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# Value-Based Payments:
## A Comprehensive State Survey

A compilation of state laws and regulations with respect to risk-sharing in value-based payment arrangements.

November 2020

# Value-Based Payments: A Comprehensive State Survey

## EXECUTIVE SUMMARY

Epstein Becker Green ("EBG") is proud to release our Value-Based Payment Laws survey. EBG has researched, compiled, and analyzed state-specific content about the regulatory requirements involved in providers moving away from fee for service reimbursement (such as discounted fees and per diems) and towards value-based payment arrangements involving "downside" risk or insurance risk-sharing with insurers, HMOs, and other types of state-regulated health plans. Some types of risk-sharing arrangements include capitation, shared savings and losses, and percentage of premium reimbursement. Each state regulates insurance risk-sharing arrangements differently—some regulate only prepaid compensation models, some regulate all forms of risk, and some also regulate intermediary network entities which assume risk on behalf of networks. This survey is EBG's most comprehensive compilation of state laws, regulations, and policies with respect to risk-sharing types of value-based payment arrangements.

**General VBP Provisions Across the 50 States**

Much of the state level regulatory guidance on risk sharing in value based payment arrangements between healthcare providers and health insurers or HMOs is found in insurance laws and HMO laws. Since insurers and HMOs are licensed by states to take insurance risk (and required to post reserves and are otherwise subject to regulatory oversight about such risk), states have an interest when such licensed entities transfer that risk on to providers (who typically are not licensed to take insurance risk). Risk-sharing arrangements have a complicated past. Some providers in the 1990s were financially harmed by certain risk-sharing arrangements, which led some states to adopt more stringent oversight of such arrangements. Different states took different approaches and today there remains a patchwork of state laws addressing such arrangements. This survey looks at the following categories relevant topics:

- Regulatory agencies and laws governing both health insurers and HMOs or comparable entities
- Definition of "insurance" or insurance risk under state law
- Laws addressing the transfer of insurance risk from insurers and HMOs to providers
- Requirements that apply if insurance risk transfer to providers is permitted

This survey is not an exhaustive analysis of the potential repercussions of entering into a risk transfer arrangement. While some states specifically designate vehicles or types of entities for risk sharing, others do not, or do not address risk sharing outside of the designated vehicle. In those instances, it is possible that entering into a risk-sharing arrangement could constitute the practice of insurance, and therefore requires an insurance (or similar) license. In addition, some states regulate network of providers even if they are not reimbursed on a risk sharing basis. Those regulations are outside

the scope of this survey. Anyone relying on this survey should seek professional counsel to ensure that a proposed relationship between a health plan and provider does not inadvertently constitute the practice of insurance without the appropriate licensure.

**Conclusion**

Overall, interest in, and acceptance of, value-based payment methodologies continues to increase. Ongoing increases in health care costs and corresponding increases in premiums paid for health insurance have put more pressure than ever on federal and state legislators as well as employers to move away from fee-for-service payment and towards value-based payment for health care services. Providers and plans should continue to monitor developments in federal and state laws, regulations, and policies to assess value-based opportunities while maintaining compliance with applicable laws.

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## ALABAMA

### Health Insurance

**What regulatory body governs health insurance?**

Department of Insurance

**What statutes govern health insurance?**

Ala. Code, Tit. 27.

**How is "insurance" defined?**

"Insurance" is "[a] contract whereby one undertakes to indemnify another or pay or provide a specified amount or benefit upon determinable contingencies". An "insurer" is any "person engaged as indemnitor, surety or contractor in the business of entering into contracts of insurance."

ALA. CODE § 27-1-2.

**Can insurers transfer risk to providers?**

There is no provision affirmatively granting the authority of insurers to do so, but various references in the Code of Alabama contemplate risk-based arrangements. For example, the prompt pay law states:

"This section shall only apply to payments made on a claims basis and shall not apply to capitation or other forms of periodic payments to providers."

ALA. CODE § 27-1-17.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

### HMO

**What regulatory body governs HMOs?**

Department of Public Health and Department of Insurance




# ALABAMA

**What statutes govern HMOs?**

Ala. Code, Tit. 27 Ch. 21A.

**Can an HMO transfer risk to providers?**

There is no provision affirmatively granting an HMO the authority to do so, but various references in the Alabama Administrative Code contemplate risk-based arrangements. For example, the provider contract section of the HMO chapter states that a provider contract must:

"If utilized, withhold or other incentives or reimbursement arrangement incentives must be clearly defined."

ALA. ADMIN. CODE r. § 420-5-6-.10.

**What requirements apply if an HMO transfers risk to a provider?**

None identified in statutes or regulations.

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## ALASKA

### Health Insurance

**What regulatory body governs health insurance?**

Department of Commerce, Community, and Economic Development, Division of Insurance

**What statutes govern health insurance?**

Alaska Stat., Tit. 21 Ch. 51.

**How is "insurance" defined?**

"Insurance means a contract whereby one undertakes to indemnify another or pay or provide a specified or determinable amount or benefit upon determinable contingencies."

ALASKA STAT. § 21.97.900.

a) "Health insurance is insurance of human beings (1) against bodily injury, disablement, or death by accident or accidental means; (2) against the resulting expenses of the injury, disablement, or death; (3) against disablement or expense resulting from sickness or childbirth; (4) against expense incurred in prevention of sickness; (5) for dental care; and (6) including every insurance that applies to injury, disablement, or death. Transaction of health insurance includes disability insurance and stop-loss insurance but does not include workers' compensation insurance. Health care insurance described in (b) of this section is a type of health insurance under this subsection.

b) Health care insurance means that part of health insurance that provides, delivers, arranges for, pays for, or reimburses any of the costs of medical care."

ALASKA STAT. § 21.12.050.

**Can insurers transfer risk to providers?**

It's not clear. A Division of Insurance Bulletin dated February 6, 1997, Bulletin No. B97-04, states that any entity assuming insurance risk must be licensed as an insurer. It is unclear if this is still the policy position of the Alaska Division of Insurance.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.



# ALASKA

## HMO

**What regulatory body governs HMOs?**

Department of Commerce, Community, and Economic Development, Division of Insurance

**What statutes govern HMOs?**

Alaska Stat., Tit. 21 Ch. 86.

**Can an HMO transfer risk to providers?**

Yes, statutes contemplate the prepayment of healthcare services to a provider, and other financial models:

“In addition to basic health care services, a health maintenance organization may provide, or arrange for, other health care services on a prepayment or other financial basis.”

ALASKA STAT. § 21.86.060(b).

**What requirements apply if an HMO transfers risk to a provider?**

None identified in statutes or regulations.


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## ARIZONA

### Health Insurance

**What regulatory body governs health insurance?**

Department of Insurance

**What statutes govern health insurance?**

Arizona Rev. Stat. Tit. 20, Chap. 4, Art. 9.

**How is "insurance" defined?**

"Insurance" is a contract by which one undertakes to indemnify another or to pay a specified amount on determinable contingencies."

ARIZ. REV. STAT. § 20-103.

**Can insurers transfer risk to providers?**

Yes, statutes contemplate services rendered by a "Health Care Services Organization" ("HSCO") that are reimbursable on a prepaid or other basis. Transfer of risk from a payor to an entity other than an HSCO may constitute the practice of insurance, as defined above.

"'Health care services organization' means any person that undertakes to conduct one or more health care plans. Unless the context otherwise requires, health care services organization includes a provider sponsored health care services organization."

ARIZ. REV. STAT. § 20-1051.

"'Health care plan' means any contractual arrangement whereby any health care services organization undertakes to provide directly or to arrange for all or a portion of contractually covered health care services and to pay or make reimbursement for any remaining portion of the health care services on a prepaid basis through insurance or otherwise. A health care plan shall include those health care services required in this article or in any rule adopted pursuant to this article."

ARIZ. REV. STAT. § 20-1051.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.




## HMO

**What regulatory body governs HMOs?**

Arizona only regulates “Health Care Service Organizations,” discussed above, which includes insurers and HMOs.

**What statutes govern HMOs?**

Arizona only regulates “Health Care Service Organizations,” discussed above, which includes insurers and HMOs.

**Can an HMO transfer risk to providers?**

Arizona only regulates “Health Care Service Organizations,” discussed above, which includes insurers and HMOs.

**What requirements apply if an HMO transfers risk to a provider?**

Arizona only regulates “Health Care Service Organizations,” discussed above, which includes insurers and HMOs.

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## ARKANSAS

## Health Insurance

**What regulatory body governs health insurance?**

Insurance Department

**What statutes govern health insurance?**

Ark. Code Ann. Tit. 23, Ch. 85.

**How is "insurance" defined?**

"'Insurance' is any agreement, contract, or other transaction whereby one party, the 'insurer', is obligated to confer benefit of pecuniary value upon another party, the 'insured' or 'beneficiary', dependent upon the happening of a fortuitous event in which the insured or beneficiary has, or is expected to have at the time of such a happening, a material interest that will be adversely affected by the happening of such an event."

ARK. CODE ANN. § 23-60-102.

**Can insurers transfer risk to providers?**

The statutes only address risk transfer within the context of Medicaid:

"The Insurance Commissioner shall regulate the licensing and financial solvency of risk-based provider organizations, as defined in § 20-77-2703, participating in the Medicaid provider-led organized care system for enrollable Medicaid beneficiary populations as defined in§ 20-77-2703."

ARK. CODE ANN. § 23-61-117.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

## HMO

**What regulatory body governs HMOs?**

Insurance Department



# ARKANSAS

**What statutes govern HMOs?**

Ark. Code Ann. Tit. 23, Ch. 76.

**Can an HMO transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an HMO transfers risk to a provider?**

None identified in statutes or regulations.


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## CALIFORNIA

### Health Insurance

**What regulatory body governs health insurance?**

Department of Insurance

**What statutes govern health insurance?**

Cal. Ins. Code

**How is "insurance" defined?**

"Insurance is a contract whereby one undertakes to indemnify another against loss, damage, or liability arising from a contingent or unknown event."

CAL. INS. CODE § 22

**Can insurers transfer risk to providers?**

California allows "risk-bearing organizations" to enter into "risk arrangements" with health insurers/HMOs. Entities which are not risk-bearing organizations entering into "risk arrangements" may be practicing insurance, as defined above.

"[A] 'risk-bearing organization' means a professional medical corporation, other form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure pursuant to subdivision (l) of Section 1206, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services, but does not include an individual or a health care service plan, and that does all of the following:

(A) Contracts directly with a health care service plan or arranges for health care services for the health care service plan's enrollees[;]

(B) Receives compensation for those services on any capitated or fixed periodic payment basis[; and]

(C) Is responsible for the processing and payment of claims made by providers for services rendered by those providers on behalf of a health care service plan that are covered under the capitation or fixed periodic payment made by the plan to the risk-bearing organization. Nothing in this subparagraph in any way limits, alters, or abrogates any responsibility of a health care service plan under existing law."

CAL. HEALTH & SAFETY CODE § 1375.4.

"'Organization' means a risk-bearing organization as defined in Health and Safety Code Section 1375.4(g). An organization includes an entity that contracts directly with the plan or subcontracts with another organization to arrange for the health care services of a plan's enrollees and meets the requirements of Health and Safety Code 1375.4(g)."

CAL. CODE REGS. tit. 28, §1300.75.4(b).

"'Risk arrangement' is defined to include both 'risk-sharing arrangement' and 'risk-shifting arrangement,' which are defined as follows:

1) 'Risk-sharing arrangement' means any compensation arrangement between an organization [RBO] and a plan under which the organization shares the risk of financial gain or loss with the plan.

2) 'Risk-shifting arrangement' means a contractual arrangement between an organization and a plan under which the plan pays the organization on a fixed, periodic or capitated basis, and the financial risk for the cost of services provided pursuant to the contractual arrangement is assumed by the organization."

CAL. CODE REGS. tit. 28, §1300.75.4(d).

**What requirements apply if an insurer transfers risk to a provider?**

"Every contract between a health care service plan and a risk-bearing organization that is issued, amended, renewed, or delivered in this state on or after July 1, 2000, shall include provisions concerning the following, as to the risk-bearing organization's administrative and financial capacity, which shall be effective as of January 1, 2001:

1) A requirement that the risk-bearing organization furnish financial information to the health care service plan or the plan's designated agent and meet any other financial requirements that assist the health care service plan in maintaining the financial viability of its arrangements for the provision of health care services in a manner that does not adversely affect the integrity of the contract negotiation process;

2) A requirement that the health care service plan disclose information to the risk-bearing organization that enables the risk-bearing organization to be informed regarding the financial risk assumed under the contract;

3) A requirement that the health care service plans provide payments of all risk arrangements, excluding capitation, within 180 days after close of the fiscal year."

CAL. HEALTH & SAFETY CODE § 1375.4.

See also, Department of Managed Healthcare RBO Frequently Asked Questions.

## HMO

**What regulatory body governs HMOs?**

Department of Managed Health Care

**What statutes govern HMOs?**

Cal. Health & Safety Code Ch. 2.2.

**Can an HMO transfer risk to providers?**

California allows "risk-bearing organizations" to enter into "risk arrangements" with health insurers/HMOs. Entities which are not risk-bearing organizations entering into "risk arrangements" may be practicing insurance, as defined above.

"[A] 'risk-bearing organization' means a professional medical corporation, other form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure pursuant to subdivision (l) of Section 1206, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services, but does not include an individual or a health care service plan, and that does all of the following:

(A) Contracts directly with a health care service plan or arranges for health care services for the health care service plan's enrollees[;]

(B) Receives compensation for those services on any capitated or fixed periodic payment basis[; and]

(C) Is responsible for the processing and payment of claims made by providers for services rendered by those providers on behalf of a health care service plan that are covered under the capitation or fixed periodic payment made by the plan to the risk-bearing organization. Nothing in this subparagraph in any way limits,

alters, or abrogates any responsibility of a health care service plan under existing law."

CAL. HEALTH & SAFETY CODE § 1375.4.

"'Organization' means a risk-bearing organization as defined in Health and Safety Code Section 1375.4(g). An organization includes an entity that contracts directly with the plan or subcontracts with another organization to arrange for the health care services of a plan's enrollees and meets the requirements of Health and Safety Code 1375.4(g)."

CAL. CODE REGS. tit. 28, §1300.75.4(b).

"'Risk arrangement' is defined to include both "risk-sharing arrangement" and "risk-shifting arrangement," which are defined as follows:

1) 'Risk-sharing arrangement' means any compensation arrangement between an organization [RBO] and a plan under which the organization shares the risk of financial gain or loss with the plan[;]

2) 'Risk-shifting arrangement' means a contractual arrangement between an organization and a plan under which the plan pays the organization on a fixed, periodic or capitated basis, and the financial risk for the cost of services provided pursuant to the contractual arrangement is assumed by the organization."

CAL. CODE REGS. tit. 28, §1300.75.4(d).

**What requirements apply if an HMO transfers risk to a provider?**

"Every contract between a health care service plan and a risk-bearing organization that is issued, amended, renewed, or delivered in this state on or after July 1, 2000, shall include provisions concerning the following, as to the risk-bearing organization's administrative and financial capacity, which shall be effective as of January 1, 2001:

1) A requirement that the risk-bearing organization furnish financial information to the health care service plan or the plan's designated agent and meet any other financial requirements that assist the health care service plan in maintaining the financial viability of its arrangements for the provision of health care services in a manner that does not adversely affect the integrity of the contract negotiation process;

2) A requirement that the health care service plan disclose information to the risk-bearing organization that enables the risk-bearing organization to be informed regarding the financial risk assumed under the contract;

3) A requirement that the health care service plans provide payments of all risk arrangements, excluding capitation, within 180 days after close of the fiscal year."

CAL. HEALTH & SAFETY CODE § 1375.4.

See also, Department of Managed Healthcare RBO Frequently Asked Questions.



# CONNECTICUT

## Health Insurance

**What regulatory body governs health insurance?**

Insurance Department

**What statutes govern health insurance?**

Conn. Gen. Stat. Tit. 38a, Ch.700C.

**How is "insurance" defined?**

"'Insurance means any agreement to pay a sum of money, provide services or any other thing of value on the happening of a particular event or contingency or to provide indemnity for loss in respect to a specified subject by specified perils in return for a consideration. In any contract of insurance, an insured shall have an interest which is subject to a risk of loss through destruction or impairment of that interest, which risk is assumed by the insurer and such assumption shall be part of a general scheme to distribute losses among a large group of persons bearing similar risks in return for a ratable contribution or other consideration."

CONN. GEN. STAT. § 38a-1

**Can insurers transfer risk to providers?**

Preferred Provider Networks ("PPNs") may accept financial risk when entering into arrangements with health insurers/HMOs. Entities which are not PPNs which accept financial risk from a health insurer/HMO may be practicing insurance, as defined above.

"'Preferred provider network' means a person that is not a managed care organization, but that pays claims for the delivery of health care services, accepts financial risk for the delivery of health care services and establishes, operates or maintains an arrangement or contract with providers relating to (A) the health care services rendered by the providers, and (B) the amounts to be paid to the providers for such services. "Preferred provider network" does not include (i) a workers' compensation preferred provider organization established pursuant to section 31-279-10 of the regulations of Connecticut state agencies, (ii) an independent practice association or physician hospital organization whose primary function is to contract with insurers and provide services to providers, (iii) a clinical laboratory, licensed pursuant to section 19a-30, whose primary payments for any contracted or referred services are made to other licensed clinical laboratories or for associated pathology services, or (iv) a pharmacy benefits manager

responsible for administering pharmacy claims whose primary function is to administer the pharmacy benefit on behalf of a health benefit plan[.]"

CONN. GEN. STAT. § 38a-479aa(7).

PPNs may contract with insurers or "health care centers."

CONN. GEN. STAT. § 38a-478(6), (7).

**What requirements apply if an insurer transfers risk to a provider?**

"On and after May 1, 2004, no managed care organization may enter into or renew a contractual relationship with a preferred provider network that is not licensed in accordance with section 38a-479aa. On and after May 1, 2005, no managed care organization may continue or maintain a contractual relationship with a preferred provider network that is not licensed in accordance with section 38a-479aa."

CONN. GEN. STAT. §38a-479bb(a).

Managed care organizations that contract with preferred provider networks must follow the requirements in CONN. GEN. STAT. §38a-479bb.

## HMO

**What regulatory body governs HMOs?**

Insurance Department

**What statutes govern HMOs?**

Conn. Gen. Stat. Tit. 38a, Ch. 698A.

**Can an HMO transfer risk to providers?**

PPNs may accept financial risk when entering into arrangements with health insurers/HMOs. Entities which are not PPNs which accept financial risk from a health insurer/HMO may be practicing insurance, as defined above.

"'Preferred provider network' means a person that is not a managed care organization, but that pays claims for the delivery of health care services, accepts financial risk for the delivery of health care services and establishes, operates or maintains an arrangement or contract with providers relating to (A) the health care services rendered by the

providers, and (B) the amounts to be paid to the providers for such services. “Preferred provider network” does not include (i) a workers' compensation preferred provider organization established pursuant to section 31-279-10 of the regulations of Connecticut state agencies, (ii) an independent practice association or physician hospital organization whose primary function is to contract with insurers and provide services to providers, (iii) a clinical laboratory, licensed pursuant to section 19a-30, whose primary payments for any contracted or referred services are made to other licensed clinical laboratories or for associated pathology services, or (iv) a pharmacy benefits manager responsible for administering pharmacy claims whose primary function is to administer the pharmacy benefit on behalf of a health benefit plan[.]”

