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The Aftermath of HMO Insolvency: Considerations for Providers

Jay M. Howard*

INTRODUCTION

Membership in health maintenance organizations (HMOs) reached 45 million subscribers in 1994, with enrollment expected to exceed 100 million persons by the end of the decade.¹ The American Medical Association (AMA) reports that HMO contracts exist in 42% of physicians' practices. The AMA report also notes that only 35% of these same physicians possessed HMO contracts in 1988.² The average revenue from alternative delivery system contracts held by physicians increased to 32% of total revenues in 1992, from 23% in 1988.³

President Clinton's health care reform package debated in 1993-94 furthered the perceived importance of managed care,

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1. *HMO Membership Hits 45 Million*, HEALTH LAW. NEWS REP., Jan. 1994, at 1 [hereinafter HEALTH LAW NEWS].

2. Kurt D. Gillis & David W. Emmons, *Physician Involvement With Alternative Delivery Systems*, 1993 SOCIOECONOMIC CHARACTERISTICS MED. PRAC. 15, 15-19. For the purposes of this study, HMO employees, generally found in staff model HMOs, are excluded. The authors claim that employed physicians represent only about 2.4% of the AMA's 1988-1992 Socioeconomic Monitoring Survey respondents. The represented physicians are those involved in "nonfederal patient care," and include only those under contract with non-IPA model HMOs. *Id.*

3. *Id.* at 16. The definition of alternative delivery system used in the AMA study, as well as this article, includes such structures as HMOs, preferred provider organizations (PPOs), and independent physician associations (IPAs). This article addresses HMOs and IPAs.

although competitive markets are regarded as the specific driving force behind the emergence of HMOs. As HMOs rapidly form and expand, concern has been expressed with regard to the incidence and impact of HMO insolvencies. Providers in the current health care market can expect to be affected by an insolvency, whether it is of an entity with which the provider contracts or one with which it competes. The concern for HMO financial insolvency heightens as managed care markets become increasingly competitive, while a market shift towards providing care in the outpatient setting has created a surplus capacity for inpatient services. Financial stability is crucial to surviving in today's competitive and volatile health care market.

Recent predictions paralleled accountable health plans with the financial struggle experienced by early formed HMOs.⁴ The bankruptcy of either entity adversely impacts participating providers, creating unanticipated financial risks of an undetermined amount. It is imperative that providers and their counsel appreciate the consequences of an insolvency or bankruptcy proceeding by an HMO with which providers have a contractual relationship.

HMO solvency has been generally improving industry wide,⁵ though financial losses are substantial when they do occur. A survey by the Solvency Working Group of the National Association of Insurance Commissioners (NAIC) found that providers are owed an average of \$2,005,000 at the time of an HMO insolvency.⁶

4. See HEALTH LAW NEWS *supra* note 1.

5. See Keith E. Boles, *Insolvency in Managed Care Organizations: Financial Indicators*, 19 TOPICS IN HEALTH CARE FINANCING 2, at 40 (1992) [hereinafter *Indicators*] (In 1988, 31% of all HMOs were profitable while 50% were reported profitable in 1989. By 1990, 65% were profitable.); GROUP HEALTH ASS'N OF AM., HMO INDUSTRY PROFILE 57 (1993) (The Group Health Association of America (GHAA), a national trade group representing HMOs, reported that 83% of the HMO industry experienced positive gross income in 1991. For a summary of the HMO industry financial performance, see chapter V, *Financial Performance*) (on file with author); Paul Kenkel, *Financial Health Gives HMOs Hope in Reform Discussions*, MODERN HEALTH CARE, Jan. 11, 1993, at 33 (results of a smaller survey of 45 HMOs showed that 91% of the HMOs anticipated finishing 1992 in the black); SUSAN PALSBO, GROUP HEALTH ASS'N OF AM., HMO MARKET POSITION REPORT 2 (1993) [hereinafter MARKET] (The GHAA reported that an estimated 89% of HMOs expected a surplus in 1993.) (on file with the author).

6. NATIONAL ASS'N OF INS. COMM'RS, PROCEEDINGS OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, 1989-1 NAIC Proc. 344, at 362 [hereinafter PROCEEDINGS]. The survey conducted encompassed 35 states and 595 HMOs, or 92% of the country's HMO industry. *Id.* at 344. See also, *Indicators*, *supra* note 5, at 40 (Total HMO losses were reported at \$311 million and \$851 million in 1986 and 1987,

The Solvency Working Group survey further reports that only 21% of the states responding to the survey were confident that they were authorized to govern HMO rehabilitation or conservation activities.⁷ Clearly, the need for regulation of HMO solvency, and control of the insolvency process, is greater than ever. This article addresses HMO fiscal soundness statutes, regulations, standards, and model act provisions that constitute the legal playing field governing HMO solvency. Reference will be made to the different levels of risk incurred by a provider when an HMO proceeds with liquidation under a state insurance procedure as well as the risks experienced when an HMO seeks liquidation or reorganization under federal bankruptcy laws. This article will also review cases that resolve the conflict between HMOs seeking relief under the Federal Bankruptcy Code and insurance commissioners advocating the resolution of HMO insolvencies pursuant to their state insurance procedures.⁸

I. AN OVERVIEW OF HEALTH MAINTENANCE ORGANIZATIONS

To appreciate the impact of an HMO insolvency on providers, it is important to understand the different types of HMOs and the ways in which they structure their provider relationships. The definition of an HMO has been forced to evolve as quickly as the number of emerging applications. Traditionally, an HMO was defined as an entity that financed and delivered complete health care services to enrollees for a prepaid fee per enrollee. No longer, however, can an HMO be defined by prepaid financing.⁹ A contemporary definition acknowledges that an HMO is also a health plan that possesses primary care physicians as gatekeepers and shifts varying degrees of financial risk for medical

respectively, while in 1988 reported losses equaled \$821 million. In 1989, there were at least 800,000 enrollees in bankrupt or closed HMOs in California alone.). See also Cynthia Mines, *Local HMOs Dipping Further into Red*, WICHITA BUS. J., Apr. 16, 1993, at 1 (of four HMOs serving the Wichita and surrounding areas in Kansas, three reported net losses for 1992).

7. PROCEEDINGS, *supra* note 6, at 347.

8. Obviously, numerous parties may incur losses when an HMO is insolvent, including enrollees, hospital providers, employers, state regulators and citizens, other HMOs, creditors, and interest groups. This article is narrowly aimed at the specific impact of such failures on providers, and will accordingly address only issues arising in this context.

9. See 42 U.S.C. § 300e (1988). Section 300e provides a detailed definition of an HMO, including organizational requirements and the "manner of supplying basic and supplemental health services to members." *Id.* § 300e(b). See also 42 C.F.R. § 417 (1995) (regulatory definition of an HMO).

expenses to providers.¹⁰ Subscribers who enroll in an HMO are generally restricted to utilizing the participating providers in order to receive full plan coverage.

An HMO might feature any one of, or a hybrid of, four broad structures distinguished by the differing relationships between the entity and the medical care providers. A “staff model” HMO directly employs physicians to provide medical care at the organization’s facilities and exclusively to the organization’s enrollees. Generally, HMO staff physicians are salaried employees. According to a Group Health Association of America (GHAA) survey, staff model HMOs represented 11% of all plans and 14% of all enrollees by the end of 1992.¹¹

The second structure, a “group model” HMO, is an HMO that contracts with an independent multispecialty physician membership to render care to enrollees without limiting the physician’s service to enrollees.¹² Payment to the contracted physicians is generally set through a “capitated” basis, not dependent upon enrollee utilization. The GHAA reports that by the end of 1992, group model HMOs represented 10% of HMO plans and 24% of all enrollees.¹³

In contrast to the group model, a “network” HMO contracts with *several* groups as well as individual physicians to furnish medical services for HMO enrollees in the physician’s office. Again, there is no limitation on the physician’s ability to service nonmember patients. A physician may contract with as many HMOs as feasible. Network HMOs constituted 16% of HMO plans and 16% of all enrollees by the end of 1992, according to the GHAA survey.¹⁴

A similar lack of restrictions upon the allowable patient base is standard in the contractual relationship between an HMO and an “independent practice association” (IPA).¹⁵ The IPA entity is a voluntary formation consisting of individual physicians or groups. The open nature of the IPA—allowing any physicians

10. Peter R. Kongstvedt, *Glossary of Terms, Jargon, and Common Acronyms*, in *THE MANAGED HEALTH CARE HANDBOOK* 504 (Peter R. Kongstvedt ed., 2d ed. 1993) [hereinafter *HANDBOOK*].

11. *GROUP HEALTH ASS’N OF AM., 1993 NATIONAL DIRECTORY OF HMOs* 23 [hereinafter *DIRECTORY*].

