Issue Brief
Findings from HSC

INSOLVENCY AND CHALLENGES OF REGULATING PROVIDERS THAT BEAR RISK

By Linda R. Brewster, Leslie Jackson and Cara S. Lesser

Risk contracting and capitation are two widely used financial mechanisms that give incentives to health care providers to control costs. Risk-bearing arrangements have failed in a number of communities, however. This has shaken local markets, disrupting consumers' access to health care services and triggering losses for physicians and hospitals. It also has raised questions about the adequacy of related regulatory oversight, which holds important implications for local and national policy makers. This Issue Brief provides case studies of failed risk-contracting arrangements in two of the 12 communities that the Center for Studying Health System Change (HSC) tracks intensively—Northern New Jersey and Orange County, Calif.—and examines implications for policy makers.

Regulation of Risk-Bearing Entities

Despite extensive legislative activity in recent years regarding health maintenance organizations (HMOs), relatively little attention has been given to policy questions surrounding managed care plans' delegation of financial risk for health care services to provider groups or contracting entities. The Balanced Budget Act of 1997 established regulations that allowed provider-sponsored organizations (PSOs) to bypass HMOs and obtain independent Medicare risk contracts. However, the more common form of risk contracting involves HMOs' delegating financial risk for patient care to contractors, such as provider groups or contracting intermediaries. Typically, these arrangements have been viewed as any other business subcontract and have not been subject to special regulatory scrutiny. In fact, few states have expanded their regulation of HMOs to include oversight of risk-bearing arrangements or the provider groups that accept them.

California became one of the first to do so in 1996, when it began to require licensure for organizations entering into global risk contracts with HMOs involving the transfer of financial risk for hospital, physician and other medical services. Ironically, three years later, California was among the first states to experience large-scale disarray in the health care system as a result of global risk contracting, pointing to some of the limitations of the regulations that had been put in place, as well as the complexity of related contracting arrangements.

States have long regulated insurance to ensure that consumers receive coverage promised in exchange for premium payments, but HMO regulation historically has been complicated by the integration of insurance and care delivery. As HMOs have evolved—from predominantly staff- and group-model organizations that retained sole responsibility for the risk associated with providing patient care services to plans that contract with a broader panel of providers—regulation has become increasingly complex.

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CASE STUDY: NEW JERSEY

State Responds to Failed Health Plan Contracting Arrangement

In 1998, New Jersey regulators found themselves embroiled in the takeover of a prominent HMO that had succumbed to financial collapse, following a disastrous subcontracting arrangement with an out-of-state management company. Executives at HIP Health Plan of New Jersey, the state's fourth largest HMO, had hoped that PHP Healthcare Corp., a Virginia-based provider management company, would save the failing HMO. Instead, the arrangement left 190,000 people scrambling for new health care coverage and more than $120 million in unpaid claims to hospitals and physicians.

HIP of New Jersey, a subsidiary of HIP of New York, first entered the New Jersey marketplace in 1980, at the request of state and federal regulators, to assist a failing HMO, Rutgers Community Health Care Plan. HIP and Rutgers merged in 1991, and HIP continued Rutgers' model of providing care exclusively through clinics that were staffed by a multispecialty group of physicians. By the mid-1990s, HIP had expanded its product offerings and supplemented its clinics with an external network of physicians.

Despite considerable growth, HIP began suffering financial losses in 1995, exacerbated in the following year by contract disputes with its core physician group. When negotiations collapsed, HIP spent considerable resources to assemble and manage a new group of physicians to staff its clinics and to invest in infrastructure to bring delivery operations and utilization management in-house. Meanwhile, HIP moved to capture greater market share by lowering its premium rates by more than 20 percent, placing it in the middle of rates offered by competitors.

