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MANAGED-CARE RISK-SHARING ARRANGEMENTS

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- Insurance company and HMO joint ventures
- Employer arrangements with insurance companies and HMOs
- HMO provider risk contracting

MR. JOHN F. FRITZ: I'm chief actuary of FHP Inc., a large regional HMO headquartered in Southern California. Mitch Goodstein is president and CEO of HMO California. Brent Greenwood is a principal of Tillinghast, a Towers Perrin Company. Harry Sutton is senior vice president and chief actuary of R. W. Morey & Associates.

When we think of managed-care risk-sharing arrangements, we generally think of provider-type risk-sharing arrangements. But with the various programs that we now have, there are a number of risk-sharing arrangements involving other parties. So we have divided our topic into three areas: employer risk-sharing, joint-venture risk-sharing between insurance companies and HMOs, and the provider risk-sharing piece. Brent Greenwood will deal with the topic of employer risk-sharing.

MR. BRENT LEE GREENWOOD: As John said, we're going to be talking about different risk-sharing arrangements. We decided to go from macro down to the micro. The arrangements between employers and managed-care organizations are between the customer and the carrier. Think of this as the macro. Then there could be arrangements between an insurance carrier and an HMO, in order to provide a product to a particular employer. Finally, the micro level is where we'll be looking at the provider arrangements, between the HMO and the providers. And it's very likely that all three of these risk-sharing arrangements can take place at the same time for the same employee group. So we'll look at this arrangement from different perspectives.

In the case of employer risk-sharing arrangements, these have generally evolved over the past five years with the evolution of PPO products, point-of-service products, and consolidations of risk pools. There are several different types of risk-sharing arrangements that we'll discuss, but I'd like to point out that not all of them are necessarily widely accepted. But as many employers and consultants might tell you, it doesn't hurt to ask. It doesn't necessarily mean that a carrier or HMO needs to use them all.

First, let's talk a little bit about why employers want to share the risk. Over the past five years, employers experienced significant cost increases and wanted to do something to curb those cost trends. Also, they saw that their risk pools were

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starting to segment where they had several HMOs being offered, and there was a lot of discussion about adverse selection. "How can we negate this adverse selection?" was often being asked. So that's one of the reasons why employers wanted to get into risk-sharing arrangements. Also, when we talk about employer risk sharing, we're usually talking about very large accounts, probably a minimum of 5,000 employees, but, in most cases, in the 10,000-employee (plus) range with multiple sites. So, obviously, these types of employer groups have a lot of leverage over the carrier, and the carrier is very willing to try a few new things to keep that account.

These arrangements have basically been the result of implementation of new types of programs. As I said before, the PPO product, the point-of-service (POS) product, the multiple-option dual-option product, the "whatever-option-you-want" product were all out there as mechanisms to try to consolidate the risk pool. To date, there really hasn't been a good track record for many of these new products. So the carriers will basically come to the employers and say "trust us." But really these programs did not have a very good track record, and so to be able to sell the management of that employer, the carrier had to come up with a new twist. In addition, if the human resource department of that particular employer wanted to sell it to upper management, it needed to show management that the carrier was willing to take a financial risk to guarantee its performance under this new type of product.

I doubt that any of these risk-sharing arrangements were structured to have one party win and one lose. Obviously, the objective of these risk-sharing arrangements is to have really a win-win situation, because what you're looking at is a fairly long-term type of arrangement that will last at least three years, and you're hoping it will go farther than that. So having an arrangement where one organization wins is not going to be an advantage to anybody.

Let's go over some of the types of arrangements, and I'll define these later in a little bit more depth. We have a rate guarantee, a rate trend ceiling, a trend guarantee, a risk-sharing arrangement dealing with claim costs, and a performance guarantee. For the most part, all of these arrangements primarily work if the risk pool is not fragmented. And so if you continue, as a large employer, to have 15 area HMOs, an indemnity plan, a point-of-service plan, and so on, risk-sharing arrangements of this type, in most cases, won't really work. You find these arrangements where the employer consolidates its risk pool into maybe one or three different risk pools, and a majority have a primary carrier that is overseeing the entire program. I'd like to explain a little bit further these different items, and I also want to point out that these risk-sharing arrangements are not necessarily mutually exclusive, such that you may have any combination of one, two, or three of these within an employer arrangement.

