Comments to House Bill 2724 – Retainer Dental Practice
House Committee on Health Care

- Willamette Dental began as a dental practice in 1970. It began to accept the risk of providing dental services for members through Blue Cross in 1974. In the mid-1980s, Willamette developed plans that HB 2724 contemplates today. At that time, Willamette had four offices in Portland and 14 dentists. Oregon, following the same rules as other states, defined this activity as insurance and required a certificate of authority issued by DCBS.

- As drafted, HB 2724 would overturn existing law of insurance: "*an agreement between one or more health care providers and one or more purchasers of health care services constitutes the transaction of insurance * * * if the providers are compensated for the actual or potential delivery of health care services in a manner that involves risk sharing such as capitation, a fixed or "global" payment, or any similar arrangement.*" See attached DCBS Bulletin INS 96-2, section B. In this arrangement an insured pays a fixed periodic payment to the provider in exchange for the provider's assumption of the risk to deliver an unpredictable volume of services and to absorb the unknown future costs of such care. Willamette Dental's first plan was $50.00 per year – the covered member could receive an annual exam, cleaning and X-rays for this fee. All other services delivered to the patient were charged at a reduced fee for service rate. This kind of benefit plan constitutes the transaction of insurance.

- These arrangements have been defined as insurance because of the risk shift to the provider and the potential of harm to the consumer. Among other things, an Oregon insurer must: (i) file policy forms to be reviewed and approved by DCBS, (ii) include state and federal coverage mandates, (iii) file individual plan rates for DCBS approval, (iv) meet and maintain regulated financial reserves and solvency requirements, (v) submit financial statements, and (vi) undergo strict scrutiny of DCBS audits of market conduct and financial health.

- Because we must comply with the law, we have had to turn away potential business opportunities - most recently with a group that did not want to include coverage of domestic partners (a required offering for state regulated insurance in Oregon). We advised the group that we could not issue a policy without the domestic partner coverage. The group asked if we could do a direct retainer agreement with them to circumvent the Insurance Code. We had to say "no" because the assumption of risk is the transaction of insurance. To transact insurance requires a valid Certificate of Authority and the issuance of an insurance policy in conformance with the law, including domestic partner coverage.

- We testified in 2011 against SB 86 – Retainer Medical Practice. Dental was excluded. Dental should continue to be excluded. Dentistry is primary care and HB 2724 permits unfettered primary care agreements with consumers. In effect the legislature would be creating an unregulated insurance product for dentistry. The creation of a new and slanted playing field is inherently unfair and not in the best interests of consumers.

- Thank you for the opportunity to testify.

Willamette Dental Group
If you have questions about this testimony, please contact Doug Barber at (541) 221-3072

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INSURANCE DIVISION BULLETIN INS 96-2

TO: All Interested Parties

FROM: Kerry Barnett, Insurance Commissioner

SUBJECT: Application of the Insurance Code to Health Benefit Arrangements That Include Provider Risk Sharing

DATE: April, 1996

The delivery and financing of health care services are undergoing rapid evolution. One of the prominent trends has been the expansion of risk sharing arrangements with participating health care providers. This bulletin is intended to advise interested parties about the circumstances in which such arrangements constitute the transaction of insurance and are subject to regulation under the Insurance Code.

A. **The Transaction of Insurance:** Oregon law defines insurance as, "A contract whereby one undertakes to indemnify another or pay or allow a specified or ascertainable amount or benefit upon determinable risk contingencies," (ORS 731.102). The transaction of insurance is defined as, "Making or proposing to make an insurance contract," (ORS 731.146). All persons transacting insurance in Oregon shall comply with the Insurance Code (ORS 731.022) and must obtain a certificate of authority from the Insurance Division (O RS 731.354 and, for health care service contractors, ORS 731.026 and 750.055).

B. **When Provider Risk Sharing Constitutes the Transaction of Insurance:** An agreement between one or more health care providers and one or more purchasers of health care services constitutes the transaction of insurance if the following conditions exist:

The purchaser(s) are individuals or entities that have not been issued a certificate of authority and are not specified in the Insurance Code as exempt; and

The provider(s) are compensated for the actual or potential delivery of health care services in a manner that involves risk sharing such as capitation, a fixed or "global" payment, or any similar arrangement.

Questions and Answers:

Q1

How does the federal Employee Retirement Income Security Act (ERISA) affect the treatment of a provider risk sharing arrangement under the Insurance Code?

A1

ERISA specifies that the regulation of insurance is a matter of state jurisdiction. If providers engage in a risk sharing arrangement as described in section B above, they are transacting insurance and such activity is subject to the Insurance Code. Although employee benefit plans that are operated on a "self-funded" or "self-insured" basis are exempt from state regulation

under ERISA, a provider risk sharing arrangement with a plan sponsor does not operate on a self-insured or self-funded basis. Rather, by its very nature, such an arrangement creates the transaction of insurance by establishing a transfer of risk from the plan sponsor to the providers.

Q2

Are providers who are compensated on a capitated basis by a health insurer or health care service contractor (HCSC) required to obtain a certificate of authority?

A2

Not 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. Important Note: Providers would need a certificate of authority if the capitation arrangement were separate from a policy of insurance. F or instance, 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 .

Q3

Is an arrangement in which providers are compensated on a discounted fee-for-service basis considered to be a risk sharing arrangement?

A3

Not if the arrangement is truly fee-for-service (i.e., a fee is payable for each service that is rendered) and the discounts are explicit and limited. Similarly, a sliding scale of discounts may be established, but the scale must have explicit and reasonable limits, e.g., "Discounts of 5% to 20% will be applied, depending on total patient volume." An open-ended scale, or one with extreme limits, would constitute a risk sharing arrangement because it would transfer an open-ended or virtually open-ended portion of risk to the providers. Important Note: The use of a fee-for-service schedule within a capitated arrangement would still constitute the transaction of insurance. Insurance exists if the purchaser pays on a capitated basis, even if payments are allocated to individual providers within the contracting group on a fee-for-service basis.

Q4

Is an arrangement in which providers are compensated on a fee-for-service basis, subject to withholds, considered to be a risk sharing arrangement?

A4

Not if the arrangement is truly fee-for-service and the withholds are explicit, limited, and reasonable (see A3 above).

Q5

Is an arrangement in which providers are compensated on a per-case basis (e.g., a DRG basis or a packaged-service basis) considered to be a risk sharing arrangement?

A5

Not if the arrangement is truly fee-for-service (see A3 above). Risk sharing would exist if fixed or prepaid compensation is paid for an uncertain number of future cases.

_______(signed)_______

Kerry Barnett, Director and
Insurance Commissioner