Nonetheless, financial problems continued to mount, and HIP sought a new partner to manage its medical operations. PHP stepped forward with an offer to buy more than 60 percent of HIP's assets, including 18 of its health centers, which represented the bulk of its delivery system, and agreed to accept 91.5 percent of premiums in exchange for providing health care services to HIP members. Under this arrangement, PHP assumed responsibility for most of HIP's health care delivery operations, leaving HIP to concentrate on administrative tasks, such as collecting premiums and enrolling new members. This arrangement meant that HIP was dependent on a single contractor to fulfill its contractual obligations.

Nevertheless, PHP's experience running other New Jersey clinics made it appear to be a suitable partner for HIP. After the plan's collapse, however, newspapers reported that at the time of the merger —apparently unbeknownst to HIP—PHP was facing allegations of mismanagement from existing business partners and did not have sufficient financing to support the HIP venture.

The HIP-PHP agreement required state regulatory approval because HIP's sale of its assets altered its operating license. However, the portion of the deal related to the subcontracting arrangement fell outside the state's purview. This large-scale transfer of risk concerned regulators, who asked PHP to obtain licensure as an HMO; PHP refused. The state ultimately approved the deal in October 1997, with the understanding that HIP would remain the licensed entity, and that regulators would rely on HIP to ensure that PHP fulfilled its contractual obligations.

Collapse of HIP

Within a year, both PHP and HIP were facing financial ruin. PHP had stopped paying providers, and HIP's net worth had fallen substantially below the state's requirement, in part because the HMO needed to set aside money to compensate PHP's unpaid claims. In addition, PHP had fired 340 staff without notifying the state, a move that violated state regulations and PHP's contract with HIP. In response to these events, regulators placed HIP under administrative supervision in September 1998. Regulators quickly discovered the extent of HIP's problems and moved to assume control of the HMO. HIP eventually acquiesced to this plan, terminating its contract with PHP and placing itself under state control by entering into voluntary rehabilitation in November 1998. PHP, meanwhile, filed for bankruptcy.

Once HIP entered rehabilitation, the state focused on maintaining continuity of care and paying providers. Providers agreed to accept 30 cents

per dollar for outstanding debts and to continue treating HIP members at 75 percent of the contracted reimbursement amount during the period in which HIP was in rehabilitation. By February 1999, however, regulators decided that efforts to rehabilitate HIP would not be successful, and the state obtained court permission to close the plan on March 31. To help consumers maintain health insurance coverage, the state ordered all HMOs to offer an open enrollment period for HIP members, with premiums set at plans' standard rates.

Policy Responses

The crisis unleashed a storm of criticism over the state's rationale for approving the deal, as well as its inability under existing law to regulate subcontractors and their capitated arrangements with health plans. Through a combination of regulatory and statutory actions, state policy makers have proposed reforms to avoid future insolvencies and situations in which they are unable to regulate the operations of an entity providing health care services to New Jersey consumers.

Within six months of HIP's coming under state control, the state adopted regulations that increased regulators' ability to monitor an HMO's financial condition and to supervise an HMO's ability to deliver services. If such regulations had already been in place, regulators might have learned earlier of the extent of HIP's financial troubles.

Increased HMO Monitoring. A key problem in the HIP-PHP arrangement was that once HIP outsourced virtually its entire delivery system to a single contractor, regulators essentially lost oversight of the HMO's delivery of care. To address this issue, legislators have proposed subjecting HMOs to the current law that regulates insurance holding company systems. This legislation gives the insurance commissioner the ability to review major business actions concerning HMOs, including changes in operational or managerial control. In addition, the commissioner could impose requirements concerning an HMO's management agreements and transactions with other companies. The legislation also addresses other issues that arose with the HIP-PHP arrangement, such as allowing regulators to obtain PHP's financial records and holding public hearings to give consumers, providers and other interested parties an opportunity to express their concerns about the proposed deal.

Subcontractor Oversight. Proposed legislation also calls for oversight of organizations that provide or arrange for the delivery of health care services through subcontracting arrangements with an HMO or other health plan. Examples of regulated entities include physician-hospital organizations providing comprehensive health care services and organizations providing carve-out benefits, such as vision or mental health services.

