

3-2003

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Recommended Citation

Rosenbaum, S. (2003). Managed care corporate failures: An overview of bankruptcy and insurance insolvency procedures. Washington, DC: Center for Health Services Research and Policy, School of Public Health and Health Services, The George Washington University.

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Managed Care Corporate Failures: An Overview of Bankruptcy and Insurance Insolvency Procedures

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March, 2003

Introduction

This Issue Brief examines managed care corporate failures and the legal process. Managed care organizations are corporate hybrids that possess the features of both insurance and health care. As a result, the question of whether the proper legal forum for addressing a failure is the federal bankruptcy process or state insurance insolvency procedures is a complex one. The answer to this question is more than academic: legal protections for purchasers, members, and health care providers differ significantly depending on which legal system is used.

In essence, the bankruptcy process, a fundamental safeguard under U.S. law, is designed to protect debtors and to permit them to recover from financial failure. A prime goal of insurance insolvency proceedings, however, is protection of the contract of insurance itself, which means greater safeguards for plan members. Thus, the forum and the process matter a great deal, particularly for persons at higher medical risk, who depend on insurance insolvency proceedings to protect their coverage rights.

Remarkably, despite the huge growth of managed care over the past two decades (along with many managed care corporate failures), the issue of what legal process applies is a murky one. This confusion can be traced to the hybrid nature of managed care, along with the concomitant failure on the part of U.S. law to keep pace with the transformation of health insurance from an indemnity model to one based that combines the features of health insurance and medical care. This “bankruptcy versus insurance insolvency” dilemma is hardly the only example of legal confusion generated by the transformation of health insurance. Indeed, depending on the legal context, MCO defenses can change radically. For example, in the area of professional medical negligence, courts have increasingly come to view MCOs as health care companies that can be held liable under principles of medical negligence, not merely as health insurers.¹ Ironically, in the context of corporate failure, it is in an MCO’s interest to be viewed in precisely the opposite fashion -- as a health care corporation that is eligible for bankruptcy debtor status and not as a health insurer barred from the federal bankruptcy process and subject to state insurance regulation.

The March 11, 2003 bankruptcy filing by Magellan Health Services, the nation’s largest provider of mental health care may raise a new round of “bankruptcy versus insurance” questions. In its commercial business, Magellan appears to function as a subcontractor to insurers and self-insured

¹ See e.g., *Pegram v Herdrich* 530 U.S. 211 (2000); *Roark v Humana Health Care* 307 F. 3d 298 (5th Cir., 2002); *Cicio v Does* 321 F. 3d 83 (2d Cir., 2003); *Pappas v Asbel* 768 A. 2d 1089 (Penn., 2001).

employee health benefit plans,² and as a result, no direct contract of insurance between Magellan and subscribers appears to be involved. In the case of Medicaid and other public health agencies, the situation is somewhat murkier. Whether or not Magellan can be treated as an insurer at least in certain contexts and thus covered by state insolvency procedures is a major question.

This report begins with a working definition of managed care and describes several different corporate models that will be used to guide the ensuing discussion. It then examines how various forms of risk-bearing managed care entities are classified under state insurance laws and describes the model HMO legislation developed by the National Association of Insurance Commissioners (NAIC).

The report then provides an overview of state insurance insolvency and federal bankruptcy law, highlighting key differences from a creditor and consumer perspective. It then reviews the federal bankruptcy case law to date, as well as the standards that are currently used by courts to determine whether a managed care failure will be treated as a state law insurance insolvency or a federal bankruptcy. The report concludes with a discussion of the implications of Magellan's bankruptcy filing for public purchasers such as Medicaid agencies and county and state mental health agencies.

