7 State Regulation of Health Plans

Lesson Objectives

After completing this lesson, you should be able to:

- Describe the major provisions of the NAIC HMO Model Act
- Describe the types of state regulation that apply to PPOs, EPOs, POS products, TPAs, and UROs.
- Explain how the risk-based capital approach is used to set capital requirements for health plans.

In this lesson and the two that follow, we will look at how states regulate health plans. This lesson focuses on the licensing and oversight of different types of plans and organizations.

State Regulation of HMOs

In the 1970s many states had laws that governed health maintenance organizations (HMOs). But these laws were designed to regulate insurance companies, hospital and medical service corporations, or other entities, not health insurance plans.[1] They often constrained or restricted the development of HMOs. For example, some state laws required an HMO to be approved by a medical society, and the members of such societies often saw HMOs as a threat to their way of practicing medicine and put up roadblocks to deter their formation.

In 1972 the National Association of Insurance Commissioners (NAIC) adopted the **Health Maintenance Organization Model Act (HMO Model Act)**, a model law designed to regulate the licensure and operations of HMOs. This model has since been updated, most recently in 2003. It serves as the basis for the laws of many states. Since it is not possible to examine every state's HMO laws in this lesson, we will use the NAIC HMO Model Act as a framework for our discussion.

In the HMO Model Act, a "health maintenance organization" is defined as an entity that "undertakes to provide or arrange for the delivery of basic healthcare services to covered persons on a prepaid basis, except for a covered person's responsibility for copayments, coinsurance, or deductibles."[2] "Basic healthcare services" are defined as "the following medically necessary services: preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services. It does not include mental health services or services for alcohol or drug abuse, dental or vision services, or long-term rehabilitation treatment."[3] If an entity meets the definition of an HMO, it must comply with the licensing requirements and all other applicable requirements of the particular state's HMO statute.

Under the HMO Model Act and most state laws, an entity that wishes to operate as an HMO must obtain a **certificate of authority (COA),** often called a **license.** A COA is issued by the state authority that regulates HMOs, and it asserts that all state requirements for the establishment of an HMO have been met. Generally, the purpose of licensing is to ensure that an HMO is a solid, dependable organization, which is fiscally sound and able to meet specified quality standards for healthcare delivery. Some states allow only domestic corporations to obtain a COA, while others grant it to foreign corporations as well. To obtain a certificate of authority, an organization must file an application form and additional information with the insurance department or another state agency.

Items to Be Submitted for HMO Certificate of Authority

Typically, the submission must include specific documents and information, including, but not limited to, the following:

- Organizational documents such as partnership agreements, trust agreements, or articles of incorporation and bylaws (depending on the organizational form under which the applicant operates)
- Information on the owners and ownership/affiliate structure of the organization
- Biographical information about the individuals who will be responsible for the HMO's day-to-day operations and copies of all contract forms the HMO will use for agreements with those individuals
- Current and historical financial statements (or, if not applicable, a list of assets representing the initial net worth of the entity) and a financial feasibility plan detailing projected enrollments, how the HMO will calculate premium rates, projected financial statements, and sources of working capital or other funding resources
- A description of the procedures or processes the HMO will follow to meet the protection against insolvency requirements in the HMO Model Act or state statute
- A description of the HMO's quality assurance program
- Contract forms the HMO will use for agreements with other parties providing services, such as healthcare providers and third-party administrators
- Copies of the evidence of coverage forms that the HMO will issue to enrollees
- Contract forms the HMO plans to use for group contracts with employers, unions, trustees, or other organizations
- A description or map of the geographic area in which the HMO proposes to operate
- A description of the proposed network adequacy standards that ensure adequacy, accessibility, and quality of healthcare
- A description of the internal and external grievance procedures the HMO will follow to investigate and resolve enrollee complaints
- Other information required by the state regulatory authority to determine whether to issue a COA

In many states the department of insurance and the department of health each have responsibilities for regulating HMOs.

- The insurance department may have responsibility for matters pertaining to solvency, financial statements, rate filings, group contract filings, evidence of coverage filings, benefit mandates, and member grievances.
- The health department may have responsibility for quality assurance, service area expansions, provider networks, and provider relations.

In other states, either the insurance department or the health department has responsibility for all HMO regulation, and in still others, this is the responsibility of a separate state agency, such as the Department of Managed Care in California.

The HMO Model Act authorizes the state insurance department to conduct an examination of the affairs of an HMO, its providers, and risk-bearing entities as often as is reasonably necessary, but at least once every five years. A state may accept the report of an examination made by another state. The insurance department is also authorized to take a number of actions, including suspending or revoking an HMO's certificate of authority, to enforce state laws and regulations and to protect the public.