The proposed legislation is very broad, requiring all entities subject to state oversight to establish quality assurance and grievance procedures before they contract with health plans, as well as requiring state approval of contracts with health plans. In addition, organizations that assume financial risk for services beyond those that the organization is licensed to provide would have to submit financial information and meet minimum net worth requirements.

The existence of such oversight may have enabled the state to regulate PHP directly and to require PHP to establish reserves and meet net worth requirements. However, providers worry that if reserve requirements are too strict, they may not be able to meet them. They also are concerned that oversight may stymie their efforts to develop innovative payment arrangements that give them a stake in controlling the cost of patient care. HMOs argue that the regulations would increase costs for customers and impede HMOs' ability to conduct business. However, advocates of the legislation say it is needed to keep pace with quality-of-care and financial-solvency issues that exist under contractual arrangements that directly affect health care. ●

New Jersey regulators found themselves embroiled in the takeover of a prominent HMO, following a disastrous subcontracting arrangement.

CASE STUDY: CALIFORNIA

Insolvency Concerns Lead State to Bolster Consumer Protections

The downfall of FPA and MedPartners, two national PPMCs, had major repercussions in California, resulting in millions of dollars of unpaid claims, disruptions in health plan and provider arrangements and dramatic steps by state regulators to limit future upheaval in the health care system. The threat of further insolvency problems has led to calls for extending the state's regulatory authority to encompass all provider groups that accept risk from HMOs.

In 1996, California began regulating provider risk arrangements by requiring organizations that accept global risk from HMOs to obtain licensure. The licenses were issued under the state law that regulates HMOs, the Knox-Keene Act. Under this law, provider groups that receive limited licenses may enter into global risk contracts only with HMOs. Holders of limited licenses must comply with the same financial requirements as HMOs, including demonstrating specific levels of tangible net worth, but are granted waivers from meeting service area, marketing and other terms of full HMO licensure. FPA and MedPartners were among the first to obtain limited licenses.

Demise of FPA and MedPartners

The first crisis occurred with the bankruptcy of FPA, a former San Diego family practice group that grew into a national business providing physician groups with access to capitated contracts and medical management services. Under aggressive national expansion urged by Wall Street investors, FPA began purchasing physician groups, including several in California, and entered into contracts with 20 California health plans that covered more than 400,000 enrollees in the state. In May 1998, FPA announced large losses to shareholders, causing the value of its stock to plummet. As the company's financial condition continued to deteriorate, FPA stopped making payments to providers, prompting several California HMOs to terminate their contracts with the company.

In response to these events and earlier provider complaints about late payments, the Department of Corporations (DOC), the state's regulatory agency, conducted a special review of the company's books. Finding cause for concern, DOC gave the company 10 days to meet state net worth requirements and to stop making loans to its financially troubled parent in Delaware. To the apparent surprise of DOC and virtually the entire health care industry, FPA filed for Chapter 11 bankruptcy protection six days later, leaving California providers with an estimated $60 million in unpaid claims.

Meanwhile, MedPartners, which had contracts covering 3.9 million members—nearly 17 percent of California's HMO enrollment—saw its stock collapse after an attempted merger with another national PPMC, PhyCor, foundered in January 1998. By November, MedPartners decided to quit the PPMC business and sell its physician practices across the country.

Fearing a repeat of the FPA fiasco, DOC intervened in March 1999 to prevent MedPartners from transferring any funds from its operations in California to company headquarters in Alabama. Shortly thereafter, DOC seized MedPartners' contracting affiliate, appointed a conservator and forced the local company into Chapter 11 bankruptcy reorganization to preserve the status quo while problems related to divestiture and settlement of debts could be addressed.

Following the failures of FPA and MedPartners, DOC was criticized for not providing stronger oversight of limited license plans. However, efforts to oversee the PPMCs were hampered by the complex corporate management structures of these organizations. DOC could only monitor the contracting entity—not the parent or other local affiliates. In the case of MedPartners, the contracting entity was set up as a shell corporation that kept just enough assets to meet the state's licensure requirements, while the company's unregulated physician groups incurred losses.

