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Milliman USA
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2002 Valuation Actuary Symposium

**Walt Disney World Dolphin Resort
Lake Buena Vista, Florida
September 19 – 20, 2002**

Workshop #15

Provider Liability Reserves

**1:30 PM to 3:00 PM
Thursday, September 19, 2002**

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Summary of Actuarial Liabilities

- A. Claims reserves
 - 1. Claims reserves
 - 2. Claims liabilities
- B. Active life reserves (policy reserves)
 - 1. Unearned premium reserves (UPR)
 - 2. Contract reserves (additional reserves, benefit reserves, policy reserves)
- C. Premium deficiency reserves (PDR)
- D. Outcome-based contractual reserves
 - 1. Employer-based contractual liabilities
 - 2. Provider liabilities

Definitions of Actuarial Liabilities

- A. Claims reserves

This estimated amount represents a contractual obligation to pay benefits as of the valuation date. Statutorily defined as “reserve” plus “liability.”

 - 1. Claims “reserves” are losses that have occurred on or before the valuation date, but the service has not been rendered as of the valuation date
 - 2. Claims “liabilities” are the cost of services that have been rendered before the valuation date, but the claim has not been paid as of the valuation date
- B. Active life reserves (Policy reserves)
 - 1. Unearned premium reserves (UPR) are usually asset entries. It represents premiums that have been collected and entered in the ledger, but are actually allocated to a period of time after the valuation date. A model premium is booked as of a given point in time, but a portion of that premium is designed to cover a period of time beyond the valuation date.

2. Contract reserves (additional reserves, benefit reserves, policy reserves) are established when some portion of the premium collected in a contract's early durations is *intentionally* designed to help pay for anticipated higher claims costs in later durations.

? Entry age-rated (level premium) products

? Medically underwritten products with durational morbidity patterns

? Coverage that has a rate guarantee whereby the claims costs are anticipated to increase faster during the guarantee period than the premiums. (If the actual increase in claims exceeds that expected in the original pricing of the rate guarantee, the need for a premium deficiency reserve may also be appropriate.)

C. Premium deficiency reserves (PDR)

This reserve is set up when it is determined that future premiums are not sufficient to cover future claims payments and expenses. This reserve is usually estimated using a gross premium valuation. The distinction between Contract Reserves and PDR Reserves lies in initial pricing *intent*. A PDR covers liabilities created by claims experience outcomes, which may not have been intended at the time the policy was issued.

D. Outcome-based contractual reserves

1. Employer-based contractual liabilities include refund liabilities created when claims cost experienced under a given retrospectively experience-rated employer contract is less than expected. These amounts are also known as experience-rated refunds, premium/claims/rate stabilization reserves, contingency reserves, dividend liabilities, premium refund liabilities, etc.
2. Provider liabilities are created by certain contracts between an insuring entity and a provider of medical services, typically in managed care environments. These contracts create a liability for payment after the valuation date for services performed before the valuation date. These are payable under some alternative contractual arrangement in which payments are not related to a single claim event. An element of *risk* of reimbursement to the provider is anticipated in such a payment methodology. Amounts related to a provider's submission of a claim for payment relative to a specific service rendered is typically categorized as a claims liability.

Alternatively,

Provider liabilities represent the value of any risk-sharing payments accrued as of the valuation date that have not been settled as of that date. This obligation is to make a future payment to providers under some form of risk-sharing arrangement, under which:

- ? The payment is not related to a specific service performed by that provider, and
- ? The payment is contingent on certain financial or operational goals being achieved.

To differentiate provider liabilities from claims reserves there must be an element of *risk* to the provider. Typically, an after-the-fact assessment of experience outcomes is developed as part of the settlement process. There must also be a contractual relationship that defines the future payments to be made to providers.

Provider Liabilities

[ASOP – The actuary should be familiar with the provider contracts to ensure that the liability estimates take into account any risk sharing involved and special settlement provisions of the provider contracts.]