In some states, HMOs that have received accreditation from an external accreditation organization are deemed to meet a variety of state requirements, including those concerning quality assurance and/or utilization review. A few states require accreditation. (For example, Florida requires HMOs to apply for accreditation within one year and be accredited within two years of receipt of their COA.) More than 35 states either require accreditation or deem accredited health plans in compliance with certain provisions of state law.[4] Organizations from which health plans receive accreditation that may be accepted by states include NCQA, American Accreditation Healthcare Commission (The Commission/URAC-discussed later), and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Financial Requirements for HMOs

HMO laws seek to apply appropriate net worth or capital requirements to help ensure that HMO members are enrolled in financially viable entities with the resources to pay for their current and future healthcare needs. These requirements, along with provisions for financial reporting, accounting, liquidity, investment practices, and related matters, are often referred to as **financial standards.** HMO laws also seek to ensure that members are adequately protected in the event of **insolvency**, which occurs when an entity's liabilities exceed its assets or when it is unable to meet its financial obligations on time.

Adequate capital and surplus is essential to allow HMOs (as well as other types of health plans) to withstand losses incurred due to unexpected fluctuations in operating costs. If a health plan does not have a cushion to absorb such losses, its members may experience adverse consequences. These might include disruption of care, having to pay for medical expenses that should have been covered by the health plan (such as for emergency or specialty care out of the network), or the loss of a premium paid in advance.

The NAIC HMO Model Act requires an HMO seeking to obtain a COA to have an initial net worth of the greater of:

- the amount required under the state risk-based capital law (reflecting the NAIC Risk-Based Capital for Health Organizations Model Act, discussed below); or
- $3,000,000; or
- (at the state insurance commissioner's discretion) a greater amount as indicated by the business plan and a projected risk-based capital calculation after the first full year of operation, based on the most current NAIC Health Annual Statement Blank.

Thereafter, the HMO must maintain a minimum net worth, as shown in the box below.

NAIC HMO Model Act: Ongoing Net Worth and Capital Requirements

A. A health maintenance organization shall maintain a minimum net worth equal to the greater of $2,500,000 or the amount necessary to maintain capital required pursuant to [the state law equivalent to the NAIC Risk-Based Capital for Health Organizations Model Act].

B. The amount in paragraph A may be adjusted annually at the commissioner's discretion.

The NAIC offers the following alternative for states that have not adopted risk-based capital requirements:

A. A health maintenance organization must maintain a minimum net worth equal to the greater of $2,500,000; or an amount equal to the sum of:

(1) Eight percent (8%) of annual healthcare expenditures except those paid on a capitated basis or managed hospital payment basis as reported on the most recent financial statement filed with the commissioner

(2) Four percent (4%) of annual hospital expenditures paid on a managed hospital payment basis as reported on the most recent financial statement filed with the commissioner.

Source: National Association of Insurance Commissioners, Health Maintenance Organization Model Act, Section 17 (2003).

Net worth is an organization's **total admitted assets** minus its total liabilities. (The liabilities do not include fully subordinated debt.)

Assets are items of value owned by a company; an **admitted asset** is an asset whose full value can be reported on the assets page of a company's annual statement.[5] The annual statement is a financial report that most health plans have to file to comply with state insurance regulations.

Risk-based capital (RBC) is a method of taking into account an organization's size, structure, and risk profile to set the minimum amount of capital needed for that organization to support its overall business operations (discussed later in this lesson).

Although financial standards provide a useful tool for state regulators to assess an organization's financial viability, they cannot completely eliminate the possibility of insolvency. To further protect HMO members, state regulators rely on other regulatory measures, such as:

- deposit requirements,
- requirements for HMOs to have a plan for handling insolvency,
- administrative supervision and receivership, and
- replacement coverage requirements.

Deposit Requirements

The HMO Model Act requires an HMO to place in trust with the state insurance commissioner a deposit that can be used to protect the interests of enrollees in case the HMO becomes financially impaired. At the discretion of the commissioner, the deposit can be placed with an organization or trustee acceptable to the commissioner. The deposit, regardless of where it is placed, must be in cash and/or securities and must at all times have a minimum value as specified by law. The amount deposited is treated as an admitted asset for purposes of determining the amount of the HMO's net worth.[6] Sometimes an HMO must make an additional deposit in trust with the state insurance department to protect members from creditors in the event of the HMO's insolvency. The need for this deposit depends on the amount of the HMO's uncovered expenditures.

If an HMO becomes insolvent, in some cases a member will be liable for payment of healthcare services. Generally, network providers may not seek payment from members, under the hold harmless clause of their contract with the HMO. But if a member receives out-of-network care from a non-contracted provider (in an emergency, for instance), she may be liable for payment. Expenditures by an HMO that members would be liable for in the event of insolvency are **uncovered**; those they are not liable for are **covered**. If an HMO's uncovered expenditures exceed 10 percent of its total healthcare expenditures, it must place an **uncovered expenditures insolvency deposit** in trust with the state insurance department. If the HMO becomes insolvent, this money may be used by the commissioner on behalf of enrollees to pay claims for uncovered expenditures.[7]

A Plan for Insolvency

The HMO Model Act requires each HMO to have a plan for handling insolvency. If the HMO becomes insolvent, this plan must allow for the continuation of benefits for contract periods for which it has received premium payments. Benefits must also continue for members who are confined in an inpatient facility on the date of insolvency, until they are discharged. The state insurance department may require such a plan to include the following types of features:

- Insurance to cover the expenses to be paid for continued benefits
- Provisions in provider contracts requiring them to render services the HMO is obligated to provide following an insolvency
- Insolvency reserves

- Acceptable letters of credit

Administrative Supervision

If the state insurance commissioner determines, after a notice and a hearing, that the financial condition of an HMO is such that its continued operation might be hazardous to its enrollees, its creditors, or the general public, the commissioner may proceed with a number of interventions to protect against insolvency. These might include:

- monitoring a corrective plan developed by the company;
- suspending or limiting the writing of new business for a period of time, or reducing the volume of new business being accepted;
- reducing expenses by specified methods;
- taking over the management of the business; or
- selling the company or merging it with a financially sound company.