Policy Responses

Immediately after FPA declared bankruptcy, the California Medical Association (CMA) began pushing to resolve the question of who is responsible for paying for services rendered when a provider group

fails. CMA petitioned the state for confirmation that provisions in the Knox-Keene Act required plans to act as payment guarantors for their subcontractors. The California Association of Health Plans did not agree with CMA's opinion and argued that plans should not be made to pay twice if a subcontractor gets into financial trouble.

The state denied CMA's petition, so CMA took a different approach by filing suit against eight of California's largest HMOs in an attempt to force the plans to pay physicians separately when a medical group declares bankruptcy, even if the plan already has made capitated payments to the group. Although it is not clear that these tactics will result in HMOs' taking responsibility for the unpaid provider claims, CMA's efforts have helped to drive the debate over whether the state's regulatory role should be expanded further.

Regulatory Overhaul. As a result of the failures, questions were raised about the adequacy of the regulatory structure to fulfill its mandated responsibilities. DOC's primary role is regulating the financial services industry, and historically only a small portion of its governing agency's budget and staff has been devoted to managed care organizations.

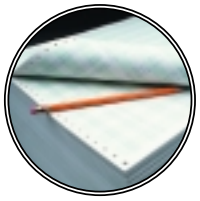
In response to calls to overhaul the state's regulatory structure, the governor signed a package of managed care reform bills in September 1999, including legislation to establish California's first Department of Managed Care. The dedicated managed care regulatory agency is intended to sharpen the state's ability to focus on oversight and enforcement. To assist the new agency in getting started and to address concerns about provider group solvency, the legislation also establishes a two-year moratorium on issuing new limited Knox-Keene licenses, which effectively prevents new entrants from pursuing global risk.

Monitoring Provider Group Solvency. Only about 10 percent of the 300 or more provider groups in the state accept global risk and, thus, are licensed under the Knox-Keene Act. The remaining provider groups are neither licensed nor regulated by California, even though many accept capitated payments and some degree of risk from HMOs. The uncertain financial condition of many provider groups led lawmakers to consider whether the state's role should be expanded to oversee all provider groups for solvency and whether the state should ensure the adequacy of payment rates under risk contracts. Legislation that ultimately passed did not give the state a role in overseeing provider payment rates, but it did strengthen the state's oversight of risk-contracting arrangements under a financial solvency standards board.

When it is established, the board will set rules relating to contractual arrangements between plans and their risk-bearing provider groups. Provider groups, for example, will be required to furnish plans with financial information and be subject to audits to ensure that plans are able to maintain the viability of their delivery systems. Similarly, plans will be required to disclose data to provider groups, such as pharmacy costs, to assist them in managing risk.

The board also will implement a process for grading the financial capabilities of risk-bearing groups, based on criteria that evaluate providers' adherence to performance standards and solvency indicators, such as timeliness of claims payments and adequate levels of working capital and net worth. In addition, the board will require that plans establish mutually acceptable corrective action processes when provider groups are found to have financial deficiencies. Providers also can seek state enforcement actions against plans that fail to comply with the new regulations. Through these reforms, California seeks to reorganize the regulatory structure to provide a stronger framework for monitoring risk-contracting arrangements, thereby protecting the interests of consumers and health care providers. ●

The downfall of FPA and MedPartners resulted in millions of dollars of unpaid claims and disruptions in health plan and provider arrangements.



There are concerns that providers are accepting risk similar to that of insurance companies, with no assurances that they can handle the potential for large losses.

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In an effort to align financial interests, HMOs sometimes have delegated financial risk to their contracted provider groups. The scope of these risk arrangements ranges from those in which physicians are at risk only for the services they provide to those that involve provider groups' accepting global financial risk for professional and hospital services. The latter approach has raised concerns that providers are accepting risk similar to that of insurance companies, with no assurances that they have the expertise or the financial strength to handle the potential for large losses.

