

House of Representatives, April 2, 1998. The Committee on Public Health reported through REP. MCDONALD, 148th DIST., Chairman of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING PROVIDER SPONSORED ORGANIZATIONS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. (NEW) As used in sections 1 to 4,
2 inclusive, of this act:

3 (1) "Department" means the Insurance
4 Department;

5 (2) "Commissioner" means the Insurance
6 Commissioner;

7 (3) "ERISA" means the Employee Retirement
8 Income Security Act of 1974, 29 USC Section 1001
9 et seq., as amended;

10 (4) "Health benefit plan" means: (A) Any
11 hospital or medical expense policy or certificate;
12 (B) nonprofit hospital, medical surgical and
13 health service corporation contract or
14 certificate; (C) a health benefit plan offered by
15 a provider sponsored integrated health delivery
16 network; (D) a self-insured plan or a plan
17 provided by a multiple employer welfare
18 arrangement, to the extent permitted by ERISA; (E)
19 health maintenance organization contract; and (F)
20 standard and supplemental health benefit plans;

21 (5) "Insurer" means: (A) A provider sponsored
22 integrated health delivery network that offers a

23 health benefit plan and that complies with the
24 financial and other criteria established by the
25 department to protect against financial insolvency
26 and to assure capability of providing required
27 services; and (B) a person who provides health
28 benefit plans in this state and is subject to
29 insurance regulation in this state, including an
30 authorized insurance company, health maintenance
31 organization, self-insurer or multiple welfare
32 arrangement not exempt from state regulation by
33 ERISA, and nonprofit hospital, medical surgical,
34 dental and health service corporation;

35 (6) "Provider sponsored integrated health
36 delivery network" and "provider sponsored network"
37 means an organization that is wholly owned,
38 governed and managed by health care providers and
39 that provides directly, or through arrangements
40 with others, a health benefit plan to consumers
41 voluntarily enrolled with the network on a per
42 capita or a predetermined, fixed prepayment basis.

43 Sec. 2. (NEW) (a) A provider sponsored
44 integrated health delivery network may be created
45 by health care providers for the purpose of
46 providing health care services.

47 (b) No person in this state shall be, act as
48 or hold itself out as a provider sponsored
49 integrated health delivery network unless it holds
50 a certificate of filing from the commissioner.

51 (c) An applicant for a certificate of filing
52 as a provider sponsored integrated health delivery
53 network shall submit information acceptable to the
54 commissioner to satisfactorily demonstrate that
55 the applicant:

56 (1) Is composed of participating providers
57 who are licensed and in good standing with the
58 appropriate licensing authority;

59 (2) Has demonstrated the capacity to
60 administer the health plans it is offering;

61 (3) Has the ability, experience and structure
62 to arrange for the appropriate level and type of
63 health care services;

64 (4) Has the ability, policies and procedures
65 to conduct utilization management activities;

66 (5) Has the ability to achieve, monitor and
67 evaluate the quality and cost effectiveness of
68 care provided by its provider network;

69 (6) Meets financial solvency requirements, as
70 set forth in section 3 of this act;

71 (7) Has the ability to assure enrollees
72 adequate access to providers, including geographic
73 availability and adequate numbers and types;

74 (8) Has the ability and procedures to monitor
75 access to its provider network;

76 (9) Has a satisfactory grievance procedure
77 and the ability to respond to enrollees' inquiries
78 and complaints;

79 (10) Does not limit the participation of any
80 health care provider in its provider network in
81 another provider network;

82 (11) Has the ability and policies that allow
83 patients to receive care in the most appropriate,
84 least restrictive setting;

85 (12) Does not discriminate in enrolling
86 members;

87 (13) Participates in coordination of
88 benefits;

89 (14) Uses standardized electronic claims and
90 billing processes and formats;

91 (15) Discloses cooperative reimbursement
92 arrangements with providers; and

93 (16) Assures that all services covered by the
94 provider sponsored integrated health delivery
95 network are available to all persons enrolled in
96 the plan within a reasonable distance of each
97 person's place of residence, to the extent those
98 services are available within that area, and
99 assures that all services not available therein
100 are offered at sites as near to the enrollee as
101 possible.