1. Managed Care: A Working Definition and Structural Overview

As it has come to be used, the concept of “managed care” can be used to denote an enormous variation in entity type. For purposes of this analysis, the term “managed care” means any entity that enters into a contract for a preset fee to provide or arrange one or more types of health services through an organized provider network. The network can be tightly or loosely structured (e.g., a loose PPO model versus a closed panel HMO). The services can be specific to certain types of conditions or comprehensive (e.g., behavioral health only versus general major medical). The entity's network can be limited to physicians or can be fully integrated, and the contract may provide for both upside and downside risk (i.e., financial incentives versus risk of loss). Under this broad definition, all of the following entities might be considered “managed care” companies:

- MCOs that also hold licenses in one or more states as health insurers and thus are legally authorized to sell *contracts of insurance* directly to individual and group purchasers. In most states, as noted below, HMOs are a subclass of insurer.
- MCOs that may hold corporate business licenses in states but that are not licensed as insurers. These entities may operate as administrators of benefit plans and may hold risk, but they are not selling contracts of insurance. They also may operate as sub-contractors to insurers, taking on certain contractual duties; an example of this is the Magellan/Aetna relationship.

² In re Magellan Health Services (U.S. Bank Ct., S. D.N.Y., 2003). See, Bill Brubaker, “Magellan Files for Chapter 11 to Reduce Debt,” Washington Post March 12, 2003 (p. E-1).

- Entities that operate as both insurers and as subcontractors. An example of such an entity is United Health Care, which sells both insurance products and utilization management products to self insured plans.³

Figure 1 presents a typology that describes the key elements of each generic type of managed care entity and provides examples of entities that can be thought of as falling into various MCO categories.

Figure 1. A Generic Managed Care Typology

Type of entity	key characteristics	examples
Risk-bearing entity that is licensed under state law as an insurer or HMO	Sells contracts of insurance directly to group and individual purchasers	Insurers and other entities classified as insurance under state law that sell network products such as HMOs and PPOs (e.g., Aetna, Blue Cross, Kaiser) A larger corporation holding an insurance subsidiary
Risk-bearing entities that do not hold an insurance license or the equivalent but that operate as subcontractors to licensed insurers	Sells managed care products to HMOs, insurers, self insured employee benefit plans, and public agencies	MBHOs, PBMs, disease management companies, Medicare+Choice PSOs that do not hold insurance licenses.
Risk-bearing entities that operate as both an insurer (or the equivalent) and as a subcontractor.	May be licensed in some states as an insurer or HMO. Also may sell certain services to self insured employee health benefit plans, public agencies, other insurers	United Healthcare, Blue Cross, Aetna, etc. Could also conceptually include limited service corporations such as MBHOs in states that elect to license such companies as insurers or HMOs

2. State Regulation of Insurance: The NAIC Model HMO Act and Other State Laws

As of 1995, 47 states maintained legislation that regulated health maintenance organizations as a specific sub-class of insurer.⁴ Most states base their HMO laws on a model HMO Act developed by the National Association of Insurance Commissioners.⁵ The Model Act classifies HMOs as “domestic insurance companies,”⁶ thereby triggering the insurance exclusion under federal bankruptcy law, which is reviewed in the following section. The Model Act provides as follows:

The rehabilitation, liquidation, or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation or conservation of an insurance company and shall be conducted under the supervision of the [commissioner]

³ See, e.g., *Corcoran v United Health Care*, 965 F. 2d 1321 (5th Cir., 1992); cert. den. 506 U.S. 1033 (1992), in which a self insured employer bought general administration and network services from Blue Cross and utilization management from United, which operates in states as a licensed HMO in its own right.

⁴ Jay M. Howard, “The Aftermath of HMO Insolvency,” 4Ann. Health L. 87 (1995), p. 94.

⁵ Id.

⁶ Id.

pursuant to the law governing the rehabilitation, liquidation and conservation of insurance companies.”⁷

The NAIC Model Act⁸ defines an HMO as:

“a person that undertakes to provide or arrange for the delivery of basic health care services to covered persons on a prepaid basis, except for a covered person’s responsibilities for copayments, coinsurance, or deductibles.”

Specifically excluded from the definition of “basic health services” as used in the model act are “mental health services and services for alcohol and drug use.” The Model Act similarly excludes dental benefits from the definition.