When an HMO is in hazardous financial condition, has failed to comply with insurance laws, or for other reasons, or by consensual agreement, the insurance commissioner may place an HMO under the state's **administrative supervision**. When the commissioner judges that an HMO's financial difficulties are so severe that more serious action is warranted, she may place the insurer in **receivership**. The commissioner, acting for a state court, takes control of and administers the HMO's assets and liabilities. **Rehabilitation** occurs when an insolvent HMO continues in existence under receivership. During this period, state authorities try to find ways to return the organization to normal operation. **Liquidation** occurs when all of the HMO's business and assets are transferred to other carriers, or when assets are sold to satisfy the HMO's outstanding obligations and the HMO's business is terminated.

Replacement Coverage

If an HMO becomes insolvent and is liquidated, provision is made to replace the coverage of the HMO's members.

- For a covered group, the commissioner can order all other carriers that participated in the group's most recent enrollment period to offer their plans to the insolvent HMO's group enrollees.[8]
- If no other carriers offered coverage to a group enrolled in the insolvent HMO, or if the commissioner determines that the other health plans do not have sufficient resources to assume responsibility for all of the group enrollees, the commissioner can allocate the insolvent HMO's group contracts among all HMOs that operate in the insolvent HMO's service area.[9]
- An insolvent HMO's non-group enrollees can also be allocated among all HMOs that operate within a portion of the HMO's service area.[10]

Other Requirements for HMOs

In addition to financial matters, state HMO laws address other concerns, which we will discuss in this section. These include:

- Healthcare delivery (including network adequacy, quality assurance programs, and grievance procedures)
- Enrollee contracts
- Filing and Reporting
- Disclosure

Network Adequacy

The HMO Model Act requires an HMO seeking to obtain a certificate of authority to file a description or map of the geographic area in which it proposes to operate and a list of the names, addresses, and license numbers of all providers in its network. Typically, state regulators examine this information to ensure that providers are located within a reasonable distance of all locations in the HMO's service area and that the HMO maintains adequate numbers of providers for the number of members enrolled.

With the growth of the health plan industry, the NAIC developed additional standards that were not contemplated in the original HMO Model Act. In 1996, the NAIC adopted the **Managed Care Network Adequacy Model Act** to establish network standards and to ensure the adequacy, accessibility, and quality of healthcare services offered under all health plans, including HMOs. This act was later renamed the **Health Benefit Plan Network Access and Adequacy Model Act** and revised during 2015 in light of concerns about narrow networks and the search for network adequacy standards for plans sold through exchanges under the Affordable Care Act.

Quality Assurance Program

A quality assurance program establishes procedures to ensure that healthcare services provided to enrollees are rendered under reasonable standards of quality of care, consistent with prevailing professionally recognized standards of medical practice. The purpose of a quality assurance program is to evaluate, maintain, and improve the quality of healthcare services delivered to covered persons.

The HMO Model Act also requires an HMO applying for a COA to file a description of its proposed program for quality assurance, which must comply with the state law equivalent of the NAIC Quality Assessment and Improvement Model Act. Under the HMO Model Act, an HMO's quality assurance program must include a written statement of goals, lines of authority, accountability, evaluation tools, data collection responsibilities, performance improvement activities, and an annual effectiveness review of the quality improvement program. The program must keep records of quality assurance program activities and make those records available to the commissioner of health or other authorized regulatory official. Before a COA is issued, the insurance department may confer with the health department to ensure that the HMO's proposed quality assurance program meets the appropriate standards.

The HMO Model Act requires an HMO applying for a COA to file a description of its proposed grievance procedures. Internal grievance procedures must comply with the state law equivalent of the NAIC Health Carrier Grievance Procedure Model Act.Procedures for independent external review of grievances must comply with the state law equivalent of the NAIC's Health Carrier Review Model Act.

Enrollee Contracts

Under the HMO Model Act, HMOs are required to provide each group and individual contract-holder with a document that specifies the benefits and services available to enrollees. This information is in the contract and may also be included in an **evidence of coverage (EOC)** (or **certificate of coverage**). For groups, the HMO typically provides a copy of the contract to the group contract-holder and an EOC to individual enrollees.

Individual HMO contracts must provide for a 10-day period in which the enrollee may examine and return the contract in exchange for a full premium refund. If an enrollee receives services during the 10-day period and returns the contract for a premium refund, the enrollee must pay for all services received.