102 (d) The commissioner shall issue a
103 certificate of filing to an applicant if the
104 commissioner finds that the applicant has met the
105 requirements of subsection (c) of this section.

106 Sec. 3. (NEW) (a) To qualify as a provider
107 sponsored integrated health delivery network, an
108 organization shall meet the requirements set forth
109 in subsections (b) to (j), inclusive, of this
110 section.

111 (b) The provider sponsored network shall
112 maintain a fidelity bond or fidelity insurance in
113 an amount not less than two hundred fifty thousand
114 dollars on employees and officers, directors and
115 partners who receive, collect, disburse or invest
116 funds of the provider sponsored network.

117 (c) The provider sponsored network shall have
118 an initial net worth of, or surety bond for, one

119 million five hundred thousand dollars and shall
120 thereafter maintain the minimum net worth required
121 under subsection (d) of this section.

122 (d) Every provider sponsored network shall
123 maintain a minimum net worth equal to the greater
124 of:

125 (1) One million dollars;

126 (2) Two per cent of annual premium revenues
127 as reported on the most recent annual financial
128 statement filed with the commissioner on the first
129 one hundred fifty million dollars of premiums and
130 one per cent of annual premiums on the premiums in
131 excess of one hundred fifty million dollars;

132 (3) An amount equal to the sum of three
133 months uncovered health care expenditures as
134 reported on the most recent financial statement
135 filed with the commissioner; or

136 (4) An amount equal to the sum of eight per
137 cent of annual health care expenditures, except
138 for those paid on a capitated basis or managed
139 hospital payment basis, and four per cent of
140 annual hospital expenditures paid on a managed
141 hospital payment basis as reported on the most
142 recent financial statement filed with the
143 commissioner.

144 (e) In determining net worth, no debt shall
145 be considered fully subordinated unless the
146 subordination clause is in a form acceptable to
147 the commissioner. Any interest obligation relating
148 to the repayment of any subordinated debt shall be
149 similarly subordinated. The interest expenses
150 relating to the repayment of any fully
151 subordinated debt shall be considered covered
152 expenses. Any debt incurred by a note meeting the
153 requirements of this section, and otherwise
154 acceptable to the commissioner, shall not be
155 considered a liability and shall be recorded as
156 equity.

157 (f) Unless otherwise provided in this
158 section, each provider sponsored network shall
159 deposit with the commissioner or, at the
160 discretion of the commissioner, with any
161 organization or trustee acceptable to the
162 commissioner through which a custodial or
163 controlled account is utilized, cash, securities
164 or any combination of cash or securities or other
165 measures that are acceptable to the commissioner
166 that at all times have a value of not less than

167 three hundred thousand dollars. The deposit shall
168 be an admitted asset of the provider sponsored
169 network in the determination of net worth. All
170 income from deposits shall be an asset of the
171 provider sponsored network. A provider sponsored
172 network that has made a securities deposit may
173 withdraw that deposit or any part thereof after
174 making a substitute deposit of cash, securities or
175 any combination of cash or securities or other
176 measures of equal amount and value. Any securities
177 shall be approved by the commissioner before being
178 deposited or substituted. The deposit shall be
179 used to protect the interests of the provider
180 sponsored network's enrollees and to assure
181 continuation of health care services to enrollees
182 of a provider sponsored network that is in
183 rehabilitation or conservation. The commissioner
184 may use the deposit for administrative costs
185 directly attributable to a receivership or
186 liquidation. If the provider sponsored network is
187 placed in a receivership or liquidation, the
188 deposit shall be deemed an asset.