Thus, for purposes of regulating managed care, NAIC recommends that entities that sell certain types of products to group and individual purchasers be classified as HMOs and subject to state insurance insolvency proceedings in the event of failure. Special-purpose MCOs do not fall within this NAIC definition, although draft 2002 amendments would extend the HMO classification to all “risk bearing entities” doing business in the state. This amendment, if adopted, effectively would require that all classes of MCO outlined above hold licenses of insurance which might be crucial to a determination of which legal process – federal bankruptcy or state insurance insolvency proceedings -- applies. The amendments would define a risk bearing entity as:

An intermediary organization that is at financial risk for services provided through contractual assumption of the obligation for the delivery of specified health care services to covered persons of the health maintenance organization.”⁹

In sum, it appears that under NAIC’s current model HMO legislation, an MBHO is a special-purpose entity that is not recommended for treatment as an HMO for state insurance insolvency law purposes. However, the 2002 amendments would extend the provisions of the Model Act to any “risk bearing entity,” which in turn appears to be defined sufficiently broadly to encompass any special purpose managed care organization that subcontracts with HMOs to provide or arrange for one or more contractual services.

The number of states that have adopted such an expansive definition of an HMO is not known. This question can be answered only by examining the insolvency laws of all states. Even more importantly, it is not clear under current case law whether or not classification of an MBHO as an HMO for insolvency purposes is in fact enough to extinguish an MBHO’s bankruptcy rights in the states that have opted for this expansive approach.

It is also worth noting that while the Model HMO Act places single line MCOs outside the scope of the HMO definition, states have “unauthorized insurer” laws that subject entities to state insurance

⁷ Model Act, §21(A).

⁸ NAIC, Model HMO Act, www.naic.org (accessed Feb. 18, 2003).

⁹ Draft 12/9/02, Revisions to Model Act <http://www.naic.org/1papers/models/docs/HMO12.doc> (accessed Feb. 18, 2003). It should be noted that a search of the term “managed care insolvency” at the NAIC website turned up 830 related documents, suggesting the amount of time and energy that this issue has consumed.

law if they are engaged in the business of insurance.¹⁰ Whether this “catch-all” provision of law could be used as a basis for invoking the insurer exception to the federal bankruptcy law is unclear, since the answer turns on whether under federal bankruptcy jurisprudence, courts would view certain types of MCOs as engaged in “the business of insurance.”

3. Federal Bankruptcy Law versus State Insurance Insolvency Law

The biggest obvious difference between bankruptcy and state insurance insolvency procedures is the forum. Bankruptcy is a federal process guaranteed by the U.S. Constitution, and bankruptcies are governed by national, uniform federal standards under The Bankruptcy Reform Act of 1978.¹¹ However, the Bankruptcy Act specifically carves out an insurance exception in recognition of the role of states in regulating insurance under the 1946 McCarran Ferguson Act. Because insurance insolvency is governed by state law, entities that are considered insurers will find themselves barred from bankruptcy proceedings and subject to the standards and procedures of dozens of different state jurisdictions.

Although insurance represents one of the principal exceptions to who can be a debtor under federal bankruptcy law, the reach of this exception is ambiguous, thus creating the confusion evident today. Section 109(b)(2) of the Bankruptcy Code defines the entities that are eligible to be classified as bankruptcy “debtors” for purposes of Chapter 7 (liquidation) or Chapter 11 (business reorganization). (Magellan in fact has sought Chapter 11 protection and does not intend to liquidate). Section 109(b)(2) excludes from the scope of the Bankruptcy Act both “banks” and “domestic insurance companies” as eligible debtors. But the Bankruptcy Act fails to define the term “domestic insurance company,” instead deferring to state law to determine the scope of the exclusion. As discussed below, this silence in federal law, coupled with a rapidly changing marketplace and the absence of clear state law, has led to litigation as various types of managed care entities have sought to invoke bankruptcy protections and state insurance authorities simultaneously have sought to claim control over their businesses and assets pursuant to §109(b)(2).

The differences between bankruptcy and insurance insolvency go well beyond the federal/state jurisdiction matter. At the heart of the two systems are fundamental differences in their basic goals and aims. The implications of these differences for consumers, particularly consumers with serious mental illness, are profound. This basic difference can be crudely summarized as follows: insurance insolvency protects enrollees, while bankruptcy protects the company.