[ASOP - The actuary should take into account the relevant contractual arrangements with providers and any changes in such arrangements. These arrangements can affect trends, claim cost levels, and claims processing. The actuary should consider any relevant variation in these arrangements by region or product, and any provider contractual arrangements that do not provide for reimbursement through the claim payment process, for example, capitation.

The arrangements will also typically specify what portion of the risk (if any) has been shifted to the providers. If the providers bear a substantial portion of the risk, the actuary should consider the overall ability of the provider to meet its obligations. Depending on the purpose of the analysis, the actuary should take into account any statutory limitations on the credits for such transfers of risk.

Additional amounts may be owed to providers for supplemental payments for high cost medical treatment beyond capitation, return of payment withholds, or incentive payments based on financial results. Certain contractual arrangements may also result in amounts due from providers based on financial results.]

Examples of provider liabilities:

1. Capitation payments owed, but not yet paid as of the valuation date
 - ◆ [NAIC Health Reserves Guidance Manual – Claims reserves include the amount of any capitation payments that are due as of the valuation date, but have not been paid as of that date.]
 - ◆ This amount is often handled by the accounting departments as a payable, and may not be considered as a liability of an actuarial nature needing review by an actuary.
 - ◆ [ASOP – Occasionally, MCHPs make concessions in the form of retroactive supplemental capitation payments to capitated providers experiencing adverse financial results under their MCHP contract. The actuary should recommend that liabilities and rates include adequate provision for such actual or anticipated settlements that fall outside the scope of the contract.]
 - ◆ Sometimes advances to capitated providers are made contractually in anticipation of future services. These receivables can be admitted as assets only under certain specified conditions. See the later discussion.
2. Amounts withheld from the provider at time of payment of services or capitations, but which later become payable based on contractually defined experience outcomes
3. Bonuses or other contractual incentive payments based on contractually defined experience outcomes
4. Settlements under stop loss contracts
 - ◆ A stop loss provision is sometimes included in risk-sharing arrangements contingent on financial goals
 - ◆ Could remove large claims from the settlement calculations
 - ◆ Could remove organ transplants or AIDS claims from the settlement calculations
 - ◆ Typically results in a larger payout, although the targeted claims costs are usually reduced by the expected amount of pooled claims.

5. Provider discounts expressed in terms of aggregate claims

- ◆ Claims in a claims lag grid are usually recorded net of any discounts received from providers.
- ◆ However, some provider discounts are expressed in terms of aggregate claims.
 - ? A hospital settlement at the end of each calendar year whereby the discount for the year is determined based on the volume of business the carrier has at that hospital during the year, as an example.
 - ? Physicians may be paid on the basis of a specified unit value schedule and a floating conversion factor(s). Initially, the claims are paid using an estimated conversion factor and, later, an aggregate adjustment is made to settle to a final conversion factor.
- ◆ In this instance, a provider settlement liability needs to be estimated and accrued as of the valuation date.

Withhold settlements:

- ◆ Assume a \$100 claim is presented for services rendered. Assume further that a check is cut to the provider for \$80 and \$20 is withheld. The \$20 is typically put into a withhold liability account. If specified financial targets are met during the contract period, the amounts withheld on claims incurred during the contract period will be paid to the providers. If financial targets are not met during the contract period, some, or all, of the amounts withheld will be kept by the carrier.
- ◆ An accrued calculation should be completed for the contract period through the valuation date to determine whether or not the financial target has been met. This calculation is typically completed using incurred claims that reflect:
 - A. The claims incurred during the contract period and paid through the valuation date (\$80), plus
 - B. The aggregate amounts withheld on these claims (\$20), plus
 - C. The estimated IBNP claims reserve on the valuation date net of amounts withheld (\$80), plus
 - D. The estimated amounts to be withheld on these IBNP claims (\$20).