189 (g) Each provider sponsored network shall,
190 when determining liabilities, include an amount
191 estimated in the aggregate to provide for any
192 unearned premium and for the payment of all claims
193 for health care expenditures that have been
194 incurred, whether reported or unreported, that are
195 unpaid and for which the provider sponsored
196 network is or may be liable and to provide for the
197 expense of adjustment or settlement of such
198 claims.

199 (h) Each contract between a provider
200 sponsored network and a participating provider of
201 health care services shall be in writing and shall
202 set forth that, in the event the provider
203 sponsored network fails to pay for health care
204 services as set forth in the contract, the
205 enrollee shall not be liable to the provider for
206 any sums owed by the provider sponsored network.
207 If the participating provider contract has not
208 been reduced to writing as required by this
209 subsection or if the contract fails to contain the
210 required prohibition, the participating provider
211 shall not collect or attempt to collect from the
212 enrollee sums owed by the provider sponsored
213 network.

214 (i) Each provider sponsored network shall
215 have a plan for handling insolvency that
216 guarantees the continuation of benefits for the
217 duration of the contract period for which premiums
218 have been paid and continuation of benefits to
219 members who are confined on the date of insolvency
220 in an inpatient facility until their discharge or
221 expiration of benefits.

222 (j) If at any time uncovered expenditures
223 exceed ten per cent of total health care
224 expenditures, a provider sponsored network shall
225 place an uncovered expenditures insolvency deposit
226 with the commissioner or with any organization or
227 trustee acceptable to the commissioner through
228 which a custodial or controlled account is
229 maintained, in cash or securities that are
230 acceptable to the commissioner. This deposit shall
231 at all times have a fair market value in an amount
232 of one hundred twenty per cent of the provider
233 sponsored network's outstanding liability for
234 uncovered expenditures for enrollees, including
235 incurred but not reported claims, and shall be
236 calculated as of the first day of the month and
237 maintained for the remainder of the month. The
238 provider sponsored network shall file a report
239 within forty-five days of the end of the calendar
240 quarter with information sufficient to demonstrate
241 compliance with this subsection. The provisions of
242 subsection (i) of this section shall apply to the
243 deposit required in this subsection.

244 Sec. 4. (NEW) The commissioner may adopt
245 regulations, in accordance with chapter 54 of the
246 general statutes, in order to effect the
247 provisions of sections 1 to 3, inclusive, of this
248 act.

249 STATEMENT OF LEGISLATIVE COMMISSIONERS: In section
250 1, a definition of "guaranteed issue basis" was
251 deleted as unnecessary in that the term is not
252 used in the bill. Subdivision (5) of section 1 was
253 given subparagraph designators for clarity.
254 Sections 2 and 3 were reversed in order for
255 clarity and consistency with the usual order of
256 statutes. In section 2(c) "To qualify as a
257 provider ... and applicant" was changed to "An
258 applicant for a certificate of filing as a
259 provider ..." for clarity and "the provider ...:"
260 was changed to "the applicant:" Section 2(c)(1)

261 was reworded for clarity. Section 2(c)(6) was
262 reworded for consistency. Subsection (d) was added
263 to section 2 to make it clear, consistent with
264 subsection (b), how the applicant obtains a
265 certificate of filing. In section 3(a), "the
266 network" was changed to "an organization" for
267 clarity and consistency with the bill's definition
268 of "network" in subdivision (6) of section 1, and
269 "financial solvency requirements" was changed to
270 "requirements" for consistency with the
271 requirements set forth in the bill. In section
272 2(c), "initial net worth requirement" was changed
273 to "initial net worth" for clarity.

274 PH COMMITTEE VOTE: YEA 23 NAY 0 JFS

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"THE FOLLOWING FISCAL IMPACT STATEMENT AND BILL ANALYSIS ARE PREPARED FOR THE BENEFIT OF MEMBERS OF THE GENERAL ASSEMBLY, SOLELY FOR PURPOSES OF INFORMATION, SUMMARIZATION AND EXPLANATION AND DO NOT REPRESENT THE INTENT OF THE GENERAL ASSEMBLY OR EITHER HOUSE THEREOF FOR ANY PURPOSE."

