Are HMOs engaged in insurance business?

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Written by Dennis B. Funa

Are Health Maintenance Organizations (HMOs) engaged in insurance business? This question was squarely placed before the Supreme Court in *Philippine Health Care Providers, Inc. v. Commissioner of Internal Revenue* (G.R. No. 167330). The Court (First Division) at first ruled (June 12, 2008) that yes, HMOs are engaged in insurance business and that the petitioner's health care agreement was in the nature of a non-life insurance contract. However, in a motion for reconsideration, the Special First Division (Resolution, September 18, 2009), but through the same *ponente*, reversed itself and ruled that HMOs are NOT engaged in the business of insurance.

In two earlier cases, *Blue Cross Healthcare, Inc. v. Olivares* (G.R. No. 169737, February 12, 2008) and *Philamcare Health Systems, Inc. CA* (429 Phil. 82 [2002]), the Supreme Court ruled that a health care agreement is in the nature of a non-life insurance policy. However, it was clarified in *Philippine Health Care Providers, Inc.* (Resolution) that those cases only involved the interpretation of health care agreements as contracts of adhesion similar to an insurance contract which are also contracts of adhesion.

An HMO was first defined in 1995 through Republic Act No. 7875 ("National Health Insurance Act of 1995"), Section 4, (o), enumerating what are health care providers: "a health maintenance organization, which is an entity that provides, offers, or arranges for coverage of designated health services needed by plan members for a fixed prepaid premium". Among the pioneer HMOs in the Philippines are Health Maintenance, Inc. (HMI) and Bancom Health Care Corp. (later renamed to Integrated Health Care Services, Inc. (or Intercare). HMI was first organized in 1965 but formally incorporated only in 1991. Bancom was formed in 1974.

The Supreme Court applied the *Principal Object and Purpose Test,* as formulated in American jurisprudence, in reaching the said conclusion. The test is "whether the assumption of risk and indemnification of loss (which are elements of an insurance business) are the principal object and purpose of the organization or whether they are merely incidental to its business. If these are the principal objectives, the business is that of insurance. But if they are merely incidental and *service is the principal purpose*, then the business is not insurance." In other words, if the main object is to provide health services rather than indemnity, it is not engaged in insurance business. The

“mere presence of risk would be insufficient to override the primary purpose of the business to provide medical services as needed, with payment made directly to the provider of these services. In short, even if petitioner assumes the risk of paying the cost of these services even if significantly more than what the member has prepaid, it nevertheless cannot be considered as being engaged in the insurance business.”

Before this test is applied, there is a need “to scrutinize the operations of the business as a whole and not its mere components.” The operations of an HMO must first be characterized. It operates as “a prepaid group practice health care delivery system or a health maintenance organization to take care of the sick and disabled persons enrolled in the health care plan and to provide for the administrative, legal, and financial responsibilities of the organization”. “Individuals enrolled in its health care programs pay an annual membership fee and are entitled to various preventive, diagnostic and curative medical services provided by its duly licensed physicians, specialists and other professional technical staff participating in the group practice health delivery system at a hospital or clinic owned, operated, or accredited by it.” Its medical services also provide for the following general health care services: preventive, diagnostic, and curative.

The Court cited *Jordan v. Group Health Association* (107 F.2d 239. D.C. App. 1939) which held that Group Health Association should not be considered as engaged in insurance activities since it was created primarily for the distribution of health care services rather than the assumption of insurance risk.

The Principal Purpose Test was also applied in *California Physicians Service v. Garrison* (28 Cal. 2d 790 [1946]) and *Michigan Podiatric Medical Association v. National Foot Care Program, Inc*. (438 N.W.2d 350 [Mich. Ct. App. 1989]).

Moreover, other distinctions were also pointed out by the Court. Applying *Somerset Orthopedic Associates, P.A. v. Horizon Blue Cross and Blue Shield of New Jersey* (345 N.J. Super. 410, 785 A.2d 457 [2001]), it pointed out that the main difference between an HMO and an insurance company is that HMOs undertake to provide or arrange for the provision of medical services through participating physicians while insurance companies simply undertake to indemnify the insured for medical expenses incurred up to a pre-agreed limit.

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Dennis B. Funa (dennisfuna@yahoo.com) is the current Insurance Commissioner. He was appointed by President Rodrigo R. Duterte as the new Insurance Commissioner in December 2016.