Cir. Feb. 14, 1997). *See* 29 U.S.C. § 1144(b)(2)(B)(2) (1988 & Supp. V. 1993) (explaining that employee benefit plans are not deemed to be entities engaged in the business of insurance or banking).

116. *Stuart*, 995 F.2d at 501 (stating that ERISA's deemer clause, 29 U.S.C. § 1144(b)(2)(B), precludes employer self-funded employee benefit plans from being brought within the scope of VA. CODE § 38.2-3407 (Virginia AWP law)). *See also* Richter v. Capp Care, Inc., 868 F. Supp. 163, 166 (E.D. Va. 1994) (recognizing the inapplicability of Virginia's AWP

In analyzing the various state's AWP laws as they "relate to" an ERISA plan for purposes of ERISA preemption,¹¹⁷ these courts found that AWP laws "related to" self-funded benefit plans and were preempted. The Fifth Circuit Court of Appeals found that application of Louisiana's AWP law impeded the employers' and plan sponsor's discretion regarding the structure of the benefit plan.¹¹⁸ The Fourth Circuit in *Stuart Circle Hospital* found that the Virginia AWP laws "relate to" employee benefit plans by restricting the plans ability to limit the provider pool.¹¹⁹ The Superior Court in *Hollis* stated that the Connecticut AWP laws directly impacted plan administration, and created a potential conflict between state laws.¹²⁰ And while the Fourth Circuit in *Stuart Circle Hospital* found that the insurance "savings clause" applied to the Virginia AWP law in the instant case,¹²¹ all of these courts found that AWP laws were preempted by ERISA.

The same reasoning which mandates ERISA preemption of AWP laws would apply equally to the prohibition of unlicensed PHOs accepting capitated payments directly from a self-funded employer plan. Just as an AWP law mandates a structure for employee benefit plans, PHO capitation proscriptions mandate a benefit plan structure. Under an AWP law, plans must contract with more providers than they deem optimal from a cost and network design perspective, and must incur additional administrative burdens to contract with and administer the contractual relationships with such unneeded providers. Analogously, plans that want to pay capitated rates to their PHO providers are prevented from doing so and can only contract on a fee-for-service basis. They must incur additional costs and administrative burdens in administering and paying many fee-for-service claims, and take on medical man-

law to self-funded plans), *aff'd* 77 F.3d 470 (4th Cir. 1996).

117. See 29 U.S.C. § 1144(a) (1988 & Supp. V. 1993) (explaining that ERISA regulations regarding employee health plans supersede state laws regarding the same).

118. See *Cigna*, 82 F.3d at 649.

119. *Stuart*, 995 F.2d at 502.

120. *Hollis*, 1994 W.L. 757530, at *8. AWP laws vary from state to state, with some states free of AWP laws (New Mexico) and some states regulating both PPOs and HMOs.

121. *Stuart*, 995 F.2d at 504. Cf. *Hollis*, 1994 WL 757530, at 8. *Accord Cigna*, 82 F.3d at 650 (holding that the "savings clause" did not apply because the AWP law did not regulate the business of insurance).

agement functions to control utilization. If the plan could capitate directly with the PHO, administration would be streamlined, and medical management could be delegated to the PHO. For these reasons, state insurance commissioners' prohibitions on direct PHO capitation are preempted by 29 U.S.C. § 1144(a), and such actions should not be sustainable against self-funded plans and their capitated service providers.¹²²

A PHO which desires to contract directly with a self-funded plan for capitated services will be faced with the task of convincing a court that ERISA preempts state proscriptions against direct capitation without the benefit of precedential authority. Making a PHOs task more daunting is obtaining the requisite standing to assist such a claim. To attain standing to prosecute an action against a state insurance commissioner so that a PHO can directly capitate with a self-funded employer plan, it may be able to do so as a "fiduciary"¹²³ of the plan pursuant to 29 U.S.C. § 1132(a)(3).¹²⁴ Section 1132(a)(3) per-

122. *Stuart*, 995 F.2d at 504. An advisory opinion by the North Carolina Attorney General concurs with this position. See John L. Crill, *Advisory Opinion: Durham County Hospital Corp.-Contracting with Self-Insured Employee Benefit Plans and Health Care Providers*, (Oct. 9, 1996) <[http://www.jus.State.nc.us:80/Justice/opinion/advisory/adv96.htm#\[278\]](http://www.jus.State.nc.us:80/Justice/opinion/advisory/adv96.htm#[278])>. The North Carolina Attorney General stated that the North Carolina HMO Act licensure provisions "relate[d] to" a proposed self-funded employee plan involving capitated reimbursement for healthcare services, and were "preempted" pursuant to 29 U.S.C. § 1144. Also, the HMO Act was not "saved" from preemption pursuant to the insurance "savings" clause. *Id.* However, the North Carolina Commissioner of Insurance issued a letter on October 22, 1996 which was strongly critical of the Attorney General's opinion. (Both the Attorney General's advisory opinion and the letter from the Commissioner of Insurance are on file with the author).

