Assuring The Solvency Of Provider-Sponsored Organizations

Groups of physicians are forming provider-sponsored organizations to meet changing market needs. Should these risk-bearing groups be regulated as insurers to assure their solvency?

by Edward Hirshfeld

William Sage predicts that provider risk-bearing arrangements will increase the number of financial failures among managed care organizations. This is the topic of an obscure but important regulatory debate that may dramatically affect the nature of competition in the market for health care delivery and finance. The debate concerns the extent of regulation needed to assure the solvency of provider-sponsored organizations that assume risk from group purchasers of health care services. In this Perspective I expand on Sage’s point by summarizing the debate and offering a solution.

Provider-sponsored organizations are health care delivery networks owned and operated by providers. Their business is contracting to deliver health care services to licensed health plans, self-insured employers, and other group purchasers. Provider-sponsored organizations often assume the risk that members of the groups will need health care. This is usually referred to as financial risk, although some forms are similar to, and may be, insurance risk. In fact, some provider-sponsored organizations have become licensed insurers.

Two issues are pertinent: (1) Should all provider-sponsored organizations that assume risk be regulated by state insurance commissioners? (2) If regulation is warranted, should regulations for provider-sponsored organizations be the same as those for health maintenance organizations (HMOs) and other insurers?

What is at stake. Much is at stake in this debate. Risk assumption is credited with reducing the rate of increase in health care expenditures. All kinds of group purchasers want access to risk-bearing provider organizations to reduce their costs. However, requiring all such organizations to obtain an insurance license would severely restrict their availability to group purchasers, since the cost of compliance is high. Licensure involves minimum capitalization requirements, burdensome reporting requirements, and state mandates about the design of benefit packages. On the other hand, failure to regulate these organizations might allow irresponsible ones to become insolvent. As Sage notes, failure then could cascade, causing failure of the HMO, employer, or other group purchaser involved, and patients could be left without coverage.

Most states do not require provider-sponsored organizations to have an insurance license when they assume risk from a licensed health plan such as an HMO, although some states are reconsidering this position. They believe that capitalization requirements enable licensed health plans to weather a provider-sponsored organizations’ financial failure. However, most states require these organizations to be licensed when they assume risk from a self-insured employer, a union sponsored health benefit plan, a Taft-Hartley plan, or any other unlicensed purchaser. State regulation of the health benefit plans of these purchasers is preempted by the Em-
ployee Retirement Income Security Act of 1974 (ERISA), and thus their regulation is handled by the federal government. States believe that federal regulations are too lax and that some purchasers may not have sufficient capital to weather a financial failure.

Allowing the provider-sponsored organization to assume risk only from licensed health plans creates a market for licensed insurers that is protected by regulation. If ERISA plans want the low costs of risk assumption, they must purchase a health plan from a licensed insurer that transfers risk to provider-sponsored organizations. This raises ERISA purchasers' costs for two reasons. First, the licensed insurer must pay its own administrative costs and make a profit, and those amounts are included in its premium charges. Second, the requirement bars ERISA plans from avoiding the costs of state regulation. Licensed insurers are required by the state to offer certain benefit packages and to comply with other costly regulations. These costs then are passed on to the customers of licensed insurers. However, ERISA preempts states from applying the same regulations to self-insured employers and other group purchasers. Self-insured purchasers may design and administer their own benefit plans.

ERISA plans have been successful in reducing the costs of benefit plan options, such as indemnity and preferred provider plans, that do not involve transferring risk to providers, by contracting directly with provider-sponsored organizations instead of purchasing these plans from licensed insurers. They want to do the same with HMO plans by contracting directly with risk-bearing provider-sponsored organizations instead of buying them from licensed HMOs. Requiring provider-sponsored organization licensure prevents ERISA plans from achieving these cost savings.

Not surprisingly, licensed insurers believe that risk-bearing provider organizations should be licensed. The provider-sponsored organizations and the group purchasers that are subject to ERISA oppose licensure requirements. The primary forum for this debate is the National Association of Insurance Commissioners (NAIC), which for the time being agrees with the licensed insurers.

Legal analysis. Whether or not states may require the licensure of risk-bearing provider-sponsored organizations hinges on whether they are engaged in the business of insurance, which is defined as a scheme to spread and share the risk that a person may suffer a specified loss. It is distinct from business risk, which is the risk that a business will lose money on the sale of its products, or service risk, which is a risk assumed as incidental to the sale of a product. The concepts of insurance and business or service risk blur when, for example, a car dealer includes warranties on new cars. The warranty is an insurance-like scheme to spread and share the risk of repair costs. It is also similar to service risk, in that the warranty is an attribute of the car and is incidental to its sale.

Provider risk-bearing arrangements are in this blurred area. Such arrangements assume the risk that a population of patients will need health care services. At the same time, however, the primary business of provider-sponsored organizations is to sell health care services, and assumption of risk is incidental to that primary goal.

However, not all provider risk-bearing arrangements are alike, and some resemble insurance more than others do. Such arrangements include (1) global fees, where the provider-sponsored organization agrees to provide all care needed to treat a specific injury or illness for a fixed fee, regardless of the resources required to care for any given patient; (2) fee-withholding arrangements, in
which part of each fee charged by an organization is withheld and paid only if utilization goals are met; (3) capitation, whereby the provider-sponsored organization provides its services in return for a fixed payment per month for each patient assigned to it; (4) global capitation, whereby the organization provides its services and those of outside providers for care that it cannot deliver, in return for a fixed payment per patient per month; and (5) percentage-of-premium arrangements, which resemble global capitation, except that the provider-sponsored organization is paid a fixed percentage of the premium paid to the HMO.

These arrangements fall on a continuum with respect to the amount of risk assumed by the provider-sponsored organization. Global fee or fee-withholding arrangements are at one end of the continuum. The risk assumed is clearly business or service risk, as it is incidental to the sale of the services and an attribute of them. Global capitation and percentage-of-premium arrangements are at the other end of the continuum and resemble insurance risk. At the extreme end, the provider-sponsored organization assumes risk for the entire benefit package and is similar to a staff-model HMO. The question is where on the continuum the provider-sponsored organization becomes engaged in insurance.

A regulatory solution. The burden of insurance regulation makes it difficult to know where to draw the line. There is no regulatory transition for provider-sponsored organizations under state law whereby they become subject to increasingly demanding regulations as the amount of risk assumed increases. Either a provider-sponsored organization is an HMO or it is not.

The solution is not to draw an arbitrary line between intensive regulation and no regulation, but rather to develop a regulatory structure that increases the amount of regulation as the risk assumed by the provider-sponsored organization increases. At the business and service risk end of the continuum there would be no regulation. In the middle there would be light regulation. At the opposite end of the continuum, where the provider-sponsored organization was assuming full risk for an entire benefit package, more intensive regulation would be required. Such a scheme would protect the public but not unreasonably chill risk assumption by provider-sponsored organizations.

NOTES
5. Ibid.