12. See 42 U.S.C. § 300e-1(4) (1988) (defining “medical group”); 42 C.F.R. § 417.1 (1995) (defining “medical group”).

13. *DIRECTORY*, *supra* note 11, at 23.

14. *Id.* at 23, 176-80, 220-28.

15. See 42 U.S.C. § 300e-1(5) (1988) (defining “individual practice association”); 42 C.F.R. § 417.1 (1995) (defining “individual practice association”).

who meet the selection criteria to join—explains the common reference to this form as an “open panel.” The providers contract with the IPA entity to provide care in their offices in exchange for payments on either a fee-for-service or capitated basis. In addition, an IPA can subcapitate to physicians outside of the IPA or to another IPA. Endless variations, or “mixed-model” HMOs, exist in the market.

In an IPA setting, the HMO often contracts as a management organization, usually providing a capitated payment to the IPA in order to meet state statutory requirements.¹⁶ As in the other forms, the HMO contracting with an IPA continues to function as the marketing director. The IPA physicians are generally allowed to continue to see an unlimited number of nonenrollees. The IPA model HMO constituted 63% of HMO plans by the end of 1992 and covered 46% of all enrollees.¹⁷ Various aspects of these four general HMO structures are often shared within a single HMO.¹⁸

Conceptually, different forms of HMO delivery systems are unified by the way in which they place financial risk. Traditional third-party indemnity insurance involves a risk-accepting insurer who receives a prepaid premium.¹⁹ In exchange, the insurer reimburses a determined amount and type of medical care. In contrast, an HMO provides or arranges for care while shifting degrees of risk for financial loss to the medical care providers. Risk-transferring techniques may include established cost containment incentives, utilization controls, and organized compensation arrangements.²⁰ In a staff model HMO, risk transference may take the form of incentive arrangements or bonuses to physicians based on their performance.²¹ Nevertheless, traditional

16. See, e.g., KAN. STAT. ANN. § 40-3202(f)(2) (1993) (requiring “predetermined periodic rate basis” except for copay amounts); MO. REV. STAT. § 354.400(6) (1991) (defining an HMO in terms of providing services on a prepaid basis).

17. DIRECTORY, *supra* note 11, at 23. See also *id.* at 176-80, 220-28.

18. *Id.* The GHAA reports that 16% of all HMOs were mixed models in 1992, with the IPA form representing the least mixed. Shared variations were observed in almost one-half of all staff model HMOs.

19. See GEORGE J. COUCH, 1 COUCH ON INSURANCE § 1:3 (rev. ed. 1984) (“The primary requisite essential to a contract of insurance is the assumption of risk of loss and the undertaking to indemnify the insured against such loss.”).

20. John F. Monahan & Michael Willis, *Special Legal Status for HMOs: Cost Containment Catalyst or Marketplace Impediment?*, 18 STETSON L. REV. 353, 355 (1989). The topic of risk transference to providers in the HMO setting is beyond the scope of this article, and is amply covered in works dedicated solely to the concept.

21. See Peter R. Kongstvedt, *Compensation of Primary Care Physicians in Open Panels*, in HANDBOOK, *supra* note 10, at 58. A popular compensation arrangement to

legal differences between indemnity insurance and HMOs have blurred as quickly evolving alternative delivery systems become more complex.

An illustration of the gray area between an insurance "product" and an HMO is found in the increasingly popular form of HMO offering known as a "point-of-service" (POS) option.²² Under a POS, an enrollee may seek care from a *non*-HMO physician and the HMO will reimburse that care, although typically a fairly substantial copay (and/or deductible) will be required. Conversely, no payment might be necessary if the enrollee seeks care from an HMO physician. Further blurring the separation, insurance plans now include utilization management tracking procedures that were previously only found in HMOs.²³

The "dual-quality" aspect of certain contemporary HMOs and insurance products, both reimbursing and arranging for care, creates a difficult situation for courts and insurance commissioners confronted with an HMO facing bankruptcy. Should an insolvent HMO be allowed to be a debtor and liquidate or reorganize pursuant to the Bankruptcy Code, or is an HMO an insurance company which proceeds towards liquidation under the regulation of a state insurance commissioner? The procedures, as well as the potential success of creditors seeking payment, differ under each scheme. This uncertainty is particularly unsettling to health care providers who contract with an HMO that ultimately becomes insolvent, as well as to providers' counsel.²⁴

transfer risk may take the form of a "withhold arrangement," which allows the HMO to retain a percentage of the capitation pool to compensate for costs exceeding those allotted for institutional or referral services.

22. See MARKET, *supra* note 5, at 2. At that time, the GHAA anticipated that 83% of HMOs would offer a point-of-service option in 1994.

23. Eric R. Wagner, *Types of Managed Care Organizations*, in HANDBOOK, *supra* note 10, at 12-16.

24. See Colette B. Resnik, *Maxicare as a Guide for Health Maintenance Organizations (HMOs) in Bankruptcy*, 8 BANKR. DEVS. J. 271, 273 (1991). Medical services are rendered to HMO members through both "contract" and "noncontract" providers. Contract providers agree to deliver care based on a capitated or other agreed-upon payment structure. Noncontract providers render care when contract providers are unavailable or unable to deliver services. A noncontract provider is often utilized for emergency care or specialty services and is paid on a reduced fee-for-service schedule. *Id.* at 273-74. Both types of providers face losses should the HMO become insolvent. However, the provider receiving capitated payments may be better off than the provider operating on a fee-for-service basis. It is not uncommon for an HMO to fall several months behind in its fee-for-service payments, which, of course, cover services already provided. In the capitation system, the provider receives pre-set, reg-

II. FEDERAL HMO LEGISLATION AND REGULATIONS

HMOs received federal guidance and legitimacy with the congressional enactment of the Health Maintenance Organization Act of 1973 (HMO Act), pursuant to which plans can voluntarily become "federally qualified."²⁵ Although certainly not all HMOs are so qualified, obtaining federal qualification offers certain advantages.²⁶ The HMO Act initially offered numerous grants, loans, and other financial development benefits for qualified HMOs as well as establishing organizational, operating, and continuing regulatory requirements.²⁷ Additional advantages accompanying federal qualification exist: a dual-choice mandate, scheduled to end in 1995, requiring specified employers to offer an HMO if a federally qualified organization approaches the employer, a perceived stability for employers who may view qualification as a federal stamp of approval; a reduced time period for Medicare risk contracting; and exemptions from excessively restrictive state laws.²⁸

These advantages come at the price of additional regulations, particularly in the area of solvency. For example, the federal HMO Act's organizational requirements compel an HMO to possess "(1) a fiscally sound operation, and (2) adequate provision against the risk of insolvency"²⁹ The organization must assume the entire financial risk for the provision of medical care on a prospective basis, subject to the ability to obtain insurance in prescribed circumstances.³⁰ An HMO, however, is allowed to arrange to shift or share the prospective financial risk through provisions with participating individuals or institutions.³¹ Nevertheless, the HMO must continue to protect its enrollees. The HMO Act prohibits enrollees from "incurring liability for payment of any fees which are the legal obligation" of the HMO.³²

ular payments; if the HMO falls behind in its payments, the provider may have a warning of financial instability.

25. Pub. L. No. 93-222, 87 Stat. 931 (1973) (codified at 42 U.S.C. § 300e (1982)). See 42 U.S.C. § 300e-9(d) (1988) (defining "qualified health maintenance organization"); see also Health Maintenance Organization Act of 1973, S. REP. NO. 129, 93d Cong., 1st Sess. (1973), reprinted in 1973 U.S.C.A.N. 3033, 3039-40 (providing the justification for enactment).

26. *Health Maintenance Organizations*, in ASPEN HEALTH LAW CTR., MANAGED CARE LAW MANUAL § 3-2, at 7 (1994).

27. *Id.*

28. *Id.*

29. 42 U.S.C. § 300e(c)(1)(i), (ii) (1988).

30. *Id.* § 300e(c)(2) (1988).

31. *Id.* § 300e(c)(2)(D).

32. *Id.* § 300e(c)(7) (1988). Allowable forms of protection include:

Annual information regarding the fiscal soundness of the qualified HMO must be made available to the Secretary of Health and Human Services.³³ Significantly, however, the federal law provides no guidance as to the procedures governing a plan that becomes insolvent.

HMOs seeking to achieve qualified status under the HMO Act must additionally comply with regulations promulgated by the Health Care Financing Administration.³⁴ The regulatory requirements include those relating to insolvency protection. The fiscal soundness of the HMO must be proved to the Secretary by generally demonstrating that assets are greater than liabilities and that a net operating surplus exists.³⁵ Of importance to providers, a federally qualified HMO must possess a plan that continues benefits to enrollees in the event the plan becomes insolvent.³⁶ Further, the regulations require the HMO to take steps to assure that members are not held liable for any fees that are the HMO's legal obligation.³⁷ However, the regulations also provide no guidance as to the procedures to be followed in the event of an insolvency of an HMO.