The overarching goal of federal bankruptcy law is to permit debtors to make fresh starts either through liquidation or through business reorganization. The focus is on the debtor and on a process for resolving debts owed in a manner that does not defeat the potential for recovery. The debtor is permitted to discharge and terminate contracts (including contracts of insurance and provider agreements) in order to make reorganization possible. In short, bankruptcy offers no guarantee of continued coverage.¹² Indeed, because the primary purpose of a bankruptcy is to allow reorganization and reemergence in a position to do business, the bankruptcy process might allow the

¹⁰ Communication from Gary Claxton, The Kaiser Family Foundation, March 20, 2003.

¹¹ In fact there is more variation in federal bankruptcy proceedings than this statement would suggest, since large portions of the Bankruptcy Act contain broad terms that are defined by underlying state law, such as the scope and meaning of property interests in specific jurisdictions.

¹² Id.

HMO not only to curtail services but cancel contracts with its most costly members who represent adverse risks.¹³

An insurance insolvency on the other hand has as its primary purpose the honoring of contracts of insurance and the protection of enrolled members. The major concern of a state is the continuation of coverage, regardless of actuarial risks posed by members and on the same terms that previously existed between the HMO and its members.¹⁴ State insurance insolvency procedures permit state insurance commissioners to intervene, assume control of a troubled insurer, protect insured persons, and avoid liquidation. For example, the Model HMO Act requires that all MCO/provider subcontracts prohibit participating providers from billing members in the event of an HMO insolvency.

In short, bankruptcy law is meant to favor the enterprise that is bankrupt. State insurance law on the other hand is designed to favor insured persons. Federal bankruptcy law essentially strips insured persons of their contractual rights places them on the same basis as other unsecured creditors. Federal bankruptcy law puts insured persons on the same basis as other unsecured creditors (e.g., providers) and affords no guarantees of continued coverage. Like other unsecured creditors, enrollees would share equally in a liquidation, a meaningless guarantee where the interest at stake is insurance coverage for chronic illness.¹⁵

Over the years, numerous commentators have called for the federalization of managed care bankruptcies,¹⁶ arguing that the national nature of the business and the hybrid nature of the enterprise argue in favor of a unified federal process. The bankruptcy reform legislation that died in the 107th Congress did not take this step, nor does it appear that there is any realistic likelihood that this would occur. Indeed, just as managed care is a national business, so are older forms of health insurance, yet the domestic insurer exemption is a longstanding tenet of bankruptcy law. Indeed, as noted above, MCOs naturally argue for recognition as insurers when such a classification would afford them a legal advantage (e.g., when questions of medical liability arise). Thus, it should not be surprising that modern insurance law would view at least certain types of managed care organizations as domestic insurers when the issue is an insolvency proceeding.

As the NAIC model legislation indicates, states are zealous guardians of their insurance regulation prerogatives; indeed, the Model Act's 2002 amendments indicate that states are seeking to expand, rather than limit, the classes of managed care organizations that would be treated as domestic insurance companies for purposes of insolvency proceedings. This zealousness would appear to be based on the logical concern about maintaining insurance coverage for HMO enrollees, including persons with serious and chronic behavioral and related health conditions, who could find themselves uninsurable and subject to the highest risk and costliest individual group market without protection of their coverage.

¹³ Id.

¹⁴ HMO Eligibility for Bankruptcy, op. cit. p. 449.

¹⁵ The Aftermath of HMO Insolvency, op. cit. p. 97.

¹⁶ See, e.g., S. Stephen Rosenfeld, Health Insurance Insolvency Law: A First Look, <http://rosenfeld.com/Articles/insolv/him>; Lewis E. Hassett and Jessica Pardi, Health Maintenance Organization Insolvency: Bankruptcy Jurisdiction of State Proceedings, The Receiver (Winter 1999). http://www.mmmlaw.com/publications/print_articles.asp?articleid=58; Patrick Collins, HMO Liability for Bankruptcy: The Case for Federal Definitions of §109(b)(2) entities 2 Am. Bankr. Inst. L. Rev. 425 -451 (Winter, 1994) <http://web.lexis-nexis.com>.