CONN. GEN. STAT. § 38a-479aa(7).

Preferred Provider Networks may contract with insurers or “health care centers.”

CONN. GEN. STAT. § 38a-478(6), (7).

**What requirements apply if an HMO transfers risk to a provider?**

“On and after May 1, 2004, no managed care organization may enter into or renew a contractual relationship with a preferred provider network that is not licensed in accordance with section 38a-479aa. On and after May 1, 2005, no managed care organization may continue or maintain a contractual relationship with a preferred provider network that is not licensed in accordance with section 38a-479aa.”

CONN. GEN. STAT. §38a-479bb(a).

Managed care organizations that contract with preferred provider networks must follow the requirements in CONN. GEN. STAT. §38a-479bb.

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## COLORADO

### Health Insurance

**What regulatory body governs health insurance?**

Division of Insurance

**What statutes govern health insurance?**

Colo. Rev. Stat. Tit. 10, Art. 16.

**How is "insurance" defined?**

"'Insurance' means a contract whereby one, for consideration, undertakes to indemnify another or to pay a specified or ascertainable amount or benefit upon determinable risk contingencies, and includes annuities."

COLO. REV. STAT. § 10-1-102.

**Can insurers transfer risk to providers?**

"Risk bearing entities" are permitted to enter into risk-based arrangements with health insurers/HMOs. Entities which are not Risk-Bearing Entities entering into risk-based arrangements may be practicing insurance, as defined above.

"Colorado law permits carriers to enter into contracts with risk bearing entities."

3 COLO. CODE REGS. § 702-3:3-1-14-2.

"'Risk Bearing Entity' is any entity assuming risk from a licensed Carrier to provide covered benefits and services under a managed care plan, which risk the entity would not otherwise have the ability and legal authority to provide."

3 COLO. CODE REGS. § 702-3:3-1-14-4(A).

A "Carrier" is defined as both an insurer and an HMO.

COLO. REV. STAT. § 10-16-102(8).

**What requirements apply if an insurer transfers risk to a provider?**

Carriers and risk bearing entities are subject to 3 COLO. CODE REGS. § 702-3-1-14-2 *et seq*.

"The transfer of risk for consideration, such as capitated contracts for the provision of health care services, constitutes the transaction of insurance business and subjects the entity assuming the risk to relevant insurance regulatory requirements. Division of Insurance Regulation 2-1-9, concerning Limited Service Licensed Provider Networks, waives the licensing requirement for providers that accepts health risks only when the entity transferring the risk is a licensed carrier and retains ultimate, legal liability for all risk transferred.

...

The Division interprets existing law to prohibit carriers that provide administrative services for self-funded risks from commingling self-insured risks with insured risks in any capitated contract with providers. To avoid unintentional subjecting self-insured risks to insurance regulation, fee-for-service arrangements, not capitation, should be utilized."

Colo. Ins. Bulletin B-2.03.

## HMO

**What regulatory body governs HMOs?**

Division of Insurance

**What statutes govern HMOs?**

Colo. Rev. Stats Tit. 10, Art. 16, Part 4.

**Can an HMO transfer risk to providers?**

Risk-bearing entities may enter into risk-based arrangements with health insurers/HMOs. Entities which are not risk-bearing organizations entering into "risk arrangements" may be practicing insurance, as defined above.

"Colorado law permits carriers to enter into contracts with risk bearing entities."

3 COLO. CODE REGS. § 702-3:3-1-14-2.

"'Risk Bearing Entity' is any entity assuming risk from a licensed Carrier to provide covered benefits and services under a managed care plan, which risk the entity would not otherwise have the ability and legal authority to provide."

3 COLO. CODE REGS. § 702-3:3-1-14-4(A).




A “Carrier” is defined as both an insurer and an HMO.

COLO. REV. STAT. § 10-16-102(8).

**What requirements apply if an HMO transfers risk to a provider?**

Carriers and risk bearing entities are subject to 3 COLO. CODE REGS. § 702-3-1-14-2 *et seq.*

“The transfer of risk for consideration, such as capitated contracts for the provision of health care services, constitutes the transaction of insurance business and subjects the entity assuming the risk to relevant insurance regulatory requirements. Division of Insurance Regulation 2-1-9, concerning Limited Service Licensed Provider Networks, waives the licensing requirement for providers that accepts health risks only when the entity transferring the risk is a licensed carrier and retains ultimate, legal liability for all risk transferred.

...

The Division interprets existing law to prohibit carriers that provide administrative services for self-funded risks from commingling self-insured risks with insured risks in any capitated contract with providers. To avoid unintentional subjecting self-insured risks to insurance regulation, fee-for-service arrangements, not capitation, should be utilized.”

Colo. Ins. Bulletin B-2.03.



# DELAWARE

## Health Insurance

**What regulatory body governs health insurance?**

Department of Insurance

**What statutes govern health insurance?**

Del. Code Ann. Tit. 18, Chs. 33, 35, and 36.

**How is "insurance" defined?**

"'Insurance' means a contract whereby one undertakes to pay or indemnify another as to loss from certain specified contingencies or perils, called 'risks,' or to pay or grant a specified amount or determinable benefit in connection with ascertainable risk contingencies or to act as surety."

DEL. CODE ANN. tit. 18, § 102.

**Can insurers transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

## HMO

**What regulatory body governs HMOs?**

Department of Insurance

**What statutes govern HMOs?**

Del. Code Ann. Tit. 18, Ch. 64.




## DELAWARE

**Can an HMO transfer risk to providers?**

The issue is not directly addressed, though the definition of a "managed care organization" contemplates that such an organization may "arrange for health-care services on a prepayment or other financial basis."

DEL. CODE ANN. tit. 18, § 6403

**What requirements apply if an HMO transfers risk to a provider?**

None identified in statutes or regulations.

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## DISTRICT OF COLUMBIA

### Health Insurance

**What regulatory body governs health insurance?**

Department of Insurance, Securities and Banking

**What statutes govern health insurance?**

D.C. Code. Div. V, Tit. 31, Subtitle IV.

**How is "insurance" defined?**

"'Insurance' means any of the lines of authority enumerated in § 31-1131.07(a)."

D.C. CODE § 31-1131.02(5).

"'Insurer' means a company offering protection through the sale of an insurance policy to an insured."

D.C. CODE § 31-1131.02(7).

**Can insurers transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

### HMO

**What regulatory body governs HMOs?**

Department of Insurance, Securities and Banking

**What statutes govern HMOs?**

D.C. Code, Div. V, Tit. 31, Subtitle IV, Ch. 34.

**Can an HMO transfer risk to providers?**

Not directly addressed, but statutes contemplate capitated arrangements:

"'Capitated basis' means fixed per member per month payment or percentage of dues payment wherein the provider or an affiliation of providers assumes the full risk for the cost of contracted services without regard to the type, value, or frequency of services provided. For the purposes of this definition, the term 'capitated basis' includes the cost associated with operating staff or group model facilities."

D.C. CODE § 31-3401(4).

**What requirements apply if an HMO transfers risk to a provider?**

None identified in statutes or regulations.

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## FLORIDA

## Health Insurance

**What regulatory body governs health insurance?**

Florida Department of Financial Services, Office of Insurance Regulation

**What statutes govern health insurance?**

Fla. Stat. Ch. 627, Part VI.

**How is "insurance" defined?**

"'Insurance' is a contract whereby one undertakes to indemnify another or pay or allow a specified amount or a determinable benefit upon determinable contingencies."

FLA. STAT. § 624.02

**Can insurers transfer risk to providers?**

PPNs may enter into "alternative" payment rates with health insurers. Entities which are not PPNs which accept financial risk from a health insurer may be practicing insurance, as defined above.

"'Preferred provider network' means a group of licensed health care providers with each of which the insurer has directly or indirectly contracted for alternative or reduced rates of payment."

FLA. STAT. § 627.6471(1)(c).

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

## HMO

**What regulatory body governs HMOs?**

Florida Agency for Health Care Administration
Florida Department of Financial Services, Office of Insurance Regulation



# FLORIDA

**What statutes govern HMOs?**

Fla. Stat. Ch. 641.

**Can an HMO transfer risk to providers?**

Yes, the statutes contemplate HMOs transferring financial risk to contracted providers:

"Each health maintenance organization shall file, upon the request of the office, financial statements for all contract providers of comprehensive health care services who have assumed, through capitation or other means, more than 10 percent of the health care risks of the health maintenance organization. However, this provision shall not apply to any individual physician."

FLA. STAT. § 641.2342.

**What requirements apply if an HMO transfers risk to a provider?**

The issue is not directly addressed, but the statutes contemplate HMOs entering into risk-based arrangements:

"Each health maintenance organization shall file, upon the request of the office, financial statements for all contract providers of comprehensive health care services who have assumed, through capitation or other means, more than 10 percent of the health care risks of the health maintenance organization. However, this provision shall not apply to any individual physician."

FLA. STAT. § 641.2342.

# GEORGIA

## Health Insurance

**What regulatory body governs health insurance?**

Office of Insurance and Safety Fire

**What statutes govern health insurance?**

O.C.G.A. Title 33, Chapters 20, 29A, 50, and 60.

**How is "insurance" defined?**

"'Insurance' means a contract which is an integral part of a plan for distributing individual losses whereby one undertakes to indemnify another or to pay a specified amount or benefits upon determinable contingencies."

Ga. Code Ann. § 33-1-2.

**Can insurers transfer risk to providers?**

Health Care Corporations may accept financial risk when entering into arrangements with health insurers. Entities which are not Health Care Corporations which accept financial risk from a health insurer may be practicing insurance, as defined above.

"A health care corporation may enter into contracts with a corporation or association in this state or elsewhere so that ... or hospital or other health care services may be provided for subscribers of the corporation or other corporations or associations by means of risk sharing and other joint undertakings, including reinsurance, which the directors of the corporation may from time to time approve in accordance with the laws of this state."

Ga. Code Ann. § 33-20-17(b).

"'Health care corporation' means a corporation established in accordance with the provisions of this chapter to administer one or more health care plans."

O.C.G.A. § 33-20-3(2).

**What requirements apply if an insurer transfers risk to a provider?**

"A provider sponsored health care corporation shall ... maintain the minimum subscriber surplus required pursuant to O.C.G.A. § 33-20-13(d)."

Ga. Comp. R. & Regs. 120-2-75-.06.

"[E]ach provider sponsored health care corporation shall obtain and thereafter maintain an aggregate excess reinsurance policy that is acceptable to the Commissioner."

Ga. Comp. R. & Regs. 120-2-75-.06.

"Any provider sponsored health care corporation ... shall file annual and quarterly financial statements. ..."

Ga. Comp. R. & Regs. 120-2-75-.07.

## HMO

**What regulatory body governs HMOs?**

Office of Insurance and Safety Fire

**What statutes govern HMOs?**

O.C.G.A. Title 33, Chapter 21.

**Can an HMO transfer risk to providers?**

The statutes can be interpreted to prohibit an HMO from sharing risk:

"Every health maintenance organization shall be responsible for the assumption of full financial risk of providing basic health services to its members, except that the health maintenance organization may reinsure its risk with solvent reinsurers. ..."

O.C.G.A. § 33-21-10(a).

**What requirements apply if an HMO transfers risk to a provider?**

None identified in statutes or regulations.

## Health Insurance

**What regulatory body governs health insurance?**

Department of Commerce & Consumer Affairs

**What statutes govern health insurance?**

Hawaii Statutes Title 24, Chapter 431, Article 10a.

**How is "insurance" defined?**

"Insurance is a contract whereby one undertakes to indemnify another or pay a specified amount upon determinable contingencies."

Haw. Rev. Stat. Ann. § 431:1-201(a).

**Can insurers transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

## HMO

**What regulatory body governs HMOs?**

Department of Commerce & Consumer Affairs

**What statutes govern HMOs?**

Hawaii Statutes Title 24, Chapter 432D-2.

**Can an HMO transfer risk to providers?**

The statutes contemplate the transfer of capitated risk:

"'Capitated basis' means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted

services without regard to the type, value, or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities."

**What requirements apply if an HMO transfers risk to a provider?**

None identified in statutes or regulations.

# IDAHO

## Health Insurance

**What regulatory body governs health insurance?**

Department of Insurance

**What statutes govern health insurance?**

Idaho Code Title 41, Chapters 40 and 42.

**How is "insurance" defined?**

"'Insurance' is a contract whereby one undertakes to indemnify another or pay or allow a specified or ascertainable amount or benefit upon determinable risk contingencies."

Idaho Code Ann. § 41-102.

**Can insurers transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

## HMO

**What regulatory body governs HMOs?**

Department of Insurance

**What statutes govern HMOs?**

Idaho Code Title 41, Chapter 39.

**Can an HMO transfer risk to providers?**

The statutes suggest that such arrangements are permissible, but do not directly address them:

"Nothing in this section shall be construed to prohibit contracts that contain incentive plans that involve general payment such as capitation payments or shared risk agreements. ..."

Id. Code §41-3928.

**What requirements apply if an HMO transfers risk to a provider?**

Not addressed in statutes or regulations.

# ILLINOIS

## Health Insurance

**What regulatory body governs health insurance?**

Department of Financial and Professional Regulation

**What statutes govern health insurance?**

Illinois Stat. Chapter 215, Act 105.

**How is "insurance" defined?**

"'Insurer' means an insurance company or a health service corporation authorized in this State to issue policies or subscriber contracts which reimburse for expenses of health care services."

215 ILCS 5/370g.

**Can insurers transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

## HMO

**What regulatory body governs HMOs?**

Department of Financial and Professional Regulation

**What statutes govern HMOs?**

Illinois Stat. Chapter 215, Act 125.

**Can an HMO transfer risk to providers?**

The issue is not directly addressed, although the regulations contemplate capitated agreements with MCOs, which include intermediary provider organizations such as IPAs and PHOs:

"'Managed Care Organization' or 'MCO' means a partnership, association, corporation or other legal entity, including but not limited to individual practice associations (IPAs) and Physician Hospital Organizations (PHOs), that delivers or arranges for the delivery of health care services through providers it has contracted with or otherwise made arrangements with to furnish those health care services."

50 IL ADC 4521.20.

**What requirements apply if an HMO transfers risk to a provider?**

The statute requires certain provisions be in capitated agreements with MCOs:

"All MCO capitated agreements shall contain provisions requiring the disclosure of language whereby the MCO agrees to fully cooperate with, and disclose all relevant information requested by, the HMO's actuaries for the preparation of their opinion in accordance with the Actuarial Standards Board Actuarial Standards of Practice No. 16.

All MCO capitated agreements shall contain provisions under which the HMO acknowledges that, in the event of the MCO's insolvency, the HMO is secondarily liable as the ultimate risk bearer for unpaid health care services rendered to its enrollees."

50 IL ADC 4521.50(d).

# INDIANA

## Health Insurance

**What regulatory body governs health insurance?**

Department of Insurance

**What statutes govern health insurance?**

Ind. Stat. Title 27, Article 8.

**How is "insurance" defined?**

"'Insurance' means a contract of insurance or an agreement by which one (1) party, for a consideration, promises to pay money or its equivalent or to do an act valuable to the insured upon the destruction, loss or injury of something in which the other party has a pecuniary interest, or in consideration of a price paid, adequate to the risk, becomes security to the other against loss by certain specified risks; to grant indemnity or security against loss for a consideration."

Ind. Code Ann. § 27-1-2-3(a).

**Can insurers transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

## HMO

**What regulatory body governs HMOs?**

Department of Insurance

**What statutes govern HMOs?**

Idaho Code Title 41, Chapter 39.

**Can an HMO transfer risk to providers?**

The issue is not directly addressed, but the statutes contemplate capitated arrangements:

"'Capitated basis' means fixed per member per month payment or percentage of premium payment under which the provider assumes the full risk for the cost of contracted services without regard to type, value, or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities."

Ind. Code Ann. § 27-13-1-5.

*See also* Ind. Code Ann. § 27-13-12-3

**What requirements apply if an HMO transfers risk to a provider?**

None identified in statutes or regulations.

# IOWA

## Health Insurance

**What regulatory body governs health insurance?**

Insurance Division

**What statutes govern health insurance?**

Iowa Stat. Title XIII, Ch. 514A.

**How is "insurance" defined?**

"'Policy of accident and sickness insurance' includes a policy or contract covering insurance against loss resulting from sickness, or from bodily injury or death by accident, or both."

IA St. § 514A.1.

**Can insurers transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

## HMO

**What regulatory body governs HMOs?**

Department of Human Services

**What statutes govern HMOs?**

Iowa Stat. Title XIII, Ch. 514B.

**Can an HMO transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an HMO transfers risk to a provider?**

None identified in statutes or regulations.

## Health Insurance

**What regulatory body governs health insurance?**

Department of Insurance

**What statutes govern health insurance?**

KS Stat. Ch. 40.

**How is "insurance" defined?**

"The term 'insurance company' shall mean and include all corporations, companies, associations, societies, fraternal benefit societies, reciprocal exchanges, persons or partnerships writing contracts of insurance, indemnity or suretyship in this state upon any type of risk or loss ..."

Ks. St. § 40-222c.

"Any of the following acts in this state effected by mail or otherwise by or on behalf of an unauthorized insurer is deemed to constitute the transaction of an insurance business in this state:

1) The making of or proposing to make, as an insurer, an insurance contract;

2) the taking or receiving of any application for insurance;

3) the receiving or collection of any premium, commission, membership fees, assessments, dues or other consideration for any insurance or any part thereof;

4) the issuance or delivery of contracts of insurance to residents of this state or to persons authorized to do business in this state;

5) directly or indirectly acting as an agent for or otherwise representing or aiding on behalf of another any person or insurer in the solicitation, negotiation, procurement or effectuation of insurance or renewals thereof or in the dissemination of information as to coverage or rates, or forwarding of applications or delivery of policies or contracts or investigation or adjustment of claims or losses or in the transaction of matters subsequent to effectuation of the contract and rising out of it or in any other manner representing or assisting a person or insurer in the transaction of insurance with respect to subjects of insurance resident in this state. Nothing herein shall be construed to prohibit full-

time salaried employees of a corporate insured from acting in the capacity of an insurance manager or buyer in placing insurance in behalf of such employer;

6) the transaction of any kind of insurance business specifically recognized as transacting an insurance business within the meaning of the statutes relating to insurance; or

7) the transacting of or proposing to transact any insurance business, in substance equivalent to any of the foregoing, in a manner designed to evade the provisions of this act."

K.A.S. 40-2702(b).

1) "The failure of an insurer transacting insurance business in this state to obtain a certificate of authority from the commissioner of insurance shall not impair the validity of any act or contract of such insurer and shall not prevent such insurer from defending any action at law or suit in equity in any court of this state, but no insurer transacting insurance business in this state without a certificate of authority shall be permitted to maintain an action in any court of this state to enforce any right, claim or demand arising out of the transaction of such business until such insurer shall have obtained a certificate of authority.