An HMO's contract must contain a clear statement of the following information:

- The name and address of the HMO
- Eligibility requirements
- Benefits and services within the service area
- Emergency care benefits and services
- Out-of-area benefits and services, if any
- Copayments, coinsurance, deductibles, or other out-of-pocket expenses
- Limitations and exclusions
- Enrollee termination procedures
- Enrollee reinstatement procedures, if any
- Claims procedures
- Grievance procedures
- Procedures for requesting independent external review
- Utilization review procedures
- Continuation of coverage
- Conversion
- Extension of benefits, if any
- Coordination of benefits, if applicable

- Subrogation, if any
- Description of the service area
- Procedures for obtaining a provider directory
- The existence of a formulary and procedures for obtaining a copy of the formulary list (if any)
- Entire contract provision
- Term of coverage
- Cancellation
- Renewal
- Grace period
- Conformity with state law

Filing and Reporting

We have already discussed the information and documentation an HMO must submit with its application for a certificate of authority. In addition, in most states if an HMO wishes to make changes to its group contract and evidence of coverage forms, it must file the changes with the appropriate state agency. Some states also require HMOs to file changes in premium rates.

- Many states require **prior approval**. That is, an HMO is not permitted to use new forms (or rates, if rate filing is required) until the state agency reviews and approves the filing.
- Some states, however, operate on a **file and use** basis. This means that the HMO must submit a filing with the state at least 30 days prior to issuance or delivery, but prior approval is not required for the HMO to begin using the forms (or rates), although the regulator may later disapprove any forms or rates found to violate state laws.

HMOs must file with the state insurance department or other state agency an annual report detailing financial information and certain operational information. This annual report must be filed on a form approved by the state and must be verified by at least two of the HMO's principal officers. Under the HMO Model Act, HMOs also must file the following information each year:

- audited financial statements
- a list of the healthcare providers that have executed a contract agreeing to provide services to HMO enrollees

- a description of the HMO's grievance procedures, the total number of grievances handled, a compilation of the causes underlying those grievances, and a summary of the final disposition of the grievances

The HMO Model Act also gives the state the authority to require additional reports deemed necessary and appropriate, such as reports that provide information on quality assurance programs.

There is some variation by state in reporting requirements:

- Some states do not require an annual filing of a list of the HMO's contracted providers.
- Some states require that material business changes be reported more frequently than once a year. Such a filing may be required to update the state's records of the HMO's enrollee materials, including the handbooks it uses to describe coverage, provider lists, and sample member identification cards. Some states require regulatory approval of material business changes before the changes are allowed.
- An HMO may have to make a filing to obtain state approval to expand its service area.

Disclosure

We have noted that the HMO Model Act requires HMOs to provide enrollees with certain information about the HMO, its services, and its providers. Upon enrollment, an enrollee must receive a list of the HMO's healthcare providers. Any "material change" in the operation of an HMO affecting enrollees must be reported to enrollees within 30 days of the change.

For example, a major change in the provider network is considered a material change that must be reported to enrollees. By contrast, the termination of one medical care provider from the provider network would not qualify as a material change unless that provider is a primary care provider. When a primary care provider (PCP) is terminated from the network, the HMO must notify all enrollees who receive primary care from the terminated provider and help them transfer to another PCP.

More disclosure requirements:

- The HMO must help enrollees obtain information about HMO services and notify them where additional information on access to services can be found.
- The HMO must supply a toll-free telephone number that enrollees can use to contact the HMO.

Newly enacted consumer protection laws contain additional disclosure requirements intended to provide members with information about topics such as risk arrangements, plan financial information, and prescription drug formularies.

State Regulation of PPOs

Preferred provider organizations (PPOs) generally offer a network of contracted healthcare providers but cover services furnished by both network and non-network providers. However, PPOs generally provide financial incentives (for example, lower coinsurance or copayments) for members to use network providers. More Americans are enrolled in PPOs than any other health plan type.

A PPO may or may not bear risk. The American Association of Preferred Provider Organizations (AAPPO) makes this distinction:

- “The primary focus of a non-risk PPO is to contract with providers in a geographical area to form an interconnected network of providers and services. The non-risk PPO network leases and/or ‘rents’ its network for a fee to insurance companies, self-insured employers, union trusts, third-party administrators, business coalitions, and associations.”[11]

- “A risk PPO (or insured PPO) has a similar structure, but unlike a non-risk PPO, it assumes the financial risk for an enrollee’s medical costs. Traditionally, insurance companies offer risk PPOs that include a benefit plan and network services, either provided by the risk PPO or leased from a non-risk PPO network.”[12]

State regulation of PPOs is difficult to summarize because PPOs are regulated in different ways depending on the state and on whether the PPO is risk-bearing.

- Many states require PPOs to be licensed, registered, or certified.

- States generally require that risk-bearing entities meet solvency standards. Frequently the solvency standards for risk-bearing PPOs are the same as for an indemnity insurance plan or an HMO.

The NAIC had a Preferred Provider Arrangements Model Act (PPA Model Act) that established minimum standards for preferred provider arrangements and the health benefit plans that include such arrangements. However, few states adopted this act and in 2004 it was dropped. Some states make sections of the state HMO laws applicable to PPOs, and some states have general “managed care” laws that apply to PPOs.