At the same time, because the overarching purpose of state insurance law is to protect persons who hold insurance contracts, it is not at all clear whether most states either do or would classify as insurers MCOs that act solely as risk managers and insurer sub-contractors. The extent to which states have extended HMO status to single line companies is an important matter as is the application of “unauthorized insurer” laws to MCOs that manage risk for insured populations. The overarching motivation on the part of states is to treat these risk managing MCOs as insurers is to ensure that the assets of the company remain accessible to the state insurance department in order to keep the company functioning. On the other hand, as the cases below illustrate, the major reason why courts honor the “domestic insurance” exception to federal bankruptcy law is to allow states to protect their insured residents. Where the failing entity is acting as a subcontractor and not as an insurer of individuals or groups, the application of the “domestic insurance company” exception under the Bankruptcy Act is unclear.

4. Bankruptcy and Managed Care: The Current State of the Law

Despite the significance of the bankruptcy/insolvency question and the large number of managed care failures, there is only a relatively small amount of caselaw relevant to the question of whether managed care organization failures trigger state insurance insolvency procedures or federal bankruptcy proceedings.

One of the leading cases in the field that deals with the power of states to define the scope of the §109(b)(2) bankruptcy exclusions is *Cash Currency Exchange v Shine*.¹⁷ *Cash Currency* involved the failure of a series of community currency exchanges located in Illinois. The case posed the question of whether currency exchanges could be considered debtors under the Bankruptcy Code or were excluded by virtue of the §109(b)(2) exclusion of banks and domestic insurance companies. The state Director of Financial Institutions argued that under the state’s Community Currency Exchange law, the exchanges were to be classified as banks for purposes of insolvency proceedings and that as a result, his challenge to the bankruptcy court’s jurisdiction to proceed with the exchanges’ bankruptcy petition should be upheld.

Rejecting the position of the Director, the Court of Appeals for the 7th Circuit, considered one of the most influential in the country on matters related to the business of health care, set forth what is considered by legal experts to be the basic framework for analyzing claims of state jurisdiction under §109(b)(2). Under this framework, a court first looks to state law to determine how a particular institution is to be classified. If it is classified as a bank or domestic insurance company, the inquiry *generally* but not always stops there, and bankruptcy jurisdiction ceases. However, a court can go beyond a state’s facial classification scheme in order to determine whether or not the underlying purpose of the Bankruptcy Act and its 109(b) exclusion would be advanced by honoring the state’s claim of jurisdiction. A federal court faced with a motion to exclude a debtor from bankruptcy, nonetheless can determine that state law notwithstanding, the fundamental goals of federal bankruptcy law would be advanced by giving the debtor federal bankruptcy status.

What makes *Cash Currency* so relevant to the question explored in this report is the analytic framework developed by the court. The *Cash Currency* approach to Bankruptcy Act preemption of state insolvency procedures is similar to that found in ERISA cases, in that the analytic approach is

¹⁷ 762 F. 2d 542(7th Cir., 1985), cert. den. 474 U.S. 954 (1985).

both *textual* and *contextual*.¹⁸ That is, a court begins by looking at the text of the federal bankruptcy law as well as the state law at issue. But then, because supercedure of state law is at issue (as well as federal court's own jurisdiction), the court considers the underlying intent of the federal bankruptcy law in order to determine if Congressional intent would be advanced or frustrated were the state law to apply. This type of double-phased examination is particularly appropriate in cases in which federal law is ambiguous (in the case of the Bankruptcy Act, the ambiguity arises from the lack of a definition for the term "domestic insurer"). It is also appropriate where the issue before a court is a complex federal remedial scheme that displaces other important state laws.

Cash Currency is also highly relevant because of the types of interests that the court found important to weigh. The court viewed as highly significant the fact that, despite the state's assertion that the exchanges were classified as banks under state law, Illinois law actually prohibited cash currency exchanges from accepting deposits and limited their powers to check cashing and money orders. In other words, cash currency exchanges did not hold individuals' funds but merely processed certain types of transactions. Since the underlying purpose of the banking exclusion in the Bankruptcy Act was to permit states to protect *individual depositors' interests*, where no deposits were allowed, no such compelling interests were at stake. Thus, the lesson of *Cash Currency* is that while state classifications are significant, they are not conclusive evidence to the extent that the result is determined to be in conflict with the Bankruptcy Act. Since the purpose of the Bankruptcy Code is to protect debtors, courts will protect them from situations in which state laws are viewed as overreaching and in effect little more than an effort to preserve assets within the state's borders for its own use. There must be clear individual property interests in the form of bank deposits or contracts of insurance before federal law will allow a §109(b) exception to be triggered.

