

Department of Banking, Insurance,  
Securities and Health Care Administration  
89 Main Street, Drawer 20, Montpelier, VT 05620-3101

**MEMORANDUM**

TO: Applicants Seeking Authority to Operate a Health Maintenance  
Organization in Vermont

FROM: Elizabeth R. Costle, Commissioner

RE: Department of Banking, Insurance, Securities and Health Care  
Administration Review Process of CON and COA Applications

With the passage of S.345 (enacted as Act 180) in the spring of 1996, the regulatory responsibilities of the Health Care Authority were merged into the Department of Banking, Insurance and Securities with a goal of unifying the insurance and health care regulatory functions of state government. This memorandum describes what types of review a proposed HMO must undergo in applying for a COA from the Division of Insurance and a CON from the Division of Health Care Administration, two distinct Certificates required to do business in Vermont. The Department's goal in outlining these procedures is to provide a clear outline of the review process. It should be noted, however, that the following is a general description of the processes. Each HMO review, both in terms of insurance regulation and health care regulation, may differ from that described herein depending on the particular facts and circumstances of the applications.

**I. CERTIFICATE OF NEED**

Applicants seeking to operate an HMO in Vermont are subject to CON review as "the construction, development, or other establishment of a new health care facility." 18 V.S.A. §9434 (a) (1). The statute requires all CONs to be reviewed in light of a variety of considerations, most notably the twenty-one "general criteria" established in 18 V.S.A. §9436 (a) and five "mandatory criteria" of §9437.

Not all criteria apply to all CON applications. In practice, the Commissioner determines which of the general criteria are relevant and applicable to a given CON application, and then limits the presentation of arguments and evidence accordingly. See *In re Manchester Health Services, Inc.* (Vt. Health Care Authority, April 13, 1995), slip op. At 4 (Division has discretion to limit the scope of issued to those "necessarily and actually implicated" by the CON application and to require the applicant to limit its presentation accordingly), *aff'd*, No. 95-317 (Vt. Feb. 1, 1996).

In the following discussion, we have analyzed the general and mandatory criteria to determine which, as a general rule, are relevant in the Commissioner's review of a CON application related to the establishment of an HMO in Vermont. The objective is to ensure that reviews of such applications are focused on the issues that are both relevant and material to the Commissioner's decision.

**A. The "Mandatory Criteria"**

Before issuing a CON, the Commissioner must be satisfied that the proposed project meets all of the applicable "mandatory criteria" established in 18 V.S.A. §9437. In the case of HMOs, this means that the following three findings must be made:<sup>1</sup>

- (1) *Superior alternatives to the proposed HMO in terms of cost, efficiency and appropriateness do not exist, and the development of such alternatives is not practicable.*<sup>2</sup> This has been interpreted as requiring the HMO applicant to affirmatively show both that it has the institutional ability to operate an HMO as well as that it has the resources (health care providers, facilities and ancillary services) necessary to serve its proposed population and service area.
- (2) *In the absence of the proposed HMO, Vermonters would experience serious problems in terms of costs, availability, or accessibility in obtaining health care services.*<sup>3</sup> This criterion is most important when reviewing proposed HMOs seeking to offer new services not previously available in their service territories. In any event, it will generally be met by evidence that the proposed HMO will have a positive impact on lowering costs or making services within the proposed HMO's service territory more easily accessible or available.
- (3) *The proposed HMO is consistent with the 1993-1996 Health Resource Management Plan (HRMP).*<sup>4</sup> The HRMP establishes no specific policies on the entry of HMOs into Vermont. The HRMP does, however, contain general principles that may apply to these types of CON applications, including Principle B (that health care providers should be held accountable for, and accept public oversight of, their services to

---

<sup>1</sup> The other two findings relate to proposals involving new construction and the addition of skilled nursing or intermediate care beds, neither of which applies to the establishment of an HMO.

<sup>2</sup> 18 V.S.A. §9437 (1).