- ◆ If a gain exists, C above should be held as a claims reserve and B + D above should be held as a withhold liability as of the valuation date. The expectation is that this amount will be returned to the providers.
- ◆ If a loss exists, and the loss is less than the total of the amounts withheld on paid and IBNP claims (B + D above), C above should be held as a claims reserve and B + D less the loss should be held as the withhold liability. The expectation is that this amount, the aggregated amounts withheld less the loss, will be returned to the providers under the withhold settlement.
- ◆ If a loss exists, and the loss is greater than B + D above, C above should be held as a claims reserve and nothing should be held as a withhold liability. The expectation is that nothing will be returned to the providers under the withhold settlement.
- ◆ A simpler and more conservative method is to hold the entire withhold as a liability until it becomes certain that it will not be paid. In the above example C would be held as a claims reserve and B + D would be held as a withhold liability as of the valuation date. This approach may be particularly applicable in the early months of a provider contract.

Types of contractually defined experience outcomes or financial results used in risk-sharing arrangements:

- ◆ Risk may be shared on the basis of a target cost per member per month (PMPM) or a targeted loss ratio.
- ◆ The bonus or incentive is often defined as the difference between experience and targeted costs times the volume of members or premium for which risk has been assumed.
- ◆ Such targets may not be based on the services normally performed by the provider. A primary care physician may have Rx or specialty physician cost targets, as an example.
- ◆ Settlement calculations are often lagged several months after the end of the contract period to minimize the impact of incurred claims estimates.
- ◆ Provision for adverse deviation should be included in the estimates of provider liabilities.

- ◆ Reserves as of the valuation date, if used in these accrued settlement calculations, typically do not include any provision for conservatism. In the development of the liability associated with a risk-sharing arrangement, a conservative reserve estimate may be one that is on the low side, resulting in a provider liability estimate that is on the high side, i.e., is conservative.
- ◆ Out-of-network claims and/or out-of-area claims may be excluded from these settlements.
- ◆ Deficits from prior contract period settlements may be carried forward and recouped from current year gains before any settlement is paid to providers. Similarly, differences between estimated and actual reserve levels might also be reflected in subsequent settlements.
- ◆ Different funds could be involved in the settlement calculations, with varying percentages at risk.
- ◆ The various providers could have varying contract periods or effective dates, and yet be included in a common claims lag grid.
- ◆ Interim payments of the risk-sharing incentive accruing during the contract period may have been made.
- ◆ If the data in the accrued settlement development is not credible, it is common to use pricing assumptions, historical loss ratios, or reserving all or a part of withhold payments based on historical experience.
- ◆ The liability can be calculated on an aggregate or seriatim basis. However, the aggregate reserve calculation should group contracts with similar types of provider liabilities.
- ◆ Examples of payments contingent on operational goals include:
 - ? Number of hospital days.
 - ? Percentage of insured children who receive a standard set of inoculations.
 - ? Number of referrals made by primary care physicians (PCPs) to specialist physicians.
 - ? Number of Rx scripts written by PCPs.

What if risk is shifted to a provider who becomes insolvent?

- ◆ [ASOP - The actuary should consider the impact of unpaid medical costs resulting from failed contractors under capitation or losses incurred by contractors deemed to be related parties.]
- ◆ [ASOP - The actuary should include in all MCHP claims liability and rate opinions a statement disclosing the actuary's knowledge of all capitated risk contracts between the MCHP and provider entities. This statement should indicate whether the actuary has evaluated the financial position of the provider entities. The actuary should make appropriate inquiries of responsible persons regarding the financial condition of provider entities that assume financial risk through a capitation mechanism. The actuary's statement should disclose knowledge of, and make appropriate provisions for, any financially insolvent provider entity that may have a material effect on the MCHP's rates, reserves, or financial condition.]
- ◆ Under most jurisdictions, a carrier may be required to reimburse policyholder claims on a fee-for-service basis if the providers to whom they have capitated or otherwise prepaid services should become insolvent. If any provider insolvency is anticipated, the carrier must establish a reserve for services that must still be provided to policyholders. The claims reserves should reflect this additional contingent liability.
 - ? Credit worthiness of the capitated provider needs to be considered.
 - ? Contracts with IPAs that have capitation contracts with multiple other carriers should be considered. Although an insurer might know how its capitated contract is working out financially for the IPA, it has no way of knowing how the other contracts of that IPA are doing financially.
 - ? In addition, if the responsibility for processing and paying claims is shifted to these entities, they frequently have inadequate systems for monitoring financial results and could have no requirements to submit claims to the insurer. A capitated entity could be financially insolvent for some time before the situation came to the attention of the insurer.
 - ? Consideration should be given to whether or not the capitated provider is directly providing the care. As an example, a small physician group that refers a large number of patients to other physicians, yet assumes financial liability for that care under the terms of the insurer's contract, probably represents a larger risk of potential liability exposure to the insurer than a physician group that refers relatively few patients.

