

Potential Regulation of Third Party Administrators

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Office of the Insurance Commissioner

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Executive Summary

This report provides information on a study by the University of Washington Health Policy Analysis Program and William M. Mercer, Incorporated, performed under the direction of the state Office of the Insurance Commissioner. The study assesses the need for regulation of third party administrators (TPAs) or entities that assume risk from, or affect the risk of, regulated insurers (carriers, health care service contractors, and HMOs).¹

The study entailed a:

- Review of historical information on economic and other failures of risk-bearing health care delivery, financing, and administrative entities and their sub-contractors,
- Literature review on “down stream risk” and TPA regulation,
- Review of information from, and discussions on this topic with, staff of the National Association of Insurance Commissioners (NAIC),
- Survey of a sample of representatives of departments of insurance in other states about the extent of TPA regulation in their jurisdictions, if any, the reasons for such regulation, and their assessments of the effects of regulating TPAs, and
- Series of interviews with stakeholders in Washington State about their perceptions of potential positive and negative ramifications of TPA regulation here.

Based on our analysis of this information, we do not find any compelling reason to initiate regulation of TPAs in Washington at this time. However, the state may wish to consider implementation of basic TPA registration requirements, clarification or tightening of solvency requirements of insurers using TPAs, regular monitoring of insurer-TPA contracts, and clarification of requirements pertaining to the collection and use of sensitive data.

¹ *Third party administrators serving self-insured plan sponsors are not being considered at this time.*

Introduction

Background

In 1998, an administrative services organization called HealthLink, working on behalf of Physician Health Network and Northwest Medical Services, was unable to distribute benefit payments to approximately 2,000 health care providers in Eastern Washington. Because none of these organizations was technically an insurer, they were alleged to have been able to operate with inadequate financial controls and records, resulting in bankruptcy. As a result, providers were also unable to recover a portion of their fees.

In the latter half of 2000, concerns were raised by chiropractors throughout Western Washington about the developing alliance between Regence Blue Shield and Complementary Health Plans (CHP). Regence's objective in outsourcing chiropractic network activities to CHP was to ensure "sufficient access, a qualified network of expert providers and the effective management of this care in order to keep these benefits at a reasonable cost to our employer groups and members." Chiropractic providers were concerned about their possible exclusion from the proposed network, restrictions on their reimbursements for the care of Regence members, restrictions on covered services, and other matters affecting their practices (e.g., facility changes for patient privacy).

The anticipated actions of Regence and CHP, the latter of which is not regulated in Washington, spurred the development of legislative bill HB 1383, "Regulating the activities of third party administrators" sponsored by Representative Thomas Campbell. The relationship of Regence and CHP has since terminated,¹ and the bill did not pass.

At present, certain risk-bearing entities – i.e., organizations that are "at financial risk for services provided by others through contractual assumption of liability for the delivery of specified health care services to covered persons of the carrier" – are regulated by the state. They include HMOs, carriers, and health care service contractors. However, in light of the activity associated with HB 1383, the Legislature allocated funds to explore the necessity of, and potential approach to, regulating organizations that accept risk-related functions from these types of organizations. The study of potential regulation of third party administrators has been directed by the Office of the Insurance Commissioner (OIC). This report discusses the approach and findings of that study, which was undertaken by the University of Washington Health Policy Analysis Program (UW HPAP) and William M. Mercer, Incorporated (Mercer).

¹ *Variations of these situations continue to arise from time to time. For example, certain physician groups have had operating problems, reportedly because of the nature of their managed care contracts. In 2000, Valley Medical Center in Renton terminated its preferred relationship with Premera Blue Cross, alleging the inadequacy of reimbursement. Similar problems have been encountered since by other plans (e.g., Regence concerning St. Joseph Hospital, Tacoma's anesthesiologists; PacifiCare concerning MultiCare Medical Center-Tacoma's staff physicians and Aetna concerning Swedish Hospital & Medical Center), although some of these problems have been resolved.*

Objectives and Methodology

This study explored whether a “compelling State interest” exists to regulate third-party administrators (TPAs). A compelling State interest to intervene in the private marketplace occurs when actual or potential harm might otherwise be suffered by state residents and businesses.

Since the focus of OIC interest is on economic harm, the focus of this study was similarly on those organizations that have the potential to cause economic harm through their assumption of certain insurance functions on behalf of otherwise regulated insurers. These insurance functions can have an influence on the economic risk of insurers, and would include¹:

- Evaluating applicants for coverage (underwriting)
- Collecting and forwarding premium payments
- Repricing provider bills (e.g., applying discounts or contracted limits on charges)
- Processing claims
- Paying claims

To explore this issue, the researchers:

- Explored historical information on economic and other failures of risk-bearing health care delivery, financing, and administrative entities and their sub-contractors,
- Reviewed literature on “down stream risk” and TPA regulation,
- Reviewed information from and participated in discussions with staff of the National Association of Insurance Commissioners (NAIC),
- Surveyed a sample of representatives of departments of insurance in other states about the extent of TPA regulation in their jurisdictions, if any, the reasons, and their assessments of the results, and
- Interviewed stakeholders in Washington about their perceptions of potential positive and negative ramifications of TPA regulation in-state.

Please note that both UW HPAP and Mercer are consulting organizations and cannot provide legal advice. Accordingly, the OIC should review this report with its own legal counsel.

¹ *Determining premiums (actuarial support) is not included, because the insurer is responsible for this function, and is assumed to seek actuarial opinions only.*

TPA Regulation Issues

Definitions, Functions and Impacts

A shared definition of a “third party administrator” (TPA) is difficult to find, so that some organizations like the NAIC define TPAs by what they are not. Additionally, some administrative service organizations indicate in their contracts that they are not to be considered TPAs, for reasons unspecified.

The term “TPA” is often used to refer to administrative entities that process claims on behalf of self-insured plans. These entities are delegated responsibility for adjudicating claims in accordance with eligibility and benefit provisions of plans, as well as applicable law, but are not directly responsible for overall claim costs. However, these types of entities and services are explicitly excluded from NAIC model legislation and current state law because the operations of self-funded life and health plans fall under the federal Employee Retirement and Income Security Act (ERISA) of 1974, as amended, which provides preemption from state insurance law.

Accordingly, to assess the potential scope and value of state preventive or ameliorative interventions with regard to TPAs, several definitional questions needed to be addressed first:

- What is a third party administrator for purposes of potential state oversight and control?
- What functions do TPAs perform, who is affected by TPAs and how?

We have attempted to answer these questions below and present stakeholder and expert viewpoints about TPA regulation.

What is a third party administrator (TPA) for purposes of potential State oversight and control?

