REHABILITATION OF MANAGED CARE ORGANIZATIONS:

A THUMBNAIL SKETCH OF

CERTAIN KEY CONSIDERATIONS

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INTRODUCTION

This brief article seeks to provide an overview of four critical aspects of the rehabilitation of an insolvent or impaired managed care organization ("MCO"). It will address first the problems a rehabilitator is likely to face immediately upon seizure of the organization. Attention will then turn in the second section to issues in the preservation of the health care provider network. Consideration will be given in the third section to certain matters in the "back office". The fourth and final section will address preservation of the customer base. The brevity of this article precludes detailed consideration of any of these topics and an assumption is made that the reader is familiar with the fundamentals of rehabilitation and liquidation of insurers. While the aim of the following paragraph is to provide useful and practical suggestions for the actual management of a managed care rehabilitation, it is not intended to constitute a comprehensive checklist of the items to which the rehabilitator should address himself. There exists a growing body of literature that can serve as useful references for the fundamentals of rehabilitations and liquidations, a key component of which is the NAIC *Receivers Handbook for Insurance Company Insolvencies.*[2] The reader may also benefit from reference to the NAIC's *Health Maintenance Organization Model Act* ("Model Act") and the corresponding statute in the state in which the reader is interested.

I. IMMEDIATE PRIORITIES

Though certainly not exhaustive, the list of problems on which the rehabilitator must focus his attention immediately after seizure includes control of the organization, addressing patient care needs, and the dissemination of information.

A. CONTROL OF THE ORGANIZATION

The seizure of control of a MCO is a matter that is not dissimilar from the issues that arise in any insurer or similar insolvency. Suffice it for our purposes to note that it is essential to obtain unrestricted control of the assets of the organization, including its cash, lines of credit, reinsurance recoveries and other sources of funding. Equally important is

effective control of the physical plant, including all offices, data processing and management information systems, equipment, and books and records.

A principal respect in which these issues may present themselves differently in the context of the MCO than in the context of an insurer insolvency arises from the possibility that bankruptcy proceedings may also be instituted for the organization by management or a frustrated creditor. In that event, a jurisdictional contest may ensue the resolution of which will be of critical importance to the rehabilitator. While a detailed discussion of these issues is beyond the scope of this paper, it may be helpful to note that the current state of American law with respect to the availability of bankruptcy jurisdiction for insolvent health maintenance organizations ("HMOs") generally tends to favor state insurance proceedings such as to require that bankruptcy proceedings be abated or dismissed.[3] However, the facts of each case are of critical importance and the U.S. Supreme Court has not addressed this subject. But it is important to note that a bankruptcy proceeding is likely to divest the insurance commissioner or other state regulator of jurisdiction or, at a minimum, to substantially impede his or her ability to discharge rehabilitation responsibilities and perform associated functions.

B. PATIENT CARE

Having achieved control of the organization, an equally important priority is that surrounding the delivery of health care to the MCO's subscribers or members. In at least four circumstances, patient care needs may present urgent problems. The first arises in the context of medical emergencies. Remembering that MCOs (unlike insurers) play a substantial and very active role in the actual delivery of health care (as distinguished from simply financing it), provision must be made immediately by the rehabilitator to assure that members will receive emergency medical care when necessary. To achieve this goal the rehabilitator must assure that hospitals, physicians, ambulance services and other health care providers to whose services the members are contractually entitled will continue to provide such services despite the financial difficulties faced by the MCO. Assuring the availability of such services in the event of emergencies may require nothing more than contacting the relevant providers to remind them of what are likely to be their contractual or statutory obligations to continue providing care and to assure that they will abide by such obligations. There may, of course, be other ethical and legal requirements imposing a similar duty on the health care providers and it may be helpful to remind them of those as well. The issue of how to deal with recalcitrant providers will be addressed in more detail below.

Equally important will be the need to assure that subscribers or members confined in health care facilities (hospitals, hospices, nursing homes and the like) on the date of seizure will continue to receive uninterrupted health care. Specifically, steps must be taken to assure that confined individuals are not discharged prematurely or do not face reductions in health care services as the result of the MCO's misfortunes. Again, this point can be addressed by immediate contact with the relevant health care facilities. It may be necessary to make special arrangement for the facilities to assure that payment will be made for prospective care, even if payment due in arrears cannot yet be made due

to applicable priority schemes or other constraints. In most instances, assurances that prospective payment will be made (typically defensible as a cost of administering the estate) suffices to continue treatment that has commenced prior to the seizure. More importantly, however, such facilities may be obligated to continue providing such care without prospective payment guaranties under terms of contracts in force or applicable statutes. The rehabilitator should review these sources before contacting the providers. If possible, such review should take place even before the seizure.