2) In the event of failure of any such unauthorized insurer to pay any claim or loss within the provisions of such insurance contract, any person who assisted or in any manner aided, directly or indirectly, in the procurement of such insurance contract shall be liable to the insured for the full amount of the claim or loss in the manner provided by the provisions of such insurance contract."

K.A.S. 40-2702(c).

**Can insurers transfer risk to providers?**

The issue is not directly addressed, but the statutes contemplate capitated arrangements and risk sharing:

"Compensation arrangements which involve capitation payments or other risk sharing provisions shall not be considered inducements."

Ks. St. § 40-4605.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

## HMO

**What regulatory body governs HMOs?**

Department of Insurance

**What statutes govern HMOs?**

KS Stat. Ch. 40, Art. 32.

**Can an HMO transfer risk to providers?**

The issue is not directly addressed, but the statutes contemplate capitated arrangements:

"'Capitated basis' means a fixed per member per month payment or percentage of premium payment wherein the provider assumes risk for the cost of contracted services without regard to the type, value or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities."

KS Stat. § 40-3202(c).

**What requirements apply if an HMO transfers risk to a provider?**

None identified in statutes or regulations.

# Value-Based Payments: A Comprehensive State Survey

## KENTUCKY

### Health Insurance

**What regulatory body governs health insurance?**

Department of Insurance

**What statutes govern health insurance?**

Ky Stat. Ch. 304, Subtitle 17, 17a.

**How is "insurance" defined?**

"'Insurance' is a contract whereby one undertakes to pay or indemnify another as to loss from certain specified contingencies or perils called 'risks,' or to pay or grant a specified amount or determinable benefit or annuity in connection with ascertainable risk contingencies, or to act as surety."

KRS § 304.1-030.

**Can insurers transfer risk to providers?**

"An insurer that offers a health benefit plan that enters into any risk-sharing arrangement or subcontract agreement shall file a copy of the arrangement with the commissioner. The insurer shall also file the following information regarding the risk-sharing arrangement:

a) The number of enrollees affected by the risk-sharing arrangement;

b) The health care services to be provided to an enrollee under the risk-sharing arrangement;

c) The nature of the financial risk to be shared between the insurer and entity or provider, including but not limited to the method of compensation;

d) Any administrative functions delegated by the insurer to the entity or provider. The insurer shall describe a plan to ensure that the entity or provider will comply with KRS 304.17A-500 to 304.17A-590 in exercising any delegated administrative functions; and

e) The insurer's oversight and compliance plan regarding the standards and method of review."

KRS 304.17A-527(2).

An insurer may transfer risk through a risk sharing arrangement if they file a sample copy with the commission at least 60 days before its use. The sample must include a compensation arrangement, a completed and signed Fact sheet and Verification Form HIPMC-F1, and a filing fee of $50. The arrangement will be disapproved if a complete filing is not made within 60 days of the date of filing. Failure to file a sample copy may result in civil penalties under KRS 304.99.

806 KAR 17:300.

**What requirements apply if an insurer transfers risk to a provider?**

See KRS 304.17A-527(2) and 806 KAR 17:300 above.

## HMO

**What regulatory body governs HMOs?**

Department of Insurance

**What statutes govern HMOs?**

Ky Stat. Ch. 304, Subtitle 38.

**Can an HMO transfer risk to providers?**

Any HMO may transfer risk to a provider if they “take reasonable steps” to ensure the provider can manage the risk. Furthermore, the HMO shall submit a plan for evaluating the provider ability to manage the risk to the Department of Insurance of Kentucky for approval at least 45 days prior to the transfer date.

KRS § 304.38-075.

**What requirements apply if an HMO transfers risk to a provider?**

See KRS §304.38-075 above. Additionally, if an HMO transfers risk to a provider not in compliance with the standards in its approved plan, or, prior to filing or receiving approval of its plan, the commissioner may require the HMO to retain additional reserves to cover the risk transferred.

# LOUISIANA

## Health Insurance

**What regulatory body governs health insurance?**

Department of Insurance

**What statutes govern health insurance?**

La. R. S. Title 22, Ch. 4, Part III.

**How is "insurance" defined?**

"'Insurance' is a contract whereby one undertakes to indemnify another or pay a specified amount upon determinable contingencies."

LSA-R.S. 22:46.

**Can insurers transfer risk to providers?**

The issue is not directly addressed, but the statutes contemplate capitated arrangements and risk sharing:

"Nothing in this Section shall be construed to prohibit contracts that contain incentive plans that involve general payments, such as capitation payments, or shared-risk arrangements that are not tied to specific medical decisions involving specific insured or groups of insureds with similar medical conditions. The payments rendered or to be rendered to physicians, physician groups, or other licensed health care providers under these arrangements shall be deemed confidential information."

LSA-R.S. 22:1008.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

## HMO

**What regulatory body governs HMOs?**

Department of Insurance

**What statutes govern HMOs?**

La. R. S. Title 22, Ch. 4, Part I.

**Can an HMO transfer risk to providers?**

The issue is not directly addressed, but the statutes contemplate capitated arrangements and risk sharing:

"Nothing in this Section shall be construed to prohibit contracts that contain incentive plans that involve general payments, such as capitation payments, or shared-risk arrangements that are not tied to specific medical decisions involving a specific insured or groups of insureds with similar medical conditions. The payments rendered or to be rendered to physicians, physician groups, or other licensed health care practitioners under these arrangements shall be deemed confidential information."

LSA-R.S. 22:263(F).

**What requirements apply if an HMO transfers risk to a provider?**

Regulations reference risk sharing contracts in context of protecting rural hospitals and physicians, e.g.:

"In establishment of capitation based pricing mechanisms or risk sharing arrangements, a managed care organization is authorized to use reasonable criteria that includes the scope of services available at the hospital and patient volume. A managed care organization may consider the amount and scope of services being included under such contractual arrangements in negotiating reimbursement amounts. However, in no instance shall a managed care organization base reimbursement on the exclusion of one or more qualifying rural hospitals or otherwise limiting enrollee access to appropriate medical care from such hospitals that are located in the community where the enrollee or plan member resides.

A managed care organization shall be authorized to use payment differentials to establish a network of providers in a geographic area. A managed care organization shall be authorized to exclude application of such payment differentials to a qualifying

rural hospital unless such payment differentials are being offered to other hospitals in the same geographic area. In no instance shall a managed care organization be prohibited from offering payment differentials to a qualifying rural hospital to gain access to health care providers in a geographic area."

La. Admin Code Title 37, Part XIII. 5309 (cf. 5311).

No other requirements identified in statutes or regulations.

# MAINE

## Health Insurance

**What regulatory body governs health insurance?**

Department of Professional & Financial Regulation, Bureau of Insurance

**What statutes govern health insurance?**

M.R.S.A. Title 24-a, Ch. 32-a, 33, 35, 56-C.

**How is "insurance" defined?**

"'Insurance' means a contract under which one undertakes to pay or indemnify another as to loss from certain specified contingencies or perils, to pay or grant a specified amount or determinable benefit or annuity in connection with ascertainable risk contingencies or to act as surety ..."

24-A M.R.S.A. § 3.

**Can insurers transfer risk to providers?**

Carriers (including insurers) may share financial risk with providers similar to HMOs under MRSA Title 24-a, Ch. 56-A (see HMO section below).

Otherwise, Preferred Provider Arrangements may accept financial risk when entering into arrangements with health insurers:

"Preferred provider arrangement may include capitated payments that are limited to the health services provided by the provider.

Preferred provider arrangements may embody risk transfer between carriers and providers in accordance with Chapter 56-A, subchapter III. Any other acceptance of insurance risk by a person that does not hold a valid certificate of authority or license and is not exempt by law from licensure constitutes unauthorized transaction of insurance within the meaning of section 404 and chapter 21."

24-A M.R.S.A. § 2676.

**What requirements apply if an insurer transfers risk to a provider?**

"A carrier or administrator who proposes to offer a preferred provider arrangement shall file with the superintendent proposed agreements, rates, geographic service areas,

provider networks and other materials relevant to the proposed arrangement. The superintendent shall disapprove any preferred provider arrangement if the arrangement contains any unjust, unfair or inequitable provisions; unreasonably restricts access and availability of health care services; or fails to comply with other requirements of this chapter 32 for the Preferred Provider Arrangement Act, chapter 56-A for the Health Plan Improvement Act or rules adopted by the superintendent."

24-A M.R.S.A. § 2673-A.

## HMO

**What regulatory body governs HMOs?**

Department of Professional & Financial Regulation, Bureau of Insurance

**What statutes govern HMOs?**

24-A M.R.S.A. § 4202-A(10)

**Can an HMO transfer risk to providers?**

Yes, providers can accept risk provided that the risk transfer does not exceed a certain threshold:

"Downstream entities that do not exceed the risk threshold described in section 4334 may enter into downstream risk arrangements . . . ."

24-A M.R.S.A. § 4333

Taking financial risk does not obligate providers to become HMOs:

Nothing in this subsection prevents a health maintenance organization from providing fee-for-service health care services as well as health maintenance organization services. A health care provider or affiliated entity that does not offer health insurance or health benefit plans may not be or become a health maintenance organization subject to this chapter solely by reason of arrangements with insurers or hospital or medical service organizations for reimbursement in whole or in part on a capitated basis, the financial risk to the provider or affiliated entity associated with reimbursement arrangements with such 3rd-party payors or the furnishing by the provider or affiliated entity of utilization or case management services.

[PL 1995, c. 673, Pt. D, §1 (AMD).]



**What requirements apply if an HMO transfers risk to a provider?**

Downstream entities that do not exceed the risk threshold in section 4334 may enter into downstream risk arrangements only if:

A. The requirements of section 4332(1) and sections 4335 and 4336 are met, and

B. No specific payment is made directly or indirectly under the plan to a provider as an inducement to reduce or limit medically necessary services furnished to an enrollee.

24-A M.R.S.A. §4333

Notwithstanding any other provisions of this Title or Title 24, including, without limitation, sections 4341 and 4342, an arrangement between a carrier and a downstream entity with which the carrier has contracted to provide or arrange for the provision of services that allows the downstream entity to accept a limited degree of insurance risk is permitted and such a risk arrangement is deemed not to be engaging in the business of insurance by the downstream entity if:

A. The arrangement does not involve substantial insurance risk or substantial enrollment risk as described in section 4332; and

B. The arrangement meets the requirements of sections 4335 and 4336.

24-A M.R.S.A. §4332(1)

Carriers and downstream entities that wish to develop downstream risk arrangements that exceed the risk threshold described in section 4334 may jointly request that the superintendent grant a waiver that allows the downstream entity to accept a limited degree of insurance risk without being licensed as an insurer, a health maintenance organization or an insurance administrator. The joint request for a waiver must include a plan for managing financial exposure, based upon reasonable enrollment and utilization projections and upon the contracts, parties and features proposed, sufficient to quantify in dollars per quarter and per annum all elements of downstream risk to be assumed by the downstream entity. All other risk arrangements are prohibited unless the arrangements meet the appropriate licensing standards or are expressly permitted by the superintendent.

24-A M.R.S.A. §4332(2)

Substantial insurance risk is risk based on the use or costs of referral services only, when the downstream entity is at risk for more than 25% of potential payments by the carrier to the downstream entity. Substantial enrollment risk exists when a carrier enters into a risk arrangement with a downstream entity involving more than 25% of the enrollees served by the carrier in the State unless the risk arrangement is a risk-sharing arrangement.

24-A M.R.S.A. §4334

Full copies of contracts and summary descriptions of contracts must be provided to the superintendent. The following provisions must be included in contracts between a carrier and a downstream entity:

1. an enrollee is not liable to provider for sums owed by the carrier;
2. maintenance of books, accounts and records;
3. prohibition on assignment of rights or obligations in the absence of carrier's consent;
4. carrier's right to be advised and right to object to any subcontractor;
5. termination of contract;
6. compliance with utilization review laws, rules and licensing requirements;
7. provision requirement downstream entity to advise carrier on the ability to perform; and
8. provision requiring contract between carrier and downstream entity to be attached to all contracts between downstream entity and those of the entity's participating providers contractually obligated to provide services to the carrier's enrollees under contract between the carrier and the downstream entity.

24-A M.R.S.A. §4335.

Each carrier shall provide information concerning the carrier's downstream risk arrangements as required or requested by the superintendent. Disclosure must contain the following information in sufficient detail:

A. Whether services not furnished by the downstream entity are covered by the risk arrangement. If the services furnished by the downstream entity are covered by

the risk arrangement, disclosure of other aspects of the plan need not be made;

B. The type of risk arrangement; for example, withhold, bonus, capitation;

C. If the risk arrangement involves a withhold or bonus, the percent of the withhold or bonus;

D. The panel size, the number of enrollees covered by the downstream entity and the total number of enrollees covered by the carrier in the State; and

E. In the cause of capitated downstream entities, capitation payments paid to primacy care providers for the most recent year broken down by percent for primary care services, referral services to specialists, hospital services and other types of provider services, including but not limited to, nursing home and home health agency services.

Disclosure is required at least annually and a carrier shall provide capitation data for the previous calendar year by April 1st of each year. A carrier will provide information on whether the prepaid plan uses a downstream risk arrangement that affects the use of referral services, and, the type of risk arrangement to an enrollee upon request.

24-A M.R.S.A. §4336.

## Health Insurance

**What regulatory body governs health insurance?**

Insurance Administration

**What statutes govern health insurance?**

Md. Code, Insurance, Title 15.

**How is "insurance" defined?**

"'[I]nsurance' means a contract to indemnify or to pay or provide a specified or determinable amount or benefit on the occurrence of a determinable contingency."

MD Insurance § 1-101(s).

**Can insurers transfer risk to providers?**

Yes, insurers are permitted to enter into capitation arrangements with providers:

"When a carrier arranges for health care services and compensates health care providers through a capitation payment to provide specified services, the carrier has transferred risk to the health care provider, who assumes the risk that the capitation payment will be enough to cover the provision of health care services. Conduct that transfers risk in this manner falls within the definition of 'insurance business.' Health care providers conduct 'insurance business' 'by insuring the provision of health care benefits on the occurrence of certain determinable contingencies, for the payment of a premium in the form of a capitation payment.' (See 75 Opinion Attorney General 319, page 327 [. . .]) However, because the carrier remains responsible for the fulfillment of the insurance contract or HMO contract, health care providers paid capitation are not required to obtain a certificate of authority."

Maryland Insurance Administration Bulletin 08-19.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

## HMO

**What regulatory body governs HMOs?**

Insurance Administration

**What statutes govern HMOs?**

Md. Code, Health-General, Title 19, Subtitle 7.

**Can an HMO transfer risk to providers?**

Yes, HMOs are permitted to enter into capitation arrangements with providers:

"When a carrier arranges for health care services and compensates health care providers through a capitation payment to provide specified services, the carrier has transferred risk to the health care provider, who assumes the risk that the capitation payment will be enough to cover the provision of health care services. Conduct that transfers risk in this manner falls within the definition of 'insurance business.' Health care providers conduct 'insurance business' 'by insuring the provision of health care benefits on the occurrence of certain determinable contingencies, for the payment of a premium in the form of a capitation payment.' (See 75 Opinion Attorney General 319, page 327 [. . .]) However, because the carrier remains responsible for the fulfillment of the insurance contract or HMO contract, health care providers paid capitation are not required to obtain a certificate of authority."

Maryland Insurance Administration Bulletin 08-19.

**What requirements apply if an HMO transfers risk to a provider?**

Provider contracts that include bonuses and other incentive based compensation mechanisms are required to be filed with the Department of Insurance Administration.

Md. Code, Insurance, Title 15 Section 113.

# Value-Based Payments: A Comprehensive State Survey

## MASSACHUSETTS

### Health Insurance

**What regulatory body governs health insurance?**

Office of Consumer Affairs and Business Regulation, Division of Insurance

**What statutes govern health insurance?**

M.G.L.A. Part 1, Title XCII, Ch. 175.

**How is "insurance" defined?**

"A contract of insurance is an agreement by which one party for a consideration promises to pay money or its equivalent, or to do an act valuable to the insured, upon the destruction, loss or injury of something in which the other party has an interest."

M.G.L.A. 175 § 2.

**Can insurers transfer risk to providers?**

Risk-Bearing Provider Organizations may accept financial risk when entering into arrangements with health insurers.

211 CMR 155.

Entities which are not Risk-Bearing Provider Organizations which accept financial risk from a health insurer may be practicing insurance, as defined above.

An "alternative payment contract" is "any contract between a provider or provider organization and a health care payer which utilizes alternative payment methodologies."

M.G.L.A. 176T § 1; 211 CMR 155.

"Alternative payment methodologies or methods" are "methods of payment that are not solely based on fee for service reimbursements; provided, however, Alternative Payment Methodologies may include, but shall not be limited to, shared savings arrangement, bundled payments, and global payments; and further provided, that Alternative Payment Methodologies may include fee-for-service payments, which are settled or reconciled with a bundled or global payment."

M.G.L.A. 176T § 1; 211 CMR 155.

"Downside risk" is defined as "the risk taken on by a Provider Organization as part of an Alternate Payment Contract with a carrier or other payer in which the provider organization is responsible for either the full or partial costs of treating a group of patients that may exceed the contracted budgeted payment arrangements."

M.G.L.A. 176T § 1; 211 CMR 155.

**What requirements apply if an insurer transfers risk to a provider?**

Each registered provider organization that enters into or renews an alternative payment contract with a carrier or public health care payer in which the provider organization accepts downside risk shall file an application for a risk certificate with the division; provided, however, that integrated care organizations or senior care organizations contracted under section 9D or 9E of chapter 118E which have undergone a financial solvency certification shall be deemed to have satisfied the risk certificate requirements for purposes of this chapter.

A risk-bearing provider can apply for a risk certificate waiver to demonstrate that its alternative payment contracts do not contain a significant downside risk. If the division, upon reviewing the application, agrees, it must forward the waiver to the commission and the center.

M.G.L.A. 176T § 3, M.G.L.A. 6D § 11, and 211 CMR 155.04-05.

## HMO

**What regulatory body governs HMOs?**

Office of Consumer Affairs and Business Regulation, Division of Insurance

**What statutes govern HMOs?**

MGLA 176G; 211 CMR 43 *et seq.*

**Can an HMO transfer risk to providers?**

Risk-Bearing Provider Organizations may accept financial risk when entering into arrangements with an HMO. Entities which are not Risk-Bearing Provider Organizations which accept financial risk from an HMO may be practicing insurance, as defined above.

An "alternative payment contract" is "any contract between a provider or provider organization and a health care payer which utilizes Alternative Payment Methodologies."

M.G.L.A. 176T § 1; 211 CMR 155.

"Alternative payment methodologies or methods" are "methods of payment that are not solely based on fee for service reimbursements; provided, however, Alternative Payment Methodologies may include, but shall not be limited to, shared savings arrangement, bundled payments, and global payments; and further provided, Alternative Payment Methodologies' may include fee for service payments, which are settled or reconciled with a bundled or global payment."

M.G.L.A. 176T § 1; 211 CMR 155.

"Downside risk" is defined as "the risk taken on by a Provider Organization as part of an Alternate Payment Contract with a carrier or other payer in which the Provider Organization is responsible for either the full or partial costs of treating a group of patients that may exceed the contracted budgeted payment arrangements."

M.G.L.A. 176T § 1; 211 CMR 155.