123. 29 U.S.C. § 1002 (21)(A) (West 1997) defines a "fiduciary" as:

Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated under section 1105(c)(1)(B) of this title.

Id.

124. 29 U.S.C. § 1132 (a)(3) states as follows:

(a) Persons empowered to bring a civil action. A civil action may be brought— (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations of (ii) to enforce any provisions of this title or the terms of the plan.

mits a fiduciary (or a beneficiary or participant) to enjoin or seek other appropriate relief from any act or practice in violation of ERISA. While service providers generally seek to avoid becoming ERISA "fiduciaries" because of the potential liability,¹²⁵ it is possible that a PHO may have the requisite discretionary authority over plan management or administration of the plan provisions to trigger ERISA fiduciary status. If an employer health plan would delegate medical management functions (which necessarily involve treatment and benefit determinations) to the PHO under a capitated reimbursement arrangement, it is possible that such a PHO would be a "fiduciary."¹²⁶ If such a PHO could attain "fiduciary" status, it may then have standing to pursue an equitable action against a state insurance commissioner, or defend itself in an action pursued by an insurance commission. In a Ninth Circuit Court of Appeals case, *General Motors v. California Board of Equalization*,¹²⁷ the Court held that plan fiduciaries had standing to bring an action to enjoin enforcement of a premium tax upon stop-loss insurance purchased by a self-funded health plan.¹²⁸ Also, in the case of *NGS American, Incorporated v. Barnes*¹²⁹ the Court enjoined the Texas Insurance commissioner from enforcing premium taxes and other burdensome regulatory requirements against third-party administrators who administer self-funded employer plans.¹³⁰ Armed with these cases, a PHO has a colorable claim that it has standing to argue that ERISA preempts enforcement of PHO capitation proscriptions.

Id.

125. 29 U.S.C. § 1109 (West 1996) provides that a fiduciary is personally liable for the breach of any responsibility or duty it owes to the plan.

126. Courts often find that administrators of self-funded employer plans are not "fiduciaries" because they do not possess discretionary authority to grant or deny claims or make other benefit determinations on behalf of the plan. *See, e.g., Pohl v. Nat'l Benefit Consultants, Inc.*, 956 F.2d 126 (7th Cir. 1992); *Baxter v. C.A. Muer Corp.*, 941 F.2d 451 (6th Cir. 1991).

However, it has also been held that administrators are fiduciaries because they undertake discretionary authority to administer the employer's plan. *See Libbey-Owens-Ford Co. v. Blue Cross & Blue Shield Mut. of Ohio*, 982 F.2d 1031 (6th Cir. 1993); *Reilly v. Blue Cross & Blue Shield United of Wis.*, 846 F.2d 416 (7th Cir. 1988). *See also Health Cost Controls v. Skinner*, 44 F.3d 535 (7th Cir. 1995) (allowing plaintiff to amend its complaint and demonstrate its "fiduciary" status).

127. 815 F.2d 1305 (9th Cir. 1987).

128. *See id.* at 1308.

129. 805 F. Supp. 462 (W.D. Tex. 1992), *aff'd*, 998 F.2d 296 (5th Cir. 1993).

130. *See id.* at 474.

VII. HEALTHCARE MARKET PLACE TRENDS: MOVING TOWARD PHO RISK ACCEPTANCE

The actions of state insurance regulators, and the NAIC in condemning direct risk arrangements between PHOs and self-funded employer plans, are on a potential collision course with potent shifts in the healthcare delivery market. Just as PHOs see the importance of contracting directly with payors, and accepting capitated reimbursement where appropriate, employers and employer health benefit purchasing coalitions are requesting that PHOs enter into direct contracts with them. In the Minneapolis-St. Paul communities of Minnesota (Twin Cities), a coalition of large employers intend to bypass managed care companies and directly contract with PHOs and other provider groups.¹³¹ The Twin Cities' Business Healthcare Action Group (BHCAG) intends to offer directly contracted plans in 1997, and desires to directly contract with various provider entities.¹³² The BHCAG believes better quality and lower cost healthcare will result from these relationships.¹³³ It will contract with another entity for claims processing and customer service.¹³⁴ The compensation to be paid providers will be a modified fee-for-service basis with a targeted utilization rate, and rewards or penalties for providers who come in above or below such target rate.¹³⁵ The BHCAG is aware of the potential application of insurance regulation, but desires to eventually pay full capitation to the PHOs and other IDs and providers.¹³⁶ Not surprisingly, the BHCAG actions, and the provid-