Non-risk bearing PPOs generally partner with an insurer or a self-funded employer group plan.

- If a PPO contracts with an insurer, the PPO is frequently subject to regulation as a downstream contractor of the insurer. That is, the state laws apply to the insurer and flow down to the non-risk PPO. For example, some states require that an insurer that contracts with a non-risk PPO submit documentation that the network is compliant with state requirements for network adequacy, timely claims processing, and grievances and appeals procedures.

- If a non-risk PPO contracts with a self-funded employer plan, state law may not apply, but the PPO must comply with requirements of the federal Employee Retirement Income Security Act (ERISA) (discussed in a later lesson)

Whether a PPO is regulated directly or as a downstream contractor of an insurer, some of its activities are governed by state laws. Some examples:

- Where PPOs perform utilization review, they may be subject to state laws regulating it.

- Where they pay claims on behalf of a self-insured employer, they may be regulated under state third-party administrator statutes.

- Where they act as an intermediate entity between an insurer and providers, they may be subject to state regulation of provider networks and credentialing.

At least six states have adopted versions of the **Rental Network Contract Arrangements Model Act** adopted in 2008 by the National Conference of Insurance Legislators. This act recognizes that frequently entities that are not insurers but solely provide provider networks are not regulated under state law. It requires all businesses that contract with providers to deliver healthcare services (known as "contracting entities") to register with the applicable state.

The Model Act prohibits contracting entities from granting access to providers' contractual discounts unless the applicable provider agreement specifically states that third-party use of the discounted rates is allowed. It obligates the third-party healthcare payers accessing the discounted rates to comply with all terms, limitations, and conditions of the agreement between the provider and contracting entity.

EPOs and POS Products

Exclusive Provider Organizations (EPOs)

An **exclusive provider organization (EPO)** can be thought of as a hybrid of a PPs and an HMO. As in a PPO, generally no primary care provider or referrals are required (although prior authorization may be required for specified services). But as in an HMO, for non-emergency services to be covered, they must generally be furnished by a network provider. EPOs, like HMOs, are closed network health plans.

Like PPOs, EPOs may be risk bearing or non-risk bearing. In some instances, EPOs are created specifically for an employer, but most PPOs and national insurers offer EPO plans to employers using their existing PPO networks.[13] They are frequently implemented by self-insured employers concerned with cost savings.[14]

In states that authorize EPOs, they are generally subject to similar regulation as PPOs. Where they are risk-bearing entities, they are subject to state solvency requirements.

- EPOs serving self-insured employers are generally subject to ERISA but not state laws.
- Other EPOs must generally comply with state laws regarding prompt payment, network adequacy, provider contracting, appeals, and utilization review.

Point-of-Service (POS) Products

A **point-of-service (POS) plan**, like an EPO, can be thought of as a hybrid of an HMO and a PPO, but the mix is different. As in an HMO, a primary care provider and referrals are usually required. But as in a PPO, a member can get care outside the network (with higher cost-sharing). There are two types of POS products:

- **Standalone POS product.** The HMO directly underwrites coverage of healthcare services rendered by providers outside its network, without the involvement of an insurer. Some states do not allow this, but others do, provided the HMO meets certain requirements.

- **Wraparound POS product.** The HMO arranges for coverage of non-network care through an insurance contract. If the HMO or an affiliated company is a licensed insurer, it can issue the contract; if not, a separate insurer can provide coverage for non-network care.

The financial viability of an HMO depends largely on its ability to manage costs by using network-based managed care techniques, and an HMO that does not want its financial condition impacted by "non-managed" non-network claims can offer a wraparound POS product, where permitted by law. Network benefits are subject to the laws that pertain to HMOs. Insured out-of-network benefits are subject to insurance laws.

Third-Party Administrators[15]

Third-party administrators (TPAs) are companies that provide various administrative services to insurers or self-funded employer health plans. TPAs often perform insurance functions such as claims processing, and the states have the authority to regulate these activities, and most states have adopted laws and/or regulations to do so.[16]

As we will discuss in more depth in a later lesson, for employer-sponsored health plans, especially self-funded plans, the federal Employee Retirement Income Security Act (ERISA) preempts some state laws. That is, such plans are exempt from certain state laws because they are regulated by ERISA instead. In some states, the state's regulatory authority over TPAs that contract with self-funded plans has been challenged based on ERISA.

Courts have taken both sides in this controversy, but a recent U.S. Supreme Court decision may provide for broader preemption of state laws. The Court held that, for self-insured employer plans, a Vermont law that requires reporting of health plan claims, cost, and other information to a state database is preempted by ERISA.[17] According to the Court, ERISA sets forth its own reporting and record retention requirements, and similar requirements from multiple states could "create wasteful administrative costs and threaten to subject plans to wide-ranging liability."[18]

The **NAIC Third-Party Administrator Model Statute** is designed to regulate operations of third-party administrators, and many states have laws based on it. We will look at five areas of regulation:

- Certificate of authority
- Written agreements and records
- Payor responsibilities
- TPA responsibilities
- Suspension or revocation of the COA

Certificate of Authority (Licensing)

An organization that directly or indirectly underwrites; collects charges, collateral, or premiums from; or adjusts or settles claims on residents of the state in connection with life, annuity, health, stop-loss, or workers' compensation coverage is considered a TPA for purposes of the TPA Model Statute. Exempted

are TPAs administering plans covered by ERISA, insurance companies acting as TPAs, and a few other entities. However, a TPA exempted by ERISA must still register with the state.