A comparable concern may arise with respect to pregnant subscribers. Given the importance of adequate prenatal care (for the health of both the mother and the child), it is incumbent on the rehabilitator to assure that such care will not be interrupted because of the MCO's seizure. Lamentably, there exists a sordid history of difficulty on the part of pregnant subscribers of troubled MCOs in obtaining appointments for prenatal checkups or other prenatal care, including scheduling of confinement for delivery. Notwithstanding contractual or other obligations to provide care even in the case of insolvency, there have certainly been episodes in which obstetricians have frustratingly been unable to find on their calendars slots for prenatal office visits of such individuals. Such providers should again be reminded of their obligations. When that does not suffice, the rehabilitator may be compelled to make alternate arrangements by enlisting the assistance of non-participating obstetricians upon promises of guaranteed prospective payment. In smaller communities, however, that may be difficult. For example, the author wrestled with one such situation in which all of the obstetricians in the MCO's community were contracting providers who in a cartel-like fashion refused entirely to provide obstetric services to the HMO. In that instance, therefore, it became necessary to make arrangements with obstetricians from a neighboring community to provide such care. Such arrangements are expensive, burdensome, and awkward, and the need for them should be avoided if at all possible. In addition, the rehabilitator should take the necessary steps to assure that the hospitals in which participating obstetricians have privileges will facilitate the confinement of the subscriber at the required time. Again, contractual and statutory obligations may be dispositive but candid discussions with the institutions may nonetheless be necessary.

Finally, in the category of urgent patient care, attention should be devoted to the needs of chronically ill patients who find themselves in a continuous course of treatment, frequently from specialists, not simply primary care providers. Again, the contractual arrangement in effect with such specialists should be reviewed to ascertain what obligations they have to continue providing such care if the MCO becomes insolvent. If a satisfactory answer cannot be found in relevant statutes or contracts, it may be necessary to make an ad hoc arrangement with each such provider to guarantee partial or complete prospective payments so that care is delivered without interruption. Similar arrangements may be necessary with therapeutic and diagnostic facilities which play a role in the necessary course of medical treatment.

C. PUBLIC INFORMATION

Another area of immediate concern to which the rehabilitator should devote his or her efforts involves the dissemination of information. Unfortunately, the insolvency or near-insolvency of a MCO frequently receives adverse publicity without the control of the rehabilitator or state regulators. In such instances, mitigation of the adverse results is both possible and necessary. Most effective in many such cases is the dissemination of balancing information. Thus, where the printed or electronic media announces the demise of the MCO in terms which dramatize the adverse impact on the delivery of health care and the continuation of coverage, the panic or severe concern which is likely to ensue must be prevented or at least minimized by more factual and positive information disseminated by the rehabilitator. The very same print and electronic media can typically be persuaded to run balancing stories, indeed may be very interested in doing so. To achieve the best result, the rehabilitator should first compile and organize through careful thought the information he or she intends to disseminate. Such information typically must include appropriate assurances about the continued availability of health care for those in need of such services, information about the continuation of coverage, information about the availability of "safety nets" such as guaranty fund coverage and the like where available, and (if possible) quotes from key health care providers incorporating helpful assurances.

Beyond such public information, equally important is the dissemination of more specific information to affected constituencies, such as health care providers, employers or enrolled groups, reinsurers and lenders. Typically such constituencies become most alarmed when they learn from third parties of the MCO's insolvency and, in the absence of favorable information, will tend to jump to the most adverse conclusions. The conduct that will follow such conclusions, not surprisingly, is likely to be disadvantageous to the rehabilitator. To prevent this, therefore, it is useful for the rehabilitator to contact such constituencies early in the process explaining to the maximum degree possible the circumstances in which the MCO finds itself (so as to prevent even more dire assumptions) and providing a preview of the measures that the rehabilitator will implement for the protection of such constituencies. Thus, by way of illustration, health care providers can be told that arrangements will be made for prospective payments in short order even if payment of amounts due for care delivered prior to the seizure may have to be postponed to a less definite date.

II. PRESERVATION OF THE PROVIDER BASE

What MCOs do for a living is to arrange for the delivery of health care services to enrolled populations on a prepaid basis. They do so by entering into contractual arrangements (the nature of which may vary along a broad spectrum of structures that are the fruit of imaginative lawyers and managers) with the entire array of health care providers. With few exceptions, primary care physicians (general practitioners, family physicians and, in at least some cases, obstetricians and internists) become principally