**What requirements apply if an HMO transfers risk to a provider?**

"Each registered provider organization that enters into or renews an alternative payment contract with a carrier or public health care payer in which the provider organization accepts downside risk shall file an application for a risk certificate with the division; provided, however, that integrated care organizations or senior care organizations contracted under section 9D or 9E of chapter 118E which have undergone a financial solvency certification shall be deemed to have satisfied the risk certificate requirements for purposes of this chapter.

A risk-bearing provider can apply for a risk certificate waiver . . . to demonstrate that its alternative payment contracts do not contain a significant downside risk. . . . If the division, upon reviewing the application, agrees, it must forward the waiver to the commission and the center."

M.G.L.A. 176T § 3, M.G.L.A. 6D § 11, and 211 CMR 155.04-05.

# Value-Based Payments: A Comprehensive State Survey

## MICHIGAN

### Health Insurance

**What regulatory body governs health insurance?**

Department of Insurance and Financial Services

**What statutes govern health insurance?**

MI ST Ch. 500 (Insurance Code of 1956), Ch. 37.

**How is "insurance" defined?**

An insurance policy or contract "means a contract of insurance, indemnity, suretyship, or annuity issued or proposed or intended for issuance by a person engaged in the business of insurance. Unless the context requires otherwise, insurance contract includes a health maintenance contract, as that term is defined in section 3501."

MI ST 500.116.

**Can insurers transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

### HMO

**What regulatory body governs HMOs?**

Department of Insurance and Financial Services

**What statutes govern HMOs?**

MI ST Ch. 500 (Insurance Code of 1956), Ch. 35.

**Can an HMO transfer risk to providers?**

Yes, a provider may assume financial risk from an HMO:

"A health maintenance organization shall assume full financial risk on a prospective basis for the provision of health services under a health maintenance organization contract. A health maintenance organization may do any of the following:

a) Require an affiliated provider to assume financial risk under the terms of its contract."

MI ST 500.3569(3)(1).

An HMO shares financial risk with a provider if the provider shares a portion of the chance of loss, including expenses incurred, related to services for enrollees. This includes, but is not limited to, capitation agreements, withholds, risk corridors, and indemnity agreements.

MI ST 500.3569(3).

**What requirements apply if an HMO transfers risk to a provider?**

"If the [HMO] requires an affiliated provider to assume financial risk under the terms of its contract, the contract must require both of the following:

a) The [HMO] to pay the affiliated provider, including a subcontracted provider, directly or through a licensed third party administrator for health services provided to its enrollees.

b) The [HMO] to keep all pooled funds and withhold amounts and account for them on its financial books and records and reconcile them at year end pursuant to the contract."

MI ST 500.3569(2).

"Contracts which propose sharing risk with a provider or provider organization (e.g. IPA, PHO, Pharmacy Benefit Manager) must disclose all proposed risk provisions, including risk-sharing information pertaining to withhold amounts, fund allocations, risk corridors (may be expressed in a range) and the allocation of deficits and surplus. The applicant must also describe any method(s) used in the settlement of any risksharing pools or other risk-sharing arrangements. Model contracts to be used by the applicant to contract with a provider organization (PHO, IPA, etc…) must contain all underlying contracts

between the provider organization and its affiliated providers (including the reimbursement arrangements). All such underlying contracts must also meet the minimum requirements of Section 3529 of the Michigan Insurance Code."

HMO Application for Certificate of Authority, Exhibit C.4.

# MINNESOTA

## Health Insurance

**What regulatory body governs health insurance?**

Department of Commerce

**What statutes govern health insurance?**

M.S.A. Ch. 62A, 62E.

**How is "insurance" defined?**

"'Insurance' is any agreement whereby one party, for a consideration, undertakes to indemnify another to a specified amount against loss or damage from specified causes, or to do some act of value to the assured in case of such loss or damage."

M.S.A. § 60A.02(3).

**Can insurers transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

## HMO

**What regulatory body governs HMOs?**

Department of Health

**What statutes govern HMOs?**

M.S.A. Ch. 62D.

**Can an HMO transfer risk to providers?**

Not addressed in statutes or regulations.


## MINNESOTA

**What requirements apply if an HMO transfers risk to a provider?**

None identified in statutes or regulations.

# Value-Based Payments: A Comprehensive State Survey

## MISSISSIPPI

## Health Insurance

**What regulatory body governs health insurance?**

Insurance Department

**What statutes govern health insurance?**

MS St. Title 83, Ch. 9.

**How is "insurance" defined?**

"A contract of insurance is an agreement by which one party for a consideration promises to pay money or its equivalent, or to do some act of value to the assured, upon the destruction, loss, or injury of something in which the assured or other party has an interest, as an indemnity therefor."

MS ST § 83-5-5.

**Can insurers transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

## HMO

**What regulatory body governs HMOs?**

Insurance Department

**What statutes govern HMOs?**

MS St. Title 83, Ch. 41, Art. 7.

**Can an HMO transfer risk to providers?**

Statutes suggest that capitated arrangements are permissible:

"Capitated basis" is defined as fixed monthly payments wherein the provider assumes the cost of contracted services.

Miss. Code Ann § 83-41-303(b).

**What requirements apply if an HMO transfers risk to a provider?**

An HMO, in which 75% or more of the providers are paid on a capitated basis, must maintain a minimum net worth in an amount equal to the sum of:

i. "Eight percent (8%) of annual health care 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; and

ii. 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."

Miss. Code Ann §83-41-325(2)(d).

# Value-Based Payments: A Comprehensive State Survey

## MISSOURI

## Health Insurance

**What regulatory body governs health insurance?**

Department of Insurance

**What statutes govern health insurance?**

V.A.M.S. Title XXIV, CH. 376.

**How is "insurance" defined?**

Insurance is defined as "any line of authority, including life, accident and health or sickness, property, casualty, variable life and variable annuity products, personal, credit and any other line of authority permitted by state law or regulation."

V.A.M.S. 375.012(4).

**Can insurers transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

## HMO

**What regulatory body governs HMOs?**

Department of Insurance

**What statutes govern HMOs?**

V.A.M.S. Title XXIV, CH. 354.

**Can an HMO transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an HMO transfers risk to a provider?**

None identified in statutes or regulations.

# Value-Based Payments: A Comprehensive State Survey

## MONTANA

### Health Insurance

**What regulatory body governs health insurance?**

Office of the Montana State Auditor, Insurance Department

**What statutes govern health insurance?**

MT St. Title 33, Ch. 30.

**How is "insurance" defined?**

"'Insurance' is a contract through which one undertakes to indemnify another or pay or provide a specified or determinable amount or benefit upon determinable contingencies."

Mt. St. 33-1-201(5)(a).

**Can insurers transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

### HMO

**What regulatory body governs HMOs?**

Office of the Montana State Auditor, Insurance Department

**What statutes govern HMOs?**

MT St. Title 33, Ch. 31.

**Can an HMO transfer risk to providers?**

Statute contemplates "Affordable Care Organizations," with the ability to assume risk. It is unclear, however, if Accountable Care Organization discussed in state statute is applicable outside of the federal Medicare Shared Savings Program.

"'Accountable care organization' means a group of health care providers that are willing and capable of accepting accountability for the total cost and quality of care for a defined population."

M.C.A. 33-31-102(1).

"The commissioner may waive the requirements of this section for an accountable care organization. Upon establishment of a medicare shared savings program pursuant to 42 U.S.C. 1395jjj, an accountable care organization shall demonstrate compliance with the program requirements in a manner determined by the commissioner."

M.C.A. 33-31-201(8)(a)(i).

**What requirements apply if an HMO transfers risk to a provider?**

An application of a HMO for a certificate of authority must include any applicable provisions that "permit or require a provider to assume a financial risk in the [HMO], including any provisions for assessing the provider, adjusting capitation or fee-for-services rates, or sharing in the earnings or losses. . . ."

M.C.A. §33-31-201(2)(d)(v)(B).

# Value-Based Payments: A Comprehensive State Survey

## NEBRASKA

### Health Insurance

**What regulatory body governs health insurance?**

Department of Insurance

**What statutes govern health insurance?**

Ne. St. Ch. 44, Art. 52, 69.

**How is "insurance" defined?**

"[I]nsurance shall mean a contract whereby one party, called the insurer, for a consideration, undertakes to pay money or its equivalent or to do an act valuable to another party, called the insured, or to his or her beneficiary, upon the happening of the hazard or peril insured against whereby the party insured or his or her beneficiary suffers loss or injury."

Ne. St. § 44-102.

**Can insurers transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

### HMO

**What regulatory body governs HMOs?**

Department of Insurance

**What statutes govern HMOs?**

Ne. St. Ch. 44, Art. 32.

**Can an HMO transfer risk to providers?**

Regulations contemplate risk-bearing entities at least within the context of Medicaid:

"Provider Sponsored Organization [means] public or private entities established by or organized by health care providers or a group of affiliated providers that provide a substantial portion of health care items and services directly through providers or affiliated groups of providers. Affiliated providers share, directly or indirectly, substantial financial risk, and have at least a majority financial interest in the PSO."

471 Neb. Admin. Code Ch. 3-004.

**What requirements apply if an HMO transfers risk to a provider?**

None identified in statutes or regulations.

# Value-Based Payments: A Comprehensive State Survey

## NEVADA

## Health Insurance

**What regulatory body governs health insurance?**

Department of Business and Industry, Division of Insurance

**What statutes govern health insurance?**

NV St. Title 57, Ch. 689A, 689B, 689C.

**How is "insurance" defined?**

"Health Insurance" is defined as "insurance of human beings against bodily injury, disablement or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness, and every insurance appertaining thereto, together with provisions operating to safeguard contract of health insurance against lapse in the event of strike or layoff due to labor disputes."

N.R.S. 681A.030.

**Can insurers transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

## HMO

**What regulatory body governs HMOs?**

Department of Business and Industry, Division of Insurance

**What statutes govern HMOs?**

NV St. Title 57, Ch. 695C.

**Can an HMO transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an HMO transfers risk to a provider?**

None identified in statutes or regulations.

# Value-Based Payments: A Comprehensive State Survey

## NEW HAMPSHIRE

## Health Insurance

**What regulatory body governs health insurance?**

Department of Insurance

**What statutes govern health insurance?**

N.H. St. Chs. 415, 415-a.

**How is "insurance" defined?**

"'Health insurance' means any arrangement with any entity which pays medical claims on behalf of an individual, an employee, or dependents, including any such arrangement evidenced by a hospital or medical policy or certificate, hospital or medical service plan or contract, or health maintenance organization group or individual subscriber contract, or self insurance plan or contract, or other evidence of coverage, except for the purposes of this chapter, 'health insurance' shall not mean life, disability income, or long-term care insurance."

NH ST § 141-H:1(V).

**Can insurers transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

## HMO

**What regulatory body governs HMOs?**

Department of Insurance

**What statutes govern HMOs?**

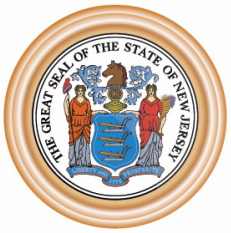
N.H. St. Chs. 420-B.

**Can an HMO transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an HMO transfers risk to a provider?**

None identified in statutes or regulations.




# Value-Based Payments: A Comprehensive State Survey

## NEW JERSEY

### Health Insurance

**What regulatory body governs health insurance?**

Department of Banking & Insurance

**What statutes govern health insurance?**

N.J. St. Title 17b, Subtitle 3.

**How is "insurance" defined?**

"Health Insurance" is defined as "a contract or agreement whereby an insurer is obligated to pay or allow a benefit of pecuniary value with respect to the bodily injury, disablement, sickness, death by accident or accidental means of a human being, or because of any expense relating thereto, or because of any expense incurred in prevention of sickness, and includes every risk pertaining to any of the enumerated risks. Health insurance does not include workmen's compensation coverages."

N.J.S.A. 17B:17-4.

**Can insurers transfer risk to providers?**

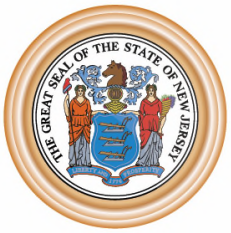
New Jersey allows "Organized Delivery Systems" to assume financial risk from health insurers / HMOs. Entities which are not Organized Delivery Systems which accept risk may be practicing insurance, as defined above.

"'Carrier' means an insurer authorized to transact the business of health insurance as defined at N.J.S.17B:17-4, a hospital service corporation authorized to transact business in accordance with P.L.1938, c. 366 (C.17:48-1 *et seq*.), a medical service corporation authorized to transact business in accordance with P.L.1940, c. 74 (C.17:48A-1 *et seq.*), a health service corporation authorized to transact business in accordance with P.L.1985, c. 236 (C.17:48E-1 *et seq*.) or a health maintenance organization authorized to transact business pursuant to P.L.1973, c. 337 (C.26:2J-1 *et seq*.)."

N.J.S.A. 17:48H-1.

"An organized delivery system which receives compensation on a basis that entails the assumption of financial risk shall submit an application for licensure to the Commissioner of Banking and Insurance."

N.J.S.A. 17:48H-11.






**What requirements apply if an insurer transfers risk to a provider?**

An Organized Delivery System (ODS) that assumes financial risk must become licensed unless the Department determines the financial risk is de minimus. An ODS that does not assume financial risk or is determined to assume only a de minimus financial risk must become certified.

Although a carrier remains responsible to assure compliance with the Health Care Quality Act, the ODS also becomes legally responsible to assume compliance with the Health Care Quality Act, N.J.S.A. 26:2S-1 *et seq.,* and is subject to N.J.S.A. 17:48H-1 *et seq.*

a) "Except as provided in (i) below, a licensed organized delivery system shall, at all times, have and maintain a minimum net worth, determined on a statutory accounting basis, in an amount equal to the greater of:

    1) Two percent of the annual compensation received by the organized delivery system for all of its contracts, but in no event less than $100,000; or

    2) An amount equal to the sum of eight percent of the annual health care expenditures (not including those expenditures paid on a capitated basis and those made on a managed hospital payment basis), as reported for the most recent four calendar quarters, plus four percent of the annual hospital expenditures paid on a managed hospital payment basis for the most recent four calendar quarters.

        i. The amounts set forth in (a) above may be adjusted by the Commissioner to the extent the applicant demonstrates there is a limitation on its exposure to financial loss that results from a contract with a carrier that provides that any liabilities of the system may be satisfied by means of reductions or offsets against monies due to the system from the carrier, and which reductions or offsets the Commissioner finds will not adversely affect the system's ability to meet its contractual obligations.

        ii. The minimum net worth requirements shall be phased-in over 48 months, so that an ODS shall maintain 25 percent of the minimum net worth required in (a) above at the end of the 12th month after it was issued a license; 50 percent of the minimum net worth required at the end of the 24th month following the month it was issued a license; 75 percent of the minimum net worth required at the end of the 36th month following the month it was issued a license; and 100

percent of the minimum net worth required at the end of the 48th month following the month it was issued a license.

b) A licensed organized delivery system shall establish and maintain a segregated account with respect to the financial risk assuming operations of its business. Such segregated account shall include the income, disbursements, assets and liabilities associated with the financial risk assuming operations of the system. The segregated account shall, at all times, contain assets in an amount at least equal to the sum of its liabilities, including its reserve liabilities, plus the minimum net worth requirement set forth in (a) above. Such assets shall be segregated as separate and distinct funds, independent of all other funds of the organized delivery system. Assets in the segregated account shall be first utilized to provide treatment or services, including attendant administrative expenses, according to the terms of contracts with carriers under which the ODS assumes financial risk.

c) Assets in the segregated account equal to its liabilities, including its reserve liabilities, and minimum net worth as set forth above, at any point in time, shall be held in cash or publicly traded securities with one year or less to maturity.

d) Except for payment of benefits under the contract including attendant administrative expenses, a licensed organized delivery system shall obtain the prior non-disapproval of the Commissioner to withdraw funds from the segregated account in all cases where the fair market value of the funds to be withdrawn, together with that of other amounts withdrawn from the segregated account within the immediately preceding 12 months, exceeds 10 percent of the total net worth of the segregated account as of December 31 immediately preceding. Prior written notice of the intent to withdraw shall be filed with the Commissioner at least 45 days before the withdrawal, and if the withdrawal has not been disapproved prior to the expiration of the 45-day period, then the organized delivery system may proceed to make the withdrawal. In no event may the net worth of the segregated account fall below the minimum net worth requirement set forth in (a) above.

e) A licensed organized delivery system shall deposit with the Commissioner in accordance with the procedures set forth in N.J.A.C. 11:2–32, cash, securities, or any combination of these or other measures that is acceptable to the Commissioner in an amount equal to 50 percent of the highest calendar quarterly compensation of the most recent four quarters, but in no event less than $25,000, which amount shall be adjusted annually in accordance with changes in the Consumer Price Index. The deposit shall be deemed an admitted asset of the system in the determination of net worth. The deposit amount, above the $25,000 minimum, shall be payable over a two-year period, with 50 percent of the

required amount above the minimum required amount payable at the end of the 12th month after it was issued a license.

f) All income from deposits shall be an asset of the licensed organized delivery system. A licensed organized delivery system may withdraw a deposit or any part thereof after making a substitute deposit of equal amount and value, except that a security may not be substituted unless it has been approved by the Commissioner.

g) If a licensed organized delivery system is placed in rehabilitation or liquidation, the deposit shall be treated as an asset subject to the provisions of N.J.S.A. 17B:32–31 *et seq*.

h) A licensed organized delivery system shall maintain in force a fidelity bond in its own name on its officers and employees, in an amount not less than $100,000.

i) Any organized delivery system that pursuant to the terms of the contract, accepts risk in an amount represented by 50 percent or more of any carrier's consideration received to provide services or benefits, shall satisfy all net worth and financial requirements set forth in N.J.A.C. 8:38–11.

j) For purposes of determining net worth and deposit requirements set forth in this section, “compensation” shall mean amounts paid to the ODS by a carrier or other ODS for specified health care benefits (for example, hospital/medical, dental, radiology, etc.) provided to the policyholders or members of the carrier pursuant to agreements whereby the ODS assumes financial risk.

k) For purposes of determining net worth and deposit requirements set forth in this section, “health care expenditures” means amounts paid for provider services provided under a contractual arrangement and includes salaries, including fringe benefits, paid to providers for delivery of health care services; capitation payments paid by the ODS to providers for delivery of health care services; and fees paid to providers on a fee-for-service basis for delivery of health care services, including capitated referrals; and net of reinsurance recoveries. Annual health care expenditures do not include expenses for the time of providers devoted to administrative tasks.”

N.J.A.C. 11:22-4.8.

## HMO

**What regulatory body governs HMOs?**

Department of Banking & Insurance

**What statutes govern HMOs?**

N.J. St. Title 26, Ch. 2J.

**Can an HMO transfer risk to providers?**

New Jersey allows "Organized Delivery Systems" to assume financial risk from health insurers / HMOs. Entities which are not Organized Delivery Systems which accept risk may be practicing insurance, as defined above.