-
- (A) a contractual arrangement with any hospital that is regularly used by the members of such organization prohibiting such hospital from holding any such member liable for payment of any fees which are the legal obligation of such organization;
 - (B) insolvency insurance, acceptable to the Secretary;
 - (C) adequate financial reserve, acceptable to the Secretary; and
 - (D) other arrangements, acceptable to the Secretary, to protect members, except that the requirements of this paragraph shall not apply to a health maintenance organization with protection from liability for payment of any fees which are the legal obligation of such organization

Id.

33. *Id.* § 300e-17 (1988).

34. See 42 C.F.R. § 417.1 (1995). Although the argument has been made by counsel in HMO insolvency cases, as will be seen in the remaining discussion, the mere fact that an HMO is governed in part by federal regulations does not conclusively indicate that federal bankruptcy protocol prevails in the event of an insolvency. See *Selcke v. Medicare HMO*, 147 B.R. 895, 902 (N.D. Ill. 1992), *aff'd sub nom. In re Estate of Medicare HMO*, 998 F.2d 436 (7th Cir. 1993).

35. 42 C.F.R. § 417.120(a) (1995) (The regulation requires each HMO to: "(1) [H]ave a fiscally sound operation, as demonstrated by the following: (i) Total assets being greater than total unsubordinated liabilities[;] (ii) Sufficient cash flow and adequate liquidity to meet obligations as they become due[; and] (iii) A net operating surplus, or a financial plan [pursuant to the next paragraph].").

36. *Id.* §§ 417.120(a)(iv), 417.122(b) (1995) (an HMO must have a plan for handling insolvency that allows for continuation of benefits for the duration of the contract period for which payment has been made and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge).

37. *Id.* § 417.122(a) (1995).

An important section of the HMO Act addresses the situation that arises when state laws are found to be more restrictive than the federal structure. It provides that an HMO that is prohibited from operating as an HMO by a state law will not be prevented from operating in accordance with the HMO Act. One of the preempted state law restrictions is any requirement that an HMO meet insurance company standards regarding "initial capitalization and establishment of financial reserves against insolvency."³⁸ Thus, regulation by the federal government over federally qualified HMOs conflicts with the regulation of insurers, which is nearly the exclusive jurisdiction of the states.³⁹

III. STATE HMO LEGISLATION AND THE MODEL HMO ACT

Comprehensive HMO legislation has been enacted in forty-seven states, while the District of Columbia, Hawaii, Oregon, and Wisconsin regulate HMOs according to other laws, including those governing insurance companies.⁴⁰ The majority of state legislation is based on a Model HMO Act developed by the NAIC, though many variations exist in the actual implementation of the Model Act.⁴¹

The Model HMO Act contains expansive regulations and requirements for receiving a certificate of operation. Section 13 of the Model Act contains a formula to calculate suggested initial and minimum net worth requirements. In addition, a deposit of at least \$300,000 is required in order to protect the HMO enrollees and assure continued services if the organization is in rehabilitation or conservation.⁴²

A "hold-harmless" clause must be included in all provider contracts to protect a subscriber or enrollee from liability for

38. 42 U.S.C. § 300e-10(a)(1)(D) (1988).

39. See *PROCEEDINGS*, *supra* note 6, at 347; see also *Selcke v. Medicare HMO*, 147 B.R. 895 (N.D. Ill. 1992), *aff'd sub nom. In re Estate of Medicare HMO*, 998 F.2d 436 (7th Cir. 1993). The HMO argued that the state liquidation scheme was preempted by the federal HMO Act, specifically 42 U.S.C. § 300e-10. The district court stated that this provision does not provide an alternate liquidation scheme because it refers to initial capitalization amounts. Further, the court noted that state provisions not expressly conflicting with the federal HMO Act are generally not preempted. *Id.* at 907 n.7 (citing *Health Care Plan of N.J. v. Schweiker*, 553 F. Supp. 440, 446 (D.N.J. 1982), *aff'd mem.*, 707 F.2d 1391 (3d Cir.), *cert. denied*, 464 U.S. 815 (1983)).

40. See *HANDBOOK*, *supra* note 10, at 7.

41. *Id.* at 8.

42. See *HEALTH MAINTENANCE ORG. MODEL ACT* § 13(B)(5), 2 Model Reg. Serv. (Nat'l Ass'n Ins. Comm'rs) (1990) [hereinafter *MODEL HMO ACT*].

HMO debts.⁴³ The HMO must also maintain a plan to ensure that services will not be interrupted in the event of an insolvency. Approved methods for achieving this goal include insurance, insolvency reserves, letters of credit, and other acceptable arrangements.⁴⁴ An approved plan also mandates provisions in provider contracts that require the continuation of the provider's services for which payment has been made, despite an HMO's insolvency. It is also suggested that providers be required to give 60 days notice prior to terminating an agreement.⁴⁵

An additional insolvency deposit is required when uncovered expenditures, which are HMO costs for health care services for which an enrollee could be liable in the event of an insolvency, exceed a specified amount.⁴⁶ For example, if uncovered expenditures exceed ten percent of total health care expenditures at any time, the deposit is required.⁴⁷ Further, in the event of insolvency, the state insurance commissioner, in order to grant

43. *Id.* § 13(D). See also M.E. Overlock, *Managed Care and the Infamous Hold Harmless Clause*, J. TENN. MED. ASS'N, Oct. 1993, at 453, 453-56. Overlock notes that the "hold-harmless" clause "may form the backbone of state and national health care reform since health insurers can effectively use them to pass off financial and liability risks to physicians." He notes that hold-harmless clauses generally come in two forms, while a third type of clause is often incorrectly labeled. The first form of a hold-harmless clause is observed in a physician's agreement in an HMO contract not to bill an enrollee for fees beyond those allowed by the HMO, or in the event the HMO does not or is unable to pay the doctor. A second type contains the physician's covenant not to request a "contribution" from an HMO to assist with the payment of a damages claim. The third type, which the author argues should not be categorized as a hold-harmless clause, mandates the physician to "indemnify" the HMO by compensating the entity for any damages and legal fees for which it may be held accountable in a court decision. *Id.* at 453.

44. MODEL HMO ACT, *supra* note 42, § 13(E)(1), (3)-(5).

45. *Id.* § 13(F).

46. *Id.* § 2. "Uncovered expenditures" are

the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization, for which an enrollee may also be liable in the event of the health maintenance organization's insolvency and for which no alternative arrangements have been made that are acceptable to the commissioner [director, superintendent].

Id. The Comment to this Model Act provision states that the definition is for use in section 13. The defined expenditures

will vary in type and amount, depending upon the arrangements of the HMO. They may include out-of-area services, referral services and hospital service. They do not include expenditures for services when a provider has agreed not to bill the enrollee even though the provider is not paid by the HMO, or for services that are guaranteed, insured or assumed by a person or organization other than the health maintenance organization.

Id.

47. *Id.* § 14. The provision requires in subsection (A) that

sufficient protection and time to provide replacement coverage for enrollees, may require other HMOs to hold a period for nonmember enrollment.⁴⁸

The Model Act section governing the regulation of an insolvent HMO states that “[a]ny rehabilitation, liquidation, or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation, or conservation of an insurance company and shall be conducted under the supervision of the commissioner . . . pursuant to the law governing the rehabilitation, liquidation or conservation of insurance companies.”⁴⁹ This provision essentially labels the HMO a “domestic insurer” for these purposes, thereby specifically preventing the HMO from seeking the protection of the Bankruptcy Code.

Thus, the priority of claims is determined by the law that the state has adopted to govern the liquidation of its insurers. The HMO members will have the same priority in a distribution of general assets as would be granted to the holders of an insurance policy in an insurer liquidation.⁵⁰ In general, the policyholders of an insurance company subject to an order of liquidation are of equal status with general unsecured creditors, sharing pro rata in the insurance company’s assets.⁵¹

If an HMO member is liable to a provider for care rendered under the plan, the liability is shifted to “the status of an enrollee claim for distribution of the general assets.”⁵² Providers subject to a hold-harmless clause are allowed priority after that of enrollees and enrollees’ beneficiaries “and immediately preceding the priority of distribution described in [the insurance code of the state].”⁵³ In other words, the HMO member is granted priority over the provider’s claim as a creditor, and the

[i]f at any time uncovered expenditures exceed ten percent (10%) of total health care expenditures, a health maintenance organization shall place an uncovered expenditures insolvency deposit with the commissioner [director, superintendent], with any organization or trustee acceptable to the commissioner [director, superintendent] through which a custodial or controlled account is maintained, cash or securities that are acceptable to the commissioner. Such deposit shall at all times have a fair market value in an amount of 120% of the HMO’s outstanding liability for uncovered expenditures for enrollees in this state

48. *Id.* §§ 14-15.