Recent experiences in New Jersey and California provide foundation for these concerns. In an arrangement that proved to be disastrous for both parties, HIP Health Plan of New Jersey contracted its entire health care delivery operations to a single out-of-state provider management company, PHP Healthcare Corporation. PHP was unable to manage medical costs for the contracted payment amount, which, in addition to other financial difficulties, ultimately led to the company's bankruptcy and, in turn, the HMO's insolvency. Although there was no statutory authority for the state to review the subcontracting arrangement or to oversee PHP's operations, the state was left to pick up the pieces and ensure continuity of care for HIP enrollees when the two companies became insolvent.

Similar events unfolded in California. Despite state regulation that requires licensure of entities that accept global risk, California was unable to prevent the failure of either MedPartners or FPA Medical Management, two national physician practice management companies (PPMCs) that had global risk arrangements with multiple health plans. The complexity of the flow of funds through both PPMCs' out-of-state corporate management structures severely restricted California's efforts to oversee the global risk portion of these companies' business. More recently, regulators in California have confronted concerns about the solvency of other provider groups with more limited risk arrangements that are not regulated by the state.

Swift State Actions

Public outcry in New Jersey and California over these events provided strong support for increasing state regulation. The policy debate in both states focused on a mix of initiatives that included increasing oversight of HMOs, monitoring entities that accept risk from HMOs and establishing contingency plans to clarify financial responsibility in the event of insolvency.

Increasing State Oversight of HMOs. After HIP was placed under state control, New Jersey moved quickly to create more stringent reserve and deposit requirements for HMOs to protect against insolvency, based on standards being developed by the National Association of Insurance Commissioners (NAIC). The HMO industry has cautioned that such policies increase the cost of doing business, which, in turn, may be passed on to consumers through higher premiums. Furthermore, the more stringent reserve requirements increase the need for capital, which may present a financial hardship for some plans, threatening their viability or acting as a barrier to entry.

Both New Jersey and California now are monitoring HMOs' operations more closely, giving regulators greater opportunities to identify problems and respond quickly. New Jersey enacted regulations to increase the frequency of HMOs' financial reports to the state and proposed legislation that would require notifying the insurance commissioner of HMOs' major operational changes.

Meanwhile, California is creating a new regulatory agency to monitor the managed care industry. The agency will include a financial solvency standards board with authority to develop and recommend regulations concerning solvency standards, audits and financial reporting requirements. By appointing a "managed care czar" who

will bring expertise and exclusive focus on the managed care industry, policy makers hope to improve regulators' ability to monitor plan activity and the performance of their contracted providers. This is in contrast to other states where HMO regulation has evolved out of existing regulatory structures and commonly is split among state agencies that monitor insurance, financial services or health.

Neither New Jersey's nor California's efforts to increase monitoring of HMOs have escaped criticism. Some have questioned whether these efforts will overburden regulators and health plans and whether they will result in useful data. Others argue that the time delays inherent in the process will continue to limit states' ability to monitor plans' financial condition.

Monitoring for Solvency. Both states have attempted to bolster regulation of risk-contracting arrangements by targeting provider entities that accept risk contracts from HMOs, but their approaches are quite different. New Jersey has selected a model to bring plans and certain subcontractors under direct state oversight, while California aims to strengthen the process for monitoring risk-bearing provider groups indirectly through health plans.

New Jersey has proposed legislation to begin direct monitoring of provider organizations and intermediaries that contract for services beyond the scope of services they provide themselves. Because this legislation extends to intermediaries that arrange for the delivery of services on behalf of providers, some of the barriers that existed in regulating the HIP-PHP arrangement would be removed.

The proposed legislation gives authority to state regulators to determine whether providers and risk contractors are capable of delivering the promised services, based on an assessment of the group's financial capacity and ability to meet certain reserve requirements. This approach would grant regulators authority over entities involved in risk contracting, establishing a clear line of accountability for the viability of organizations entering into these arrangements. Critics contend that this is intrusive and have expressed concern that reserve requirements for intermediaries may serve as a barrier to entry. Furthermore, providing direct oversight may require additional funding, staff and other resources; the New Jersey legislation would pass at least part of these expenses on to plans through fees.