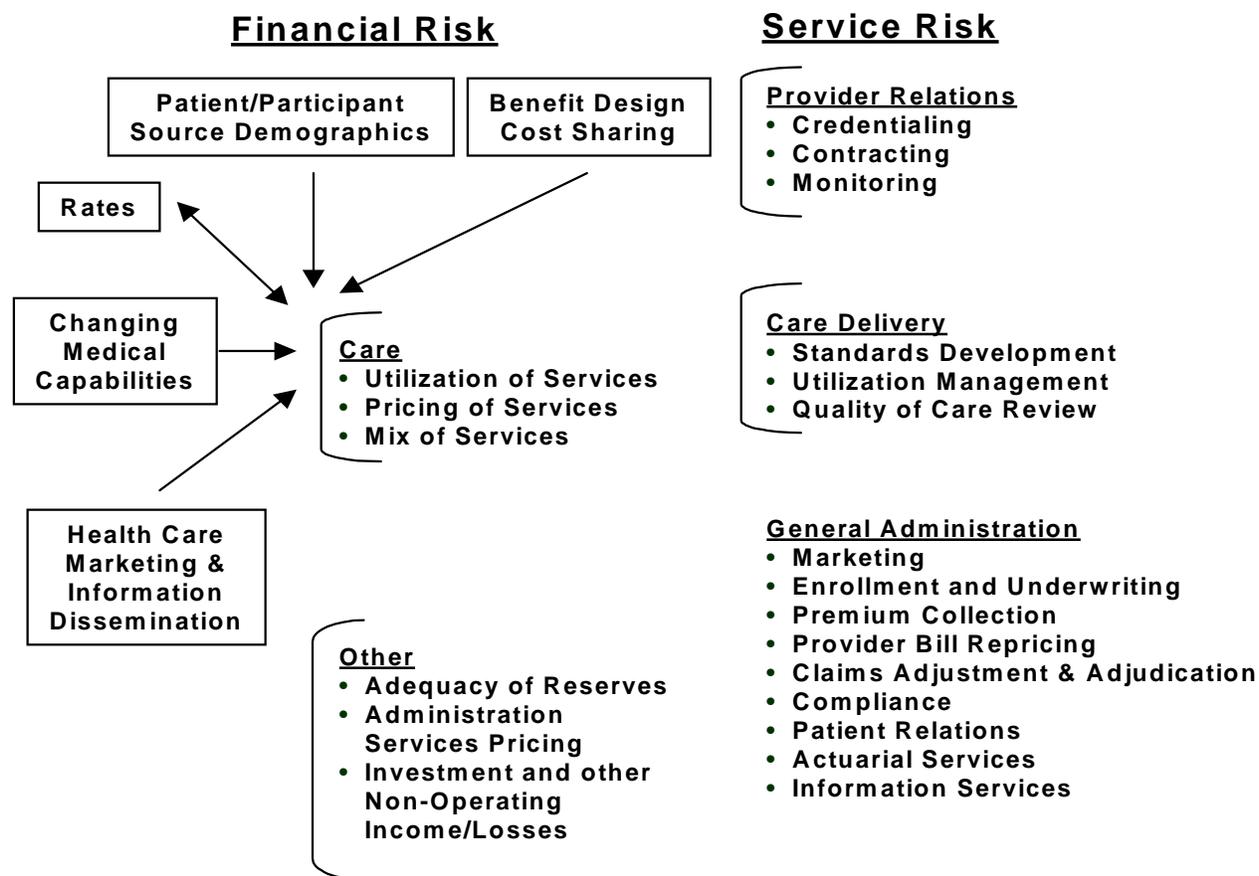
Given the difficulty of defining a TPA, we have elected to use a functional definition for purposes of this study. The National Association of Managed Care Regulators (NAMCR) provides an interesting discussion of the functions of TPAs in a paper titled “Downstream Risk & Delegation.” (Downstream risk delegation might also be called outsourcing or sub-contracting.) The NAMCR broadly groups downstream risk into two categories – those presenting “financial risk” and those presenting “service risk.” (See exhibit on next page.)

Financial risk activities directly address insurance issues, including pricing products (insurance plans), setting reserves, determining and implementing investment policy, and other measures. At present, these activities are generally governed by existing state insurance law when performed by insurers, health maintenance organizations, and health care service contractors. In some cases, these functions are “shared” with providers who accept risk because they believe they can better manage and retain the funds allocated for care; these arrangements are not specifically addressed in state law, except to the extent that they fall under certain “managed

care” considerations (e.g., under HMOs). Additionally, some financial risk activities are supported by non-risk-bearing entities (TPAs) that are considered, and consider themselves, to be in a consultative role only; again, these arrangements are not specifically addressed in state law.

Other functions are not directly subject to insurance law, despite their importance, as they are generally considered to be administrative functions. Among these “service risk” activities are provider relations activities, care management and delivery-related functions, as well as marketing, underwriting, premium collection, benefit payment, and other services. When these activities are performed by TPAs on behalf of a self-insurer, they may fall beyond the purview of state regulation. However, to the extent TPAs perform services on behalf of an insuring entity subject to state law – e.g., in a subcontracted role – their independence from regulation may be questioned, because they may affect risk to the insuring entity itself, persons covered by insured plans, and providers of care. It is to the latter functions, when performed for insured plans, that further TPA discussion turns.

Types of “Risk”* Subject to “Downstream Delegation” or Outsourcing



Care

- Utilization of Services
- Pricing of Services
- Mix of Services

Other

- Adequacy of Reserves
- Administration
Services Pricing
- Investment and other
Non-Operating
Income/Losses

*Graphic conceptualization suggested by “Downstream Risk & Delegation” by National Association of Managed Care Regulators, June 1, 2001.

What functions do TPAs perform, who is affected and how?

Because insuring entities are generally focused on activities directly related to the assumption and management of risk, they often purchase selected services from other organizations focused on non-core functions. Non-core functions may involve infrequent activities or services that require specialty capabilities (e.g., printing of new booklets or ID cards, promulgating treatment guidelines for purposes of setting and enforcing standards of care and utilization).

However, major risk-related functions also may be sub-contracted to TPAs including, but not limited to those shown in the following table, along with the issues they present to affected parties.

Risk-Related TPA Functions, and Issues for Affected Parties

General Activity	Related Tasks and Activities	Who is Affected and How?		
		Risk-Bearing Entities	Consumers	Health Care Providers
Evaluating Applicants for Coverage		Risk of claim	Access to coverage	Number of actual and potential patients with insurance
Premium Collection		Availability of funds for payment of claims and development of reserves	Initiation and/or continuation of coverage	Number of persons with in-force insurance
Provider Networking	Determination of network size	Marketability of plans	Choice of providers from whom services may be received with certain levels of benefits	Volume of potential patients and certain associated fees from both insurers and patients
	Development of participation criteria, the development and evaluation of provider application materials and ongoing "re-credentialing"	Reduced provider management responsibility, perceived quality of network providers in the plans marketed	Choice of providers, with specified levels of benefits and cost sharing limits available for the services they provide	Ability to participate in certain plans, expected volume of potential patients and associated fees
	Authorizing care, whether in collaboration with providers or unilaterally (utilization management)	Volume and type of services for which benefits will be paid (expected claim mix and expense)	Volume and type of services for which benefits will be paid	Volume and type of services for which benefits will be paid
	Managing benefits (plan design)	Marketability of plans, risk of claim	Perceived adequacy of benefits, cost sharing expectations	Volume and type of services for which benefits will be paid
	Repricing provider bills (applying discounts or other limits on charges)	Reduced administration, and reduced claim risk	Should be relatively invisible	Level of patient care revenues
	Adjudicating claims	Cash flow, current and future claims expenditures, level of future premiums	Ability to obtain care under usual benefit provisions (normal cost sharing obligations); avoidance of duplicate billing	Ability to cover practice costs
	Ongoing quality (of care) monitoring	Possible marketability of plans	Perceived quality of care	Perceived intrusion into care practices, uncertain legal liability
Processing and Paying Claims Only		Cash flow, current and future claims expenditures, level of future premiums	Ability to obtain care under usual benefit provisions (normal cost sharing obligations); avoidance of duplicate billing	Ability to cover practice costs

Specific examples of entities that might be considered specialty or carve-out TPAs are listed below by specialty area. A number of functions that they perform have a bearing on financial risk. These functions include negotiating with providers, repricing bills, adjudicating claims, and paying claims. However, the extent to which they perform these types of functions for in-state, regulated insurers appears to be small.