<sup>3</sup> 18 V.S.A. §9437 (3).

<sup>4</sup> 18 V.S.A. §9437 (5).

ensure they are appropriate, effective and financially responsible, Principle C (the need to collect comprehensive health data for quality improvement purposes), and Principle D (health care services should be appropriately balanced between prevention, home health, long-term and acute care services).

In order to make these findings, the Commissioner will generally rely on evidence and arguments presented on the 21 “general criteria,” as well as any other applicable policies.

CON applicants will be expected to present evidence and arguments only as to those criteria that are clearly relevant. As a general rule, applicants should not address the remaining criteria, unless otherwise advised by the Division. Those other criteria that need not be addressed include those that do not, on their faces, apply to the establishment of HMOs in Vermont; those that are reviewed by other regulatory agencies; and those that do not materially assist the Commissioner in making a final decision on the application.

***B. General Criteria and Policies Applicable to All CON Reviews of Proposed HMOs***

The following criteria and policies are directly relevant to the findings that must be made before a proposed HMO can be granted a CON, and HMO applicants should be prepared to address these in detail. To assist applicants in so doing, the Division of Health Care Administration will prepare a set of general questions relevant to these criteria that all person proposing to establish HMOs in Vermont will be required to answer.

- *The relationship of the proposed HMO to the HRMP.*<sup>5</sup> This criterion is virtually identical to the third mandatory criterion. Information that supports this criterion will generally include, but is not limited to, evidence of the proposed HMO’s policies and procedures relating to regulatory requirements and oversight by the state, their willingness to participate in the state’s voluntary data collection project, and their educational and prevention activities.
- *The availability of resources, including health care providers, management personnel, and funds for capital and operating needs, for the proposed HMO.*<sup>6</sup> This criterion requires evidence from the applicant that it has a sufficient network of health care providers and health care facilities, as well as ancillary service providers (like ambulance services and pharmacies), to serve its proposed population and service area.

---

<sup>5</sup> 18 V.S.A. §9436 (a) (2).

<sup>6</sup> 18 V.S. A. §9436 (a) (8).

- *The relationship of the proposed HMO to ancillary or support services.*<sup>7</sup> For HMOs, this criterion overlaps the previous one. If number 8 is met, this one is met as well.
- *Improvements or innovations in the financing and delivery of health services that foster constructive competition and serve to promote quality assurance and cost-effectiveness.*<sup>8</sup> This criterion will require evidence on the effects of the entry of the proposed HMO into the Vermont marketplace and its effect on overall quality assurance and cost-effectiveness.
- *In the case of existing HMOs, the quality of care provided by those facilities in the past.*<sup>9</sup> This criterion will require evidence of the HMO's quality practices in the states in which it operates.
- *The contribution of the proposed HMO in meeting the needs of medically underserved groups and the goals of universal access to health services.*<sup>10</sup> Evidence on this criterion should include, at a minimum, the proposed HMO's policies on free care.
- *The impact of the proposal on state Medicaid dollars.*<sup>11</sup> This criterion will require evidence as to the impact, if any, on the money paid by the state in connection with the Medicaid program.
- *Whether the proposed HMO promotes the general good of the state.*<sup>12</sup> This criterion will be interpreted broadly. Evidence on this criterion can include, but is not limited to, how an HMO applicant proposes to actually manage care (as opposed to costs), how the new entity will affect other insurers and providers in Vermont, whether or not it intends to serve Medicare or Medicaid clients and the extent to which it will engage in educational efforts.
- *Does the proposed HMO have in place the necessary policies and procedures to*

---

<sup>7</sup> 18 V.S.A. §9436 (a) (9).

<sup>8</sup> 18 V.S.A. §9436 (a) (15).

<sup>9</sup> 18 V.S.A. §9436 (a) (16)

<sup>10</sup> 18 V.S.A. §9436 (a) (18).

<sup>11</sup> 18 V.S.A. §9436 (a) (19).

<sup>12</sup> 18 V.S.A. §9436 (a) (21).