"'Carrier' means an insurer authorized to transact the business of health insurance as defined at N.J.S.17B:17-4, a hospital service corporation authorized to transact business in accordance with P.L.1938, c. 366 (C.17:48-1 *et seq*.), a medical service corporation authorized to transact business in accordance with P.L.1940, c. 74 (C.17:48A-1 *et seq*.), a health service corporation authorized to transact business in accordance with P.L.1985, c. 236 (C.17:48E-1 *et seq*.) or a health maintenance organization authorized to transact business pursuant to P.L.1973, c. 337 (C.26:2J-1 *et seq*.)."

N.J.S.A. 17:48H-1.

"An organized delivery system which receives compensation on a basis that entails the assumption of financial risk shall submit an application for licensure to the Commissioner of Banking and Insurance."

N.J.S.A. 17:48H-11.

**What requirements apply if an HMO transfers risk to a provider?**

An Organized Delivery System (ODS) that assumes financial risk must become licensed unless the Department determines the financial risk is de minimus. An ODS that does not assume financial risk or is determined to assume only a de minimus financial risk must become certified.

Although a carrier remains responsible to assure compliance with the Health Care Quality Act, the ODS also becomes legally responsible to assume compliance with the

Health Care Quality Act, N.J.S.A. 26:2S-1 *et seq.,* and is subject to N.J.S.A. 17:48H-1 *et seq*.

a) Except as provided in (i) below, a licensed organized delivery system shall, at all times, have and maintain a minimum net worth, determined on a statutory accounting basis, in an amount equal to the greater of:

    1) Two percent of the annual compensation received by the organized delivery system for all of its contracts, but in no event less than $100,000; or

    2) An amount equal to the sum of eight percent of the annual health care expenditures (not including those expenditures paid on a capitated basis and those made on a managed hospital payment basis), as reported for the most recent four calendar quarters, plus four percent of the annual hospital expenditures paid on a managed hospital payment basis for the most recent four calendar quarters.

        i. The amounts set forth in (a) above may be adjusted by the Commissioner to the extent the applicant demonstrates there is a limitation on its exposure to financial loss that results from a contract with a carrier that provides that any liabilities of the system may be satisfied by means of reductions or offsets against monies due to the system from the carrier, and which reductions or offsets the Commissioner finds will not adversely affect the system's ability to meet its contractual obligations.

        ii. The minimum net worth requirements shall be phased-in over 48 months, so that an ODS shall maintain 25 percent of the minimum net worth required in (a) above at the end of the 12th month after it was issued a license; 50 percent of the minimum net worth required at the end of the 24th month following the month it was issued a license; 75 percent of the minimum net worth required at the end of the 36th month following the month it was issued a license; and 100 percent of the minimum net worth required at the end of the 48th month following the month it was issued a license.

b) A licensed organized delivery system shall establish and maintain a segregated account with respect to the financial risk assuming operations of its business. Such segregated account shall include the income, disbursements, assets and liabilities associated with the financial risk assuming operations of the system. The segregated account shall, at all times, contain assets in an amount at least equal to the sum of its liabilities, including its reserve liabilities, plus the minimum

net worth requirement set forth in (a) above. Such assets shall be segregated as separate and distinct funds, independent of all other funds of the organized delivery system. Assets in the segregated account shall be first utilized to provide treatment or services, including attendant administrative expenses, according to the terms of contracts with carriers under which the ODS assumes financial risk.

c) Assets in the segregated account equal to its liabilities, including its reserve liabilities, and minimum net worth as set forth above, at any point in time, shall be held in cash or publicly traded securities with one year or less to maturity.

d) Except for payment of benefits under the contract including attendant administrative expenses, a licensed organized delivery system shall obtain the prior non-disapproval of the Commissioner to withdraw funds from the segregated account in all cases where the fair market value of the funds to be withdrawn, together with that of other amounts withdrawn from the segregated account within the immediately preceding 12 months, exceeds 10 percent of the total net worth of the segregated account as of December 31 immediately preceding. Prior written notice of the intent to withdraw shall be filed with the Commissioner at least 45 days before the withdrawal, and if the withdrawal has not been disapproved prior to the expiration of the 45-day period, then the organized delivery system may proceed to make the withdrawal. In no event may the net worth of the segregated account fall below the minimum net worth requirement set forth in (a) above.

e) A licensed organized delivery system shall deposit with the Commissioner in accordance with the procedures set forth in N.J.A.C. 11:2–32, cash, securities, or any combination of these or other measures that is acceptable to the Commissioner in an amount equal to 50 percent of the highest calendar quarterly compensation of the most recent four quarters, but in no event less than $25,000, which amount shall be adjusted annually in accordance with changes in the Consumer Price Index. The deposit shall be deemed an admitted asset of the system in the determination of net worth. The deposit amount, above the $25,000 minimum, shall be payable over a two-year period, with 50 percent of the required amount above the minimum required amount payable at the end of the 12th month after it was issued a license.

f) All income from deposits shall be an asset of the licensed organized delivery system. A licensed organized delivery system may withdraw a deposit or any part thereof after making a substitute deposit of equal amount and value, except that a security may not be substituted unless it has been approved by the Commissioner.

g) If a licensed organized delivery system is placed in rehabilitation or liquidation, the deposit shall be treated as an asset subject to the provisions of N.J.S.A. 17B:32–31 *et seq*.

h) A licensed organized delivery system shall maintain in force a fidelity bond in its own name on its officers and employees, in an amount not less than $100,000.

i) Any organized delivery system that pursuant to the terms of the contract, accepts risk in an amount represented by 50 percent or more of any carrier's consideration received to provide services or benefits, shall satisfy all net worth and financial requirements set forth in N.J.A.C. 8:38–11.

j) For purposes of determining net worth and deposit requirements set forth in this section, “compensation” shall mean amounts paid to the ODS by a carrier or other ODS for specified health care benefits (for example, hospital/medical, dental, radiology, etc.) provided to the policyholders or members of the carrier pursuant to agreements whereby the ODS assumes financial risk.

k) For purposes of determining net worth and deposit requirements set forth in this section, “health care expenditures” means amounts paid for provider services provided under a contractual arrangement and includes salaries, including fringe benefits, paid to providers for delivery of health care services; capitation payments paid by the ODS to providers for delivery of health care services; and fees paid to providers on a fee-for-service basis for delivery of health care services, including capitated referrals; and net of reinsurance recoveries. Annual health care expenditures do not include expenses for the time of providers devoted to administrative tasks.”

N.J.A.C. 11:22-4.8



# NEW MEXICO

## Health Insurance

**What regulatory body governs health insurance?**

Office of Superintendent of Insurance

**What statutes govern health insurance?**

N.M.S.A. Ch. 59A, Art. 22.

**How is "insurance" defined?**

"'Insurance' is a contract whereby one undertakes to pay or indemnify another as to loss from certain specified contingencies or perils, or to pay or grant a specified amount or determinable benefit in connection with ascertainable risk contingencies, or to act as surety."

N.M.S.A. 1978, §59A-1-5.

**Can insurers transfer risk to providers?**

New Mexico allows "Preferred Provider Arrangements" to assume financial risk from health insurers / HMOs. Entities which are not Preferred Provider Arrangement which accept financial risk may be practicing insurance, as defined above.

"[A]ny health care insurer may enter into preferred provider arrangements.

A. Such arrangements shall:

1) establish the amount and manner of payment to the preferred provider. Such amount and manner of payment may include capitation payments for preferred providers; . . ."

N.M.S.A. § 59A-22A-4.

Regulations refer to a "provider service network":

"'[P]rovider service network' means two or more providers affiliated for the purpose of providing health care services on a capitated or similar prepaid, flat-fee basis.'

N.M.S.A. 1978, § 59A-42A-2(I).

**What requirements apply if an insurer transfers risk to a provider?**

"Except as provided otherwise in this section, a provider service network shall obtain and maintain a certificate of authority under the New Mexico Insurance Code.

A provider service network is not required to obtain or maintain a certificate of authority in connection with health care coverage for which the risk of loss is directly and fully underwritten by a health care insurer, subject to any applicable deductible, coinsurance or copayment provisions.

A provider service network that obtains and maintains a certificate of authority as a health care insurer may contract directly with government agencies to provide goods and services to persons receiving public assistance, including Medicare and Medicaid.

A provider service network that does not obtain or maintain a certificate of authority as a health care insurer may contract in appropriate circumstances, including membership and participation in the association, directly with government agencies to provide goods and services to persons receiving public assistance, including Medicare and Medicaid. The contract shall incorporate and be subject to specific financial, quality-of-service and consumer-protection standards that the contracting agency shall specify by regulation."

NMSA 1978 § 59A-42A-3.

## HMO

**What regulatory body governs HMOs?**

Office of Superintendent of Insurance

**What statutes govern HMOs?**

N.M.S.A. Ch. 59A, Art. 46.

**Can an HMO transfer risk to providers?**

New Mexico allows "Preferred Provider Arrangements" to assume financial risk from health insurers / HMOs. Entities which are not Preferred Provider Arrangement which accept financial risk may be practicing insurance, as defined above.

"[H]ealth care insurer . . . includes a licensed insurance company . . . [or a] health maintenance organization. . . ."

N.M.S.A. § 59A-22A-3(E).

"[A]ny health care insurer may enter into preferred provider arrangements.

A. Such arrangements shall:

1) establish the amount and manner of payment to the preferred provider. Such amount and manner of payment may include capitation payments for preferred providers."

N.M.S.A. § 59A-22A-4(A)(1).

Regulations refer to a "provider service network":

"'[P]rovider service network' means two or more providers affiliated for the purpose of providing health care services on a capitated or similar prepaid, flat-fee basis."

N.M.S.A. 1978, § 59A-42A-2(I).

**What requirements apply if an HMO transfers risk to a provider?**

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NMSA 1978 § 59A-42A-3.

# Value-Based Payments: A Comprehensive State Survey

## NEW YORK

## Health Insurance

**What regulatory body governs health insurance?**

Department of Financial Services

**What statutes govern health insurance?**

New York Insurance Law Articles 32 (cooperative insurers) and 43 (insurance corporations).

**How is "insurance" defined?**

An "insurance contract" is a contract "whereby one party, the 'insurer,' is obligated to confer benefit of pecuniary value upon another party, the 'insured' or 'beneficiary,' dependent upon the happening of a fortuitous event in which the insured or beneficiary has, or is expected to have at the time of such happening, a material interest which will be adversely affected by the happening of such event."

N.Y. Ins. Law § 1101(a).

**Can insurers transfer risk to providers?**

Yes:

An insurer may transfer risk to a provider in compliance with NY PHL § 4403(1)(c), N.Y. Ins. Law §§ 3217-b(f), 4325(f).

**What requirements apply if an insurer transfers risk to a provider?**

A provider assuming pre-paid capitation from an insurer must comply with DFS Regulation 164. Otherwise a provider practicing insurance must comply with insurance law.

11 NYCRR 101 *et. seq.*

## HMO

**What regulatory body governs HMOs?**

Department of Health



**What statutes govern HMOs?**

New York Public Health Law Article 44.

**Can an HMO transfer risk to providers?**

Yes:

An HMO may enter into a risk-sharing arrangement with a provider (including an IPA), subject to the approval of DOH or DFS, as appropriate.

10 NYCRR 98-1.18(e), NY DOH Provider Contract Guidelines.

**What requirements apply if an HMO transfers risk to a provider?**

An MCO that intends to enter into a risk-sharing arrangement with an IPA must obtain approval from the Department of Financial Services and/or the Department of Health:

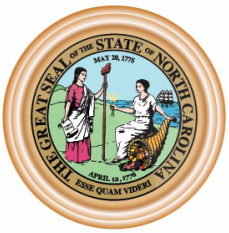
"An MCO proposing a risk sharing arrangement with an IPA may not enter into any such arrangement without first obtaining approval from the commissioner or superintendent, as appropriate, in accordance with guidelines issued by the commissioner in accordance with section 98-1.5(b)(6)(v) of this Subpart or the superintendent in accordance with Regulation 164."

10 NYCRR 98-1.18(e).

A provider assuming pre-paid capitation from an HMO must comply with DFS Regulation 164.

11 NYCRR 101 *et. seq*.

Arrangements between an HMO and a provider/IPA that do not contain downside risk are subject to "file and use" review. Arrangements that contain substantial downside risk (e.g., shared losses or retrospective capitations) are subject to prior DOH review. DOH Provider Contract Guidelines.



# Value-Based Payments: A Comprehensive State Survey

## NORTH CAROLINA

### Health Insurance

**What regulatory body governs health insurance?**

Department of Insurance

**What statutes govern health insurance?**

N.C.G.S.A. Ch. 58, Art. 50.

**How is "insurance" defined?**

"A contract of insurance is an agreement by which the insurer is bound to pay money or its equivalent or to do some act of value to the insured upon, and as indemnity or reimbursement for the destruction, loss, or injury of something in which the other party has an interest."

N.C.G.S. § 58-1-10.

**Can insurers transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

### HMO

**What regulatory body governs HMOs?**

Department of Insurance

**What statutes govern HMOs?**

N.C.G.S.A. Ch. 58, Art. 67.

**Can an HMO transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an HMO transfers risk to a provider?**

None identified in statutes or regulations.

## Health Insurance

**What regulatory body governs health insurance?**

Insurance Department

**What statutes govern health insurance?**

NDCC Ch. 26.1-36.

**How is "insurance" defined?**

"'Insurance' means a contract or arrangement in which one undertakes to pay or indemnify another as to loss from certain contingencies called 'risks,' including through reinsurance; pay or grant a specified amount or determinable benefit to another in connection with ascertainable risk contingencies; pay an annuity to another; or act as surety."

ND ST 26.1-02.1-01(6).

**Can insurers transfer risk to providers?**

North Dakota allows "Preferred Provider Arrangements" to assume financial risk from health insurers / HMOs. Entities which are not Preferred Provider Arrangement which accept financial risk may be practicing insurance, as defined above.

"Notwithstanding any provision of law to the contrary, any health care insurer may enter into preferred provider arrangements. Preferred provider arrangements must: (a) establish the amount and manner of payment to the preferred provider. The amount and manner of payment may include capitation payments for preferred providers. . . . (d) With regard to an arrangement in which the preferred provider is placed at risk for the cost or utilization of health care services. . . ."

NDCC, 26.1-47-02(1).

**What requirements apply if an insurer transfers risk to a provider?**

In an arrangement in which the preferred provider is placed at risk for the cost or utilization of health care services, the preferred provider arrangement should specifically include a description of the preferred provider's responsibilities with respect to the health care insurer's applicable administrative policies and programs, including utilization review, quality assessment and improvement programs, credentialing, grievance

procedures, and data reporting requirements. Any administrative responsibilities or costs not specifically described or allocated in the contract establishing the arrangement as the responsibility of the preferred provider are the responsibility of the health care insurer.

NDCC, 26.1-47-02(1)(d).

“A preferred provider arrangement may not offer an inducement to a preferred provider to provide less than medically necessary services to a covered person. This subsection does not prohibit a preferred provider arrangement from including capitation payments or shared-risk arrangements authorized under subdivision a of subsection 1 which are not tied to specific medical decisions with respect to a patient.”

NDCC, 26.1-47-02(5).

## HMO

**What regulatory body governs HMOs?**

Insurance Department

**What statutes govern HMOs?**

NDCC Ch. 26.1-18.1.

**Can an HMO transfer risk to providers?**

North Dakota allows “Preferred Provider Arrangements” to assume financial risk from health insurers / HMOs. Entities which are not Preferred Provider Arrangement which accept financial risk may be practicing insurance, as defined above.

“Notwithstanding any provision of law to the contrary, any health care insurer may enter into preferred provider arrangements. Preferred provider arrangements must: (a) establish the amount and manner of payment to the preferred provider. The amount and manner of payment may include capitation payments for preferred providers . . . (d) with regard to an arrangement in which the preferred provider is placed at risk for the cost or utilization of health care services. . . .”

NDCC, 26.1-47-02(1).



**What requirements apply if an HMO transfers risk to a provider?**

”[A]n arrangement in which the preferred provider is placed at risk for the cost or utilization of health care services” must “specifically include a description of the preferred provider's responsibilities with respect to the health care insurer's applicable administrative policies and programs, including utilization review, quality assessment and improvement programs, credentialing, grievance procedures, and data reporting requirements. Any administrative responsibilities or costs not specifically described or allocated in the contract establishing the arrangement as the responsibility of the preferred provider are the responsibility of the health care insurer.”

NDCC, 26.1-47-02(1)(d).

“A preferred provider arrangement may not offer an inducement to a preferred provider to provide less than medically necessary services to a covered person. This subsection does not prohibit a preferred provider arrangement from including capitation payments or shared-risk arrangements authorized under subdivision a of subsection 1 which are not tied to specific medical decisions with respect to a patient.”

NDCC, 26.1-47-02(5).

# OHIO

## Health Insurance

**What regulatory body governs health insurance?**

Department of Insurance

**What statutes govern health insurance?**

Oh. St. Title XXXIX, Chapters 3918, 3963.

**How is "insurance" defined?**

"'Insurance Institution' means any corporation, association, partnership, fraternal benefit society, or other person engaged in the business of life, health, or disability insurance, including health insuring corporations. 'Insurance institution' does not include agents or insurance support organizations."

O.R.C 3904.01(K).

"'Health insuring corporation' means a corporation . . . that, pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services, supplemental health care services, or specialty health care services, or a combination of basic health care services and either supplemental health care services or specialty health care services, through either an open panel plan or a closed panel plan."

O.R.C. 1751.01(O).

**Can insurers transfer risk to providers?**

Not addressed directly, but statute contemplates such arrangements existing:

"Each health care contract shall include . . . [t]he manner of payment, such as fee-for-service, capitation, or risk."

Oh Rev. Code §3963.03.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

## HMO

**What regulatory body governs HMOs?**

Department of Insurance

**What statutes govern HMOs?**

Oh. St. Title XVII, Chapter 1751 (Health Insuring Corporations)

**Can an HMO transfer risk to providers?**

Not addressed directly, but statute contemplates such arrangements existing:

"Each health care contract shall include . . . [t]he manner of payment, such as fee-for-service, capitation, or risk."

Oh Rev. Code §3963.03.

**What requirements apply if an HMO transfers risk to a provider?**

None identified in statutes or regulations.

# OKLAHOMA

## Health Insurance

**What regulatory body governs health insurance?**

Insurance Department

**What statutes govern health insurance?**

Ok. Stat. Title 36, Arts. 44, 45.

**How is "insurance" defined?**

"'Insurance' is a contract whereby one undertakes to indemnify another or to pay a specified amount upon determinable contingencies."

36 Ok. Stat. § 102.

**Can insurers transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

## HMO

**What regulatory body governs HMOs?**

Insurance Department & Department of Health

**What statutes govern HMOs?**

Ok. Stat. Title 36, § 6901 *et seq*.

**Can an HMO transfer risk to providers?**

Yes, regulations contemplate financial risk-sharing between an HMO and a provider:

"An HMO may establish differentials based on financial risk-sharing arrangements with organizations or entities which have contracted with the HMO to provide selected basic

health care services to members of said organization or entities, as permitted by 36 O.S. § 6902 (1) and otherwise permitted by the HMO Act or this Chapter."

Oklahoma Insurance Department Rules 365:40-5-14.

**What requirements apply if an HMO transfers risk to a provider?**

None identified in statutes or regulations.

# OREGON

## Health Insurance

**What regulatory body governs health insurance?**

Division of Financial Regulation

**What statutes govern health insurance?**

Or. St. Title 56, Ch. 743, 743A, 743B.