- ◆ If the capitated contract terminates, and the carrier's contract includes an extension of benefits provision on termination of the group contract, are services provided after termination of the capitation contract on disabled individuals the liability of the capitated provider? Alternatively, would such claims have to be paid by the carrier on a fee-for-service basis?
- ◆ If a capitation agreement terminates, the anticipated fee-for-service claims to be substituted could cause premium rates to become inadequate. In this event a premium deficiency reserve should be considered.
- ◆ A carrier may continue to process and make interim payments on claims for services that are capitated.

If the carrier does this as a service for the provider, pays these claims out of the provider's account or funds, and the medical expenses in the carrier's financial statements reflect only the capitation payments, the claims lag grids used to establish the carrier's reserves should exclude these fee-for-service claims. The cash reconciliation should match in this instance.

If the carrier pays these claims out of its own accounts, the medical expenses in the carrier's financial statements would reflect the fee-for-service claims paid instead of the capitation payments. In this instance, a settlement will typically be made between the carrier and the capitated provider at the end of the contract year to adjust the carrier's obligation back to what it would have been if only the capitation amount had been paid to the provider during the contract year. If the carrier establishes an amount reflecting this accrued liability on the valuation date, no additional reserve would be needed. The claims lag grids used to establish the carrier's reserves should exclude these fee-for-service claims. The presence of such an arrangement should surface during the cash reconciliation process.

- ◆ Many states require contracts between insurers and providers include a hold harmless clause whereby the participating providers are prohibited from seeking reimbursement from patients for money owed to participating providers by the plan.
- ◆ Suppose an insurer has a contract with a risk bearing entity, and this intermediary in turn has subcontracts with providers. If the risk bearing entity becomes insolvent, or fails to make payments to its subcontractors, many states require the insurer be responsible for the payments owed to the providers.

Possible state exceptions:

- ◆ Colorado - the actuary is required to disclose whether or not the financial position of contracting providers has been reviewed. The implication is that a disclosure that such financial position has not been reviewed will not be acceptable.
- ◆ Illinois - requires a review of the financial condition of providers under capitation agreements.

? Original submission

“ABC HMO contracts with ABC Provider for the provision of most health care services. ABC HMO compensates the ABC Provider on a capitation basis. I have not examined the assets of the ABC Provider or other sub-capitated provider entities and I have formed no opinion as to their validity or value.”

? State response

“A deficiency has been identified which must be addressed before the Department will accept your Opinion as adequate. The Opinion appears to be deficient in that it does not comply with Actuarial Standard of Practice No. 16 (Actuarial Practice Concerning Health Maintenance Organizations and Other Managed-Care Health Plans), Section 5.1.4, Financial Condition of Capitated Providers. The Opinion states that no review of the financial condition of providers with which your company has capitation agreements was done, as is required by ASOP 16. The Actuarial Opinion must be revised to address this matter before the Department will accept this Opinion.”

? Accepted resubmission

“ABC HMO contracts with ABC Provider for the provision of most health care services. ABC HMO compensates the ABC Provider on a capitation basis. I examined the net current assets (current assets less current liabilities) of the ABC Provider as of December 31, XXXX. The net current assets measure indicates the ABC Provider would be reasonably able to cover its estimated Claims Payable liability of \$Y.”