49. *Id.* § 21(A).

50. *Id.*

51. JOHN A. APPLEMAN & JEAN APPLEMAN, *INSURANCE LAW AND PRACTICE* § 10721 (1982).

52. MODEL HMO ACT, *supra* note 42, § 21(B).

53. *Id.*

provider subject to a hold-harmless clause receives priority over other creditors' claims.

The following section analyzes these issues using the States of Kansas and Missouri as case studies.

A. Case Study One: Kansas

Kansas requires an HMO to apply to the Commissioner of Insurance for a certificate of authority before operating in the state.⁵⁴ The application process requires numerous disclosures, including several disclosures specifically related to fiscal soundness and projections.⁵⁵

HMOs are specifically excluded from the definition of "member insurers" under the Kansas Life and Health Insurance Guaranty Association Act.⁵⁶ The Guaranty Act would provide certain life, health, or annuity coverage in the event that a "member insurer" is impaired or becomes insolvent.⁵⁷

The Kansas legislation specifies the powers of an HMO and places certain restrictions on the organization's contracts.⁵⁸ For example, a hold-harmless clause is required for the protection of

54. KAN. STAT. ANN. § 40-3203 (1993).

55. *Id.* § 40-3203(6)(A)-(C)(iv). The provision specifically requires:

(A) descriptions of financing arrangements for operational deficits and for developmental costs if operational one year or less;

(B) a copy of the most recent unaudited financial statements of the health maintenance organization;

(C) financial projections using an accrual accounting system with generally accepted accounting principles for a minimum of three years from the anticipated date of certification and on a monthly basis from the date of certification through one year. If the health maintenance organization is expected to incur a deficit, projections shall be made for each deficit year and for one year thereafter. Financial projections shall include:

(i) monthly statements of revenue and expense for the first year on a gross dollar as well as per-member-per-month basis, with quarters consistent with standard calendar year quarters;

(ii) quarterly statements of revenue and expense for each subsequent year;

(iii) a quarterly balance sheet; and

(iv) statement and justification of assumptions.

The commissioner is vested with the power to deny, suspend, or revoke a health maintenance organization's certificate of authority and administer penalties. Upon revoking the certificate, the commissioner may inform the Attorney General, whose "duty" it becomes to "commence and prosecute an action in the proper court to dissolve such [HMO]" *Id.* § 40-3205 (1993).

56. *Id.* § 40-3005(h)(2).

57. *See id.* § 40-3002 (1993) (describing the purpose of an insurance guaranty fund); § 40-3003 (1993) (describing covered persons); § 40-3005(f) (defining impaired insurer); § 40-3005(g) (defining insurer).

58. *See id.* §§ 40-3208, 40-3209 (1993).

enrollees.⁵⁹ Further, the Commissioner has the power to examine Kansas HMOs and certain providers as necessary to protect the interests of Kansas citizens.⁶⁰ Because no other provisions exist, protection for members enrolled in insolvent HMOs in Kansas is principally established through the deposit and insurance requirements.

No specific provision is made in the Kansas HMO Act, or in implementing regulations, for procedures to govern the administration of proceedings for an insolvent Kansas HMO. Kansas has not adopted the Model HMO Act provision that requires insolvency to be governed pursuant to state insurance proceedings, nor have any other laws been adopted to prescribe the procedure to regulate an insolvent HMO in Kansas. Accordingly, health care providers that contract with a Kansas HMO have no certainty as to the priority of their claims in the event of insolvency of the HMO.

B. Case Study Two: Missouri

Missouri provides an interesting comparison with Kansas, especially in light of the fact that the two states border each other, and that Missouri allows some degree of reciprocity: HMOs established and regulated in states bordering Missouri, such as Kansas, are admitted to Missouri if they satisfy established criteria.⁶¹

59. See *id.* § 40-3209(b). An HMO is prevented from contracting with a provider if the contract

require[s] enrollees to guarantee payment, other than copayments and deductibles, to such provider in the event of nonpayment by the [HMO] for any services which have been performed under contracts between such enrollees and the [HMO]. Further, any contract between a [HMO] and a provider shall provide that if the [HMO] fails to pay for covered health care services as set forth in the contract between the [HMO] and its enrollee, the enrollee or covered dependents shall not be liable to any provider for any amounts owed by the [HMO]. If there is no written contract between the [HMO] and the provider or if the written contract fails to include the above provision, the enrollee and dependents may not be liable to any provider for any amounts owed by the [HMO].

Id.

60. *Id.* § 40-3211 (1993). In addition, an HMO operating in Kansas is also required to establish calculated deposit requirements, subject to certain exceptions, in order to compensate for uncovered expenditures. *Id.* § 40-3227 (1993).

61. MO. REV. STAT. § 354.540 (1991). The law establishes that

[a] health maintenance organization approved and regulated under the laws of another bordering state may be admitted to do business in this state by satisfying the director that it is fully and legally organized under the laws of its state, and that it complies with all requirements for health maintenance

A person seeking to operate an HMO in Missouri must first obtain a certificate of authority from the Director of the Division of Insurance of the Department of Economic Development.⁶² Insurance companies licensed in Missouri are allowed to operate an HMO subject to certain restrictions.⁶³ An HMO must file financial statements.⁶⁴ The Director must consider the HMO's financial stability and adequacy of its working capital, and the HMO must meet deposit requirements subject to certain exceptions.⁶⁵ HMOs must submit annual reports to the Director regarding the financial position of the organization.⁶⁶ The Director is also granted the authority to examine the affairs of an HMO.⁶⁷

Similar to Kansas, Missouri HMOs are specifically excluded from the Missouri Life and Health Insurance Guaranty Association Act.⁶⁸ The Missouri HMO Act provides that unless specifically stated otherwise, the laws applicable to Missouri insurance companies are not applicable to HMOs.⁶⁹

The Act establishes a priority in HMO liquidation proceedings for providers' claims for an "uncovered expenditure" over the claims of other providers.⁷⁰ This priority applies to those

organizations organized within Missouri. The director may waive or modify the provisions of sections 354.400 to 354.550 [the HMO Act] if he determines that the same are not appropriate or necessary to a particular health maintenance organization of another state.

62. *Id.* § 354.405 (1991).

63. *Id.* § 354.475 (1991).

64. *Id.* § 354.405.3(7) (1991). HMOs must submit to the director [f]inancial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent certified financial statement shall be deemed to satisfy this requirement unless the director directs that additional or more recent financial information is required for the proper administration [of this act].

Id.

65. *Id.* §§ 354.410.3-354.410.5, 354.455 (1991) (required deposit and form); § 354.410.2 (1991) (formula to determine the deposit amount).

66. *Id.* § 354.435 (1991).

67. *Id.* § 354.465 (1991).

68. *Id.* § 376.718(9) (1991).

69. *Id.* § 354.505.1 (1991).

70. *Id.* § 354.480 (1991). The definition of an "uncovered expenditure" includes the costs of health care services that are covered by a health maintenance organization, but that are not guaranteed, insured, or assumed by a person or organization other than the health maintenance organization, or those costs which a provider has not agreed to forgive enrollees if the provider is not paid by the health maintenance organization.

Id. § 354.400(12) (1991).

providers who have entered into HMO agreements with hold-harmless provisions.⁷¹ Missouri has adopted the Model HMO Act provision asserting state insurance jurisdiction over the liquidation, rehabilitation, or conservation of HMOs.⁷² Consequently, in Missouri, regulation of an insolvent HMO is to be conducted pursuant to the state laws governing an insurance company insolvency.⁷³

The procedures governing the distribution of assets belonging to a Missouri insurance company in liquidation are established by state law. Priority is established for the expenses of closing the business and disposing of the assets, taxes, debts to the United States and municipalities, and policy claims. Thereafter, other debts, claims, and unearned premiums are paid.⁷⁴ In this scheme, the claims of HMO members are analogous to those of policyholders, who receive a priority over the claims of health care providers, who, as creditors, are paid later.

71. *Id.* § 354.480.2 (1991).

72. *Id.* § 354.480.

73. *Id.* § 354.480.1 (1991).

Any rehabilitation, liquidation, or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation or conservation of an insurance company and shall be conducted under the supervision of the director pursuant to the laws governing the rehabilitation, liquidation, or conservation of an insurance company. The director may apply for an order directing him to rehabilitate, liquidate, or conserve a health maintenance organization upon any one or more grounds set out in section 354.355, or section 375.560, R.S.Mo., or when, in his opinion, the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state. Enrollees shall have the same priority in the event of liquidation or rehabilitation granted the policyholders of an insurer.

Id. See also *id.* § 375.560 (1991) (describing when director may initiate wind-up procedures).

74. *Id.* § 375.700 (Supp. 1995).