Prescription Benefits Management Organizations

AdvancePCS	National Prescription Administrators
Caremark	PCN
Certifax/Walgreens	Postal Prescription Services
Eckerd	Prescription Solutions
Express Scripts	ProVantage (a Merck-Medco Company)
Inteq	RxAmerica
Longs (an Rx America Company)	Rx Prime
MedImpact	Scrip Pharmacy Solutions
Merck-Medco	Systemed (a Merck-Medco Company)
National Medical Health Care systems	Unicare

Behavioral Health Management Organizations

APS	PacifiCare Behavioral Health
CIGNA Behavioral Health	United Behavioral Health
Magellan Behavioral Health ¹	Value Options
Managed Health Network	

Free-Standing Medical Preferred Provider Networks

Beech Street (uses First Choice network)	First Health
CCN (uses First Choice network)	PHCS
First Choice Health Network PPO	ProAmerica

Alternate Health Care Networks

American Specialty Health Network
Complementary Health Plans

¹ Provides limited services to Regence Blue Shield.

Viewpoints on TPA Regulation

Other States

Some 37 states regulate TPAs at this time. The year in which TPA legislation was enacted is shown by state in the following table.¹ Please note that certain states such as Connecticut discontinued previous TPA regulation efforts.

Date of Enactment	State	Date of Enactment	State
None	Alabama Colorado Connecticut D.C. Delaware Guam Hawaii Massachusetts Puerto Rico Vermont Virginia Virgin Islands Washington West Virginia	1988	Ohio South Carolina
1967	Minnesota	1989	Iowa New Mexico Texas
1977	Arizona California Nevada	1990	Maine
1978	Kansas	1991	Georgia Maryland Mississippi North Carolina Oregon Wisconsin
1979	Montana	1992	Alaska Nebraska
1980	Indiana Tennessee	1993	Louisiana Missouri South Dakota
1983	Florida Idaho Oklahoma	1994	New Hampshire
1984	Illinois Wyoming	1995	Pennsylvania
1985	Arkansas Michigan North Dakota	2001	New Jersey New York Rhode Island
1986	Kentucky Utah		

¹ Source: Attachment to the NAIC Third Party Administrator Statute (Model), July 2001. This information may differ from the NAIC's Compendium of State Laws on Insurance Topics: Third Party Administrator Insurance and Bond Requirements.

The table in **Appendix 1** provides NAIC's summary of the types of TPA regulatory approaches undertaken by the various states. Regulators' comments on the efficacy of their own states' programs, and their suggestions for Washington, were obtained through a telephone and e-mail survey. (The associated questionnaires are shown in **Appendices 2** and **3**. The state respondents are listed in **Appendix 4**.) State-specific responses varied in depth and are summarized below in alphabetical order. We have not made any independent attempts to verify descriptions of the states' TPA regulation programs, their history, or the language of their applicable laws.

Arizona

The representative of Arizona could not relate the legislative history of the TPA regulation, because it has been approximately 25 years (1977) since the adoption of the original laws and no historical documents are available at the department. Arizona reportedly requires that all life, health, and annuity administrators obtain a Certificate of Registration from the state. The TPA must subsequently remain solvent, file annual financial reports, and file any changes in company organization or ownership. Arizona's TPA statutes follows the NAIC model with additions based on specific state requirements. No information was provided on issues relating to the impact of the TPA regulation or how the regulation has changed.

The Arizona regulatory staff representative suggested that Washington State should start with the NAIC Model TPA Statute and modify it according to Washington's own requirements in other areas of insurance regulation. The department representative explained that since Arizona requires registration it would only follow that Arizona supports this type of authority.

Arkansas

The regulator in Arkansas provided very little information with regard to the state's TPA regulation program and added that other staff in the Department of Insurance could not provide any additional information. Arkansas requires TPAs for life and health coverage to register with the state. In addition, the Workers Compensation Commission of Arkansas has just begun to require registration of TPAs serving industrial insurance programs in the state.

Georgia

In the early 1990's, the Georgia Office of the Insurance Commissioner (OIC) pushed for regulation of workers compensation TPAs because of rising workers compensation costs and because of the industry's reliance on TPAs to handle the insurance aspects. This regulation expanded into the life and health arena. Currently, the workers compensation arena is not as active, and the Georgia OIC continues to monitor the compliance and solvency of other TPAs. The regulator explained that the initial legislation failed to acknowledge that many administrators were administering ERISA plans. The OIC subsequently made provisions for exempting these companies.

The individual we interviewed reported a continuing, high level of accountability between the TPAs and the OIC. Georgia recommends that Washington State regulate TPAs because they are such critical players in the insurance marketplace and often control much of the activity between insurers and their customers, frequently being responsible for fiduciary duties. TPA regulation in Georgia is said to be fairly strong, second only to Florida in regard to requirements for licensure.

The regulator explains that she would be pleased if Washington State employed a similar approach.

Idaho

Idaho reported it began to regulate TPAs in 1983 because of problems with claim payments and other aspects of TPA fiduciary performance. Idaho used the NAIC model and has not changed its program materially in the last twelve years. Idaho chose to regulate TPAs working for insurers that administer insured health, life, disability, and annuity products, including self-insured plans with insured stop-loss coverage. The Idaho Department of Insurance, Consumer Affairs Section is focused on how the TPAs are paid, their record keeping processes, and the fiduciary relationships they have with insurers. The regulator states that, because TPA compensation cannot legally be based on claims paid in any manner, the TPAs have no incentive to process claims if funds are not available, nor do the TPAs have an incentive to not process the claims. No formal evaluation has been performed in Idaho to look at the fiscal impact of TPA licensing, and the regulator believes that TPA regulation has not affected patient or provider access in any way.

Currently, Idaho is looking at the evolving NAIC model law to expand its focus to all TPAs, even those working with self-funded programs. The representative explained that the possibility of injury to the public is greater for TPAs of self-funded programs, because state insurance law is interpreted to hold insurers responsible on all fiduciary aspects of insured plans. Enforcing this responsibility on self-insurers might be more difficult.

Indiana

Indiana began to regulate TPAs in 1980, basing its law on the NAIC model. The focus of Indiana regulations is on protecting the customer.

Iowa

The Iowa Insurance Division supervises all insurance business transacted in the state, including transactions of health maintenance organizations and mutual hospital and health service corporations. Iowa's TPA regulation was passed in 1989, although no known events instigated it. Iowa chose to not use the NAIC model, instead relying on its own staff to develop a statute modeled on those of other states. Iowa's TPA regulation laws have not been changed since implementation.

Iowa TPA regulation applies to all administrators, including those that administer self-insured plans' premiums or settle claims on life insurance, health insurance, or annuities. The Iowa Insurance Division licenses all administrators in the state, collects fees, and assures that companies each have \$50,000 minimum bonds.

The regulator stated that the impact on various stakeholder groups has been minimal. He explained that insurers have felt no impact because they are exempt from this particular law. The Insurance Division has not suffered any major costs, because the TPA licensing process is fairly simple and takes place only once every three years. The state has not encountered any TPA resistance to registration because of the minimal licensing fees (\$100 every three years) and low bond requirement. TPA regulation does have an added benefit in Iowa, as many residents are

said to be confused about the difference between a TPA and their insurance company and call the Insurance Division to lodge complaints. Because of the law, the state has the authority to take action, as needed.

However, the regulator does not feel several areas of the law are adequate to deal effectively with TPA financial solvency. The minimum bond amount may not be adequate, because \$50,000 can be consumed in one claim.

Kansas

Initial TPA regulation was thought to have been implemented to assure financial solvency because of the threat of a TPA intermingling funds and practicing inaccurate accounting and record keeping services. Kansas used the original NAIC model to create a TPA registration process for only those organizations that have a contract with an insurer and serve Kansas residents. This process has created a licensed TPA organization “mailing list” of sorts, permitting the Insurance Department to contact TPA organizations but not affect areas of financial solvency or other matters.