**How is "insurance" defined?**

"'Insurance' means a contract whereby one undertakes to indemnify another or pay or allow a specified or ascertainable amount or benefit upon determinable risk contingencies."

O.R.S. § 731.102.

**Can insurers transfer risk to providers?**

Yes, the statute contemplates the transfer of financial risk to providers:

"Non-claims based primary care expenditures" means resources given to a primary care provider or practice for the following services or arrangements:

a) Capitation or salaried arrangements with primary care providers or practices not billed or captured through claims;

b) Risk-based reconciliation for arrangements with primary care providers or practices not billed or captured through claims;

c) Payments to Patient-Centered Primary Care Homes or Patient-Centered Medical Homes based upon that recognition or payments for participation in proprietary or other multi-payer medical home initiatives;

d) Retrospective incentive payments to primary care providers or practices based on performance aimed at decreasing cost or improving value for a defined population of patients;

e) Prospective incentive payments to primary care providers or practices aimed at developing capacity for improving care for a defined population of patients;

f) Payments for Health Information Technology structural changes at a primary care practice such as electronic records and data reporting capacity from those records; or

g) Workforce expenses including payments or expenses for supplemental staff or supplemental activities integrated into the primary care practice (i.e. practice coaches, patient educators, patient navigators, nurse care managers, etc.)."

OAR 836-053-1505(3).

**What requirements apply if an insurer transfers risk to a provider?**

Not addressed in statues or regulations.

## HMO

**What regulatory body governs HMOs?**

Division of Financial Regulation

**What statutes govern HMOs?**

Or. St. Title 56, Ch. 750 (Health Care Service Contractors).

**Can an HMO transfer risk to providers?**

Yes, the statute contemplates the transfer of financial risk to providers:

"If a plan includes risk-sharing arrangements with physicians or other providers, the information required by ORS 743.804 must contain a statement to that effect, including a brief description of risk-sharing in general and must notify enrollees that additional information is available upon request. For the purpose of this requirement, a risk-sharing arrangement does not include a fee-for-service arrangement or a discounted fee-for-service arrangement. An insurer may use the following statement or other appropriate wording to describe risk-sharing:

'This plan includes "risk-sharing" arrangements with physicians who provide services to the members of this plan. Under a risk-sharing arrangement, the providers that are responsible for delivering health care services are subject to some financial risk or reward for the services they deliver. An example of a risk-sharing arrangement is a contract between an insurer and a group of heart surgeons in which the surgeons agree

to provide all of the heart operations needed by plan members and the insurer agrees to pay a fixed monthly amount for those services.'"

OAR 836-053-1030(10).

See definition of "health benefit plan" in ORS 743B.005 for applicability to HCSCs.

**What requirements apply if an HMO transfers risk to a provider?**

Providers who are compensated on a capitated basis by a health insurer or health care service contractor ("HCSC") are not required to obtain a certificate of authority if the capitation is internal to a policy of insurance that is delivered by an authorized insurer or HCSC. In such cases, the insurer or HCSC is the ultimate risk assuming entity and it remains responsible for the fulfillment of the insurance contract. However, Providers would need a certificate of authority if the capitation arrangement were separate from a policy of insurance. For example, if an insurer or HCSC were to "lease" their capitated managed care or HMO program to a "self-funded" plan sponsor without establishing a bona fide insurance contract, the capitated providers would need a certificate of authority.

*Division of Insurance Bulletin: Application of Insurance Code to Health Benefit Arrangements that Include Provider Risk Sharing*

## Health Insurance

**What regulatory body governs health insurance?**

Insurance Department

**What statutes govern health insurance?**

Title 40 P.S., Ch. 2, Art. VI(b).

**How is "insurance" defined?**

"Health care insurer" means "[a] company which is a risk-assuming preferred provider organization, or licensed to do the business of accident and health insurance in this Commonwealth, or both."

31 Pa. Code 152.2.

**Can insurers transfer risk to providers?**

Not addressed in statute or regulation, though "Integrated Delivery Systems" may apply for licensure to bear risk, and may contract with insurers:

"*IDS-Integrated delivery system*-

(i) A partnership, association, corporation or other legal entity which does the following:

A. Enters into a contractual arrangement with a plan.

B. Employs or contracts with health care providers.

C. Agrees under its arrangement with the plan to do the following:

I. Provide or arrange for the provision of a defined set of health care services to enrollees covered under a plan contract principally through its participating providers.

II. Assume under the arrangement with the plan some responsibility for conducting in conjunction with the plan and under compliance monitoring of the plan quality assurance, UR, credentialing, provider relations or

related functions.

(ii) The IDS may also perform claims processing and other functions."

28 Pa. Code § 9.602.

**What requirements apply if an insurer transfers risk to a provider?**

Integrated Delivery Systems may, by definition, contract with an insurer or an HMO (a "plan," as defined, refers to either). Regulations relating to the transfer of risk to an IDS may be found in the Insurance regulations of Pennsylvania, but specifically reference only HMOs in the regulations. The applicable regulations are listed in the HMO section of this survey, below.

## HMO

**What regulatory body governs HMOs?**

Insurance Department/Department of Health

**What statutes govern HMOs?**

Title 40 P.S., Ch. 6, § 1551 *et seq.*

**Can an HMO transfer risk to providers?**

Not addressed directly in statute or regulation, but the statute does contemplate risk-sharing arrangements between HMOs and providers:

"A certificate of authority shall be jointly issued by order of the commissioner and secretary when . . . [t]he commissioner has found and determined that the applicant has a reasonable plan to operate the health maintenance organization in a financially sound manner. . . . In making this determination, the commissioner may consider . . . [a]ny agreement with providers of health care services whereby they assume financial risk for the provision of services to subscribers."

40 P.S. § 1555.1(b)(2)(iii).

An HMO may also contract with an IDS, and statutes and regulations specifically address the transfer of risk in such scenarios, as discussed below.

**What requirements apply if an HMO transfers risk to a provider?**

Regulations address Integrated Delivery Systems:

"An HMO shall file with the Department any contract entered into with an IDS under which the IDS will assume risk. . . ."

31 Pa. Code § 301.312(a).

"Initial contract filings may be submitted with any additional information that may be appropriate for the Department's review, such as a cover letter describing the following:

1) The extent to which functions are transferred to the IDS and the extent and type of services which will be provided by the IDS.

2) The relationship between the IDS and the participating providers, and the manner in which services will be delivered by participating providers.

3) The identities of IDS subcontractors.

4) The reimbursement methodology, and a copy of security arrangements relating thereto, between the HMO and IDS."

31 Pa. Code § 301.312(d).

b) "In evaluating the financial condition of an HMO, the Department will ascertain whether one or more of the following are present in an IDS contract:

1) An appropriate provision similar to the hold harmless provision described in § 301.122 (relating to hold harmless), prohibiting the IDS and participating providers from billing HMO members.

2) A provision for the maintenance of books, accounts and records by the IDS to assure that transactions, including the risk transfer, are clearly, accurately and completely disclosed.

3) Appropriate terms permitting the HMO to assure itself of the financial viability and condition of the IDS throughout the term of the contract. These terms might include one or more of the following:

i. A provision authorizing the HMO to access the IDS's books, accounts and records upon terms and conditions as the HMO and

the IDS may agree.

ii. A provision requiring that the IDS secure an audited financial statement on at least an annual basis and that the HMO receive the audited statement on an annual basis and interim unaudited financial statements from the IDS on a regular and ongoing basis.

iii. A provision authorizing the HMO to receive information regarding the IDS's reserves so that the HMO may adequately evaluate its reserves.

iv. A provision for the IDS to post a letter of credit or other acceptable financial security, in a reasonable amount as agreed upon between the HMO and IDS.

v. A provision establishing a withholding of the fee in a reasonable amount as agreed upon between the HMO and IDS and which may be returned to the IDS under the terms of the contract.

vi. A provision for the IDS to carry general liability insurance and for participating providers to carry professional liability insurance in an amount and from a carrier mutually acceptable to the HMO and the IDS.

vii. A provision for the IDS to secure a surety bond to cover the IDS's performance under the contract.

viii. A provision for the IDS to secure excess of loss insurance in an amount and from a carrier mutually acceptable to the HMO and the IDS.

4) A provision prohibiting the assignment of any rights or obligations under the contract in the absence of the consent of the HMO.

5) A provision granting the HMO the right to be advised of, and the right to object to, any subcontractor of the IDS with respect to services required to be performed by the IDS under the contract with the HMO.

6) Appropriate provisions for the termination of the contract, including consideration of whether the HMO has the right to immediately terminate the contract upon a valid order issued by the Commissioner or other

lawful authority.

7) A provision setting forth the circumstances under which the HMO may institute an appropriate financial monitoring plan of the IDS.

8) A provision requiring that the IDS carry appropriate insurance coverage, such as fidelity bonds covering IDS employees who handle HMO funds and workers' compensation insurance.

9) A provision requiring that the IDS timely advise the HMO of relevant matters that may have a material effect on the IDS's ability to perform under the contract, including, for example, the following:

    i. Whether the IDS or a participating provider is subject to an administrative order, cease and desist order, fine or license suspension.

    ii. Whether legal action has been taken which may have a material effect on the IDS's financial condition or the IDS's ability to perform under the contract.

c) The Department may seek additional information if one or more of the following exist:

1) A contract by which 50% or more of the HMO's annual aggregate premium is transferred to a single IDS.

2) Multiple contracts by which 75% or more of the HMO's annual aggregate premium is transferred to one or more IDSs.

3) A contract with an IDS that has control of the HMO. The Department presumes that control exists if an individual or entity, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10% or more of the voting securities of any other entity.

4) A contract by which the claims processing, claims payment or claims adjudication functions are transferred to the IDS.

5) A contract by which managerial control of the HMO's information system is transferred to the IDS.

6) A contract when the HMO employs an individual who is also employed by the IDS.
7) A contract when there is overlap between the officers or directors of the IDS and the HMO.

8) A contract that contains a provision which might be construed as impeding or limiting the Department's authority to examine the books, accounts and records of the HMO and other persons under section 903(b) and (c) of The Insurance Department Act of 1921 (40 P. S. § 323.3(b) and (c)).”

31 Pa. Code § 301.314(b), (c).

An HMO needs to file contracts and contract filing forms with the Insurance Department whenever a contact with an IDS exists, and the IDS performs the following functions: (1) Assumes risk; (2) Delivers health care services; and (3) Performs other functions as indicated in Section 8(b) of the HMO Act.

If the contract with the IDS does not result in all three criteria met, either directly or through subcontractors, then the contract does not need to be filed with the Insurance Department.

*PA Insurance Bulletin 2017*



# RHODE ISLAND

## Health Insurance

**What regulatory body governs health insurance?**

Department of Business Regulation, Insurance Division

**What statutes govern health insurance?**

R.I. Gen. Laws Title 27, Chs. 48.5, 18.6, 20.9.

**How is "insurance" defined?**

"'Business of insurance' means the writing of insurance or the reinsuring of risks by an insurer, including acts necessary or incidental to writing insurance or reinsuring risks and the activities of persons who act as or are officers, directors, agents or employees of insurers, or who are other persons authorized to act on their behalf."

27 R.I. Gen. Laws § 27-54.1-1.

**Can insurers transfer risk to providers?**

Rhode Island allows "Integrated Systems of Care" or "Accountable Care Organization" to assume financial risk from health insurers / HMOs. Entities which are not Integrated Systems of Care which accept financial risk may be practicing insurance, as defined above.

"'Integrated system of care,' sometimes referred to as an Accountable Care Organization, means one (1) or more business entities consisting of physicians, other clinicians, hospitals and/or other providers that together provide care and share accountability for the cost and quality of care for a population of patients, and that enters into a Population-Based Contract, such as a Shared Savings Contract or Risk Sharing Contract or Global Capitation Contract, with one or more Health Insurers to care for a defined group of patients."

230-RICR-20-30-4.3(12).

"Health insurer" means any entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including, without limitation, an insurance company offering accident and sickness insurance, a health maintenance organization, a non-profit hospital service corporation, a non-profit medical service corporation, a non-profit dental service

corporation, a non-profit optometric service corporation, a domestic insurance company subject R.I. Gen. Laws Chapter 27-1 that offers or provides health insurance coverage in the state and a foreign insurance company subject to R.I. Gen. Laws Chapter 27-2 that offers or provides health insurance coverage in the state.

230-RICR-20-30-4.3(9).

**What requirements apply if an insurer transfers risk to a provider?**

"Risk-sharing contracts with ten thousand (10,000) or more attributed lives shall meet the Minimum Downside Risk requirements of this § 4.10(D)(2)(d) of this Part. For the purposes of § 4.10(D)(2)(d), contracts with Physician-based Integrated Systems of Care may employ a risk exposure cap that is tied to the annual provider revenue from the health insurer under the contract or the total cost of care. Contracts with Integrated Systems of Care including Hospital Systems are to employ a total cost of care methodology.

1) For contracts with Integrated Systems of Care including Hospital Systems between ten thousand (10,000) and twenty thousand (20,000) attributed commercial lives, health insurers shall employ a risk-sharing rate of at least forty percent (40%), and if applicable, a risk-exposure cap of at least five percent (5%) of the total cost of care and a minimum loss rate of no more than three percent (3%) of the total cost of care. For such contracts entered into, renewed, or amended on or after January 1, 2021, health insurers shall employ a risk-sharing rate of at least fifty percent (50%), and if applicable, a risk-exposure cap of at least six percent (6%) and a minimum loss rate of no more than three percent (3%) of the total cost of care.

2) For contracts with Integrated Systems of Care including Hospital Systems with more than twenty thousand (20,000) attributed commercial lives, health insurers shall employ a risk-sharing rate of at least forty percent (40%), and if applicable, a risk-exposure cap of at least five percent (5%) of the total cost of care and a minimum loss rate of no more than two percent (2%) of the total cost of care. For such contracts entered into, renewed, or amended on or after January 1, 2021, health insurers shall employ a risk-sharing rate of at least fifty percent (50%), and if applicable, a risk-exposure cap of at least six percent (6%) and a minimum loss rate of no more than two percent (2%) of the total cost of care.

3) For contracts with Physician-based Integrated Systems of Care between twn [sic] thousand (10,000) and twenty thousand (20,000) attributed commercial lives, health insurers shall employ a risk-sharing rate of at least forty percent (40%), and if applicable, a risk-exposure cap of at least seven percent (7%) of provider

revenue or at least two percent (2%) of the total cost of care and a minimum loss rate of no more than three percent (3%) of the total cost of care. For such contracts entered into, renewed, or amended on or after January 1, 2021, health insurers shall employ a risk-sharing rate of at least fifty percent (50%), and if applicable, a risk-exposure cap of at least eight percent (8%) of provider revenue or at least three percent (3%) of the total cost of care and a minimum loss rate of no more than three percent (3%) of the total cost of care.

4) For contracts with Physician-based Integrated Systems of Care with more than twenty thousand (20,000) attributed commercial lives, health insurers shall employ a risk-sharing rate of at least forty percent (40%), and if applicable, a risk-exposure cap of at least eight percent (8%) of provider revenue or at least three percent (3%) of the total cost of care and a minimum loss rate of no more than two percent (2%) of the total cost of care. For such contracts entered into, renewed, or amended on or after January 1, 2021, health insurers shall employ a risk-sharing rate of at least fifty percent (50%), and if applicable, a risk-exposure cap of at least eight percent (8%) of provider revenue or at least three percent (3%) of the total cost of care and a minimum loss rate of no more than two percent (2%) of the total cost of care.

5) The Minimum Downside Risk requirements above, while not applicable to risk-sharing contracts with fewer than ten thousand (10,000) attributed commercial lives, should not be construed to preclude or discourage health insurers and providers from entering into risk-sharing contracts with fewer than ten thousand (10,000) attributed lives. OHIC recommends health insurer and provider caution when doing so, however, in order to account for the decreased statistical certainty with attributed populations less than ten thousand (10,000).

6) None of the requirements of this § 4.10(D)(2)(d) of this Part shall be construed to preclude contracts with greater degrees of provider risk assumption with health insurers including fee for service, capitation and global capitation contracts."

230-RICR-20-30-4.10(D)(2)(d).

"A health insurer shall not enter into a Risk Sharing Contract or Global Capitation contract unless the health insurer has determined, in accordance with standard operating procedures filed and approved by the Commissioner, that the provider organization entering into the contract has the operational and financial capacity and resources needed to assume clinical and financial responsibility for the provider of covered services to members attributable to the provider organization. At the reasonable request of the provider organization, the health insurer shall maintain the confidentiality of information which the health insurer requests to make its determination. The health

insurer shall periodically review the provider's organization's continuing ability to assume such responsibilities. The health insurer shall maintain contingency plans in the event the provider organization is unable to sustain its ability to manage its responsibilities. The foregoing shall not be construed to permit the transfer of insurance risk or the transfer of delegation of the health insurer's regulatory obligations."

230-RICR-20-30-4.10(D)(2)(e).

"Population-Based Contracts shall include a provision that agrees on a budget for each contract year. Review and prior approval by the Office of the Health Insurance Commissioner shall be required if any annual increase in the total cost of care for services reimbursed under the contract, after risk adjustment, exceeds the US All Urban Consumer All Items Less Food and Energy CPI ('CPI-Urban') percentage increase (determined by the Commissioner by October 1 of each year, based on the most recently published United States Department of Labor data). Such percentage increase shall be plus 1.5%."

230-RICR-20-30-4.10(D)(2)(f).

"Should any Integrated System of Care have had three (3) immediately prior years of average historical risk-adjusted total cost of care per capita spending for the provider's attributed patient population that was significantly below the health insurer's risk-adjusted commercially insured average (statistically significant at p <= .05 and excluding the provider from the calculated average), the health insurer may prospectively adjust that provider's budget upward by up to, but not more than, two percent (2%) of the provider's unadjusted expected per capita spending. The adjusted budget shall never exceed the health insurer's projected risk-adjusted commercially insured average spending. Only Integration Systems of Care with risk-sharing contracts shall qualify for the upward budget adjustment."

230-RICR-20-30-4.10(D)(2)(g).

"Population-Based Contracts shall not carve out behavioral health or prescription drug claims experience from the provider budget. Population-Based Contracts may include a methodology to reflect the member-months for which the health insurer covers pharmacy and/or behavioral health claims."

230-RICR-20-30-4.10(D)(2)(h).

"Population-Based Contracts shall include terms that relinquish the right of any party to contest the public release, by state officials or the parties to the contract, of the provisions of the contract demonstrating compliance with the requirements of § 4.10(D)(2) of this Part; provided that the health insurer or other affected party may request the Commissioner to maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying the claim of confidentiality."

230-RICR-20-30-4.10(D)(2)(g).

## HMO

**What regulatory body governs HMOs?**

Department of Business Regulation, Insurance Division

**What statutes govern HMOs?**

R.I. Gen. Laws Title 27, Ch. 41.

**Can an HMO transfer risk to providers?**

Rhode Island allows "Integrated Systems of Care" or "Accountable Care Organization" to assume financial risk from health insurers / HMOs. Entities which are not Integrated Systems of Care which accept financial risk may be practicing insurance, as defined above.

