New "insurance" regulations on providers participating in alternative payment arrangements

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INTRODUCTION

A consensus is emerging among many policy experts and regulators that fee-for-service healthcare provider reimbursement contracts create perverse incentives that drive volume and do not reward quality. As a result, a growing trend over the past several years has been to shift insurance (utilization) risk from payers to providers through alternate payment contracts (APCs) in an effort to align financial compensation with performance and financially penalize providers if certain financial and quality thresholds are not met. The Patient Protection and Affordable Care Act (ACA) encouraged the formation of accountable care organizations (ACOs), resulting in risk-sharing contracts in programs from the Centers for Medicare and Medicaid Services (CMS) such as the Pioneer ACO Model, Medicare Shared Savings Program, and Bundled Payments for Care Improvement (BPCI) Initiative.

Regionally, many states have also been pushing risk-sharing contracts as a way of controlling costs and improving provider quality. For example, on August 6, 2012, Massachusetts signed into law Chapter 224 of the Acts of 2012, "An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation." Through this law, the Commonwealth of Massachusetts is encouraging carriers to continue expanding and creating APCs.[1] For example, Blue Cross Blue Shield of Massachusetts created its risk-sharing contract, the Alternative Quality Contract (AQC), back in 2008, and it now covers about 85%[2] of its entire provider network.

WHAT DOES THIS MEAN TO PROVIDERS?

As providers assume more insurance risk through APCs, a greater percentage of their revenues is variable, and therefore they face one of the largest risks an insurance company faces—insolvency due to patients (members) utilizing more services than anticipated.

To ensure that there is not widespread disruption to the Massachusetts healthcare delivery system from provider insolvency[3] caused by not adequately addressing for this new insurance risk, its regulators are starting to require providers to appropriately quantify their financial exposure under APCs and to have an adequate financial cushion (reserves) to reduce the risk of insolvency. As a result, all risk-bearing provider organizations (RBPOs) in Massachusetts will be required to obtain an annual certification from the Division of Insurance (DOI). Among other things, in order to obtain the DOI certification, the RBPO will require a certification from a qualified actuary indicating that its APCs with downside risk are not expected to threaten the financial solvency of the RBPO.

While Massachusetts is currently a leader in imposing this level of oversight on providers who are assuming insurance risk, many other states are watching Massachusetts and some are likely to implement similar oversight in the future, especially if provider groups in their states run into financial problems that are due to risk contracts.

ITEMS TO CONSIDER WHEN REVIEWING THE APCS

Below, we outline items actuaries will likely consider when reviewing a provider's APCs:

- How is the APC budget calculated? Is it based on historical claims, a percent of premium, or something else? How is the budget trended to the performance period?
- Is the APC's budget risk-adjusted? A risk-adjusted budget will offer some protection for a population that changes in health severity from year to year.
- Are there services included in the contract that the provider has little or no ability to manage? For example, a provider organization likely has little control over the costs associated with neonatal intensive care unit (NICU) or AIDS. Including these kinds of services in an APC can expose the provider to greater risk.
- How large is the member population under the APC? The smaller the population, the greater the volatility from fluctuation in claims costs. This randomness will occur whether or not the organization has an effective care management program.

1 Massachusetts Laws of 2012, Chapter 224, Section 15, defines alternative payment methodologies as: "methods of payment that are not solely based on fee-for-service reimbursements; provided that, 'alternative payment methodologies' may include, but shall not be limited to, shared savings arrangement, bundled payments and global payments."

2 Blue Cross Blue Shield of Massachusetts. About Us: Alternative Quality Contract. Retrieved August 14, 2015, from https://www.bluecrossma.com/visitor/about-us/affordability-quality/aqc.html.

3 Massachusetts Division of Insurance. 211 CMR 155.00: Risk-Bearing Provider Organizations, Retrieved August 17, 2015, from http://www.mass.gov/ocabr/docs/doi/legal-hearings/211-155.pdf.

- Are there opportunities to earn additional revenue to offset some of the downside risk, such as quality payments?

- What other safeguards from poor claims experience does the organization have in place? Does the RBPO have individual or aggregate reinsurance, either through the APC itself or purchased from a reinsurance carrier on the open market?

MODELING THE APPROPRIATE LEVEL OF FINANCIAL RESERVES

As a next step, the actuary will likely build a model to estimate the appropriate level of financial reserves required for the risk exposure borne by the provider through the APCs. Taking the above points into consideration, a deterministic model can be built to estimate the expected APC's surplus or deficit based on projected claims and budget. The larger the projected surplus, the less likely random fluctuation from adverse events will cause financial strain on the provider, which will lower the level of required reserves.

A stochastic simulation can be built on top of this model to assign probabilities that the provider's APC produces a deficit as a result of unforeseen events. A claims probability distribution can be created either from the provider's actual APC historical claims data or another similar source.

Two main sources of claims variation that should be modeled in the simulation include:

- Mis-pricing. It is possible (probable) that the projected claims cost will not come in as expected because of inaccurate trend setting/assumptions.

- Random fluctuation. Even if the trend assumption is correct, there is always the possibility of chance events from year to year (i.e., larger-than-expected high-cost claimants).

Using this approach, actuaries can generate a reserve estimate that will be appropriate and sufficient under most market conditions. However, the magnitude of the reserves can vary greatly for different group sizes and whether or not the provider has reinsurance protection.

It is possible that the actuary's estimate of the financial reserves will result in the RBPO's auditors requiring that amount to be explicitly accounted for in its financial statements. We recommend that, early on in the solvency certification process, the RBPO discuss with its auditors how they want to handle any reserve estimate developed by the RBPO's actuary.

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