In contrast to New Jersey, California relies on health plans to monitor risk-bearing subcontractors, with plans free to define clinical and financial standards and mechanisms for oversight. Newly enacted legislation strengthens this approach by expanding state oversight to include contracts between HMOs and all provider groups that accept risk and pay claims for health care services. In addition, the legislation simplifies the process by establishing a financial solvency standards board with authority to standardize monitoring requirements. This improves the current process, which requires provider groups to comply with different reporting formats from multiple managed care plans.

Advocates of indirect oversight stress that plans, by virtue of their work with providers, are better situated to assess their capacity for risk contracting. Furthermore, relying on plans to oversee providers has the advantage of removing the onus of oversight from state regulators. Critics question whether this delegated model allows regulators to ensure consumer protection, while plans are concerned that this model requires them to be accountable for their subcontractors and may make them responsible for guaranteeing payment and continuity of care in the event of provider group insolvency.

At the same time, providers worry that plans could gain negotiating leverage over them if oversight gives the plans direct access to detailed financial records. Providers also question how plans would impose corrective action when provider groups get into financial trouble, which could become a prickly issue if the group in question is one of its core providers. California's new law addresses these concerns by authorizing

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New Jersey's approach is direct state oversight, while California monitors risk-bearing provider groups indirectly through health plans.

the creation of a more rigorous regulatory framework to define better the mutual responsibilities and accountabilities of plans and provider groups to each other and to the state, thus ensuring that consumers served by these groups are adequately protected.

Contingency Planning. While both New Jersey and California have sought to establish measures that ward against future failures, they also have considered contingency plans to clarify who should bear financial responsibility if entities fail. The collapse of HIP and the subsequent failure of a Medicaid HMO in New Jersey led to calls for an HMO guaranty fund to pay for the two failures by taxing HMO premiums over a three-year period. The fund was not created, in part because the HMO industry successfully argued that the rest of the industry should not be held responsible for other companies' failures.

In California, providers and plans have battled over who is responsible for paying providers following the PPMCs' demise. Providers have taken legal recourse to collect payment, while plans have argued that they should not have to pay twice for contracted services, contending that this would lead to an increase in premiums. Some have lobbied for legislation to establish a guaranty fund, but these efforts have not been successful to date, reflecting policy makers' reluctance to establish costly protections that may only cushion the effect of losses.

Implications for Policy Makers

The events in New Jersey and California demonstrate the complex issues that provider risk-contracting arrangements pose for regulators. HMOs' delegation of significant levels of risk to provider groups complicates states' obligation to protect consumer interests under insurance arrangements. Though most states have not subjected risk-contracting arrangements to special scrutiny, states are still likely to be held responsible for addressing the repercussions of failures. In New Jersey and California, regulators have been responsible for ensuring consumers' access to services and addressing appeals to reconcile unpaid provider claims. There also have been calls for revamping existing regulations to prevent similar occurrences. However, as the policy debates in these communities illustrate, there are no easy remedies to the problems.

While there is likely to be considerable variation across markets in the extent to which providers and HMOs enter into risk-bearing arrangements and how many of these contracts encounter difficulty, the experiences in New Jersey and California raise a number of important questions for regulators. To some, the problems posed by risk contracting may appear to be of concern only in markets where there is substantial managed care penetration. However, the fact that these problems surfaced in Northern New Jersey, which has just 24 percent HMO enrollment, provides an important counter to this argument. Though there has been much attention paid in recent years to how consumers may be protected under a system increasingly dominated by HMOs, the experiences in these two communities suggest that determining how to adapt existing regulatory structures to increase oversight over risk-bearing arrangements also may warrant attention. ●

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President: Paul B. Ginsburg
Director of Public Affairs: Ann C. Greiner
Editor: The Stein Group

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600 Maryland Avenue, SW
Suite 550
Washington, DC 20024-2512
Tel: (202) 554-7549
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