To obtain a certificate of authority, a TPA must submit a uniform application (developed by the NAIC) and provide basic organizational documents (such as articles of incorporation), bylaws, audited financial statements for the past two years, NAIC biographical data for individuals conducting the affairs of the organization, a business plan, and any additional information requested by the state. The TPA must also make available the written agreements it has entered into with health plans and employers. When evaluating an application for a TPA's COA, the insurance department will be concerned with ensuring that the TPA is solvent and that the individuals responsible for conducting its affairs are competent, trustworthy, financially responsible, and of good character.

What if a TPA is operating in a state but has a COA from another state?

- Some states allow such a TPA to operate without a COA if it provides services for 100 or fewer enrollees.

- Some states require a COA, but waive the application requirements if a TPA has a COA from another state with similar requirements.

Written Agreements and Records

A TPA's agreement with a health plan to provide administrative services must be in written form. To the extent that they pertain to the duties of the TPA, the health plan's benefits, premium rates, collateral and reimbursement procedures, and underwriting criteria must be agreed to in writing by the parties. Certain types of provisions may not be included in a TPA agreement. For example, the amount of the TPA's compensation may not be contingent on savings the TPA is able to realize from claims payments (so that the TPA is not induced to place its own financial interests above the interests of plan members).

The TPA must maintain the written agreement as a business record through the term of the agreement and five years thereafter. The TPA must maintain and make available to the health plan complete books and records of all transactions performed on behalf of the plan for at least five years after the termination of such an agreement. The insurance department has authority to examine these business records.

Payor Responsibilities

Even if an agreement between a health plan and a TPA specifies that the TPA will provide certain administrative services, the plan remains responsible for ensuring that it is administered properly. The plan also determines all premium rates, benefits, underwriting criteria, and claims payment procedures, and it must provide the TPA with written information on all such matters. If the TPA administers benefits for more than 100 policyholders of an insurer, the insurer must review the operations of the TPA at least semi-annually, with at least one review including an on-site audit.

TPA Responsibilities

A TPA must hold all funds it receives on behalf of a health plan in a fiduciary capacity. It must promptly remit all such funds to the proper parties, and it must periodically provide the plan with an accounting of all transactions it has performed on behalf of the plan. The TPA Model Law also requires a TPA to:

- Identify all charges that it collects from covered individuals.
- Disclose to the health plan all charges, fees, and commissions the TPA receives in connection with the services it provides to the plan.
- Promptly deliver to covered individuals any certificates, booklets, termination notices, or other written communications that it receives from the plan.

Reporting

A TPA is required to notify the state insurance department within 30 days of any material change in its ownership, control, or contact person, or any material change that might affect its qualification for a license. Each TPA is required to file with the insurance department an annual report, which includes information such as an audited financial report and the names and addresses of all payors that the TPA contracted with during the preceding year.

Suspension/Revocation of COA

The TPA Model Law requires the state insurance department to suspend or revoke a TPA's certificate of authority if the TPA is:

- financially unsound,
- using practices that are harmful to insured persons or the public, or
- has failed to pay any judgment rendered against it in the state within 60 days after that judgment became final.

In addition, the insurance department has discretionary authority to suspend or revoke a TPA's certificate of authority if, after notice and a hearing, the department finds that the TPA has engaged in certain specified activities such as violating the law or orders of the insurance department, refusing to be examined, or refusing to appropriately pay claims.

Utilization Review

We have looked at laws targeting different types of organizations—HMOs, PPOs, TPAs, etc. Another approach to regulating health plans is to enact laws focused on certain activities and functions. The NAIC has developed model laws in several areas, and many states have adopted or adapted them. These include models for:

- Credentialing
- Quality assurance
- Network adequacy
- Grievances and external review
- Utilization review

For a description of the model laws in these areas, go to the end of this lesson.

In this section we will explore regulation in one of these areas, utilization review.

Utilization Review (UR)

Utilization review (UR) is the evaluation of the medical necessity, efficiency, and/or appropriateness of healthcare services and treatment plans for a given patient. Utilization review may be undertaken by an in-house department of a health plan or an external entity. External entities that perform utilization review functions are called **utilization review organizations (UROs).**

Typically, state laws impose requirements on personnel conducting utilization review.

- Almost all states require UR personnel to have training and experience in the field of medicine, subject of review. Many states require a healthcare provider conducting UR to be licensed to practice medicine in the state.[19]

- States also have laws governing the accessibility of UR personnel. For example, most states require that personnel be accessible by telephone during normal business hours, five days a week. Some states require the entity performing UR to establish a toll-free telephone line, staff after-hours coverage for review determinations, and/or meet certain response times for decisions.