131. See Ron Winlow, *Employer Group Rethinks Commitment to Big HMOs*, WALL ST. J., July 21, 1995, at B1 (explaining that Minnesota employers plan to negotiate directly with doctors and hospitals); Eric Weissenstein, *Cut Out the Middleman: Coalition Seeks Big Savings by Taking the Direct Approach*, MOD. HEALTHCARE, July 3, 1995, at 28 (explaining that a coalition of Minnesota employers intend to bypass managed care companies and directly contract with PHOs and other provider groups).

132. See Weissenstein, *supra* note 131, at 28.

133. See *id.*

134. See *id.* at 30.

135. See *id.* at 29.

136. See *id.* According to the GHAA Survey, however, Minnesota requires state licensure even when a PHO accepts partial risk. See *supra* notes 17-31 and accompanying text. It is possible that PHOs which may ultimately contract with the BHCAG may obtain licensure under the Minnesota Integrated Service Act. See MINN. STAT. ANN. § 62N.01 (West 1995). See also *supra* notes 58 to 73 and accompanying text. However, without further details regarding the structure of the BHCAG provider relationships, it is impossible to determine the applicability of the

er-employer risk-sharing arrangements it intends to engage in are heavily criticized by HMOs and other health insurers.¹³⁷ When PHOs may accept capitated risk, they are moving into a position of direct competition with HMOs and other managed care plans.

Competition between HMOs/health insurers and PHOs and providers is continuously being played out in Medicare legislation before the United States House of Representatives and the United States Senate. For example, The Provider-Sponsored Organization Act of 1997 and a companion House bill, are presently pending whereby provider service organizations (PSOs) would be able to contract directly with the Medicare program without being licensed under state law.¹³⁸ Under these bills, PSOs would be subject to many of the same standards that are set out for other HMOs that are Medicare risk contractors.¹³⁹ Additionally, the bills would amend section 1876 of the Social Security Act, thereby allowing Medicare beneficiaries to enroll in PSOs and authorizing the health and human services' secretary to set up both partial and full risk payment arrangements with managed care providers.¹⁴⁰ Similarly, earlier legislation, such as the 1995 House-Senate Conference Agreement Medicare legislation, included provisions which would have permitted PSOs to contract directly for the provision of managed healthcare services to Medicare beneficiaries.¹⁴¹ Despite these legislative attempts, it is unclear whether states will relax regulation upon PSOs. However, given insurance regulators' hostility towards PHO and IDS ac-

Minnesota statute.

137. See Weissenstein, *supra* note 131, at 30. See also Garry Carneal & Marlie Gallmetzer, *Blurred Boundaries: State Regulation of PHOs*, HMO MAG., July-Aug. 1995, at 21, 24 (discussing the risks associated with new health plan models); Jonathan Gardner & Karen Pallarito, *GOP Details Medicare Plan*, MOD. HEALTHCARE, Sept. 25, 1995, at 4 (arguing that if PSNs directly contract with Medicare, other health insurers will be left out of the market).

138. See *Hospital Groups Push Legislation to Contract Directly with Medicare*, 3 BNA MANAGED CARE REP., (Feb. 5, 1997) at 126, 126-27. The Provider-Sponsored Organization Act of 1997 (S 146) was introduced in the Senate January 21, 1997, by Senators Bill Frist (R-Tenn.) and Jay Rockefeller (D.-W.Va.). *Id.* at 126. A companion bill in the House, The Medicare Provider-Sponsored Organization Act of 1997 (HR 475), was introduced by Representatives Jim Greenwood (R-Pa.) and Charles Stenholm (D. Tex.). *Id.*

139. *Id.* at 127.

140. *Id.*

141. Medicare Preservation Act of 1995, 104 H.R. 2425, § 1854(a)(1), 104th Cong., 1st Sess. (1995).

ceptance of risk, it is likely that many states will require PSOs to meet state HMO or health insurance licensure standards.

VIII. CONCLUSION

Changes in the mode of healthcare delivery and financing are occurring at a manic pace. Traditional payors and providers are all fighting to get, or maintain, a place at the proverbial "table." This struggle is made more difficult when no one in Washington, the capitals of the fifty states, or anywhere else, has much of a clue what the new table will look like, how many chairs there will be at the table, and whether the diners will receive separate checks. One thing is certain, healthcare consumers are looking for, and sometimes finding, ways to cut the bill. Direct capitated reimbursement paid by self-funded employers to PHOs and other IDSs is one mechanism which may reduce the cost of an employer's healthcare for its employees. Paternalistic insurance regulators and self-interested HMOs stand in the way of such market-driven reforms, and in addition, they present substantial obstacles to such reform.