The regulator believes that TPA regulation has had a minimal impact on insurers, TPAs, providers, and consumers, because it is a licensing process only, not designed to affect the financial solvency of the TPAs or the companies that work with them. The regulator explained that Kansas is planning to implement the new NAIC model as soon as it is approved and to register its domiciled TPA organizations so they can be involved in the general TPA market. He is concerned that states that do not adopt this new model will be preventing their domiciled TPAs from doing business elsewhere. Based on what is currently in the Kansas statute, the representative explained that he would not recommend the model that they are currently using but feels that the new NAIC model will be more helpful in regulating the industry.

Kentucky

A complete history of Kentucky legislation on TPA regulation is not available. However, the Kentucky representative explained that the regulation probably came about because Kentucky recognized the need to regulate individuals and business entities that had the potential of handling large sums of premiums and adjudicating claims on life, health, and annuity contracts. Kentucky enacted legislation in 1986 that parallels the NAIC model TPA statute but also includes numerous additions.

Kentucky uses its TPA laws to regulate the collection of premium and settlement of claims on life, health, and annuity contracts. Administrators are required to be licensed and pass an examination. The emphasis of the regulation includes: financial oversight by the insurer as well as the Department of Insurance; disclosure of the administrator's role to the insured; and regulation as a licensee, rather than as one that holds a certificate of authority. The only substantive change since 1986 is outlined in a legislative proposal for 2002. It is intended to make the licensing procedures and enforcement standards uniform across all insurance licenses, including agents, adjusters, administrators, consultants, and surplus line brokers.

Kentucky recommends that Washington State regulate administrators, because they handle a major segment of insurance transactions and should be within the purview of regulation to avoid putting insurers and consumers at unnecessary risk.

Montana

Montana's legislation was passed in 1979 but resources are not readily available on its history. Montana did not use the NAIC model for its regulation.

Administrators of health, life, property, and casualty who collect premiums or adjust claims are required to apply for a license in Montana. The representative explained that Montana TPA regulation has three areas of emphasis: to make sure that any entity acting as an administrator is licensed; to review the financial status of each administrator to ensure solvency; and to ensure that all agreements between administrators and insurers are in compliance with Montana administrator law. The regulator believes that Montana's regulation has been beneficial, but that each state should decide whether similar regulation would be appropriate.

Oklahoma

The Oklahoma regulator believed that its statute was initially adopted to protect consumers, based on the NAIC model. As outlined in the Oklahoma statute, an "administrator" means any person who collects premiums for an insurer or trust or who adjusts or settles claims for an insurer or trust in connection with life or health insurance coverage or annuities. The term is not applied to administrators of self-insured plans or associations. Under Oklahoma rules, each TPA is required to be licensed, be bonded, issue annual reports to the DOI, and pay an annual license fee of \$100. A surety bond for at least ten thousand (\$10,000) is intended to secure performance of the administrator in conformity with the laws, rules, and regulations governing third-party administrators.

The Oklahoma representative reported his belief that TPA regulation has not changed any of the relationships between insurers, TPAs, providers, and consumers, although no formal evaluation has been conducted. He recommends that Washington State "follow [our] heart" in regard to the approach that would be the most beneficial here.

Oregon

No known, documented history exists of the 1991 TPA legislation in Oregon, but the individual we interviewed believes that the NAIC model was used as its template. Oregon requires TPAs dealing with life and health coverage to be licensed with its Insurance Division. The threshold for requiring a license is whether the TPA "directly or indirectly solicits or effects the coverage of, underwrites, collects charges or premiums from, or adjuster settles claims on, residents of this state or residents of another state from offices in this state, in connection with life or health insurance coverage." The emphasis of Oregon's law is to ensure that TPAs will commit to being responsible parties. No comments or recommendations for Washington State were offered.

Pennsylvania

The Pennsylvania Insurance Department was granted the authority to begin regulating administrators in early 1995 after it encountered "several instances of unlicensed illegal activity

involving TPAs.” The Pennsylvania law used the NAIC model, and provides for “regulatory oversight of TPA activities, ... financial responsibility requirements and other protections relating to funds entrusted to TPAs.” TPAs subject to the law are those that collect charges or premiums, or adjust or settle claims for insured and wholly or partially self-funded plans, including those of multiple employer welfare arrangements and self-insured political subdivisions. No statistical or other information was provided on the impact of the law. The Pennsylvania regulator suggested that “with the development of the NAIC model for this licensure type, I would recommend a review of the applicability of the model act to the Washington insurance environment.”

South Carolina

The regulator explained that South Carolina chose to begin regulating TPAs in 1985, because these organizations were performing insurance functions (such as the collection of premiums and paying claims) for residents of the state. South Carolina adopted the NAIC model of regulation with an emphasis on consumer awareness and industry standards. South Carolina regulates TPAs if they administer fully insured plans, but not those that administer self-insured plans. The relationship between TPAs and insurance companies is said to be better than in the past. The Department recognizes that TPAs can play an invaluable role and that they are often in a more accountable position than a carrier alone. Additionally, TPAs were said to be in the best position to explain reimbursement and renewal practices of a carrier, allowing the insurer to concentrate on other markets while servicing their existing business. No evaluation has been made of South Carolina's TPA regulation program.

South Dakota

Initially, South Dakota chose to regulate TPAs because it was a requirement for NAIC accreditation and the state needed some method of requiring response with regard to claim payments on behalf of, and complaints from, consumers. These regulations have not changed since 1995.

South Dakota regulates TPAs by requiring them to be licensed if they are domiciled in the state, and registered if non-resident. All TPAs including those handling workers compensation are regulated. Consumers, the regulator explained, are better protected with this oversight if a TPA becomes insolvent.

South Dakota plans to adopt the new NAIC model when it is approved. The South Dakota representative suggests that Washington adopt the new NAIC model so that there is uniform regulation across the country.

Washington Stakeholders

Project personnel attended stakeholder meetings held by the OIC in August and November, and interviewed interested stakeholders in November and December 2001. The interviews relied on the questionnaire shown in **Appendix 5**, although the “energy” shown by many participants as they explicated their positions obviated the need to ask each question in every interview.

Interview participants are listed in **Appendix 6**. Comments from the stakeholders are summarized below by stakeholder type.

Risk-bearing entities – Insurers were especially likely to suggest that TPA regulatory initiatives might be premature or unnecessary, because past problems remained anecdotal and occasional, rather than widespread and systematic. Generally, they also felt that existing insurance laws address risk-related issues and functions adequately, whether performed by insurers or by TPAs, and that insurers acknowledge their responsibilities in contracts and actions. (Actual performance levels may vary.) They suggested that any problems could be prevented and addressed through more explicit language on ultimate risk in existing insurance law – leaving that risk with currently regulated insurers.

Insurers suggested that much of the problem with downstream financial risk may involve the financial acumen of certain provider groups that have entered into managed care risk contracts. Providers were seen as assuming responsibility for risk that they could not properly manage (e.g., physicians who accept risk for the hospitalization expenses of their patients or who accept full capitation). Additionally, providers may be complaining about negative financial impacts to themselves and patients caused by downstream risk from insurers, when the providers are simply unable to manage their own business operations. Risk-bearing entities were uncertain about the extent to which TPA regulation would protect against provider insolvency and were concerned that any new solvency rules not be stretched to address provider negotiating, network management, or other network matters.