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FISCAL IMPACT STATEMENT - BILL NUMBER SHB 5404

STATE IMPACT Cost (Insurance Fund), see below

MUNICIPAL IMPACT None

STATE AGENCY(S) Department of Insurance

	Current FY	1998-99	1999-2000
State Cost	:	:	:
(savings)	:	126,052	126,052
St Revenue	:	:	:
(loss)	:	:	:
Net St Cost	:	:	:
(savings)	:	:	:
Municipal	:	:	:
Impact	:	:	:

EXPLANATION OF ESTIMATES:

The bill requires the Department of Insurance to certify provider sponsored organizations. Some of the items the department must review are the following:

- 1) Financial standing
- 2) Capacity to administer health plans
- 3) Policies and procedures to conduct utilization review activities
- 4) Claims and billing processes

To carry out this responsibility, the department would need the following positions:

1 examiner in house @ \$47,463	\$47,463
1 field examiner @ \$47,463	\$47,463
fringe benefits	<u>\$31,126</u>
	\$126,052

While the Department of Insurance does not regulate provider sponsored organizations at the present time, there is a regulatory structure in place for HMO's. This could provide some related expertise to the department.

The department will also be required to adopt regulations which can be handled within resources.

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OLR BILL ANALYSIS

sHB 5404

AN ACT CONCERNING PROVIDER SPONSORED ORGANIZATIONS

SUMMARY: The bill specifically regulates provider-sponsored organizations (called "provider-sponsored integrated health delivery networks" by the bill). The insurance commissioner must certify such networks in order for them to operate in the state. Each provider-sponsored network must meet a variety of solvency standards, including initial and minimum net worth, minimum deposits to protect the interests of the network's enrollees, and contract provisions addressing liability and continuation of benefits in the event of insolvency.

To be certified, the network must also show that it has an adequate provider network to serve its enrollees, has the capacity to administer the health plans it offers, can conduct utilization management, can monitor and evaluate the quality and cost effectiveness of the care provided, has a satisfactory grievance procedure for enrollees, and meets other requirements related to service delivery and management.

The bill allows the commissioner to adopt implementing regulations.

EFFECTIVE DATE: October 1, 1998.

FURTHER EXPLANATION**Definitions**

The bill defines a "provider-sponsored integrated health delivery network" as an organization that is wholly owned, governed, and managed by health care providers, and that provides directly, or through arrangements with others, a health benefit plan to consumers voluntarily enrolled with the organization on a per capita or a predetermined, fixed prepayment basis. A "health benefit plan" is any hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; a health benefit plan offered by a provider-sponsored integrated health delivery network; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by the federal Employee Retirement Insurance Security Act (ERISA); a health maintenance organization contract; and standard and supplemental health benefit plan.

Certification

The bill allows health care providers to create provider-sponsored integrated health delivery networks to provide health care services. To do so, a provider-sponsored network must obtain a certificate of filing from the insurance commissioner before it can act or hold itself out as a provider-sponsored integrated health delivery network.

The integrated network must submit information acceptable to the commissioner that satisfactorily demonstrates that it:

1. is licensed and in good standing with the licensure boards for participating providers;
2. has demonstrated the capacity to administer the health plans it is offering;
3. has the ability, experience, and structure to arrange for the appropriate level and type of health care services;
4. has the ability, policies, and procedures to

- conduct utilization management activities;
5. has the ability to achieve, monitor, and evaluate the quality and cost effectiveness of care provided by its provider network;
 6. meets the financial solvency requirements;
 7. has the ability to assure adequate access to providers, including geographic availability and adequate numbers and types;
 8. has the ability to monitor access to its provider network;
 9. has a satisfactory grievance procedure and the ability to respond to enrollees' inquiries and complaints;
 10. does not limit the participation of its care providers in another network;
 11. has the ability and policies that allow patients to receive care in the most appropriate, least restrictive setting;
 12. does not discriminate when enrolling members;
 13. participates in coordination of benefits;
 14. uses standardized electronic claims and billing processes;
 15. discloses reimbursement arrangements with providers; and
 16. assures that all services covered by the network are available to all persons enrolled in the plan within a reasonable distance of each person's place of residence, to the extent those services are available within that area, and assures that all services not available are offered at sites as close to the enrollee as possible.