"'Integrated system of care,' sometimes referred to as an Accountable Care Organization, means one (1) or more business entities consisting of physicians, other clinicians, hospitals and/or other providers that together provide care and share accountability for the cost and quality of care for a population of patients, and that enters into a Population-Based Contract, such as a Shared Savings Contract or Risk Sharing Contract or Global Capitation Contract, with one or more Health Insurers to care for a defined group of patients."

230-RICR-20-30-4.3(12).

"'Health insurer' means any entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including, without limitation, an insurance company offering accident and sickness insurance, a health maintenance organization, a non-profit hospital service

corporation, a non-profit medical service corporation, a non-profit dental service corporation, a non-profit optometric service corporation, a domestic insurance company subject R.I. Gen. Laws Chapter 27-1 that offers or provides health insurance coverage in the state and a foreign insurance company subject to R.I. Gen. Laws Chapter 27-2 that offers or provides health insurance coverage in the state."

2130-RICR-20-30-4.3(9).

**What requirements apply if an HMO transfers risk to a provider?**

"Risk-sharing contracts with ten thousand (10,000) or more attributed lives shall meet the Minimum Downside Risk requirements of this § 4.10(D)(2)(d) of this Part. For the purposes of § 4.10(D)(2)(d), contracts with Physician-based Integrated Systems of Care may employ a risk exposure cap that is tied to the annual provider revenue from the health insurer under the contract or the total cost of care. Contracts with Integrated Systems of Care including Hospital Systems are to employ a total cost of care methodology.

1) For contracts with Integrated Systems of Care including Hospital Systems between ten thousand (10,000) and twenty thousand (20,000) attributed commercial lives, health insurers shall employ a risk-sharing rate of at least forty percent (40%), and if applicable, a risk-exposure cap of at least five percent (5%) of the total cost of care and a minimum loss rate of no more than three percent (3%) of the total cost of care. For such contracts entered into, renewed, or amended on or after January 1, 2021, health insurers shall employ a risk-sharing rate of at least fifty percent (50%), and if applicable, a risk-exposure cap of at least six percent (6%) and a minimum loss rate of no more than three percent (3%) of the total cost of care.

2) For contracts with Integrated Systems of Care including Hospital Systems with more than twenty thousand (20,000) attributed commercial lives, health insurers shall employ a risk-sharing rate of at least forty percent (40%), and if applicable, a risk-exposure cap of at least five percent (5%) of the total cost of care and a minimum loss rate of no more than two percent (2%) of the total cost of care. For such contracts entered into, renewed, or amended on or after January 1, 2021, health insurers shall employ a risk-sharing rate of at least fifty percent (50%), and if applicable, a risk-exposure cap of at least six percent (6%) and a minimum loss rate of no more than two percent (2%) of the total cost of care.

3) For contracts with Physician-based Integrated Systems of Care between twn [sic] thousand (10,000) and twenty thousand (20,000) attributed commercial lives, health insurers shall employ a risk-sharing rate of at least forty percent (40%),

and if applicable, a risk-exposure cap of at least seven percent (7%) of provider revenue or at least two percent (2%) of the total cost of care and a minimum loss rate of no more than three percent (3%) of the total cost of care. For such contracts entered into, renewed, or amended on or after January 1, 2021, health insurers shall employ a risk-sharing rate of at least fifty percent (50%), and if applicable, a risk-exposure cap of at least eight percent (8%) of provider revenue or at least three percent (3%) of the total cost of care and a minimum loss rate of no more than three percent (3%) of the total cost of care.

4) For contracts with Physician-based Integrated Systems of Care with more than twenty thousand (20,000) attributed commercial lives, health insurers shall employ a risk-sharing rate of at least forty percent (40%), and if applicable, a risk-exposure cap of at least eight percent (8%) of provider revenue or at least three percent (3%) of the total cost of care and a minimum loss rate of no more than two percent (2%) of the total cost of care. For such contracts entered into, renewed, or amended on or after January 1, 2021, health insurers shall employ a risk-sharing rate of at least fifty percent (50%), and if applicable, a risk-exposure cap of at least eight percent (8%) of provider revenue or at least three percent (3%) of the total cost of care and a minimum loss rate of no more than two percent (2%) of the total cost of care.

5) The Minimum Downside Risk requirements above, while not applicable to risk-sharing contracts with fewer than ten thousand (10,000) attributed commercial lives, should not be construed to preclude or discourage health insurers and providers from entering into risk-sharing contracts with fewer than ten thousand (10,000) attributed lives. OHIC recommends health insurer and provider caution when doing so, however, in order to account for the decreased statistical certainty with attributed populations less than ten thousand (10,000).

6) None of the requirements of this § 4.10(D)(2)(d) of this Part shall be construed to preclude contracts with greater degrees of provider risk assumption with health insurers including fee for service, capitation and global capitation contracts."

230-RICR-20-30-4.10(D)(2)(d).

"A health insurer shall not enter into a Risk Sharing Contract or Global Capitation contract unless the health insurer has determined, in accordance with standard operating procedures filed and approved by the Commissioner, that the provider organization entering into the contract has the operational and financial capacity and resources needed to assume clinical and financial responsibility for the provider of covered services to members attributable to the provider organization. At the reasonable request of the provider organization, the health insurer shall maintain the confidentiality

of information which the health insurer requests to make its determination. The health insurer shall periodically review the provider's organization's continuing ability to assume such responsibilities. The health insurer shall maintain contingency plans in the event the provider organization is unable to sustain its ability to manage its responsibilities. The foregoing shall not be construed to permit the transfer of insurance risk or the transfer of delegation of the health insurer's regulatory obligations."

230-RICR-20-30-4.10(D)(2)(e).

"Population-Based Contracts shall include a provision that agrees on a budget for each contract year. Review and prior approval by the Office of the Health Insurance Commissioner shall be required if any annual increase in the total cost of care for services reimbursed under the contract, after risk adjustment, exceeds the US All Urban Consumer All Items Less Food and Energy CPI ("CPI-Urban") percentage increase (determined by the Commissioner by October 1 of each year, based on the most recently published United States Department of Labor data). Such percentage increase shall be plus 1.5%."

230-RICR-20-30-4.10(D)(2)(f).

"Should any Integrated System of Care have had three (3) immediately prior years of average historical risk-adjusted total cost of care per capita spending for the provider's attributed patient population that was significantly below the health insurer's risk-adjusted commercially insured average (statistically significant at p <= .05 and excluding the provider from the calculated average), the health insurer may prospectively adjust that provider's budget upward by up to, but not more than, two percent (2%) of the provider's unadjusted expected per capita spending. The adjusted budget shall never exceed the health insurer's projected risk-adjusted commercially insured average spending. Only Integration Systems of Care with risk-sharing contracts shall qualify for the upward budget adjustment."

230-RICR-20-30-4.10(D)(2)(g).

"Population-Based Contracts shall not carve out behavioral health or prescription drug claims experience from the provider budget. Population-Based Contracts may include a methodology to reflect the member-months for which the health insurer covers pharmacy and/or behavioral health claims."

230-RICR-20-30-4.10(D)(2)(h).

"Population-Based Contracts shall include terms that relinquish the right of any party to contest the public release, by state officials or the parties to the contract, of the

provisions of the contract demonstrating compliance with the requirements of § 4.10(D)(2) of this Part; provided that the health insurer or other affected party may request the Commissioner to maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying the claim of confidentiality."

230-RICR-20-30-4.10(D)(2)(g).

# Value-Based Payments: A Comprehensive State Survey

## SOUTH CAROLINA

### Health Insurance

**What regulatory body governs health insurance?**

Department of Insurance

**What statutes govern health insurance?**

S.C. Code Title 38, Ch. 71.

**How is "insurance" defined?**

"'Insurance' means a contract where one undertakes to indemnify another or pay a specified amount upon determinable contingencies."

SC Code § 38-1-20(25).

**Can insurers transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

### HMO

**What regulatory body governs HMOs?**

Department of Insurance

**What statutes govern HMOs?**

S.C. Code Title 38, Ch. 33.

**Can an HMO transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an HMO transfers risk to a provider?**

None identified in statutes or regulations.

## Health Insurance

**What regulatory body governs health insurance?**

Department of Labor & Regulation, Division of Insurance

**What statutes govern health insurance?**

SDCL Title 58, Chs. 17, 18, 18b.

**How is "insurance" defined?**

"'Insurance,' a contract whereby one undertakes to indemnify another or to pay or provide a specified or determinable amount or benefit upon determinable contingencies."

SDCL 58-1-2(8).

**Can insurers transfer risk to providers?**

Not directly addressed in statute or regulation, but certain statutes contemplate such arrangements:

"The health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, and legal authority of its providers to furnish all contracted benefits to covered persons. In the case of capitated plans, the health carrier shall also monitor the financial capability of the provider."

SDCL 58-17F-8.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

## HMO

**What regulatory body governs HMOs?**

Department of Labor & Regulation, Division of Insurance

**What statutes govern HMOs?**

SDCL Title 58, Ch. 41.

**Can an HMO transfer risk to providers?**

"'Risk bearing entity,' an intermediary organization that is a financial risk for services provided through contractual assumption of the obligation for the delivery of specified health care services to covered persons of the health maintenance organization."

SDCL 58-41-1(8).

"In entering into, amending, or renewing a contract with a risk bearing entity, a health maintenance organization shall, unless already specific in the contract, provide the following: . . . a written statement describing the amount or methodology of remuneration to be paid to the risk bearing entity. . . . The statement shall specify the services and expenses for which the risk bearing entity is financially liable in whole or part[.]"
SDCL 58-41-121(1).

**What requirements apply if an HMO transfers risk to a provider?**

"A health maintenance organization shall file annually, as part of its access plan, a list of all risk bearing entities with which it has an agreement or contract and the number of covered persons assigned or selected by each risk bearing entity."

SDCL 58-41-120.

"In entering into, amending, or renewing a contract with a risk bearing entity, a health maintenance organization shall, unless already specified in the contract, provide the following, upon request, to a risk bearing entity:

1) At the time the contract is entered into, a written statement describing the amount or method of remuneration to be paid to the risk bearing entity. If any part of the remuneration is a calculated amount based on variable factors, the payment methodology upon which the calculated amount will be determined. The statement shall specify the services and expenses for which the risk bearing entity is financially liable in whole or part;

2) At the time payment is made, the basis of the calculation of that payment;

3) For health benefit plans in which the covered persons are assigned to the risk bearing entity under a capitated payment arrangement, a list of enrollees and

payments due to the risk bearing entity, to be provided monthly if not already available to the risk bearing entity;

4) At the time the contract is entered into, a copy of the health maintenance organization's most recent annual statement filed with the NAIC; and

5) Once the contract is in effect, the quarterly or annual statement."

SDCL 58-41-121.

"A health maintenance organization shall include in any contract with a risk bearing entity a requirement that the risk bearing entity provide to the health maintenance organization at the time a contract is entered into and annually thereafter the following:

1) Annual audited GAAP report in accordance with generally accepted accounting principles in the United States (U.S. GAAP);

2) Documentation that satisfies the health maintenance organization that the risk bearing entity has sufficient ability to accept risk; and

3) Documentation that satisfies the health maintenance organization that the risk bearing entity has appropriate management expertise and infrastructure."

SDCL 58-41-122.

# Value-Based Payments: A Comprehensive State Survey

## TENNESSEE

### Health Insurance

**What regulatory body governs health insurance?**

Department of Commerce & Insurance

**What statutes govern health insurance?**

Tenn. Code Ann. Tit. 56, Ch. 7, Part 10.

**How is "insurance" defined?**

"'Accident and health insurance' means insurance against bodily injury, disablement or death, by accident or accidental means, or the expense of bodily injury, disablement or death, against disablement or expense resulting from sickness, and every insurance pertaining thereto; providing for the mental and emotional welfare of an individual and members of the individual's family by defraying the cost of legal services; or providing aggregate or excess stop-loss coverage in connection with employee welfare benefit plans, managed care organizations participating in commercial plans or the TennCare program, or both, health maintenance organizations, long-term care facilities, physician-hospital organizations as defined in § 56-32-102 and provider aggregate or per-patient stop-loss protection insurance coverage as authorized by § 56-32-104."

TENN. CODE ANN. § 56-2-201.

**Can insurers transfer risk to providers?**

Not addressed directly, but the statute contemplates risk-sharing arrangements:

"Health insurance carriers shall provide or make available to a healthcare provider . . . the payment or fee schedules or other information sufficient to enable the healthcare provider to determine the manner and amount of payments under the contract . . . . The payment or fee schedule or other information . . . shall include a description of processes and factors that may be applicable and that may affect actual payment, e.g., . . . risk sharing arrangements . . . ."

TENN. CODE ANN. §56-7-1013(b).

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

## HMO

**What regulatory body governs HMOs?**

Department of Commerce & Insurance

**What statutes govern HMOs?**

Tenn. Code Ann. Tit. 56, Ch. 32.

**Can an HMO transfer risk to providers?**

Not addressed directly, but the statute contemplates risk-sharing arrangements:

"In the event the HMO enters into an agreement with any physician-hospital organization, or any other provider, provider group, or provider network, for the provision of healthcare services on a prepayment basis or other risk sharing basis, the commissioner may not disallow the agreement on the basis that it transfers risk to the physician-hospital organization or other provider, provider group or provider network; or transfers the risk of payment for services to the physician-hospital organization or other provider, provider group or provider network . . . ."

TENN. CODE ANN. § 56-32-104(E).

**What requirements apply if an HMO transfers risk to a provider?**

"In the event the HMO enters into an agreement with any physician-hospital organization, or any other provider, provider group, or provider network, for the provision of healthcare services on a prepayment basis or other risk sharing basis, the commissioner may not disallow the agreement on the basis that it transfers risk to the physician-hospital organization or other provider, provider group or provider network; or transfers the risk of payment for services to the physician-hospital organization or other provider, provider group or provider network; provided, that the HMO shall:

i. Remain contractually responsible to its enrollees;

ii. Enter into contractual arrangements utilizing contract provisions and arrangements that ensure compliance with applicable federal law, rule, regulation or waivers, including federal requirements; and

iii. Assure the physician-hospital organizations, providers, provider groups, or provider networks that are at substantial financial risk obtain either aggregate or

per-patient stop-loss protection insurance coverage for the healthcare services included in the scope of the arrangement; or the HMO remains contractually responsible to the subcontracted providers and provides a system for reserving for its continued liability; and

Any deposit of cash or security submitted in accordance with §56-32-112 . . . ."

TENN. CODE ANN. § 56-32-104 (E) & (F).

## Health Insurance

**What regulatory body governs health insurance?**

Department of Insurance

**What statutes govern health insurance?**

Tex. Ins. Code, Tit. 8.

**How is "insurance" defined?**

"'Health insurance company' means a corporation authorized under a charter to engage in business involving the payment of money or another thing of value in the event of loss resulting from disability incurred as a result of sickness or ill health."

TEX. INS. CODE ANN. § 841.001(6).

**Can insurers transfer risk to providers?**

The statutes contemplate a Health Care Collaborative. A non-provider entity that is not a Health Care Collaborative may be practicing insurance if it accepts risk from an insurer/HMO.

"'Health Care Collaborative' means an entity [] that undertakes to arrange for medical and health care services for insurers, health maintenance organizations, and other payors in exchange for payments in cash or in kind; that accepts and distributes payments for medical and health care services; that consists of: physicians; rural hospitals' physicians and other health care providers; physicians and insurers or health maintenance organizations; or physicians, other health care providers, and insurers or health maintenance organizations; and that is certified by the commissioner under this chapter to lawfully accept and distribute payments to physicians and other health care providers using the reimbursement methodologies authorized by this chapter."

TEX. INS. CODE ANN. § 848.001(2).

"Notwithstanding any other law, a health care collaborative that is in compliance with this code, including Chapters 841, 842, and 843, as applicable, may contract for, accept, and distribute payments from governmental or private payors based on fee-for-service or alternative payment mechanisms, including:

1. episode-based or condition-based bundled payments;
2. capitation or global payments; or
3. pay-for-performance or quality-based payments."

TEX. INS. CODE ANN. § 848.103(b)

**What requirements apply if an insurer transfers risk to a provider?**

"A health care collaborative that is certified by the department under this chapter may provide or arrange to provide health care services under contract with a governmental or private entity."

TEX. INS. CODE. ANN. § 848.051.

"An insurer's delegation of functions to an HCC is subject to the requirements of Insurance Code Chapter 1272 and Chapter 11, Subchapter AA of this title as if the insurer were an HMO."

28 TEX. ADMIN. CODE § 13.474(b).

"A person is not required to obtain an HCC certificate of authority to the extent that the person is: (a) a physician engaged in the delivery of medical care; or (2) a health care provider engaged in the delivery of health care services other than medical care as part of a HMO delivery network."

TEX. INS. CODE. ANN. § 848.055(b).

## HMO

**What regulatory body governs HMOs?**

Department of Insurance

**What statutes govern HMOs?**

Tex. Ins. Code, Tit. 6, Ch. 843.

**Can an HMO transfer risk to providers?**

The statutes contemplate the transfer of risk to providers, as well as a Health Care Collaborative. A non-provider entity that is not a Health Care Collaborative may be practicing insurance if it accepts risk from an insurer/HMO.

"A contract or subcontract authorized under this section may provide for compensation under:

1. a fee-for-service arrangement;

2. a risk-sharing arrangement; or

3. a capitation arrangement under which a fixed predetermined payment is made in exchange for the provision of, or for the arrangement to provide and the guaranty of the provision of, a defined set of covered services to covered persons for a specified period without regard to the quantity of services actually provided."

TEX. INS. CODE ANN. § 843.318(e).

"'Health Care Collaborative' means an entity [] that undertakes to arrange for medical and health care services for insurers, health maintenance organizations, and other payors in exchange for payments in cash or in kind; that accepts and distributes payments for medical and health care services; that consists of: physicians; rural hospitals' physicians and other health care providers; physicians and insurers or health maintenance organizations; or physicians, other health care providers, and insurers or health maintenance organizations; and that is certified by the commissioner under this chapter to lawfully accept and distribute payments to physicians and other health care providers using the reimbursement methodologies authorized by this chapter."

TEX. INS. CODE ANN. § 848.001(2).

"Notwithstanding any other law, a health care collaborative that is in compliance with this code, including Chapters 841, 842, and 843, as applicable, may contract for, accept, and distribute payments from governmental or private payors based on fee-for-service or alternative payment mechanisms, including:

1. episode-based or condition-based bundled payments;

2. capitation or global payments; or

3. pay-for-performance or quality-based payments."

TEX. INS. CODE ANN. § 848.103(b).

**What requirements apply if an HMO transfers risk to a provider?**

“A health care collaborative that is certified by the department under this chapter may provide or arrange to provide health care services under contract with a governmental or private entity.”

TEX. INS. CODE ANN. § 848.051.

“An HMO's delegation of functions to an HCC is subject to the requirements of Insurance Code Chapter 1272 and Chapter 11, Subchapter AA of this title (relating to Delegated Entities).”

28 TEX. ADMIN. CODE § 13.474(a).

“A person is not required to obtain an HCC certificate of authority to the extent that the person is: (a) a physician engaged in the delivery of medical care; or (2) a health care provider engaged in the delivery of health care services other than medical care as part of a HMO delivery network.”

TEX. INS. CODE ANN. § 848.055(b).