Unless reinsurance of a dissolved insurer is effected and its assets conveyed to the reinsuring company as provided by law, and unless such insurer is being rehabilitated under other provisions . . . , the receiver, under the direction of the court, shall apply the sums realized from the assets of such insurer in hereinafter making any partial or final distribution, in the following order:

- (1) To payment of all the expenses of closing the business and disposing of the assets of such insurer;
- (2) To the payment of all lawful taxes and debts due the state and the United States and the counties and municipalities of this state;
- (3) To the payment of policy claims;
- (4) To the payment of the other debts and claims allowed against such insurer, and the unearned premiums and the surrendered value of its policies, in proportion to their respective amounts.

IV. THE APPLICATION OF THE FEDERAL BANKRUPTCY CODE TO HMOs

If an HMO is determined to qualify as a "debtor" under the Bankruptcy Code, it may choose to file a Chapter 11 petition in order to facilitate a reorganization.⁷⁵ Holders of claims against the debtor HMO will have different rights based on when those claims arose. The Chapter 11 petition creates a stay, which provides immediate protection for the debtor against prepetition claims. Those claims will be paid pursuant to the terms of a plan of reorganization if one is confirmed. Postpetition claims, however, are to be paid in due course.⁷⁶ A provider may have claims arising in both categories.

If the debtor can generate sufficient income to pay creditors over a reasonable period of time, and the liquidation value of its assets is low, a Chapter 11 filing will best serve the interests of the HMO and its creditors. The plan confirmation process is designed to ensure that creditors receive at least as much as they would if the debtor was liquidated.⁷⁷

Alternatively, a debtor HMO unable to effectively reorganize may proceed to liquidate pursuant to Chapter 7. Generally, a trustee is appointed and charged with liquidating the debtor's assets in a way that realizes the highest value for the creditors. Chapter 7 liquidation is generally selected when maintaining the debtor as a going concern will produce lower returns than the liquidation of the organization.

The filing of a case under Chapter 11 creates an "estate," which consists of "all legal or equitable interests of the debtor in property as of the commencement of the case."⁷⁸ The automatic stay (mentioned above) is an important Code provision, which directly affects providers in relationships with an HMO seeking reorganization.⁷⁹ As soon as the Chapter 11 petition is filed and a case commences, this injunction effectively protects the debtor

75. 11 U.S.C. § 109 (1988). See generally James C. Dechene, *Bankruptcy Proceedings Affecting Healthcare*, in 3 NAT'L HEALTH LAWYERS ASS'N, HEALTH LAW PRACTICE GUIDE ch. 30 (Alice G. Gosfield et al. eds., 1993) (overview of bankruptcy) [hereinafter GUIDE].

76. It is noted that although postpetition claims are paid in due course, in most situations funds are not available for full satisfaction of such claims.

77. 11 U.S.C. § 1129(a)(7) (1988).

78. See GUIDE, *supra* note 75, § 30.04, at 30-11 (citing 11 U.S.C. § 541(a)(1)).

79. 11 U.S.C. § 362 (1988 & Supp. 1993). The automatic stay prevents:

(1) the commencement or continuation, including the issuance or employment process, of a judicial, administrative, or other action or proceeding against the debtor that was or could have been commenced before the com-

and the property of the estate from a provider who brings an action to recover claims against the debtor. Further, the stay has been extended in at least one case to prevent noncontract providers from asserting claims against HMO member patients.⁸⁰ Contract providers relinquish this power.

A second important issue for providers dealing with an HMO seeking federal bankruptcy protection under Chapter 11 is the characterization of the relationship. Pursuant to the Bankruptcy Code, a debtor is given the right to reject or assume any executory contract.⁸¹ Generally, executory contracts include contracts "under which the obligation of both the bankrupt and the other party to the contract are so far unperformed that the failure of either to complete performance would constitute a material breach excusing the performance of the other."⁸² An HMO provider contract generally imposes a continuing obligation upon the HMO to reimburse the provider for services, and a continuing obligation upon the provider to continue services to the enrollees. (A provider may also have an ethical obligation to continue to provide services through the physician-patient rela-

mencement of the case under this title, or to recover a claim against the debtor that arose before the commencement of the case under this title;

(2) the enforcement, against the debtor or against property of the estate, of a judgment obtained before the commencement of the case under this title;

(3) any act to obtain possession of property of the estate or of property from the estate or to exercise control over property of the estate;

(4) any act to create, perfect, or enforce any lien against property of the estate;

(5) any act to create, perfect, or enforce against property of the debtor any lien to the extent that such lien secures a claim that arose before the commencement of the case under this title;

(6) any act to collect, assess, or recover a claim against the debtor that arose before the commencement of the case under this title;

(7) the setoff of any debt owing to the debtor that arose before the commencement of the case under this title against any claim against the debtor;

and (8) the commencement or continuation of a proceeding before the United States Tax Court concerning the debtor.

Id. § 362(a)(1)-(8).

80. GUIDE, *supra* note 75, § 30-14[1], at 30-14 (citing *In re Family Health Servs., Inc.*, 105 B.R. 937 (Bankr. C.D. Cal. 1989)). The court took this action based on sections 105 and 362(a)(1) of the Code and an analogy to case law extending the automatic stay to nondebtor parties based on an identity of interests test. The court cited a case in which the automatic stay was extended to a third party indemnified by the debtor because an action against the third party would simply result in a claim against the debtor. Thus, the parties' identity of interests supported the extension of the automatic stay to the third party. *Id.* at 942-43.

81. 11 U.S.C. § 365 (1988 & Supp. 1993).

82. GUIDE, *supra* note 75, § 30.04[2], at 30-15 (citing Vern Countryman, *Executory Contracts in Bankruptcy: Part 1*, 57 MINN. L. REV. 439, 460 (1973)).

tionship.) An HMO provider contract generally satisfies the definition of an executory contract.

If the debtor HMO elects to assume the executory contract, the debtor is required to cure or provide assurances that it will promptly cure any defaults occurring before the petition filing.⁸³ If the debtor HMO owes the provider past payments, those accounts are required to be settled at assumption, or a plan must be provided to ensure that such payments are made.⁸⁴ The amounts must be paid in full, and it is thus in the best interests of the provider to have the contract assumed as early as possible.

Rejecting executory contracts is generally characterized as a material breach of the contract by the debtor. Such a breach would give a provider a damage claim. The breach is deemed one that occurred prior to the filing of the petition,⁸⁵ and thus is treated as a nonpriority unsecured claim to be paid according to the terms of the reorganization plan approved by the bankruptcy court.⁸⁶

Perhaps most important to a health care provider, the Bankruptcy Code prohibits a provider from terminating a provider agreement with an HMO that becomes insolvent or seeks bankruptcy protection, notwithstanding the fact that a provider may have bargained for a termination or notice provision in the provider agreement.⁸⁷ Thus, this usually valuable "termination upon notice" clause cannot be used. Attempting or threatening to terminate may even subject a provider to penalties for a violation of the automatic stay. A provider therefore must generally continue to render services pursuant to the provider contract until the debtor decides whether to assume or reject.⁸⁸ The debtor generally has the period of time until the plan of reorganization is approved to make a decision.⁸⁹ This undetermined time period, of potentially uncertain financial risk, should be acknowledged by a provider when considering forming a relationship with an HMO of unknown financial stability.

However, the nondebtor party may file a motion compelling the debtor to either assume or reject the executory contract

83. *Id.*

84. *Id.*

85. *See* 11 U.S.C. § 365(g) (1988).

86. GUIDE, *supra* note 75, § 30.04[2], at 30-15.

87. 11 U.S.C. § 365(e)(1) (1988).

88. GUIDE, *supra* note 75, § 30.04[2], at 30-17.

89. 11 U.S.C. § 365(d)(2) (1988).

within a certain period of time.⁹⁰ Pursuant to this motion, the nondebtor contracting party asks the court to set a deadline by which the debtor must make a decision to either assume or reject the contract. In this way, the nondebtor contracting party can limit the period of time during which it operates in “limbo” between the Chapter 11 filing and the debtor’s formal assumption or rejection of the contract.

However, a provider who continues services during this period is not without a remedy. An administrative priority is granted for the value of services provided during the postpetition period.⁹¹ These claims are superior to prepetition unsecured claims. Although providers may have to wait for payment, these claims must be paid in full upon confirmation of a plan of reorganization. The only class with higher priority, holders of secured claims, generally does not constitute a major portion of an HMO’s debt.⁹²

As discussed, most HMO provider contracts are required to include a hold-harmless clause, which prevents the contracting provider from seeking payment from the member directly.⁹³ These provisions transfer the financial risk from the payer to the provider. The member of an insolvent HMO is thereby insulated from having to reimburse the provider for services rendered that the member believed to be covered by the HMO contract. The hold-harmless clause protects the members of insolvent HMOs by preventing direct billing of enrollees. Contract providers must acknowledge and assess this restriction in order to be able to minimize losses caused thereby.