responsible for designing and implementing a program of health care for each enrolled subscriber. In many MCOs these primary care physicians serve the role of "gatekeepers" and must approve access by the patients to specialists or other health care facilities. It is not atypical in such cases that the primary care physician shares with the MCO benefits of successful utilization control and the adverse results of over utilization. In many cases such primary care physicians are compensated on a "capitation" basis pursuant to which each such physician is paid a flat monthly fee for each member assigned to him or her regardless of the number of times the physician sees the member during the month. By contrast, specialists and other facilities most commonly enter into contractual arrangement with the MCO under which they are paid on a fee for service basis although, hopefully, the fees are discounted or are otherwise made more advantageous than those which would be paid by other patients. In any event, the mature MCO has direct or indirect contractual relationships with the entire spectrum of health care providers whose services are necessary to fulfill the MCO's contractual obligations to the subscribers. Under the Model Act and in most states, governing statutes require that such providers agree in their contracts to continue providing care for some period of time following the cessation of business of a MCO even if compensation is not forthcoming. The period of time during which that obligation persists, however, is generally limited to three to six months. Rehabilitation of the organization requires a longer commitment from the providers, and fundamentally, the confidence of the enrolled population that derives from knowledge that the providers will be around during a prolonged period. Thus, an early responsibility and burden for the rehabilitator is to assure that a sufficient provider network will exist to satisfy contractual obligations already in place or to be undertaken by the rehabilitator as part of a turnaround plan.

Health care providers should be assumed to be economically rational. That is to say, assumptions should not be made that health care can be obtained without compensation. No more do doctors and hospitals believe that there is a free lunch than do reinsurers or other creditors. Therefore, the rehabilitator should assume that realization by the medical community that the MCO is in financial straits will lead contracting providers to seek a termination of their obligation as early as possible in order to avoid the need to provide uncompensated care. Such terminations, however, will all but doom any rehabilitation effort since the MCO will be nothing without an adequate provider network.

There is no secret formula for preserving a provider network, but there are a number of techniques which, singularly or in combination, may be very useful. First and foremost is establishing a line of communication with the affected providers the foundation of which is candor and reliability. In short, a rehabilitator should make available to each such provider as early as possible sufficient information to dispel the worst doubts and begin instilling the requisite confidence. Such information should include a candid explanation of the implications of the receivership, a practical description of the prospects for the MCO, preliminary indications of efforts contemplated by the rehabilitator to turn the MCO around, and a brief explanation of the likely effects of the MCO's problems on the affected providers. Initial information should be updated as material changes occur, with due regard for any applicable confidentiality and other constraints. In all such communications, the rehabilitator should bear in mind that the principal concerns of the

provider will be when and how much he, she or it will be paid and what impact developments will have on his, her or its practice. Thus, hospitals will want to know how many beds they must continue to commit to MCO subscribers, physicians will want to know how many office visits they should anticipate, and so on.

While contractual arrangements may deprive the providers of the right to immediate payment, a rehabilitator that can make such payments is likely to be in a much better position to establish a good working relationship with such providers. To the extent, therefore, that the applicable priority scheme permits it, at least some partial payment for prospective care should be delivered to providers along with some estimation of when and how much will be paid for amounts due for pre-takeover care.

Frequently, the rehabilitator will benefit substantially from assistance provided by the plan's medical director or other health care professionals in communicating with network providers. Physicians and health care providers have a tendency to be naturally distrustful of lawyers and state officials. What would otherwise be a very effective message may lose some of its persuasive power if delivered just by the rehabilitator. Conversely, it may become far more persuasive if delivered (at least jointly) by other physicians, preferably those not closely associated with the plan. The rehabilitator, therefore, may wish to enlist the local hospital or medical association in communicating these messages. However accomplished, the point is that health care providers should be persuaded not only to avoid interruptions in the delivery of care to subscribers immediately following the takeover, but also to commit to the provision of health care services for a longer period of time so as to enable the development and implementation of a rehabilitation plan.

III. THE BACK OFFICE

While any analysis of the many financial and administrative issues that are likely to be presented by the financial demise of a MCO are well beyond the scope of this article, a few general observations are likely to be useful. Experience teaches us that failed MCOs tend to share certain common traits that contribute to their demise. Key among these are failure to properly monitor and manage utilization of health care services, poor cash flow management, and an inadequate reinsurance or stop loss program. Recognizing the foregoing, it behooves the savvy rehabilitator to devote some of his energies in the initial stages of the process to determining the condition and the needs of the plan's back office.

Early attention should be devoted to understanding the capabilities and limitations of the MCO's management information and computer systems. For example, does the management information system ("MIS") track adequately the plan's enrollment? Many large and small MCOs have suffered tremendously because their systems did not track adequately additions to, and deletions from, the enrolled population. As a result, there have been some notable instances of organizations failing to bill for premium due to them (the passage of time making such billing all but a waste of time) and, conversely, billing individuals and groups which were no longer their customers (thereby creating a

substantial public relations problem). Little explanation is required to prompt an understanding of the potential pitfalls of such weaknesses.

Similarly, effective management of health care utilization lies at the core of a successful MCO. Effective utilization review management, in turn, depends on prompt availability of accurate utilization data which in turn depends on effective management information and data processing systems.