## Health Insurance

**What regulatory body governs health insurance?**

Insurance Department

**What statutes govern health insurance?**

Utah Code Ann. Tit. 31a, Ch. 30.

**How is "insurance" defined?**

"'Insurance' means:

i. an arrangement, contract, or plan for the transfer of a risk or risks from one or more persons to one or more other persons; or

ii. an arrangement, contract, or plan for the distribution of a risk or risks among a group of persons that includes the person seeking to distribute that person's risk.

'Insurance' includes:

i. a risk distributing arrangement providing for compensation or replacement for damages or loss through the provision of a service or a benefit in kind;

ii. a contract of guaranty or suretyship entered into by the guarantor or surety as a business and not as merely incidental to a business transaction; and

iii. a plan in which the risk does not rest upon the person who makes an arrangement, but with a class of persons who have agreed to share the risk."

UTAH CODE ANN. § 31A-1-301(92).

**Can insurers transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

## HMO

**What regulatory body governs HMOs?**

Insurance Department

**What statutes govern HMOs?**

Utah Code Ann. Tit. 31a, Ch. 8.

**Can an HMO transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an HMO transfers risk to a provider?**

None identified in statutes or regulations.


# Value-Based Payments: A Comprehensive State Survey

## VERMONT

### Health Insurance

**What regulatory body governs health insurance?**

Department of Financial Regulation

**What statutes govern health insurance?**

Vt. Stat. Ann. Tit. 8, Part 3, Ch. 107.

**How is "insurance" defined?**

"'[I]nsurance' means an agreement to indemnify or otherwise assume an obligation, provide services or any other thing of value on the happening of a particular event or contingency, or to provide indemnity for loss with respect to a specified subject by specified circumstances in return for a consideration. Without limiting the generality of the term, 'insurance' shall include any business defined in section 3301 of this title, annuity contracts, and the business of health maintenance organizations and continuing care retirement communities."

VT. STAT. ANN. tit. 8, § 3301a.

**Can insurers transfer risk to providers?**

Vermont allows an "Accountable Care Organization" to assume financial risk from health insurers/HMOs. Entities that are not Accountable Care Organizations that accept financial risk may be practicing "insurance," as defined above.

"In order to be eligible to receive payments from Medicaid or commercial insurance through any payment reform program or initiative, including an all-payer model, each accountable care organization shall obtain and maintain certification from the Green Mountain Care Board. The Board shall adopt rules pursuant to 3 Vt. Stat. Ann. chapter 25 to establish standards and processes for certifying accountable care organizations."

VT. STAT. ANN. tit. 18, § 9382(a).

"'Payment reform' means modifying the method of payment from a fee-for-service basis to one or more alternative methods for compensating health care professionals, health care provider bargaining groups created pursuant to section 9409 of this title, integrated delivery systems, and other health care professional arrangements, manufacturers of prescribed products, medical supply companies, and other companies providing health services or health supplies for the provision of high-quality and efficient health services,

products, and supplies while measuring quality and efficiency. The term may include shared savings agreements, bundled payments, episode-based payments, and global payments."

VT. STAT. ANN. tit. 18, § 9373(12).

"'Accountable care organization' and 'ACO' means an organization of health care providers that has a formal legal structure, is identified by a federal taxpayer identification number, and agrees to be accountable for the quality, cost, and overall care of the patients assigned to it."

VT. STAT. ANN. tit. 18, § 9373(16).

**What requirements apply if an insurer transfers risk to a provider?**

The Green Mountain Care Board ("GMCB"), an entity separate from the Department of Financial Regulation, is responsible for payment and delivery system reform, including setting overall policy goals for the (payment reform) pilot projects. The Director of Payment Reform must develop and implement the payment reform pilot projects consistent with policies instituted by the GMCB, and the GMCB will evaluate the effectiveness of the pilot projects in order to inform the payment and delivery system reform.

As part of the ACO certification requirements, an "ACO must conduct ongoing assessments of its legal and financial vulnerabilities and have a process for reporting the results of these assessments to the ACO's governing body."

"An ACO must ensure that it maintains at all times an adequate level of financial stability and solvency. In addition to any other reporting the [Green Mountain Care] Board may require of an ACO and any monitoring activities it may undertake under other sections of this Rule, each risk-bearing ACO must submit quarterly financial reports or statements to the Board in a form or format specified by the Board to enable the Board to monitor the ACO's financial stability and solvency."

4 VT. CODE R. § 7-5:5.204.

"If an ACO wishes to bear risk during the next Budget Year, the ACO must propose and the Board must establish as part of the ACO's budget, a Risk Cap that the ACO can cover. The ACO must support its proposed Risk Cap with the following information as part of the ACO's budget proposal or during the next Budget Year or both, as required by the Board:

1. information specified by the Board regarding the ACO's maximum potential losses under the Risk Contracts it is a party to or seeks to become a party to and the threat that these losses may pose to the ACO's solvency, which information may include reports, certifications, and other representations prepared by an Actuary, a certified public accountant, an auditor, or other financial professional;

2. a full risk mitigation plan describing how the ACO would cover the losses it could incur under the Risk Cap (e.g., through reserves, collateral, or other liquid security; risk transfers to ACO Participants; or reinsurance, withholds, or other risk management mechanisms); and

3. any other information requested by the Board, which may include information on the ACO's plans to monitor the utilization of Contracted Services under its Risk Contracts."

4 VT. CODE R. § 7-5:5.403.

## HMO

**What regulatory body governs HMOs?**

Department of Financial Regulation

**What statutes govern HMOs?**

Vt. Stat. Ann. Tit. 8, Part 3, Ch. 139.

**Can an HMO transfer risk to providers?**

Vermont allows an "Accountable Care Organization" to assume financial risk from health insurers/HMOs. Entities that are not Accountable Care Organizations that accept financial risk may be practicing "insurance," as defined above.

"In order to be eligible to receive payments from Medicaid or commercial insurance through any payment reform program or initiative, including an all-payer model, each accountable care organization shall obtain and maintain certification from the Green Mountain Care Board. The Board shall adopt rules pursuant to 3 V.S.A. chapter 25 to establish standards and processes for certifying accountable care organizations."

VT. STAT. ANN. tit. 18, § 9382(a).

"'Payment reform' means modifying the method of payment from a fee-for-service basis to one or more alternative methods for compensating health care professionals, health care provider bargaining groups created pursuant to section 9409 of this title, integrated delivery systems, and other health care professional arrangements, manufacturers of prescribed products, medical supply companies, and other companies providing health services or health supplies for the provision of high-quality and efficient health services, products, and supplies while measuring quality and efficiency. The term may include shared savings agreements, bundled payments, episode-based payments, and global payments."

VT. STAT. ANN. tit. 18, § 9373(12).

"'Accountable care organization' and 'ACO' means an organization of health care providers that has a formal legal structure, is identified by a federal taxpayer identification number, and agrees to be accountable for the quality, cost, and overall care of the patients assigned to it."

VT. STAT. ANN. tit. 18, § 9373(16).

**What requirements apply if an HMO transfers risk to a provider?**

The Green Mountain Care Board ("GMCB"), an entity separate from the Department of Financial Regulation, is responsible for payment and delivery system reform, including setting overall policy goals for the (payment reform) pilot projects. The Director of Payment Reform must develop and implement the payment reform pilot projects consistent with policies instituted by the GMCB, and the GMCB will evaluate the effectiveness of the pilot projects in order to inform the payment and delivery system reform.

As part of the ACO certification requirements, an "ACO must conduct ongoing assessments of its legal and financial vulnerabilities and have a process for reporting the results of these assessments to the ACO's governing body."

"An ACO must ensure that it maintains at all times an adequate level of financial stability and solvency. In addition to any other reporting the [Green Mountain Care] Board may require of an ACO and any monitoring activities it may undertake under other sections of this Rule, each risk-bearing ACO must submit quarterly financial reports or statements to the Board in a form or format specified by the Board to enable the Board to monitor the ACO's financial stability and solvency."

4 VT. CODE R. § 7-5:5.204.

"If an ACO wishes to bear risk during the next Budget Year, the ACO must propose and the Board must establish as part of the ACO's budget, a Risk Cap that the ACO can cover. The ACO must support its proposed Risk Cap with the following information as part of the ACO's budget proposal or during the next Budget Year or both, as required by the Board:

1. information specified by the Board regarding the ACO's maximum potential losses under the Risk Contracts it is a party to or seeks to become a party to and the threat that these losses may pose to the ACO's solvency, which information may include reports, certifications, and other representations prepared by an Actuary, a certified public accountant, an auditor, or other financial professional;

2. a full risk mitigation plan describing how the ACO would cover the losses it could incur under the Risk Cap (e.g., through reserves, collateral, or other liquid security; risk transfers to ACO Participants; or reinsurance, withholds, or other risk management mechanisms); and

3. any other information requested by the Board, which may include information on the ACO's plans to monitor the utilization of Contracted Services under its Risk Contracts."

4 VT. CODE R. § 7-5:5.403(b).

# Value-Based Payments: A Comprehensive State Survey

## VIRGINIA

### Health Insurance

**What regulatory body governs health insurance?**

State Corporation Commission, Bureau of Insurance

**What statutes govern health insurance?**

Va. Code Ann. Tit. 38.2, Chs. 42, 58.

**How is "insurance" defined?**

"'Insurance' means the business of transferring risk by contract wherein a person, for a consideration, undertakes (i) to indemnify another person, (ii) to pay or provide a specified or ascertainable amount of money, or (iii) to provide a benefit or service upon the occurrence of a determinable risk contingency. Without limiting the foregoing, 'insurance' shall include (i) each of the classifications of insurance set forth in Article 2 (§ 38.2-101 *et seq*.) of this chapter and (ii) the issuance of group and individual contracts, certificates, or evidences of coverage by any health services plan as provided for in Chapter 42 (§ 38.2-4200 *et seq*.), health maintenance organization as provided for in Chapter 43 (§ 38.2-4300 *et seq*.), legal services organization or legal services plan as provided for in Chapter 44 (§ 38.2-4400 *et seq*.), dental or optometric services plan as provided for in Chapter 45 (§ 38.2-4500 *et seq*.), and dental plan organization as provided for in Chapter 61 (§ 38.2-6100 *et seq*.). 'Insurance' shall not include any activity involving a home service contract that is subject to regulation pursuant to Chapter 33.1 (§ 59.1-434.1 *et seq*.) of Title 59.1; an extended service contract that is subject to regulation pursuant to Chapter 34 (§ 59.1-435 *et seq*.) of Title 59.1; a warranty made by a manufacturer, seller, lessor, or builder of a product or service; or a service agreement offered by an automobile club as defined in subsection E of § 38.2-514.1."

VA. CODE ANN. § 38.2-100.

**Can insurers transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

# VIRGINIA

## HMO

**What regulatory body governs HMOs?**

State Corporation Commission, Bureau of Insurance

**What statutes govern HMOs?**

Va. Code Ann Tit. 38.2, Ch. 43

**Can an HMO transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an HMO transfers risk to a provider?**

None identified in statutes or regulations.

# Value-Based Payments: A Comprehensive State Survey

## WASHINGTON

### Health Insurance

**What regulatory body governs health insurance?**

Office of the Insurance Commissioner

**What statutes govern health insurance?**

Wash. Rev. Code, Tit. 48, Chs. 48.34, 48.39.

**How is "insurance" defined?**

"Insurance is a contract whereby one undertakes to indemnify another or pay a specified amount upon determinable contingencies."

WASH. REV. CODE § 48.01.040.

**Can insurers transfer risk to providers?**

Washington allows "Health Care Service Contractors" to enter into prepaid arrangements with health insurers/HMOs. Entities that are not Health Care Service Contractors that enter into such arrangements may be practicing "insurance," as defined above.

"'Health care service contractor' means any corporation, cooperative group, or association, which is sponsored by or otherwise intimately connected with a provider or group of providers, who or which not otherwise being engaged in the insurance business, accepts prepayment for health care services from or for the benefit of persons or groups of persons as consideration for providing such persons with any health care services."

WASH. REV. CODE § 48.44.010(9).

**What requirements apply if an insurer transfers risk to a provider?**

Regarding compensation to participating providers, all issuers must comply with the following: "If an issuer enters into a reimbursement agreement that is tied to health outcomes, utilization of specific services, patient volume within a specific period of time, or other performance standards, the issuer must file the reimbursement agreement with the commissioner thirty days prior to the effective date of the agreement, and identify the number of enrollees in the service area in which the reimbursement agreement applies. Such reimbursement agreements must not cause or be determined by the commissioner

to result in discrimination against or rationing of medically necessary services for enrollees with a specific covered condition or disease. If the commissioner fails to notify the issuer that the agreement is disapproved within thirty days of receipt, the agreement is deemed approved. The commissioner may subsequently withdraw such approval for cause."

WASH. ADMIN. CODE § 284-170-480(6).

## HMO

**What regulatory body governs HMOs?**

Office of the Insurance Commissioner

**What statutes govern HMOs?**

Wash. Rev. Code, Tit. 48, Chs. 48.46.

**Can an HMO transfer risk to providers?**

Washington allows "Health Care Service Contractors" to enter into prepaid arrangements with health insurers/HMOs. Entities that are not Health Care Service Contractors that enter into such arrangements may be practicing "insurance," as defined above.

"'Health care service contractor' means any corporation, cooperative group, or association, which is sponsored by or otherwise intimately connected with a provider or group of providers, who or which not otherwise being engaged in the insurance business, accepts prepayment for health care services from or for the benefit of persons or groups of persons as consideration for providing such persons with any health care services."

WASH. REV. CODE § 48.44.010(9).

**What requirements apply if an HMO transfers risk to a provider?**

Health care service contractors must register and maintain minimum net worth and reserves.

WASH. REV. CODE § 48.44.015; WASH. REV. CODE § 44.48.037.

Regarding compensation to participating providers, all issuers must comply with the following: “If an issuer enters into a reimbursement agreement that is tied to health outcomes, utilization of specific services, patient volume within a specific period of time, or other performance standards, the issuer must file the reimbursement agreement with the commissioner thirty days prior to the effective date of the agreement, and identify the number of enrollees in the service area in which the reimbursement agreement applies. Such reimbursement agreements must not cause or be determined by the commissioner to result in discrimination against or rationing of medically necessary services for enrollees with a specific covered condition or disease. If the commissioner fails to notify the issuer that the agreement is disapproved within thirty days of receipt, the agreement is deemed approved. The commissioner may subsequently withdraw such approval for cause.”

WASH. ADMIN. CODE § 284-170-480(6).

# WEST VIRGINIA

## Health Insurance

**What regulatory body governs health insurance?**

Offices of the Insurance Commissioner

**What statutes govern health insurance?**

W. Va. Code, Ch. 33, Art. 15.

**How is "insurance" defined?**

"'Insurance' is a contract whereby one undertakes to indemnify another or to pay a specified amount upon determinable contingencies."

W. VA. CODE § 33-1-1.

**Can insurers transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

## HMO

**What regulatory body governs HMOs?**

Offices of the Insurance Commissioner

**What statutes govern HMOs?**

W. Va. Code, Ch. 33, Art. 25a.

**Can an HMO transfer risk to providers?**

Not directly addressed in statutes, but statutes do contemplate "capitation" arrangements:

"'Capitation' means the fixed amount paid by a health maintenance organization to a health care provider under contract with the health maintenance organization in exchange for the rendering of health care services."

W. VA. CODE § 33-25A-2(2).

Regulations address "intermediaries," except "group practices," taking financial risk for reimbursing providers for health care services.

W. VA. CODE R. § 114-43-1 *et seq.*

**What requirements apply if an HMO transfers risk to a provider?**

None directly, but if an "intermediary" accepts financial risk from HMO for paying any providers, then such agreement must contain certain provisions and be approved, and the intermediary must show adequate reserves or a guarantee.

W. VA. CODE R. § 114-43-1 *et seq.*

# WISCONSIN

## Health Insurance

**What regulatory body governs health insurance?**

Office of the Commissioner of Insurance

**What statutes govern health insurance?**

Wis. Stat., Ch. 600 *et seq.*

**How is "insurance" defined?**

"'Insurance' includes any of the following:

1. Risk distributing arrangements providing for compensation of damages or loss through the provision of services or benefits in kind rather than indemnity in money.

2. Contracts of guaranty or suretyship entered into by the guarantor or surety as a business and not as merely incidental to a business transaction . . . ."

WIS. STAT. § 600.03.

**Can insurers transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

## HMO

**What regulatory body governs HMOs?**

Office of the Commissioner of Insurance

**What statutes govern HMOs?**

Wis. Stat., Ch. 609.

**Can an HMO transfer risk to providers?**

Not directly addressed in statutes or regulations, but risk transfer arrangements are contemplated in regulations:

"All applications for certificates of incorporation and certificates of authority of a health maintenance organization insurer or an insurer likened to write only limited service health organization business shall include a proposed business plan . . . . The following information shall be contained in the business plan . . . . The extent to which any of the following will be included in provider agreements . . . . Permit or require the provider to assume a financial risk in the health maintenance organization insurer, including any provisions for assessing the provider, adjusting capitation or fee-for-service rates, or sharing in the earnings or losses."

WIS. ADMIN. CODE INS. § 9.05(4)(b).

**What requirements apply if an HMO transfers risk to a provider?**

None identified in statutes or regulations.

# WYOMING

## Health Insurance

**What regulatory body governs health insurance?**

Insurance Department

**What statutes govern health insurance?**

Wyo. Stat. Tit. 26, Ch. 22.

**How is "insurance" defined?**

"'Insurance' means a contract in which one undertakes to indemnify another against loss, damage or liability arising from determinable hazards or fortuitous occurrences or to pay or allow a specified amount or determinable benefit in connection with ascertainable risk contingencies."

WYO. STAT. ANN. § 26-1-102.

**Can insurers transfer risk to providers?**

Not addressed in statutes or regulations.

**What requirements apply if an insurer transfers risk to a provider?**

None identified in statutes or regulations.

## HMO

**What regulatory body governs HMOs?**

Insurance Department

**What statutes govern HMOs?**

Wyo. Stat. Tit. 26, Ch. 34.

**Can an HMO transfer risk to providers?**

Not directly addressed in statutes or regulations, but risk transfer arrangements are contemplated in statute:

"'Capitated basis' means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value or frequency of services provided. For purposes of this definition, 'capitated basis' includes the cost associated with operating staff model facilities."

WYO. STAT. ANN. § 26-34-102(iii).

"'Managed hospital payment basis' means agreements under which the financial risk is primarily related to the degree of utilization rather than to the cost of services."

WYO. STAT. ANN. § 26-34-102(xx).

**What requirements apply if an HMO transfers risk to a provider?**

None identified in statutes or regulations.

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**About Epstein Becker Green**

Epstein Becker & Green, P.C., is a national law firm with a primary focus on health care and life sciences; employment, labor, and workforce management; and litigation and business disputes. Founded in 1973 as an industry-focused firm, Epstein Becker Green has decades of experience serving clients in health care, financial services, retail, hospitality, and technology, among other industries, representing entities from startups to Fortune 100 companies. Operating in locations throughout the United States and supporting domestic and multinational clients, the firm's attorneys are committed to uncompromising client service and legal excellence. For more information, visit www.ebglaw.com.