*meet the quality assurance requirements of 18 V.S.A. §9414?* Section 9414 imposes a number of quality assurance requirements on all HMOs doing business in Vermont. These include the existence of policies and procedures as to the Proposed HMOs quality management and improvement procedures, utilization management, credentialing practices, members' rights and responsibilities, preventive health services, medical records practices, grievance and appeal procedures, member services, financial incentives or disincentives, disenrollment, provider contracting and systems and data reporting capacities. Contracts with providers are also prohibited from including so-called "gag clauses." The proposed HMO should be prepared to present the necessary policies, procedures and contracts to the Division to support a finding that it will meet these requirements.

**C. General Criteria as to Which No Evidence is Generally Necessary**

(1) *General Criteria Not Generally Applicable to Reviews of Proposed HMOs*

Several general criteria do not apply to the review of HMO applications, either by their own terms or because the consideration of those criteria will not materially assist the Commissioner in making the required mandatory findings. Those criteria include:

- *The relationship of the proposed HMO to the long-range development plan of the health care facility proposing the service.*<sup>13</sup> This criterion applies most often to the offering of new health care services, in the traditional sense of that term, by existing health care facilities. There is no particular value to requiring a proposed HMO to prove that the provision of its service in Vermont meets its long-range plan.
- *The special needs and circumstances of entities providing substantial portions of their services to individuals not within their service areas.*<sup>14</sup> Not applicable.
- *The special needs and circumstances of research projects.*<sup>15</sup> Not applicable.
- *The costs and methods of projects involving new construction.*<sup>16</sup> Not applicable.

---

<sup>13</sup> 18 V.S.A. §9436 (a) (3).

<sup>14</sup> 18 V.S.A. §9436 (a) (10).

<sup>15</sup> 18 V.S.A. §9436 (a) (12).

<sup>16</sup> 18 V.S.A. §9436 (a) (13).

- *The special circumstances of health care facilities with respect to the need for conserving energy.*<sup>17</sup> Not applicable.
- *In the case of a CON project involving a Vermont hospital subject to budget reviews, consideration of what impact the proposal will have on the hospital's budget.*<sup>18</sup> This criterion will need to be addressed only if a hospital subject to budget review in Vermont is involved in establishing the proposed HMO.

(2) *General Criteria Met by Other Regulatory Processes*

Any HMO seeking to do business in Vermont must obtain not only a CON, but an insurance license from the Division of Insurance. One of the general criteria—the one that looks at the proposal's immediate and long-term financial feasibility, and its probable impact on the cost of and charges of services provided by the applicant<sup>19</sup> — duplicates the Insurance Division's review process in considering this criterion, so the applicant will not be expected to present additional evidence on it in the course of the CON review. The applicant may be asked, however, to present the general financial information necessary to understanding the project in its entirety.

(3) *Other Criteria*

One of the primary reasons for administering the CON review program is to ensure that Vermonters are not asked to pay for unnecessary or duplicative health care equipment or services. To the extent that an HMO applicant is not proposing to offer services not otherwise available in its service region or is not purchasing new diagnostic or therapeutic equipment, then it will be acting primarily as a reorganization of existing services and providers in addition to its insurance functions. In that case, several of the criteria will not generally apply to the review process. These include:

- *The need for the proposed HMO by the population to be served.*<sup>20</sup> This criterion is similar to the second mandatory criterion. Assuming that the HMO applicant does not propose to offer new services or equipment, this criterion will generally not be material to the Commissioner's determination.

---

<sup>17</sup> 18 V.S.A. §9436 (a) (17).

<sup>18</sup> 18 V.S.A. §9434 (a) (20).

<sup>19</sup> 18 V.S.A. §9436 (a) (6).

<sup>20</sup> 18 V.S.A. §9436 (a) (4).