- Some states have laws that ban the use of financial incentives that might induce UR personnel to deny certain services or reduce a length of stay in an inpatient facility, or that might otherwise impact a UR decision.[20]

State laws also usually require an appeal procedure for adverse decisions or denials. Group health plans and health insurance issuers (with the exception of grandfathered plans) must comply with federal standards regarding determinations, internal appeals, and external appeals. Where state law is more stringent than federal law, organizations subject to state law must comply with the more stringent requirements.

Utilization review laws in some states require any entity that performs UR functions to be registered with the appropriate regulatory agency, such as the insurance department or health department. In other states, full certification is required, as discussed below. But in some states HMOs and other health plans are specifically excluded from registration or certification requirements. In states that require full certification, entities performing UR functions must meet certain requirements:

- The personnel of the entity must meet certain criteria with regard to experience, training, and education. Some states also require UR personnel to obtain reviewer licenses.

- Most states that require certification direct health plans and UROs to file a plan, confirming that the entity's personnel meet requirements and providing information about the services to be provided.

In general, states require certification to keep track of the entities performing UR services and to maintain an avenue for appeals of UR decisions. Licenses or certificates are usually valid for one to two

years and are renewable. State laws authorize officials to revoke an entity's license or certification and/or impose fines and penalties for noncompliance with UR laws.[21]

Some states allow entities conducting UR to submit evidence of their accreditation by a private accreditation organization instead of submitting an application for certification. The most prominent UR accrediting organizations are the American Accreditation Healthcare Commission (formerly URAC) and the National Commission on Quality Assurance (NCQA). Standards for accreditation focus on timely review of determinations, efficient and effective use of information to make determinations, maintenance of confidentiality standards, training and qualification of the UR staff, and the appeal process.

The Risk-Based Capital Approach to Financial Requirements

As we discussed earlier in this lesson, the HMO Model Act contains uniform solvency standards that all HMOs must meet to obtain and retain a license. However, the nature and volatility of business can vary significantly from one HMO to another. For instance, an HMO's capital and surplus requirements can be affected by factors such as out-of-network coverage provisions and provider compensation/risk-sharing arrangements. Moreover, a great diversity of organizations and arrangements have emerged over the years in the healthcare marketplace. As a result, a "one size fits all" approach for all plans has its limitations.

In response, in the early 1990s the NAIC began developing **risk-based capital (RBC)** formulas for all life and health insurance companies. Later, the organization created a separate RBC formula for all health insurers and health plans that accept risk. The most recent version of this is found in the NAIC's 2011 Risk-Based Capital for Health Organizations Model Act.

Risk-based capital (RBC) is a method of measuring the minimum amount of capital appropriate for an organization to support its overall business operations based on its size and risk profile.[22] The greater the amount of risk a health plan takes, the greater the amount of capital it must hold. In this way, RBC limits the amount of risk an organization can accept. However, RBC is intended to be a minimum regulatory capital standard and not necessarily the full amount of capital that a health plan would want to hold to meet its safety and competitive objectives.

The RBC formula for health plans is a set of calculations, based on information in the health plan's annual financial report, that yields a target capital requirement for the organization. The health organization RBC formula assesses the risk profiles of specific health plans, gives credit for payment arrangements that reduce risk, and determines appropriate capital requirements based on these risk profiles.

The health organization RBC formula takes into account four types of risk:

- **Asset risk**—the risk of adverse fluctuations in the value of assets.
- **Underwriting risk**—the risk that premiums will not be sufficient to pay for services or claims.
- **Credit risk**—the risk that providers and plan intermediaries paid by capitation will not be able to provide the services contracted for, and the risk associated with recoverability of amounts due from reinsurers.

- **Business risk**—the general risk of conducting business, including the risk that actual expenses will exceed amounts budgeted.

Generally, underwriting risk is by far the largest single determinant of a company's total RBC requirement. Underwriting risk is primarily related to the amount and distribution of a health plan's premium income. A general rule of thumb is that the minimum RBC requirement for a health plan amounts to about 10 to 15 percent of its premium income.[23] As a health plan grows, the amount of risk-based capital related to underwriting also grows. However, if a health plan transfers some of the risk for the cost of healthcare to providers (for example, on a capitation basis), the plan's risk is reduced, and the RBC requirements are reduced commensurately.

Under the Risk-Based Capital for Health Organizations Model Act, regulators are to compare an organization's capital requirements (as determined by the health plan RBC formula) with the organization's **total adjusted capital** (its net worth as shown in the filing of its annual financial statements plus any other items specified in the formula instructions). If the organization's total adjusted capital is insufficient, regulatory intervention may be triggered, ranging from requiring the submission of a corrective action plan to placing the plan under the regulatory control of the appropriate state agency. In addition to serving as a tool for state regulators, the RBC formula provides start-up companies with the information needed to estimate initial RBC levels based on their operating projections for their first full year.

Summary

States license and regulate health plans of different types:

- HMOs must meet various requirements in financial matters, healthcare delivery (including network adequacy, quality assurance programs, and grievance procedures), enrollee contracts, filing and reporting, and disclosure.

- The regulation of PPOs differs depending on whether or not they bear risk. Risk-bearing PPOs must meet financial standards, while non-risk PPOs are often regulated as downstream contractors of insurers or employer plans.