Many MCOs also enter into risk-sharing arrangements with their health care providers. While a detailed explanation of the terms of such arrangements cannot be undertaken in this article, it is important to note that performance and reporting under those arrangements is critical both to the financial viability of the plan and to the preservation of an effective relationship with the providers. To this function as well, the integrity of the plan's MIS is critical.

In addition (and certainly not surprising) it is very important that the plan's accounting systems be accurate, reliable and sufficiently quick. Both in terms of cash flow management and in terms of prompt and accurate financial reporting, the functions of the accounting staff are indispensable and shortcomings in this area can, by themselves, doom to failure an otherwise well developed rehabilitation plan. Where there is insufficient confidence in the plan's own staff, thought should be given to retention of consultants and experts at an early stage.

Equally important for many plans is the development and preservation of an effective reinsurance and stop loss program. Many small and medium sized MCOs simply lack the financial resources to shoulder in its entirety the risk transferred to them by their enrolled population. Provision, therefore, must be made for some of the risk (both as to frequency and severity) of health care claims to be assumed by a stop loss reinsurer. Although there is certainly no free lunch (and a reinsurer will presumably charge an adequate premium over a period of years which, in the aggregate, will exceed the total of claims paid by the reinsurer to the MCO by a sufficient amount to provide for a reasonable profit), the predictability afforded by an effective stop loss reinsurance program in itself constitutes a substantial value without which an effective rehabilitation plan is far less likely. Attention should therefore be given to verification that the reinsurance program has been properly constructed and is sufficiently well managed. The requisite reports must be provided to the reinsurer to avoid a fatal breach and, on the other hand, confirmation should be obtained that collection has been made of the amounts to which the plan is entitled.

It is worth observing that HMOs and other MCOs typically monitor revenues and expenses on a "per-member-per-month" ("PMPM") basis. Thus, every item of expense is calculated for individual enrollees for each covered month and, the same is true for revenue items. Stop loss reinsurance and other risk shifting devices are also frequently priced and modeled on that basis. The rehabilitator should analyze and develop corrective action plans which not only take into account financial impacts on a PMPM basis, but also in the aggregate. Blind concentration on measures which have the effect of lowering

PMPM costs or increasing revenues on that basis without recognizing aggregate impact may overlook an insurmountable cash or capital deficit, daunting aggregate debt or deficiencies in the MCO's portfolio management program.

IV. PRESERVATION OF THE CUSTOMER BASE

Even if all other ingredients exist, no rehabilitation plan can be successful if the MCO has lost all of its customers. Among the constituencies which first become nervous about a MCO's financial dilemma is likely to be its enrolled population which is so dependent upon the viability of the MCO for its indispensable medical care. At the first hint of trouble, large employer groups are likely to scatter in search of alternatives. The rehabilitator, therefore, should implement immediately an effective program of communications and assurances which will keep these enrolled groups around for the duration of the rehabilitation plan. Among other measures, important in this regard will be instilling in the customer base the confidence that the health care provider network will not only be around but will be delivering care without new burdens or conditions.

The rehabilitator should also be well informed as to when each group comes up for renewal. Even if an enrolled group is willing to stay with a MCO during the remainder of its group contract term, it is far less likely that it will renew when the contract expires (typically in the last quarter of each year). The loss of a substantial number of groups at renewal time is likely to doom any rehabilitation plan. Therefore, the rehabilitator should determine what inducements will be necessary to provide the requisite number of renewals. In doing so, however, the rehabilitator may also wish to become familiar with the utilization history of each group. There may be groups the nonrenewal of which may actually be a blessing for the plan.

CONCLUSION

This article has sought in relatively little space to provide an overview of a number of important aspects of the rehabilitation of a managed care organization. Notwithstanding its brevity, it should serve to identify many of the pitfalls that lurk in the bushes as well as the resources that will be indispensable in attempting to restore a MCO to financial viability. Many industry observers have expressed a view that the coming months and years are likely to witness an increasing number of MCO failures. If these unfortunate predictions are borne out by experience, there will be a need for well-trained and well-informed rehabilitators and liquidators to assist in the state regulatory response. It is hoped that the thoughts provided in these few paragraphs can make a contribution to that response.

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[2] The NAIC *Receivers Handbook for Insurance Company Insolvencies* provides the most current, complete information available on insurance company insolvencies. This publication can be obtained by accessing the NAIC's web site at www.naic.org.

[3] For a discussion of the bankruptcy jurisdiction issue, for example, see Patrick H. Cantilo, *Health, HMO and Related Entity Insolvencies, in*, Law and Practice of Insurance Regulation of Health Care Arrangements 13-1, 13-25 - 13-42 (Dennis G. LaGory, Ed., A.B.A. 1996).