- *The availability of less costly or more effective alternative methods of providing such service.*<sup>21</sup> This criterion will generally not apply where the proposed HMO would not be offering new services or purchasing new equipment otherwise reviewable under the CON law.
- *The relationship of the proposed HMO to the existing health care system in the area to be served.*<sup>22</sup> Assuming that the proposed HMO would not be offering new services or purchasing new equipment that would otherwise be reviewable, this criterion will generally not apply, or will be addressed in the context of the “general good” criterion.
- *The special needs and circumstances of health maintenance organizations and other comprehensive health care programs.*<sup>23</sup> This criterion addresses primarily those CON proposals involving new facilities or services and how they fit in with HMOs. As such, no evidence will generally be required on this criterion from an applicant proposing to establish an HMO itself.
- *The comparative merits of any competing applications.*<sup>24</sup> This criterion will generally not apply, unless the proposed HMOs (the original applicant and competitor) are offering new services or purchasing new equipment that would otherwise be reviewable.

## II. Certificate of Authority

A certificate of authority (COA) issued by the Commissioner of Banking, Insurance, Securities and Health Care Administration is required before any person may operate a health maintenance organization (HMO) in Vermont. The Commissioner makes decisions on COA applications based on evaluation and analysis performed by the Insurance Division, and when appropriate, outside experts. The requirements are set forth in the insurance code, specifically, 8 V.S.A. Chapter 139.

Issuance of a COA must be based on a determination by the Commissioner that:

- The proposed HMO will promote the general good of the state;

---

<sup>21</sup> 18 V.S.A. §9436 (a) (5).

<sup>22</sup> 18 V.S.A. §9436 (a) (7).

<sup>23</sup> 18 V.S.A. §9436 (a) (11).

<sup>24</sup> 18 V.S.A. §9436 (a) (14).

- The applicant is reliable and organizationally sound;
- The applicant is financially sound;
- The proposed HMO will be organizationally sound;
- The proposed HMO will be financially sound; and
- The proposed HMO is eligible for a CON.

See 8 V.S.A. §5102 (d).

Though each application will raise its own issues, generally speaking, a complete application will include:

- Charter, articles or other organizational documents, including all amendments;
- Bylaws or other internal governing documents;
- List of individuals, with their social security numbers, who will hold governing offices in the organization, including officer, directors, partners, members, managers; a statement of character and competence as to each individual so name; and such disclosure and conflict of interest statements as are required;
- All proposed contracts, including group contracts, and certificates to be issued to members setting out coverage and proposed rates;
- Most recent audited financial statements by a certified public accountant, and on an NAIC blank, if available;
- Marketing plan and five year financial plan showing that the §5102b(b) capital requirements will be met;
- Sample participating provider contracts; such contracts must hold HMO members harmless for services if the applicant fails to pay for covered services;
- If a foreign applicant, power of attorney appointing the Commissioner attorney for service of process;
- Statement describing the health care delivery system being used by the organization to deliver covered services and its quality assurance/grievance procedures;

- Proposal for meeting the §5102b(c) security;
- Insolvency plan which permits continuation of benefits as required under §5102b(f); acceptable plans could include reinsurance, letter of credit, provisions within provider contracts.

A Decision to approve or deny an application for a COA must be made by the Commissioner within 60 days. Because of the requirement that a proposed HMO be eligible for a CON, the 60 day period begins to run upon issuance of a CON. However, it is the Insurance Division's practice to commence its COA review upon receipt of a complete application and filing fee. The Commissioner, upon request, may authorize the applicant to contact potential members prior to the issuance of a certificate of authority, to discuss the health care services the applicant proposes to offer. See 8 V.S.A. §5103.

Questions regarding the CON review process for proposed HMOs should be addressed to the Director of Quality Assurance and Consumer Protection at (802) 828-2900. The Health Care Administration has also prepared a document entitled "Certificate of Need Review Process, Manual Applicants" which provides greater detail on the CON process as a whole. Questions regarding the COA review process for proposed HMOs should be addressed to Ken McGuckin, Director of Company Licensing and Examinations, Insurance Division, at (802) 828-4849.