The risk-bearing entities suggested that if additional regulation on solvency or other financial matters is deemed necessary, a clear definition of a TPA would be warranted. Said one representative, “The NAIC bill hasn’t been much help.” As an alternative, clearer language on downstream risk might be appropriate. Perhaps even more, stricter enforcement of current law might be pursued. Said one respondent, “[We are] looking for a regulatory holiday. The industry is a little bit beleaguered.”

Consumers – The familiarity of consumer representatives with the issue of TPA regulation appeared limited. Some voiced concerns about ensuring that risk was retained by the insurer, rather than having to be picked up by the consumer (patient) or taxpayer. In this vein, one consumer group’s representative suggested that the OIC at least independently confirm the solvency of a TPA through its financial statement, as should any insurer entering into a relationship with the TPA. Additionally, the OIC might require that TPAs post bonds.

Another consumer concern involved the issue of privacy, independent of any safeguards imposed by recent amendments to the federal Health Insurance Portability and Accountability Act (HIPAA) or other consumer protection measures. One consumer group raised concerns about the maintenance of patient privacy in situations where, due to downstream administration, extra individuals and organizations work with individual level eligibility and claim (service utilization) data. The interviewee was interested in the availability of insurer and OIC monitoring procedures to ensure that privacy safeguards are addressed in subcontracts, and that they are utilized.

Health Care Providers – Provider organizations focused on downstream risk issues such as repricing provider bills and adjudicating claims – i.e., those involving “handling money.” TPAs operating “carve-out” programs concerning selected benefits (e.g., behavioral health, prescription drugs) were mentioned specifically. Additionally, providers voiced concerns about other insurance-related matters, including:

- Cost sharing differentials and benefit differentials for behavioral health vs. physical health care;
- The validity of insurer or TPA oversight of treatment (for purposes of utilization management and quality assurance purposes), and its impact on professional liability risk;
- Inappropriate requests for patient-specific data gathering (e.g., on allergies and medication use when providers cannot prescribe drugs within the scope of their licenses);
- Service authorization activities (utilization management) that are not adequately coordinated with benefit verification activities. An example might occur when an entity approves 15 visits for a condition, without addressing the fact that benefits are limited to 10 visits;
- Secret and/or exclusionary network development criteria (both the criteria under which a provider might be included and the total number of providers to be allowed into the network);
- Patient referral rules and criteria; and
- Unilateral agreements issued by insurers or TPA to providers of care, with little regulatory oversight of insurer intent and provider impact.

Interest was expressed in having checks and balances so that:

- Claims would be covered if services were authorized by a TPA or insurer – thereby eliminating conflicts between the amounts of services authorized based on individual patient needs and benefit payments limited by general plan design limits. Discrepancies in this area are considered by providers to be a revocation of prior authorization;
- Required administrative activities by providers would not be unreasonable. (An example was provided by a mental health professional who was asked to complete 12 or 13 pages of information to obtain authorization of a small number of treatment sessions for a single patient. The time expended on this administrative activity was not reimbursable.);
- Providers would not be at professional (quality of care) risk for “withholding” services or providing “excess” services, in light of the treatment plans reviewed by TPAs or insurers. (One aspect of this issue might almost be considered “upstream risk,” in which a provider’s treatment approach is directed by an insurer or TPA. The provider’s legal responsibility for the patient then becomes unclear.);
- Insurers and TPAs could not delay payment to providers by invoking artificial reasons (e.g., the need to suspend payment of claims that are “not clean”);
- Providers would not be at financial risk for “excess” services authorized by an insurer or TPA;
- Providers would not be precluded from accepting direct payment from patients for services not covered by health plans (e.g., services in excess of plan limits), even when patients knowingly requested them; and

- Insurers or their TPAs could not misuse network rules and size to limit access and choice. At the same time, one provider organization representative cautioned against permitting a TPA law to become “an any willing provider law.”

Providers appeared to be fairly open to TPA regulation for the reasons listed above. They also countered expected stakeholder concerns that additional regulation would “stultify innovation” in the health financing marketplace. However, they openly stated concerns that providers might be drawn under new insurance regulation, or under changing interpretation of insurance law. One concern was whether providers accepting risk (e.g., under capitation arrangements) would be regulated by the OIC as well as by the state Department of Health (i.e., professional licensing boards), specialty boards, national associations, and other groups. Additionally, even provider organizations suggested that there is no “need to over-regulate,” and that the NAIC’s model TPA statute “doesn’t answer [providers’] issues in this state.”

Others – “Other” organizations we interviewed for this study included employer/business groups and entities that might be subject to TPA regulation.

One employer representative acknowledged that the NAIC model statute, and the OIC, are already making clear distinctions about TPAs that serve insured rather than self-insured (ERISA) plans¹. He cautioned against invoking rules for TPAs providing “purely ministerial functions” for insured plans, such as eligibility data transfer and verification. He suggested that regulated companies (insurers) are adequately overseen with regard to consumer protection, market conduct, solvency protection and hold harmless provisions. His concern was that new rules would only satisfy certain provider groups whose concerns are somewhat separate from insurance issues and would add to the cost, complexity and staffing demands of both TPAs and the OIC.

One entity that might be considered a TPA was open to regulation of some sort, if requested filings do not extend beyond other required filings (e.g., with the federal Securities and Exchange Commission) for publicly-traded organizations or financial statements for privately-held organizations. Further, the insurer might be held ultimately accountable for risk, perhaps requiring bonds from TPAs. A primary concern was that the OIC not become more intrusive, a problem posed by the prior legislation. That entity, which negotiates fees with providers and adjudicates claims on behalf of self-funded groups, indicated that, based on meetings of its representatives with the OIC, it understood that specific types of TPA organizations would not be considered under any new state insurance law.

Another potential TPA expressed neutrality on the subject of possible regulation. Regulation would require additional resources (e.g., for reporting), but otherwise would not fundamentally change “anything we do and how we do it.” He noted that current “activities are performed in accordance with the RCW [Revised Code of Washington] and WAC [Washington Administrative Code],” but that if the OIC knew more about the activities of TPA functions, TPA’s would be “rid of the majority of suspicion about what [...we] do.”

¹ *Plans subject to the federal Employee Retirement Income Security Act of 1974, as amended, and not subject to State insurance law.*

A third potential TPA actively questioned the premise of TPA regulation. He indicated its application was “based on fear-mongering of potential and theoretical situations [and was an] over-reaction to a single event.” He questioned “the point of imposing redundancy and possible wiggle room [in the relationships between insurers and TPAs].” He did recommend that efforts be undertaken to address “solvency concerns” – perhaps with suggested (not required), allocated premium or case load minimums with regard to assigning risk to provider groups and easier access (by providers) to carriers’ operating reserves for claim payment and recovery of legal fees.

Conclusion

Basic Findings

No rigorous evaluation literature appears to exist documenting the relative benefits and costs of TPA regulation in the jurisdictions in which it is enforced. Regulators in other states generally suggest that:

- TPA regulation is a complex mechanism to create and maintain if its sole purpose is to register (and maintain a database on) TPAs or, that
- the regulation fulfills its intended purpose and serves as a protection against insolvency and inaccurate accounting practices when it is more focused on exploring and preventing actual financial risk.

Most regulators who offered information were not involved in the original passage and implementation of their own state's TPA statute. Although involving stakeholders is standard practice today, most TPA legislation was passed before 1990 and stakeholders were either not identified or invited to be involved in the process. A few state representatives recall anecdotes about the reasons for passage, suggesting it was because of concern over the financial solvency of certain organizations, their record keeping processes, and the fiduciary relationships they had with insurers. Whatever the reasons, the scope of TPA regulation varies considerably from state to state, and none of the states involved in the survey has evaluated the impact of its TPA regulation program, because there is not enough funding and existing TPA regulation is not a controversial issue.