Noncontract providers face a different situation.⁹⁴ Generally, noncontract providers will not be required to continue services to an insolvent HMO’s members.⁹⁵ No hold-harmless clauses exist, and the provider may seek to bill the member directly for services rendered.⁹⁶ Noncontract providers may be able to sue enrollees directly to recover payment for services rendered prepetition.⁹⁷

90. *Id.*; FED. R. BANKR. P. 6006(b).

91. GUIDE, *supra* note 75, § 30.04[2], at 30-17.

92. Resnik, *supra* note 24, at 280, 281.

93. *Id.* at 281 n.71.

94. *Id.* at 282. In reality, few, if any, HMOs use noncontract providers.

95. *Id.* at 283-84.

96. *Id.*

97. *Id.*

V. HEALTH CARE PROVIDERS DANCE BETWEEN THE FEDERAL BANKRUPTCY CODE AND STATE INSOLVENCY LAWS

A. Claim Priorities

Generally, providers seeking payment for services will fare better in bankruptcy proceedings where providers are treated as equals with enrollees.⁹⁸ However, under state regulation, enrollees' claims are commonly given priority.⁹⁹ Further, providers generally have fewer rights under state insurance liquidation proceedings, as the general goal of such a proceeding is to continue coverage for the enrollees with minimal monetary reliance upon state insolvency funds.¹⁰⁰

The Bankruptcy Code establishes the priority of claims in proceedings.¹⁰¹ In a liquidation case under Chapter 7, after the priority claims are satisfied, unsecured claims are paid on a pro rata basis.¹⁰² Generally, unsecured claims will include those of providers as well as enrollees. In a reorganization case under

98. Jon B. Christianson et al., *State Responses to HMO Failures*, HEALTH AFFAIRS, Winter 1991, at 78.

99. *Id.* at 82 n.8 (citing Patrick Cantilo, Bankruptcy Jurisdiction: The Case for State Regulation and Management of HMO Insolvencies, Address at Health Issues 1990: A Seminar for State Regulation (April 25-27, 1990)) (offering six reasons to support state jurisdiction over insolvent HMOs).

100. *See, e.g.*, GUIDE, *supra* note 75, § 30.05[5], at 30-37.

101. Joseph C. Branch & Kevin G. Fitzgerald, *HMO Insolvency: Implications of the Maxicare Decisions*, 25 TORT & INS. LAW J. 766 (1990).

The following expenses and claims have priority in the following order:

- (1) First, administrative expenses allowed under section 503(b) of this title, and any fees and charges assessed against the estate under chapter 123 of title 28;
- (2) Second, unsecured claims allowed under section 502(f) of this title;
- (3) Third, allowed unsecured claims . . . for wages, salaries, or commissions, including vacation, severance, and sick leave pay . . . ;
- (4) Fourth, allowed unsecured claims for contributions to an employee benefit plan . . . ;
- (5) Fifth, allowed unsecured claims of persons [engaged in the production or raising of grain or engaged as a United States fisherman] . . . ;
- (6) Sixth, allowed unsecured claims of individuals . . . arising from the deposit, before the commencement of the case, of money in connection with the purchase, lease, or rental of property, or the purchase of services, for the personal, family, or household use of such individuals, that were not delivered or provided;
- (7) Seventh, allowed unsecured claims for debts to a spouse, former spouse, or child of the debtor . . . ;
- (8) Eighth, allowed unsecured claims of governmental units

11 U.S.C.A. § 507(a) (1993 & West Supp. 1994).

102. Branch & Fitzgerald, *supra* note 101, at 777-78 (citing 11 U.S.C. § 726 (1988)).

Chapter 11, payments are made pursuant to the plan of reorganization, which generally treats all unsecured claims equally.¹⁰³

By contrast, policyholders in an insolvency proceeding of a state following the Liquidation Model Act are generally given a priority for their claims, which priority supersedes the claims of providers.¹⁰⁴ The Liquidation Model Act provides the top two priorities for the costs of administration and employee claims for services performed.¹⁰⁵ While these two priorities are similar to those described under the Bankruptcy Code, the third class of claims under the Liquidation Model Act, known as “loss claims,” has no parallel in the Bankruptcy Code.¹⁰⁶ Thus, providers seeking payment for services from a liquidated insurer may be subordinated to policyholder claims. Providers will thus prefer to have insolvent HMOs liquidated or reorganized under the Bankruptcy Code pursuant to which their claims are not subject to subordination.

B. The Issue: The Federal Bankruptcy Code, the HMO, and the Procedural Exclusion

Like any debtor, an insolvent HMO may initially debate whether to seek relief under Chapter 7 (liquidation)¹⁰⁷ or Chapter 11 (reorganization)¹⁰⁸ of the Bankruptcy Code. However, neither may be available as a debtor may seek protection “only

103. *Id.* at 778 (citing 11 U.S.C. § 1123 (1988)).

104. REHABILITATION AND LIQUIDATION MODEL ACT § 46 (Nat'l Ass'n of Insurers Supervision, 1995), *in* 3 MODEL LAWS, REGULATIONS AND GUIDELINES 555-47 (1995) [hereinafter LIQUIDATION MODEL ACT].

105. *Id.* § 46(A)-(B).

106. *Id.* § 46(C).

Class 3 [loss claims include for distribution] [a]ll claims under policies including claims of the federal or any state or local government for losses incurred (“loss claims”), including third party claims, claims for unearned premiums, and all claims of a guaranty association, for payment of covered claims or covered obligations of the insurer. . . . All claims under life and health insurance and annuity policies, whether for death proceeds, health benefits, annuity proceeds, or investment values shall be treated as loss claims. That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, shall not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligation of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment by an employer to his employee shall be treated as a gratuity.

107. 11 U.S.C. §§ 701-766 (1988).

108. *Id.* §§ 1101-1174 (1988).

if such person is not . . . a domestic insurance company"¹⁰⁹ The Code, however, provides no definition of "domestic insurance company" for these purposes.¹¹⁰ The dilemma presented by the emergence of contemporary HMO structures is obvious: courts have been left to determine whether these entities are eligible for relief. If an HMO is deemed a "domestic insurance company," it will be barred from seeking relief as a debtor under the Bankruptcy Code.

Courts have generally applied three tests to determine whether an HMO is a domestic insurance company for purposes of the exclusion from bankruptcy protection. The tests include the "state classification" test, the "independent classification" test, and the "alternative relief" test.

A recent case involving the interpretation of the insurance company exclusion is *In re Estate of Medicare HMO*.¹¹¹ Medicare was a not-for-profit corporation licensed as an HMO in Illinois,¹¹² and was the seventh largest HMO in Chicago, serving 54,000 enrollees. For a fixed monthly fee, Medicare provided enrollees with hospital care, physician services, skilled, extended, and intermediate nursing care, home health care, pharmacy services, medical appliances, and ambulance services. Medicare also provided several preventative services.¹¹³ Medicare contracted with IPAs and directly provided care at four clinics.¹¹⁴

In March of 1992, the Illinois Director of Insurance delivered to Medicare a "Notice of Impairment," which required the HMO to correct an impairment of its net worth in an amount in excess of \$5 million within 30 days.¹¹⁵ When Medicare ultimately filed a

109. 11 U.S.C. § 109(b)(2) (1988). This exclusion from federal bankruptcy protection evidences a federal policy decision to defer to the states the regulation of insurance companies, H.R. REP. NO. 595, 95th Cong., 1st Sess., at 318-19 (1977), reprinted in 1978 U.S.C.C.A.N. 5963, 6275-77, a policy that started nearly one hundred years ago with the enactment of the Bankruptcy Act of 1898. Harvey R. Miller & George A. Davis, *The Interplay of Insurance Companies and the Bankruptcy Code*, in DIRECTORS' AND OFFICERS' LIABILITY INSURANCE 1993, at 247 (PLI Com. L. & Practice Course Handbook Series No. 659, 1993). This policy was reinforced when Congress enacted the McCarran-Ferguson Act. 59 Stat. 33 (codified as amended at 15 U.S.C. §§ 1011-1015 (1988)) ("The business of insurance . . . shall be subject to the laws of the several states." 15 U.S.C. § 1012.).

110. This applies to both Chapters 7 and 11. *Id.* § 109(d) (1988).

111. 998 F.2d 436 (7th Cir. 1993).

112. See 215 ILCS 125/1 to 125/6-19 (1994) (the Illinois Health Maintenance Organization Act).

113. *Selcke v. Medicare HMO*, 147 B.R. 895, 897-98 (N.D. Ill. 1992), *aff'd sub nom. In re Estate of Medicare HMO*, 998 F.2d 436 (7th Cir. 1993).

114. *Id.* at 898.