In the case of managed care organization failures, the leading case involves Maxicare, which failed more than a decade ago. In the Maxicare cases (there were many) the Bankruptcy Court claimed jurisdiction over the failure of Maxicare, declaring that HMOs were not "domestic insurers" for purposes of §109(b) and properly claimed bankruptcy debtor protection.¹⁹ In response to Wisconsin's appeal of the bankruptcy court's decision, a United States District Court held that as a licensed Wisconsin HMO, Maxicare actually insured members in addition to furnishing health care. Because members did not merely receive health care through Maxicare but actually held contracts of insurance, the court concluded that the state was legally entitled to claim jurisdiction.²⁰ Thus, in the Maxicare case, the court in essence found that the state's classification of HMOs as domestic insurance companies for purposes of insolvency not only satisfied the facial meaning of the §109 exception to the Bankruptcy Act, but even more basically, furthered its purpose. Because Wisconsin residents actually were insured by Maxicare, recognition of state insurance insolvency procedures was fundamentally compatible with federal law.

A search of the court decisions finds only a single case involving an HMO bankruptcy that directly involved a Medicaid contract. This case, *MedCare HMO v Bradley*²¹ is discussed below.

¹⁸ Rand Rosenblatt, Sara Rosenbaum and David Frankford, *Law and the American Health Care System* (Foundation Press, NY, NY, 2001-2002 Supplement)

¹⁹ *In re Family Health Services* 104 B.R. 279 (1989).

²⁰ *In re Family Health Services* 143 B.R. 232 (1992)

²¹ 788 F. Supp. 1460 (N.D. Ill., 1992)

5. Medicaid Contracts with MBHOs

Against this extended legal backdrop, the question becomes what rights Medicaid agencies and other public agencies hold in a Chapter 11 reorganization involving an MBHO, i.e., a single line MCO. Can a state insurance commissioner step in on behalf of public purchasers and claim jurisdiction to protect the state's interests, as Wisconsin did in the Maxicare case? Or would the state Medicaid agency be subject to the federal bankruptcy process along with those of other creditors?

The answer to this question seems to come down to whether Magellan's Medicaid contracts should be viewed as contracts of insurance. The answer is probably not, although this is far from clear. The conclusion that a bankruptcy is the applicable process in a case such as Magellan is based on two considerations. First, a review of the Medicaid managed care contract data base maintained by CHSRP suggests that many states do not require MBHOs (or MCOs for that matter) to hold HMO licenses in order to be qualified to do business with Medicaid. Were HMO licensure a prerequisite to Medicaid participation, then in the states that follow the Model HMO Act, state law would provide for insurance insolvency proceedings in the event of plan failure. But the Medicaid contracts do not require HMO status, nor do they appear to deem entities to be HMOs. How a state's unauthorized insurer law would apply in such a situation is unclear but the existence of such a law might offer an avenue for a state to argue for insolvency.

At the same time, the Medicaid contracts if anything stress the lack of insurance status for MBHOs; indeed, some contracts specifically provide that HMO licensure is not necessary. For example, Florida's managed behavioral health contract specifies that "the Department of Insurance does not require that the contractor be licensed in accordance with [state insurance law]." Other contracts are ambiguous and track the language that one would expect for a general business corporate license, not an insurer license. For example, Arizona's managed behavioral health contract provides that "The Contractor shall be registered [with the Arizona Medicaid program] and shall obtain and maintain all licenses, permits and authority necessary to do business * * * under this contract." These contractual provisions suggest that classification as a domestic insurer – an apparent *sine qua non* for claiming state jurisdiction under §109 of the Bankruptcy Act -- does not generally appear to be a feature of Medicaid/ MBHO agreements. But each state's contracts and their relationship to state insurance law would require scrutiny.