Here in Washington, many of the non-governmental stakeholders were aware of the events leading up to the recent TPA bill in the Legislature (i.e., the temporary alliance of Regence BlueShield and Complementary Healthcare Plans). Other commentators mentioned the HealthLink situation of 1998 and recent physician group and clinic restructurings. While there was some appreciation of protections that TPA regulation might offer, frequent comments indicated uncertainty about the potential value of TPA regulation – that is, “Is this just a solution in need of a problem?” In essence, most stakeholders saw no compelling state interest that would justify TPA regulation. Nevertheless, many stakeholders expanded upon issues that they deemed problematic without TPA regulation or potentially problematic with TPA regulation.

Problems Without TPA Regulation

- Potential for insurers to try to “shirk” their financial responsibilities and shift them onto another entity, leaving providers, the insured, or taxpayers responsible for unmet expenses
- Additional risks to consumer (patient) privacy due to the uncontrolled or unregulated handling of sensitive information by additional individuals and organizations
- Misuse of provider networks that “unfairly” limit access to providers or access to benefits.

Potential Problems With TPA Regulation

- Added expense to insurers and TPAs, and ultimately to insurance purchasers, related to new compliance functions such as registration and financial evaluation.

Options for Consideration

Many stakeholders, in particular, suggest that downstream risk problems might simply be addressed through tightened regulation and monitoring of the entities currently subject to state insurance law. This option would require that current law be clarified to make carriers ultimately responsible for downstream risk. Similarly, certain aspects of current agent, broker, and managing general agent laws might be extended into the TPA arena. Further, the state might want to consider adopting, for all types of insurers: some of the provisions on downstream risk included in the current version of the NAIC model HMO statute; federal rules for plans that participate in the Medicare+Choice program; or state Medicaid regulations for the Healthy Options program. More specific options for consideration are listed below.

General Verification

Consider requiring basic registration so that the OIC and other entities know that a TPA is operating in the state.

Solvency

Revise existing insurance law, perhaps by adding appropriate provisions or simply tightening language. Examples of appropriate changes might involve requiring that:

- Insurers using TPAs must enter into surety relationships with them, whereby insurers are unable to “shirk their risk.”
- TPAs must post bonds.
- Insurers must confirm (monitor) the financial solvency of their business partners through review of financial statements, submission of (an additional) annual report to the OIC, review of TPA Securities & Exchange Commission filings, etc.

Privacy

- Insurer-TPA contracts should include provisions addressing consumer/patient privacy. Associated language might address limiting access to eligibility and utilization data on a “need to know” basis, electronic and hard copy filing and access procedures, etc.
- Insurers or OIC would subsequently monitor the handling of patient-specific data by TPAs.

At this time, it appears that providers are most interested in the possibility of TPA regulation. In part, this interest comes from concerns about the solvency of entities that may handle their payments. However, a significant driver of their interest appears to stem from concerns about the

ability of providers to participate (provide services) under evolving managed care arrangements, to maintain professional autonomy in determining appropriate patient care, to prevent unwarranted intrusion in the provider-patient relationship, to deter unreasonable administrative demands, to limit extra professional liability generated by other entities directing care, and to discourage benefit misinformation and reduced reimbursement. These issues are important to consider, but it is not clear whether a TPA law, *per se*, is the appropriate approach.

The OIC may wish to determine whether existing laws, and the ways they are enforced, might better serve to address the service and financial risks that “TPAs” pose.

Appendix 1 – NAIC’s Compendium of State Laws on Insurance Topics: Third Party Administrator Licensure and Bond Requirements

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STATE	CITATION TO ADMINISTRATOR STATUTE	LICENSE REQUIRED	BOND REQUIRED	FEES
Alabama	No provision			
Alaska	§§ 21.27.630 to 21.27.650 Reg. tit. 3 § 31.020	Third party administrator registration	Director may require a bond.	\$300 for resident, \$900 for nonresident.
Arizona	§§ 20-485 to 20-485.12	Certificate of registration	Surety bond of at least 10% of the total funds handled, but not less than \$5,000.	Between \$65 and \$195.
Arkansas	§§ 23-92-201 to 23-92-208	Certificate of registration	\$25,000 surety bond.	\$25 filing fee annually.
California	Ins. §§ 1759 to 1759.10	Certificate of registration		\$124 biennial fee.
Colorado	No provision			
Connecticut	No provision			
Delaware	No provision			

STATE	CITATION TO ADMINISTRATOR STATUTE	LICENSE REQUIRED	BOND REQUIRED	FEES
District of Columbia	No provision			
Florida	§§ 626.88 to 626.894	Certificate of authority	Fidelity bond of at least 10% of funds handled or managed annually but not more than \$500,000.	Filing fee for original certificate of authority is \$100. Remains valid as long as administrator complies with the law.
Georgia	§§ 33-8-1, 33-23-100 to 33-23-105; Reg. 120-2-49	License as administrator from department of insurance	Fidelity bond equal to at least 10% of amount handled annually by administration or 10% estimated to be handled, but bond not less than \$100,000 or more than \$500,000. Errors and omissions policy of at least \$100,000.	Fee for original license: \$500; renewal: \$400.
Hawaii	No provision			
Idaho	§§ 41-901 to 41-915	Certificate of registration	Surety bond of not less than 10% of the amount of funds handled, but not less than \$20,000.	\$100 annual fee.
Illinois	215 ILCS 5/511.100 to 5/511.113	License from department of insurance	Surety bond for Administrator Trust Fund: greater of \$50,000 or 5% of contributions and premiums but not over \$1,000,000. Surety bond for Claims Administration Services Account: greater of \$50,000 or 5% of the claims and claims expense, but not over \$1 million. For an administrator that maintains both. ATF and CASA accounts, the greater of amounts listed above, but not over \$1 million.	\$100 annual fee.

STATE	CITATION TO ADMINISTRATOR STATUTE	LICENSE REQUIRED	BOND REQUIRED	FEES
Indiana	§§ 27-1-25-1 to 27-1-25-15; Reg. tit 760 § 1-41-1 to 1-41-5	Certificate of registration	Surety bond greater of 10% of total funds handled involving Indiana residents or \$25,000, but not to exceed \$200,000. If no funds handled previous year, \$25,000 bond required.	\$20 annual registration fee.
Iowa	§§ 510.11 to 510.23; Reg. 191-58.1 to 191-58.13	Certificate of registration	Surety bond 10% of administrator's average daily client account balance but no less than \$50,000 or more than \$1 million.	\$100 every 3 years.
Kansas	§§ 40-3801 to 40-3811	Certificate of registration	None	\$100 initial fee; \$50 annual renewal.
Kentucky	§§ 304.9-051 to 304.9-052, 304.9-371 to 304.9-377	License from department of insurance	None	\$50 biennial fee.
Louisiana	§§ 22:3031 to 22:3046 § 22:1078	Licensure by commissioner of insurance	Fidelity bond \$100,000.	\$500; license to remain valid as long as administrator remains in compliance with laws.
Maine	tit. 24-A §§ 1901 to 1912 tit. 24-A § 601	Third party administrator license from department of insurance	Fidelity bond for Administrative Trust Fund: greater of \$50,000 or 5% of contributions and premiums but not over \$1 million. Fidelity bond for Claims Administration Services Account: greater of \$50,000 or 5% of the claims and claims expense, but not over \$1 million. Both ATF and CASA accounts, the greater of amounts listed above but not over \$1 million.	Annual fee of \$100.