115. *Id.*

voluntary Chapter 11 petition for bankruptcy relief, the Director moved to dismiss the petition, claiming that the HMO was an excluded “domestic insurance company.”¹¹⁶

The bankruptcy court ruled that Medicare was not excluded from filing under the Code. The court noted that an HMO is permitted to be licensed under the HMO Act *or* the Illinois Insurance Code.¹¹⁷ It held that not all HMOs are insurance companies; only those licensed under the Insurance Code that are able to market indemnification insurance are considered insurance companies. The court ruled that the HMO’s function is the delivery of care, and that any indemnification is only incidental to this delivery.¹¹⁸ Thus, Medicare was ruled by the bankruptcy court not to be a “domestic insurance company.”¹¹⁹

The federal district court reversed on appeal. The court held that because Illinois adopted the Model HMO Act provision that requires HMO conservation, liquidation, or rehabilitation to be conducted pursuant to insurance provisions, Illinois law classifies HMOs for these purposes as insurance companies.¹²⁰ The Seventh Circuit Court of Appeals affirmed the dis-

116. *Id.* at 897. *See also* Resnik, *supra* note 24, at 275. Resnik notes that insurance regulators’ objections to Maxicare HMO affiliates’ Chapter 11 petitions were dismissed by the United States Bankruptcy Court for the Central District of California in five cases. *Id.* at n.24. *But see In re* Portland Metro Health, Inc., 15 B.R. 102 (Bankr. D. Or. 1981) (insurance commissioner’s motion to dismiss granted based on determination that HMO was an insurance company).

117. 998 F.2d at 437 (providing an account of the bankruptcy court oral decision). *See generally* 215 ILCS 125/1 to 125/6-19 (1994).

118. 998 F.2d at 438. The bankruptcy court determined that “the essential function of an HMO is the delivery of health care services and that, although this is accomplished through indemnification, the indemnification aspect is incidental to the delivery of care.” *Id.* *See also* Couch, *supra* note 19, §§ 1:2, 1:3. The definition of “insurance” is:

[a] contract by which one party, for a consideration, which is usually paid in money either in one sum or at different times during the continuance of the risk, promises to make a certain payment of money upon the destruction or injury of something in which the other party has an interest . . . [i]n a general sense, “insurance” is a contract to pay a sum of money upon the happening of a particular event or contingency, or indemnity for loss in respect of a specified subject by specified perils.

Id. § 1:2. In section 1:3, Couch explains that “[t]he primary requisite essential to a contract of insurance is the assumption of risk of loss and the undertaking to indemnify the insured against such loss.” Excepting contracts for life and accident insurance, in which the consequence is death, insurance “is a contract of indemnity by which is meant that the party insured is entitled to compensation for such loss as has been occasioned by the perils insured against, the right to recover being commensurate with the loss sustained . . .” *Id.* § 1:9.

119. 998 F.2d at 438.

120. 147 B.R. 895, 897-98.

strict court, holding that HMOs are insurance companies under Illinois law. The court noted the three tests courts utilize to determine whether an HMO is a domestic insurance company and therefore an excluded entity under the Bankruptcy Code.¹²¹ The *Medcare* court found these multiple tests unworkable and suggested an alternative.¹²²

1. The "State Classification" Test

Looking first to the statutory language of the domestic insurance company exclusion, the Seventh Circuit noted that courts have long deferred to laws of the organization's state of incorporation, in the absence of an explicit alternative, to determine whether a given entity is one that is excluded from federal bankruptcy protection.¹²³ This first test has been referred to as the state classification test.¹²⁴ The test may be satisfied either by a specific state law classification or by a determination that the organization is the "substantial equivalent" of an organization in the excluded group.¹²⁵

The Seventh Circuit implemented the "state classification" test by first looking to the Illinois HMO Act, which specifies that an HMO is classified as a "domestic company" for purposes of the Insurance Code.¹²⁶ The court placed great emphasis on the fact that Illinois adopted legislation nearly identical to the Model HMO Act provision classifying HMOs as insurance companies for purposes of liquidation, conservation, or rehabilitation.¹²⁷

121. 998 F.2d at 439.

122. *Id.* at 440. The court stated that

there should not really be three separate tests for ascertaining whether an entity is excluded from the protection of the Bankruptcy Code. Rather, absent express classification under section 109 or some other federal statute, the classification of an entity should generally follow the law of the state of its incorporation, so long as that classification does not frustrate the purposes of the Code.

Id. at 442.

123. *Id.* at 440 (citing *Security Bldg. & Loan Ass'n v. Spurlock*, 65 F.2d 768 (9th Cir.), *cert. denied*, 290 U.S. 678 (1933)).

124. See 2 COLLIER ON BANKRUPTCY § 109.02 (15th ed. 1994) (describing state classification test).

125. 998 F.2d at 438. See also *In re Cash Currency Exch.*, 37 B.R. 617 (N.D. Ill. 1984), *aff'd*, 762 F.2d 542 (7th Cir.), *cert. denied*, 474 U.S. 904 (1985) (discussion of state classification test).

126. 998 F.2d at 442.

127. *Id.* at 442-43.

Acknowledging that the existence of a state insolvency structure will not conclusively prove that the entity should be excluded pursuant to section 109(b)(2),¹²⁸ the court noted that adopting the model provision is of significance to the state classification test in three respects. First, the law specifically classifies HMO operation as a form of insurance for the purposes of rehabilitation and liquidation. Second, the provision places the insolvency process in the state law scheme created for insurance companies and supervised by the Director of Insurance. Third, the priority given to enrollee claims to maintain consumer security is consistent with priorities given to other similar claims in insolvency proceedings of other highly regulated entities excluded under section 109(b)(2).¹²⁹

To ensure that an exclusion resulting from the application of the state classification test does not disturb the effectiveness of the Bankruptcy Code, however, the Seventh Circuit also applied a “substantial equivalency” test.¹³⁰ In applying this additional test, the court stated that the focus is on the “essential attribute” of the organization.¹³¹ Factors for consideration include the degree of state regulation over the organization, the presence of a state law procedure for rehabilitation or liquidation, and the public or quasi-public nature of the organization.¹³²

In *Medcare*, the court acknowledged that the extensive powers and functions granted to insurance companies pursuant to Illinois law have no parallel within the Illinois HMO Act.¹³³ The court concluded that, based on definitions in the Illinois HMO Act, the “arrangement or management of health care is a basic attribute of an HMO”¹³⁴ The focus of this test is determining whether an insurance company and an HMO share the qual-

128. *But see In re Michigan Health Plan*, 90 B.R. 274 (E.D. Mich. 1985) (holding that HMO was not an insurance company at time of petition based on requested attorney general’s opinion of state classification).

129. 998 F.2d 436, 442-44.

130. *Id.* at 442, 444-45 (citing *Cash Currency Exchange*, 762 F.2d at 548).

131. *Id.* at 444-45.

132. *Id.* See *In re Southern Indus. Banking Group*, 59 B.R. 978 (E.D. Tenn. 1986) (application of similar three factors to issue of bankruptcy exclusion application to an industrial loan and thrift company); *In re Cash Currency Exch.*, 37 B.R. 617 (N.D. Ill. 1984) (analysis of determinative factors); see generally COLLIER, *supra* note 124, § 109.16 (“[e]ven application of the ‘state classification’ test does not prevent a bankruptcy court from looking into the substance of both the statute and the actual operations of the business under consideration”).

133. 998 F.2d at 445. See *In re Cash Currency Exch.*, 37 B.R. at 622-23 (currency exchange not granted same powers as banks subject to Banking Act).

134. 998 F.2d at 445.

ities leading to the exclusion of the former by section 109(b)(2).¹³⁵

The Seventh Circuit held that the “pivotal factor” leading to the deference to state law is the “assumption of a third party’s risk for a premium.”¹³⁶ Finding that Medicare assumed this risk, the court determined that it was the “substantial equivalent” of an excluded “domestic insurance company.”

Although the *Medicare* court holding suggests that the state classification test is the sole test, as long as the classification does not conflict with the Code, the Seventh Circuit noted that courts have differed in their applications of this particular test. Innumerable combinations of the three recognized tests appear in reported cases.

2. The “Independent Classification” Test

The “independent classification” test requires courts to interpret section 109 utilizing commonly accepted techniques of statutory construction.¹³⁷ It is a generally recognized tenet of statutory construction that when a provision enumerates exclusions, entities not specifically excluded are encompassed by the statute.¹³⁸ Exclusionary statutes such as section 109 are viewed as exhaustive, not illustrative.¹³⁹ Thus, a court might simply assess whether the HMO exercises powers and performs the functions attributed to those entities generally fitting the definition of an insurance company.¹⁴⁰ However, because the test is essentially based on a court’s own construction of the Code, courts have reached differing conclusions from applications of the independent classification test.

