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## Risk Taking in the Provider World: Is a Knox-Keene Plan a Good Strategic Move For You?

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Reimbursement for health care services in California continues its shift toward capitation, resulting in health care providers increasingly forming their own health plans under the Knox Keene Health Care Service Plan Act (the "Act"). A health plan license allows providers to contract directly with government entities, become qualified health plans on the Exchange or participate in broad-based risk arrangements down streamed by other commercial health plans.[1] Providers can also use their plan licenses in conjunction with Accountable Care Organizations or to structure innovative payment models.

Corporate entities often form health plans as a means to employ doctors and avoid California's corporate practice of medicine laws and other commercial practice restrictions. Specialized health plans, in particular, have used their plan licenses to employ or contract with doctors in retail settings to provide convenient, accessible services to patients. These specialized plans are well positioned to contract with commercial payers and qualified health plans to provide newly mandated essential benefits under the Affordable Care Act or drive traffic to health plan networks as a result of their retail presence.

**Types of Knox-Keene Health Plans**

Knox-Keene health plans are categorized as (i) full-service plans that arrange for the provision of basic and essential benefits as defined in the Act, and (ii) specialized plans that provide services in a single specialty. Specialized plans may be formed for vision, dental, mental health, acupuncture or chiropractic. A discount health plan that provides members with access to providers who discount their fees, is another model for either category.

Full service and specialized plans may design and sell their own benefit products directly to individual members and employer or other groups, large or small. Health plans that operate in the retail world (mostly specialized plans) can structure individual memberships that allow consumers to "walk-in," purchase a membership and receive services on the spot.

Many provider-based health plans are formed as "limited" full-service plans, which enter into global risk contracts with other health plans (akin to provider contracts) rather than offer their own products. The limited health plan may receive increased capitation rates or administrative fees by performing certain duties delegated to them by the other health plan, e.g., credentialing, utilization management, quality assurance. Other health plans may be formed solely for the purpose of creating Medicare Advantage Plans, to which they are restricted.

A provider considering whether to establish a health plan must determine how the arrangement fits into its strategic plan, short-term and long-term. Operating health plans are costly in terms of time and money and the benefits they achieve must be carefully analyzed.

**Benefits of Forming a Knox-Keene Health Plan**

A health plan structure can be advantageous for several reasons:

a. *Clinical Integration and Quality Improvement*: A health plan structure offers a roadmap to improving quality and integrating affiliated provider entities due to the Act's program requirements and the clinical integration involved. Today, providers need a track record showing their abilities to deliver high quality and cost-efficient services in order to contract into higher-tier health plan networks and increase their reimbursement rates. This, combined with the increased transparency in quality and cost ratings, makes the need for improved quality critical to a provider's success.

b. *Financial Integration and Efficiencies*: Risk-sharing arrangements amongst providers and with larger health plans frequently contain cost containment mechanisms. A health plan structure can help to align different types of

providers and streamline operations to create system-wide financial efficiencies.

c. *Ownership of Plan and Employment of Health Care Professionals*: A health plan can be corporate-owned and operated and employ medical professionals to provide services to health plan members. This is important to entities that prefer an employment model and view it as a key to aligning providers.

d. *Data and Management Services*: Effective data gathering and reporting is absolutely necessary with health care reform. Whether or not a health plan chooses to employ its health care professionals, it still can assist providers in integrating by providing key management services, including staffing, data gathering and reporting services and evidence-based medicine software.

e. *Referrals and Managed Care Contracting*: Health plans have the ability to direct patient referrals within their networks and to enter into plan-to-plan contracts that benefit their networks.

f. *Increased Reimbursement and Acceptance of Delegated Tasks*. Accepting delegated tasks from larger health plans can lead to increased provider reimbursement and more control over operations.

g. *Product Development*. A health plan can be licensed to develop its own health plan benefit products for employers or individuals, providing flexibility for innovative providers.

**Costs of a Knox-Keene Plan**

While a health plan structure offers clear advantages, the costs include the following:

a. *Start-up Costs*. Obtaining a Knox-Keene license includes the costs of an application fee, deposit, maintenance of tangible net equity, attorney and financial consultant fees, staff, insurance and marketing. These costs vary according to the type of health plan. A new health plan that offers group contracts has to have the financial fortitude to continue operations while selling and negotiating those contracts.

b. *Ongoing Compliance and Operational Costs*. Compliance with regulatory requirements is ongoing and includes, without limitation, financial, expansion and advertising filings, routine audits every three years and other filing submissions triggered by changes in plan operations. In addition, health plans need to maintain their administrative capacity and limit spending for non-health care services.

c. *Financial Assessments*. The Department of Managed Health Care ("DMHC") imposes annual assessments on health plans on a per member basis and for audits.

d. *DMHC Oversight*. A health plan is subject to the DMHC's oversight and monitoring and non-compliance can result in costly penalties. A health plan needs to implement a compliance plan to assist in avoiding fines and penalties that can result from delays and non-adherence to the Act's program requirements.

A health plan license carries a multitude of benefits in the risk-based world of health care reimbursement. If it fits within a provider's strategic plan, the next steps will be to determine its corporate structure, ownership, partnerships, potential lines of business, timeline, software and data base, policies and procedures for program requirements, financial projections and management. Putting together a solid project team is essential to accomplishing these goals in the shortest and least expensive manner.

1 The Act requires that any person who undertakes to arrange for the provision of or pays for health care services to subscribers or enrollees, in return for a prepaid or periodic charge from or on behalf of the subscribers or enrollees, must obtain a Knox Keene license.

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