STATE	CITATION TO ADMINISTRATOR STATUTE	LICENSE REQUIRED	BOND REQUIRED	FEES
Maryland	Ins. §§ 8-301 to 8-322	Registration from commissioner	Amount of bond not less than 10% of the average amount of funds the third party administrator expects to handle at one time, but not less than \$5,000 nor more than \$500,000.	\$50 every two years.
Massachusetts	No provision			
Michigan	§§ 550.901 to 550.962	Third party administrator shall have a certificate of authority from commissioner	None	Filing fee with application \$200; certificate of authority \$25.
Minnesota	§ 60A.23 Subd. 8 Reg. §§ 2767.0100 to 2767.0900	License from department of insurance	Bond amount equal to greater of average daily trust accounts or \$100,000 up to maximum of \$1 million for non-commingled accounts. For commingled fiduciary and claims-paying accounts, the greater of average daily balance of all trust accounts or \$250,000 up to a maximum of \$2 million.	\$1000 every 2 years.
Mississippi	§§ 83-18-1 to 83-18-29	License from department of insurance	Fidelity bond in an amount set by the commissioner of insurance.	\$200 initial fee, \$100 for annual renewal.
Missouri	§§ 376.1075 to 376.1095; Reg. tit. 20; §§ 200-9.500 to 200-9.800	Certificate of authority	\$50,000 surety bond.	Initial application \$1000, annual renewal \$250.
Montana	§§ 33-17-602 to 33-17-618	Certificate of Registration	None	Annual fee of \$100.
Nebraska	§§ 44-5801 to 44-5816	Certificate of authority	None	Application fee \$200. Certificate remains valid as long as the third party administrator meets requirements of this Act.

STATE	CITATION TO ADMINISTRATOR STATUTE	LICENSE REQUIRED	BOND REQUIRED	FEES
Nevada	§§ 683A.0805 to 683A.0893, 680B.010; Reg. §§ 683A.100 to 683A.165	Certificate of registration	Bond based on funds received and distributed: \$1 million or less \$100,000 \$1-2 million \$200,000 \$3-4 million \$400,000 \$5 million \$500,000 \$5 million or more—10% of amount received but not more than \$1 million. If bonds are unavailable, commissioner may accept E & O policy.	Application and license fee, \$125; triennial renewal, \$125. (Eff. 10/1/01)
New Hampshire	Ins. Reg. 2301.01 to 2301.20	Certificate of authority	Surety bond of \$100,000 or amount equal to 10% of administrator's average daily client account during past year, but no more than \$1 million. If unable to get a surety bond, can set aside required amount in a trust account.	\$100 annual fee.
New Jersey	No provision			
New Mexico	§§ 59A-12A-1 to 59A-12A-17; Reg. tit. 13 §§ 4.5.1 to 4.5.22	License from department of insurance	None	Application \$50, yearly renewal \$23.
New York	No provision			
North Carolina	§§ 58-56-2 to 58-56-66; Reg. tit. 11 §§ 21.0101 to 21.0110	Third party administrator license	Bond, errors and omissions policy or other security in amount determined by commissioner.	Application must be accompanied by \$100 fee.

STATE	CITATION TO ADMINISTRATOR STATUTE	LICENSE REQUIRED	BOND REQUIRED	FEES
North Dakota	§§ 26.1-27-01 to 26.1-27.12	Certificate of registration	None	\$25 annual fee.
Ohio	§§ 3959.01 to 3959.99; Reg. 3901-1-51	License from department of insurance	Fidelity bond for all persons involved in collecting money or making payments. Minimum amount: 10% of all funds handled prior year. Maximum amount: \$500,000.	\$200 application fee; \$300 annual license renewal fee.
Oklahoma	tit. 36 §§ 1441 to 1452	Third party administrator license certificate	Surety bond of an amount that will protect consumers, but no less than \$10,000.	\$100 annual fee.
Oregon	§§ 744.700 to 744.740; Reg. §§ 836-075-0000 to 836-075-0070	Third party administrator license	Errors and omissions policy in an amount of \$500,000.	
Pennsylvania	§§ 40-25-1001 to 40-25-1013	Third party administrator license	Financial responsibility to be maintained in the form of a fidelity bond or other form acceptable to the commissioner, in an amount not to exceed \$500,000.	\$100 license fee, renewed biennially.
Puerto Rico	No provision			
Rhode Island	No provision			
South Carolina	§§ 38-51-10 to 38-51-120	License from department of insurance	Surety bond or other acceptable form of deposit of \$75,000.	\$100 annual fee.
South Dakota	§§ 58-29D-1 to 58-29D-34	License from department of insurance	None	\$500 fee for application; license remains valid for as long as statutory requirements are met.
Tennessee	§§ 56-6-401 to 56-6-412	License from department of insurance	None	\$100 fee for initial application; \$50 yearly renewal fee.

STATE	CITATION TO ADMINISTRATOR STATUTE	LICENSE REQUIRED	BOND REQUIRED	FEEES
Texas	Ins. art. 21.07-6; 28 TAC §§ 7.1601 to 7.1615	Certificate of authority	Fidelity bond equal to 10% of total funds handled previous year, or 10% of funds expected to be handled, but not less than \$10,000 or more than \$500,000.	Filing fee for original application \$500.
Utah	§§ 31A-25-102 to 31A-25-402 Reg. R 590-102	License from department of insurance	Bond 10% of total funds handled by administrator, but not less than \$5,000 nor more than \$500,000.	Annual license fee \$60.
Vermont	No provision			
Virgin Islands	No provision			
Virginia	No provision			
Washington	No provision			
West Virginia	No provision			
Wisconsin	§§ 633.01 to 633.17; Reg. Ins. 8.20 to 8.32 § 601.31	License from department of insurance	Surety bond amounts equal to greater of average daily trust accounts or \$15,000 up to maximum of \$250,000 for non-commingled accounts. For commingled fiduciary and claims-paying accounts, the greater of average daily balance of all trust accounts or \$25,000 up to a maximum of \$500,000.	\$100 annual fee.
Wyoming	Ins Reg. 4	Certificate of registration and appointment	Bond 10% of total funds handled but not less than \$1,000 nor more than \$500,000.	

This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Every effort has been made to provide correct and accurate summaries to assist the reader in targeting useful information. For further details, the statutes and regulations cited should be consulted.

Appendix 2 – Questionnaire for Telephone Interviewing State Agency Staff – Other States

Introduction by Interviewer

Thank you for talking to me today. Our discussion should take no more than 20 minutes.

I am _____ from _____, and have been working with the Washington Office of the Insurance Commissioner (OIC) to explore the potential regulation of Third Party Administrators (TPAs) in Washington State. For purposes of this project, TPAs are not claim administrators that work on an administrative services only basis for self-insured plans. Instead, they are organizations that assume certain insurance functions on behalf of regulated insurers. These insurance functions can have an influence on the economic risk of insurers, and would include such responsibilities as¹:

- Evaluating applicants for coverage (underwriting)
- Collecting and forwarding premium payments
- Repricing provider bills (e.g., applying discounts or contracted limits on charges)
- Processing claims
- Paying claims

This project is funded by the Washington State Legislature, which is interested in assessing the scope and value of State interventions with regard to TPAs. As part of our study, we are exploring what TPA regulation could mean to various stakeholders in Washington State. We are gathering information through focus groups and interviews of stakeholders in Washington and, we are also looking at relevant regulatory approaches in other states. From our contacts in other states, we are hoping to determine how Washington State might define the entities to be regulated, administrative issues, financial and stakeholder costs, and compliance considerations. We will use the information we gain today as part of our report to the Washington OIC, which will in turn, work with the Washington State Legislature on any subsequent legislation.

Questions

1. What state are you in?
2. How does your state regulate TPA organizations? What types of TPAs and what functions are regulated?