In *In re Cash Currency Exchange, Inc.*, the court applied the independent classification test to currency exchanges, holding

135. *Id.* at 444 (citing *In re Beacon Health, Inc.*, 105 B.R. 178, 180 (Bankr. D.N.H. 1989)).

136. *Id.* See *In re Portland Metro Health, Inc.*, 15 B.R. 102, 105 (Bankr. D. Or. 1981) (“The central insurance concept of the underwriting of, and the spreading of risk is not changed by non-insurance or non-traditional features of the debtor’s operation which involve provider agreements rather than cash dividends.”); *In re Beacon Health, Inc.*, 105 B.R. at 186. *But see In re Family Health Servs., Inc.*, 104 B.R. 268, 275 (Bankr. C.D. Cal. 1989) (one of a number of “Maxicare” cases involving numerous affiliates in a national HMO network).

137. See COLLIER, *supra* note 124, § 109-15.

138. Adam Hodkin, Note, *Insurer Insolvency: Problems & Solutions*, 20 HOFSTRA L. REV. 727, 735 (1992).

139. *Id.*

140. *Id.*

that since Congress chose to list excluded entities under section 109 and not provide illustrative examples, currency exchanges are not excluded from bankruptcy relief.¹⁴¹ The bankruptcy court also applied the independent classification test in *In re Beacon Health, Inc.*, to an HMO seeking Chapter 11 relief.¹⁴² While inquiring whether Beacon Health had “attributes that are substantially equivalent to those of an insurance company” for section 109 purposes,¹⁴³ the court rejected the argument that an HMO cannot be an insurance company because insurance includes indemnification and not the provision of health services.¹⁴⁴ The court concluded that the HMO was a “domestic insurance company” for purposes of section 109.¹⁴⁵

In the case of *In re Family Health Services*, the bankruptcy court applied the independent classification test and concluded that since Congress was aware of the existence of HMOs at the time of revisions to the Bankruptcy Code, Congress did not desire a modification or expansion of the insurance company exception for HMOs.¹⁴⁶ The court concluded that the HMO was eligible for bankruptcy relief since it was not expressly excluded by section 109.¹⁴⁷ In contrast, in *Portland Metro Health*, the Bankruptcy Court of the District of Oregon relied upon an anal-

141. 37 B.R. 617 (N.D. Ill. 1984), *aff'd*, 762 F.2d 542 (7th Cir.), *cert. denied*, 474 U.S. 904 (1985).

142. 105 B.R. 178.

143. *Id.* at 180.

144. *Id.* at 186.

145. *Id.* at 187. The court stated:

The provision of services as opposed to direct indemnification is merely a service in kind rather than cash. The HMO is simply an insurance company covering its obligation to protect subscribers against medical care charges in excess of the premium collected from them by providing the services directly in kind, or indirectly through contract physicians, rather than after-the-fact reimbursing in cash for charges paid directly by the subscriber elsewhere. From the viewpoint of the subscriber/policy holder, there is no functional difference between an HMO and an insurance company. It is immaterial to the subscriber/policy holder whether the services are provided directly or the cost of services provided elsewhere are reimbursed.

Id. at 186-87.

146. 101 B.R. 618, 621-22 (Bankr. C.D. Cal. 1989). The “Maxicare” cases involved numerous affiliates in a national HMO network. The bankruptcy court for the Central District of California consolidated all of the Chapter 11 proceedings, holding that none of the affiliates was excluded from Code protection by the insurance company exclusion. *Id.* at 622. However, the decisions were “blunted” when a district court reversed on appeal the bankruptcy court decision regarding the Wisconsin affiliate, based on an application of the state classification test. See *In re Estate of Medcare HMO*, 998 F.2d 436, 439 n.1 (citing *In re Family Health Servs., Inc.*, 143 B.R. 232, 235 (C.D. Cal. 1992), *rev'g* 104 B.R. 279 (Bankr. C.D. Cal. 1989)).

147. 101 B.R. at 622.

ysis of shared qualities among the entities excluded from bankruptcy relief to hold that an HMO was a domestic insurance company.¹⁴⁸ In comparing the excluded entities' powers and duties, the bankruptcy court noted that these entities are thoroughly regulated, subject to specific liquidation procedures other than those set forth in the Bankruptcy Code, and are at least quasi public in nature.¹⁴⁹

3. The "Alternative Relief" Test

A third test for determining whether entities are excluded by section 109(b)(2), the "alternative relief" test, was also rejected by the *Medcare* court. The alternative relief test assesses whether, assuming the presence of a state liquidation procedure, a bankruptcy proceeding is an agreeable alternative to the state procedure. The alternative relief test is grounded in policy, offering courts broad discretion in order to "serve the purpose and intent of the Bankruptcy Code."¹⁵⁰ Under this test, "courts should consider whether a bankruptcy proceeding is a satisfactory method, compared with available State and Federal non-bankruptcy methods, of reorganizing or liquidating a would-be debtor."¹⁵¹ Courts should focus on the policies underlying the federal bankruptcy laws, emphasizing "congressional intent and factors of practicality and policy."¹⁵² Equitable treatment of all unsecured creditors may be the determining factor.¹⁵³

Applying this test, courts have differed widely in their conclusions. Several HMO cases have involved entities serving numerous states; the argument made is that subjecting these entities and their members to differing relief in each state is undesirable and problematic.¹⁵⁴ In *Medcare*, the court summarily rejected arguments that classifying HMOs as insurance companies conflicts with a federal need for a uniform interpretation of the Bankruptcy Code. The court noted that the United States Supreme Court allows states to give priority to policyholders different from that given under the federal priority statute, de-

148. 15 B.R. 102, 104 (Bankr. D. Or. 1981).

149. *Id.* (the court used this analysis while applying the state classification test).

150. Hodkin, *supra* note 138, at 736 n.50.

151. *Id.* at n.51.

152. *In re Family Health Servs., Inc.*, 101 B.R. at 626 (citing *In re Republic Trust & Sav. Co.*, 59 B.R. 606, 614 (Bankr. N.D. Okla. 1986)).

153. *Id.*

154. *See In re Family Health Servs., Inc.*, 104 B.R. 268 (Bankr. C.D. Cal. 1989) (Chapter 11 petitions were filed by 47 affiliates of the national network of HMOs across 15 states).

spite the possible result of inconsistent state applications. The *Medcare* court concluded that Congress was well aware of this possible clash, yet intended deference to respect state law structures.¹⁵⁵

An argument under the alternative relief test that quicker disposition occurs through a single federal bankruptcy forum could be validly raised in insolvency cases for HMOs such as those in Kansas and Missouri, the two model states described above. In those states, there is substantial overlap in service and enrollment. Of the 37 HMOs reported to exist in Kansas and Missouri, 12 serve residents in both states.¹⁵⁶ Nevertheless, absent a statutory amendment, allowing a single federal forum based on the fact that the debtor is a multistate organization is not supported by constitutional or statutory authority and would contradict congressional mandate.¹⁵⁷

CONCLUSION

As health care markets become increasingly competitive and alternative delivery systems are forced to achieve increased efficiencies, certain HMOs will be forced to exit the market. However, an HMO that petitions for federal bankruptcy protection faces dismissal based on the Code's procedural exclusion for domestic insurance companies.

Courts have erratically applied the "state classification," "independent classification," and "alternative relief" tests to determine whether an entity is excluded from bankruptcy protection under section 109(b)(2). In *Medcare*, the court proposed that the state classification test is controlling. In states in which the statutory and regulatory classification is ambiguous, however, this analysis will not yield consistent conclusions. Further, in multistate insolvencies, it remains a practical truth that state law classifications may result in inefficient and disparate treatment of claims. Lastly, it is not clear that Congress intended to delegate discretion to the states to control which entities will receive federal bankruptcy protection.¹⁵⁸ As courts increasingly con-

155. *In re Estate of Medicare HMO*, 998 F.2d at 447. *But see In re Family Health Servs., Inc.*, 101 B.R. at 636 (accepting argument that uniform federal reorganization is desired over state proceedings based on practical and policy factors).

156. DIRECTORY, *supra* note 11, at 176-80, 220-28. Currently, two "group model" HMOs serve counties in both Kansas and Missouri. *Id.* at 179, 224.

157. Branch & Fitzgerald, *supra* note 101, at 768.

158. Patrick Collins, *HMO Eligibility for Bankruptcy: The Case for Federal Definitions of 109(b)(2) Entities*, 2 AM. BANKR. INST. L. REV. 425, 450 (1994). *See generally*

front insolvencies of alternative delivery systems that eviscerate traditional insurance and HMO concept distinctions, the state classification test will likely prove inadequate.¹⁵⁹

id. (offering complete discussion of case for federal definitions of section 109(b)(2) entities).

159. *See id.* at 439-44 (presenting arguments surrounding state law classification test and suggesting a need for federal interpretation of the terms included in section 109(b)(2)).