Provider settlement expenses:

- ◆ A liability should be established for the future cost of calculating and distributing any provider liability existing on the valuation date. Such a liability should be established even if no payment is expected. This amount will generally be considered part of general expenses.

Follow-up studies:

- ◆ Whatever method is used to estimate provider liabilities, follow-up studies should be completed to test the adequacy of the estimates resulting from these methods as final data become available.

Financial accounting entries:

- ◆ The provider liability is included as a claim liability in the annual statements of the following carriers:
 - ? Hospital, Medical, and Dental Service or Indemnity (HMIDI)
 - ? Property and Casualty
 - ? Life, Accident and Health
 - ? Fraternal
- ◆ In the statement for Health Carriers and Health Maintenance Organizations (HMOs) the provider liability is separated into two components:
 - ? Withhold liability
 - ? Incentive or bonus pool liability
- ◆ As an example, assume the gross withhold liability is \$2,500, the withhold recapture is \$1,000, and the remaining provider incentive or bonus pool liability of \$750.
 - ? Liabilities, Capital and Surplus
 - Line 1, Claims unpaid includes the net withhold liability of \$1,500
 - Line 2, Accrued medical incentive pool and bonus payments includes \$750

- ? Statement of Revenue and Expenses, as well as the Analysis of Operations by Line of Business

Lines 8-12 includes the gross withhold liability of \$2,500

Line 13 includes the combined withhold recapture (as a negative amount) and incentive or bonus pool liability for a total of (\$250)

Provider Receivables (Admitted Assets)

[ASOP – In the case of amounts owed by providers to the MCHP when no contractual withholding provision exists, the actuary should consider the collectibility of such amounts, particularly if such amounts are netted from liabilities included in the actuary’s review.]

NAIC Accounting Practices and Procedures Manual, March 2002, Statement of Statutory Accounting Principles (SSAP) #84, Certain Health Care Receivables and Receivables Under Government Insured Plans addresses the admissibility of health care receivables. This provision took effect December 31, 2001.

1. Rebates owed to insurers by pharmaceutical benefits managers are to be booked as a separate asset.
 - ◆ When the rebates are received they are to be booked as a reduction to claims expenses rather than as a revenue item.
 - ◆ These receivables should be split into billed amounts and estimated amounts for reporting purposes.
 - ◆ The estimated amount should only reflect the rebate on prescription drugs filled within the preceding quarter.
2. Loans or advances to providers will be admitted only to the extent there is an offsetting provider-specific claims liability.
 - ◆ For most providers this cap is the reported but not yet paid liability amount, i.e. excludes the incurred but not reported amount.
 - ◆ For hospitals this cap is the total claims liability amount, if specific conditions are met, including but not limited to, the following:
 - ? The loan or advance is supported by a legally enforceable contract

- ? The contractual terms of the agreement provide for separate quarterly reconciliations
 - ? Each quarterly reconciliation is completed within nine months of the end of such quarter
 - ? A quarterly reconciled difference is settled within 90 days of the date the reconciliation is completed
3. Sometimes advances to capitated providers are made contractually in anticipation of future services. These amounts can be admitted as an asset to the extent that the advanced amount does not exceed one month of average capitation payments for the provider during the preceding 12 months, and provided the contract cannot be terminated before the end of the month for which the advanced payment was made. However, such amount still has to be collectible.
4. Risk sharing receivables should be split into billed amounts and estimated amounts for reporting purposes. Risk sharing receivables can be admitted as assets only if certain specified conditions are met, including but not limited to, the following:
- ◆ Must be based on at least six months of actual claims experience for each risk-sharing contract.
 - ◆ The contract must provide for an annual evaluation of experience.
 - ◆ The determination of the risk sharing balance must commence no later than six months following the close of such annual period.
 - ◆ The balance must be invoiced no later than eight months following the close of the annual period.
 - ◆ Receivables that have not been collected within 90 days of the date of billing will be non-admitted.