The commissioner must issue the certificate of filing if he finds that the applicant meets these requirements.

Financial Solvency

Fidelity Bond or Insurance. Under the bill, each provider-sponsored integrated health delivery network must maintain a fidelity bond or fidelity insurance of at least \$250,000 on employees and officers, directors, and partners who receive, collect, disburse, or invest network funds.

Net Worth. Under the bill, a network must have an initial net worth or surety bond for \$1.5 million. It must then maintain a minimum net worth equal to the greater of: (1) \$1 million; (2) 2% of annual premium revenues as reported on the most recent annual financial statement filed with the commissioner on the first \$150 million of premiums and 1% of annual premium revenues on premiums in excess of \$150 million; (3) an amount equal to the sum of three months' uncovered health care expenditures as reported on the most recent financial statement filed with the commissioner of insurance; or (4) an amount equal to the sum of 8% of annual health care expenditures except those paid on a capitated basis or managed hospital payment basis and 4% of annual hospital expenditures paid on a managed hospital payment basis as reported on the most recent financial statement filed with the commissioner.

In determining net worth under the bill, a debt cannot be considered fully subordinated unless the subordination clause is in a form acceptable to the commissioner. (Generally, a subordinated debt is one retained by the provider service network to meet net worth requirements.) Any interest obligation related to the repayment of a subordinated debt must be similarly subordinated. Interest expenses related to repayment of a fully subordinated debt must be considered covered expenses. Any debt incurred by a note that meets the bill's requirements and acceptable to the commissioner must not be considered a liability and must be recorded as equity.

Deposits. The bill requires each network to deposit with the commissioner (or, at the commissioner's discretion, with any organization or trustee acceptable to him) cash, securities, or any combination of other measures acceptable to him that at all times have a value of at least \$300,000. The deposit is an admitted asset of the network in determining net worth. All

income from deposits is an asset of the network. A network that has made a securities deposit can withdraw that deposit or any part after making a substitute deposit of cash, securities, or any combination of other measures of equal amount and value. The commissioner must approve any securities before their deposit or substitution.

The deposit must be used to protect the interests of the network's enrollees and to assure continuation of health care services to enrollees of a network in rehabilitation or conservation. The commissioner can use the deposit for administrative costs directly attributable to a receivership or liquidation.

Liabilities. Every network, when determining liabilities, must include an amount estimated in the aggregate to provide for any unearned premium and for payment of all claims for health care expenditures which have been incurred, which are unpaid and for which the network is or may be liable, and to provide for the expense of adjustment or settlement of such claims.

Contract Provisions. Every contract between a provider-sponsored network and a participating provider of health services must be in writing and state that in the event the network fails to pay for services as set forth in the contract, the enrollee is not liable to the provider for any sums owed by the network.

Insolvency and Continuation of Benefits. Each network must have a plan for handling insolvency that guarantees the continuation of benefits for the duration of the contract period for which premiums have been paid. It must also guarantee continuation of benefits to members who are confined on the date of the insolvency in an inpatient facility until their discharge or expiration of benefits.

If at any time uncovered expenditures exceed 10% of total health care expenditures, the network must place an uncovered expenditures insolvency deposit with the commissioner or with any organization or trustee acceptable to the commissioner, in cash or securities that are acceptable to the commissioner. This deposit must at all times have a fair market value of 120% of the network's outstanding liability for uncovered

expenditures for enrollees, including incurred but not reported claims. It must be calculated on the first of the month and maintained for the remainder. The network must file a report within 45 days of the end of the calendar quarter with information sufficient to show compliance with this section.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 23 Nay 0