¹ *Determining premiums (actuarial support) is not included because the insurer is responsible for this function, and is assumed to seek actuarial opinions only.*

3. Why did your state choose to regulate TPA organizations? Briefly describe the events that led to the implementation of TPA regulation in your state.
4. What concessions, if any, had to be made in order to get this legislation passed? To what groups?
5. In what year did your state begin to regulate TPAs?
6. Did your state use the NAIC model for its own legislation? If not, please describe the other sources.
7. Please describe the involvement of various stakeholders in the formulation of legislation and subsequent administrative rules regulation. Who sponsored it, who supported it, and who was against it, and why?
8. What is the emphasis of your state's regulation of TPAs? Has this changed since the initial implementation? If yes, in what way?
9. In your perception, how has TPA regulation changed the relationships between insurers, TPAs, providers and/or consumers, if at all?
10. Are you aware of any rigorous analysis that measured the financial, stakeholder relations, provider access or other impacts of TPA regulation in your state or elsewhere? If yes, please discuss.
11. Do you recommend regulation for Washington State? Why or why not? What issues or approaches would you recommend Washington State avoid, aggressively pursue or replicate based on your own state's experience?
12. Do you have any other comments?

Thank you for your participation. Your comments were very helpful. Should you have any other comments in the near future, please contact me at _____.

Appendix 3 – E-mail Questionnaire for State Agency Staff – Other States

The University of Washington Health Policy Analysis Program and William M. Mercer, Incorporated have been working with the Washington Office of the Insurance Commissioner (OIC) this fall to explore the potential regulation of Third Party Administrators (TPAs) in Washington State. For purposes of this project, TPAs are not claim administrators that work on an administrative services only basis for self-insured plans. Instead, they are organizations that assume certain insurance functions on behalf of regulated insurers. These insurance functions can have an influence on the economic risk of insurers, and would include such responsibilities as¹:

- Evaluating applicants for coverage (underwriting)
- Collecting and forwarding premium payments
- Repricing provider bills (e.g., applying discounts or contracted limits on charges)
- Processing claims
- Paying claims

This project is funded by the Washington State Legislature, which is interested in assessing the scope and value of State interventions with regard to TPAs. As part of our study, we are exploring what TPA regulation could mean to various stakeholders in Washington State. We are also looking at relevant regulatory approaches in other states. From our contacts in other states, we are hoping to determine how Washington State might define the entities to be regulated, administrative issues, financial and stakeholder costs, and compliance considerations. We will use the information we gain as part of our report to the Washington OIC, which will in turn, work with the Washington State Legislature on any subsequent legislation. We hope you will be able to spend 15 to 20 minutes completing this questionnaire.

Questions

1. What state are you in?
2. How does your state regulate TPA organizations? What types of TPAs and what functions are regulated?
3. Why did your state choose to regulate TPA organizations? Briefly describe the events that led to the implementation of TPA regulation in your state.

¹ *Determining premiums (actuarial support) is not included because the insurer is responsible for this function, and is assumed to seek actuarial opinions only.*

4. What concessions, if any, had to be made in order to get this legislation passed? To what groups?
5. In what year did your state begin to regulate TPAs?
6. Did your state use the NAIC model for its own legislation? If not, please describe the other sources.
7. Please describe the involvement of various stakeholders in the formulation of legislation and subsequent administrative rules regulation. Who sponsored it, who supported it, and who was against it, and why?
8. What is the emphasis of your state's regulation of TPAs? Has this changed since the initial implementation? If yes, in what way?
9. In your perception, how has TPA regulation changed the relationships between insurers, TPAs, providers and/or consumers, if at all?
10. Are you aware of any rigorous analysis that measured the financial, stakeholder relations, provider access or other impacts of TPA regulation in your state or elsewhere? If yes, please discuss.
11. Do you recommend regulation for Washington State? Why or why not? What issues or approaches would you recommend Washington State avoid, aggressively pursue or replicate based on your own state's experience?
12. Do you have any other comments?

Thank you for your participation. Your comments will be very helpful. Please forward your response to Florence Katz at William M. William M. Mercer, Incorporated. (florence.katz@us.wmmercercer.com) or (206) 382-0627 (fax). Should you have any other comments in the near future, please contact Florence Katz at (206) 808-8469.

Appendix 4

List of State Respondents

Arizona Department of Insurance
Arkansas Department of Insurance
Georgia Office of Commissioner of Insurance
Idaho Department of Insurance Services
Indiana Department of Insurance
Iowa Insurance Division
Kansas Insurance Department
Kentucky Department of Insurance
Montana State Auditor's Office
Oklahoma Insurance Department
Oregon Insurance Division
Pennsylvania Insurance Department
South Carolina Department of Insurance
South Dakota Division of Insurance

Appendix 5 – Interview Guide for Washington State Stakeholders

Introduction by Interviewer

Thank you for talking to me today. I am _____ from _____, and have been working with the Office of the Insurance Commissioner (OIC) to explore the potential regulation of Third Party Administrators (TPAs) in Washington State. For purposes of this project, TPAs are not claim administrators that work on an administrative services only basis for self-insured plans. Instead, they are organizations that assume certain insurance functions on behalf of regulated insurers. These insurance functions can have an influence on the economic risk of insurers, and would include such responsibilities as¹:

- Evaluating applicants for coverage (underwriting)
- Collecting and forwarding premium payments
- Repricing provider bills (e.g., applying discounts or contracted limits on charges)
- Processing claims
- Paying claims

This project is funded by the State Legislature, which is interested in assessing the scope and value of State interventions with regard to TPAs. As part of our study, we are exploring what TPA regulation could mean to various stakeholders in Washington State. Besides gathering information through focus groups, we are also looking at relevant regulatory approaches in other states and studying how Washington State might define the entities to be regulated and how to administrative issues, financial and stakeholder costs, and compliance considerations. We will use the information we gain today as part of our report to the OIC, which will, in turn, work with the Legislature on any subsequent legislation.

Questions/Probes

1. Are you aware of any concerns in Washington or elsewhere that have resulted from the delegation by insurers to TPAs of the responsibilities I listed earlier? If yes, please discuss.
2. Given the background just provided on the project, and the focus of regulatory interest, please indicate those aspects of the study you see as potentially positive? For whom? Why?
 - Positive aspects:

¹ *Determining premiums (actuarial support) is not included because the insurer is responsible for this function, and is assumed to seek actuarial opinions only.*

- Positively affected parties:
 - Why?
3. What aspects do you see as potentially negative? For whom? Why?
 - Negative aspects:
 - Negatively affected parties:
 - Why?
 4. Based on your knowledge of insurer-TPA problems (if any), and their affects on consumers and providers in this state or elsewhere, how would you recommend that such problems be prevented?
 5. How would you recommend that such problems be addressed if they arise?
 6. What, if any, is a reasonable role for the State?
 7. Are there other approaches by the State or by other parties that should be considered? If yes, please explain.

Thank you for your participation. We will be sharing the results of this study at a future stakeholders' meeting.

Appendix 6 – List of Interviewed Washington Stakeholders

Risk-Bearing Entities

Association of Washington Health Care Plans
Community Health Plan of Washington
First Choice Health Network
Group Health Cooperative of Puget Sound
Health Insurance Association of America
Kitsap Physicians Service
Premera Blue Cross
Regence Blue Shield and PacifiCare

Consumer Groups

Empower Alliance, a mental health services consumer group
Washington Citizen Action

Providers

Washington State Chiropractic Association
Washington State Medical Association
Washington State Podiatric Medical Association
Washington State Psychological Association

Others

Association of Washington Businesses
Complementary Healthcare Plans
Employers Health Care Coalition
Magellan, a behavioral health benefits management organization
Merck-Medco, a pharmacy benefits management organization

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