Insurance regulators could be forced to drop their objection to such arrangements through employer- and provider-led political pressure. However, fifty insurance commissioners would be difficult to herd into the direct capitation "corral." ERISA-based preemption lawsuits which challenge the validity of state insurance commissioner actions and rules are a potential mode of objection, but are costly and time-consuming. They also have no guarantee of success. State legislation such as the Minnesota Integrated Service Network Act¹⁴² may serve as a beginning point for laws which recognize that community providers and community employers should be permitted to structure their own relationships without the burdens of full HMO licensure. However, employers and provider entities that operate in several communities and in more than one state, should also be given the flexibility to develop innovative reimbursement mechanisms with minimum government intrusion. It may be impossible to attain a national consensus among state insurance commissioners given the nearly universal condemna-

142. MINN. STAT. ANN. § 62N.01 (West 1995).

tion of PHO direct capitation. Federal legislation, although hardly a fashionable proposition in the present political climate, might nonetheless best serve the call for "market place driven," rather than "government mandated," reforms that employers are demanding. Federal legislation which establishes uniform federal standards for PHO and IDS capitation and compliance would aid these "market driven" reforms. The "playing field" among the various states would be leveled and the reasonable concerns of state insurance commissioners probably would be accommodated. Absent uniform legislation, or Supreme Court blessed ERISA preemption, however, the potential cost-saving benefits of direct PHO capitation will be unrealized.

APPENDIX A: Reprinted from GHAA Survey

CHART 2: STATE REGULATORY OVERSIGHT OF PHOS*				
Key: ■ State Oversight/Licensure Required □ No State Oversight ♦ Unclear				
STATE	PHO CONTRACTS DIRECTLY WITH			
	EMPLOYER: FEE SCHEDULE SELF-FUNDING (No Risk)	EMPLOYER: PREPAID CAPITATION (Full Risk)	EMPLOYER: PRESET BUDGET (Partial Risk)	LICENSED HEALTH PLAN: PREPAID CAPITATION (Downstream Risk)
AL	□	■	■	♦
AK	□	♦	♦	♦
AZ	□	■	♦	□
AR	□	■	♦	♦
CA	□	■	■	□ ¹
CO	□	■	■	♦
CT	□	■	■	♦
DE	□	■	♦	□
DC	□	□	□	□
FL	□	■	■	□ ²
GA	□	■	■	□
HI	♦	♦	♦	♦
ID	□	■	♦	♦
IL	□	■	♦	□
IN	□	■	■	♦
IA	♦	■	■	□
KS	□	♦	♦	♦
KY	□	■	■	□
LA	□	■	■	□
ME	□	■	♦	□
MD	□	■ ³	♦	♦
MA	□	■	♦	□
MI	□	■	■	□

* This chart is reprinted from GHAA, *supra* note 17, at 11-12. The findings summarized in this chart are based upon the responses given by state insurance and health departments over the telephone on how PHOs are regulated as risk-bearing entities. However, many of the states that report that they require PHO licensure, in practice do not.

STATE	PHO CONTRACTS DIRECTLY WITH			
	EMPLOYER: FEE SCHEDULE SELF-FUNDING (No Risk)	EMPLOYER: PREPAID CAPITATION (Full Risk)	EMPLOYER: PRESET BUDGET (Partial Risk)	LICENSED HEALTH PLAN: PREPAID CAPITATION (Downstream Risk)
MN	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
MS	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
MO	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
MT	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
NE	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
NV	<input checked="" type="checkbox"/> ⁴	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
NH	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
NJ	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
NM	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
NY	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
NC	<input checked="" type="checkbox"/> ⁵	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
ND	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
OH	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
OK	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
OR	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
PA	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
RI	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
SC	<input checked="" type="checkbox"/> ⁵	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
SD	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
TN	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
TX	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
UT	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
VT	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
VA	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
WA	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
WV	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
WI	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
WY	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

1. California law requires all PHOs that accept global capitation to be licensed as an HMO under the Knox-Keene Act.
2. Florida DOI is currently working on legislation that would regulate PHO-HMO contracts.
3. Maryland's Department of Insurance position conflicts with state Attorney General opinions re: regulation of risk-bearing entities.
4. Nevada may require licensure pursuant to its unauthorized insurer statute
5. North and South Carolina require registration as a PPO