- EPOs are regulated much like PPOs. The regulation of POS plans differs for standalone and wrap-around products. The activities of TPAs and entities performing utilization review are also subject to regulation.

Risk-based capital (RBC) is a method of measuring the minimum amount of capital appropriate for a health plan based on its size and risk profile.

NAIC Model Laws Regulating Health Plan Activities

In addition to model laws that target different types of health plans, the NAIC has developed a number model laws to address various health plan activities. We briefly summarize some of these below.

In these model laws, the NAIC uses the term "health carrier." The NAIC defines this term as "an entity subject to the insurance laws and regulations of this state or to the insurance commissioner's jurisdiction that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services including a sickness and accident insurance company, a health maintenance organization, a non-profit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or healthcare services."[24]

Healthcare Credentialing Verification Model Act

All health carriers are required to establish a comprehensive credential verification program that verifies the credentials of all contracted healthcare professionals. Health carriers are required to establish written credential verification procedures that they disclose upon written request to any applying healthcare professionals. The act requires primary source verification for certain information such as licensure, liability coverage, hospital privileges, board certification, DEA registration, and education. Other information can be verified through secondary sources. Healthcare professionals must be recredentialed by obtaining primary source verification of specified information every three years. Health carriers must also allow providers to review and correct any information, including the source of the information, obtained by the health carrier as part of the credentialing process.

Quality Assessment and Improvement Model Act

This act requires health carriers that offer managed care plans to develop the systems necessary to measure and report on quality of healthcare services. All health carriers that offer managed care plans must have a quality assessment program and file a written description of the program with the insurance department. They must report to the appropriate licensure board any persistent and problematic pattern or care that leads to their termination or suspension of a contracting provider. In addition, health carriers offering closed plans or a combination plan with a closed component must have a quality improvement plan.

Health Benefit Plan Network Access and Adequacy Model Act

Under this act, health carriers offering a network plan must maintain a network that is sufficient in number and types of providers to ensure access to covered services without unreasonable delay. Health carriers must file with the insurance commissioner an access plan meeting the requirements of the act, and commissioners must determine network sufficiency under the criteria set forth in the act. Health carriers must meet general requirements pertaining to the provisions included in their intermediary and provider contracts. The act requires health carriers to provide electronic access to their provider directories and to update those directories at least monthly. This act also requires the filing of sample contract forms with the state regulatory agency and obtaining approval of any material contract changes. Recently added provisions of the act include those addressing non-contracted facility-based providers, which requires certain disclosures in non-emergency situations and provides for limitations on liability in emergencies, and provisions related to tiered provider networks.

Health Carrier Grievance Procedure Model Act

This act sets forth standards for internal review of member grievances. Under this act, health carriers must allow members to review relevant information pertaining to their grievance and submit written comments, documents, records, or other material relating to the request for benefits. Health carriers must develop written procedures for the expedited review of any grievance where the normal timeframe would jeopardize the life or health of the member. Health carriers must also use clinical peers, or peers "of the same or similar specialty" that typically manage the situation under review, to review adverse determinations related to utilization review. Grievances must be resolved within the timeframes set forth in the act. Health carriers may offer one level of review or may voluntarily offer a second level of internal review. The act provides that if the health carrier fails to follow the requirements for review or if an individual exhausts the carrier's internal grievance procedure, the individual may appeal to an independent external review organization. Under federal law enacted as part of the Affordable Care Act, group health plans and health insurance issuers must comply with requirements for conduct of internal appeals similar to those of the NAIC Model Act. To the extent that state law imposes on health insurance issuers requirements that are stricter than those imposed under federal law, health insurance issuers must comply with those provisions of state law.

Uniform Health Carrier External Review Model Act

Health carriers must allow individuals to appeal adverse determinations or final adverse determinations to an independent external review organization. Independent review organizations must be accredited by a nationally recognized accreditation organization. This act sets forth standards for the conduct of standard and expedited external reviews including timelines for resolution of such reviews. It also sets forth standards for reviewing appeals of adverse determinations based on experimental or investigational status of the requested service. Under the Affordable Care Act, group health plans and health insurance issuers must comply with the applicable state external review process that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the NAIC. If the state does not have such a process, group health plans and health insurance issuers must comply with the federal process, which is based on the NAIC Model Act.

Utilization Review and Benefit Determination Model Act

This act applies to health carriers and organizations that perform utilization review on their behalf. A health carrier that requires a request for benefits under a plan to be subject to utilization review must implement a written program that describes all review activities and procedures. The program must use documented clinical review criteria based on sound clinical evidence and evaluated periodically. Clinical peers must evaluate the clinical appropriateness of adverse determinations. Standard and expedited utilization review and benefit determinations must be made within the timeframes set forth in the act. Health carriers must provide written notice of adverse determinations with instructions for filing appeals and for requesting disclosure of the clinical rationale, including the clinical review criteria used to make the determination. Under this act, health carriers are required to cover emergency services needed to screen and stabilize a member, without prior authorization, if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Health carriers must also cover an emergency visit to a non-contracted provider if a prudent layperson would have believed that the delay in visiting a contracted provider would worsen the emergency.

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