A second reason why MBHO failures would seem to be a matter for federal bankruptcy and not insurance insolvency in the case of Medicaid managed care is more subtle and has to do with the legal status accorded enrollees by state agencies under their Medicaid agreements. Our review of contracts suggests that state Medicaid agencies rarely if ever create third party beneficiary rights in their managed care purchasing agreements. In other words, the state Medicaid agencies do not give their own beneficiaries the type of individual right of enforcement that persons who are insured enjoy as a matter of state or federal law.²²

In other words, state Medicaid agencies do not appear to treat their beneficiaries as *insured* through an MCO or an MBHO – merely *managed by them*. This distinction actually makes sense, since as a

²² In the case of ERISA-governed contracts, this right is federal (ERISA §502, 29 U.S.C. §1132). In the case of insurance contracts governed by state law (e.g., individual contracts, coverage offered to public employees) the right of enforcement would be governed by state law. In the case of Medicare, this right of enforcement is found in 42 U.S.C. §405(g), while 42 U.S.C. §1983 offers a right of enforcement in the case of Medicaid.

matter of federal entitlement law, beneficiaries can be thought of as *insured* through Medicaid, even if their care is *managed* by a risk contractor. Another way of putting it is that Medicaid MBHO contracts are management contracts rather than contracts of insurance. As in *Cash Currency* the MBHOs that do business with Medicaid agencies incur legal duties toward the state agency, not to the individuals who are served. The presence of a direct legal duty toward individual state residents would appear to be critical to whether a court would view a state's interests as paramount. Because a Medicaid MBHO insolvency does not involve personal property rights of beneficiaries (as would a bank or insurance failure), no underlying goal of the federal bankruptcy system would be advanced by permitting state insurance insolvency law to apply.

Of course, this type of situation is state specific. States that accorded HMO status to their Medicaid MCO contractors (general or single line) and extended third party beneficiary rights to their enrollees would be in a strong position to argue for application of the §109(b) exclusion. States that do not evidence any intent to accord insurance status to their Medicaid contracts probably would have a difficult time arguing for application of the exclusion.

The one case that provides insight into Medicaid managed care and bankruptcy is the *Medcare* decision noted above. In this case, a federal court ruled that a state Medicaid agency could neither disenroll its members nor could it cease payments to an MCO in Chapter 11 reorganization because both the patients and the contracts were the property of the bankrupt entity. While *Medcare* did not involve a challenge to bankruptcy jurisdiction, it does shed light on how courts view the relationship between Medicaid agencies and MCOs.

Federal amendments to Medicaid enacted in 1997 appear to codify the *Medcare* result and thereby further this view of Medicaid payments and beneficiaries as the property of bankrupt entities. Under the 1997 amendments, contracts with MCOs cannot be terminated without prior notice and hearing,²³ an extraordinary level of federal protection typically reserved under federal law for poor welfare entitlement recipients, although one that parallels insurance licensure protections. The fact that this protection is codified in federal law however suggests that Congress views such terminations as falling outside normal state insurance proceedings. The 1997 amendments permit (but do not obligate) states to allow affected beneficiaries to disenroll from MCOs in termination hearings,²⁴ further evidence that the Medicaid contract is a management agreement only and that beneficiaries fundamental insurance entitlement is a matter of federal Medicaid law that continues even during management failure. Many states of course make active provision for disenrollment and continuity of care in the event of plan failure,²⁵ although the *MedCare* case underscores that states that wish to release beneficiaries from failing plans may be barred as a matter of federal law from doing so.

It is too soon to tell how this complex issue will play out. The Magellan filing has just commenced, and obviously no state insurance commissioner has as yet stepped forward to claim jurisdiction under §109 of the Bankruptcy Code. If such a development does occur, the case will be an extremely important one to watch.

²³ 42 U.S.C. §1396u-2(e)(4)

²⁴ *Id.*

²⁵ For an excellent overview of issues in transitioning Medicaid beneficiaries out of MCOs that are exiting the market, see *Transitioning Clients When Plans Exit Medicaid Managed Care Programs*. CHCS, Princeton, NJ, 2001. [Accessed March 20, 2003 at <http://www.chcs.org>.