First, we will look at a rate guarantee. We typically find these under a fully insured contract. This is where a specific rate quote is provided, such that the price is given in the first year to be maybe \$100, in the second year to be \$105, and in the third year to be \$110 as a simple example. So here the price is fixed, and it's usually a two-year or a three-year rate guarantee. But in all honesty, we don't normally find these types of arrangements in the marketplace. This is one of those things where you may ask for this as an employer, but whether you actually get the rate guarantee is another thing. For example, the POS product has a limited track record, so you may not know what that first-year base cost might be and whether you will hit it

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correctly. Also, under a rate guarantee, you may more commonly find that your administrative fee is guaranteed under self-insured arrangements. This is where your administration fee, say \$100 per employee, might be fixed for years one, two, and three, but the claim costs vary, and you have other risk-sharing arrangements for the claim costs.

Next we have a rate trend ceiling; this is where the premium trend for future years will not exceed a certain set ceiling and, again, this is mostly under a fully insured contract. We see HMOs willing to go into these types of arrangements. But they generally go into these arrangements with very conservative trend rates. A carrier may put in additional margin in those trend rates, knowing that they shouldn't have any problem meeting those ceilings. Also, there might be certain contingencies, which I will talk about later, that would possibly remove that ceiling or adjust the ceiling.

We also have trend guarantees. These are the most common types of guarantees. A trend rate is guaranteed and applied to actual claims to help establish a future year's target claim costs. These trend guarantees are usually provided for self-insured contracts. Trends may vary by PPO, point-of-service, or depending on the particular product. Now let me give you a couple of characteristics of the trend guarantee. First, it's usually part of a risk-sharing arrangement, meaning that there might be other claim costs involved. The trend guarantee can be a flat rate or it can be formula driven, and I'll give you some examples of what those formulas might be. Also, with respect to a point-of-service-type product, it might be applied just to the network claim, but not necessarily out of network, or you may have a different trend rate for the out of network portion of a point-of-service product. Once again, you might have trend guarantees subject to certain contingencies, such as if the membership level changes very drastically. For example, the employer downsizes during the year. You may have a benefit design change. Your family mix or family size may change drastically because of the introduction of these new products. In a situation of a dual choice, where you have an HMO alongside another product, the trend guarantee may be dependent on a certain percentage of HMO penetration that may materialize. Or, with respect to a point-of-service product, you might be talking about a minimum level of in-network use to determine the trend guarantee that will be applied to the base claim cost.

I'll give you some formulas here that are usually found. First, a carrier may use 65-75% of its indemnity trends. This is because it probably does not have a very good idea of what its managed-care trend is. This was a formula used early on, where employers thought there would be some savings, and so they basically used 65-75% of the indemnity trends. But as carriers have gotten more attuned to managed care, this formula has been eliminated because they found that managed-care trend really didn't have anything to do with the indemnity trend, and to tie it to the indemnity trend didn't really make much sense. So in many cases, the employers have used the medical CPI, plus a flat 1% or 2%, or possibly the medical CPI, plus 50%, or some percentage thereof. The main reason for such a load is that the CPI generally deals with fee levels and not necessarily the utilization levels. And so by adding an additional percentage on top of the CPI, it accounts for the utilization adjustments that might be needed. In most cases, we find that managed-care organizations are willing to contract with a consumer price index, plus a flat percentage, because they have

more control over their provider networks in their risk-sharing arrangements and in how they negotiate fees. Mitch will probably get more into that. But they feel fairly comfortable in agreeing to the medical CPI.

But, on the other hand, if the employer can maintain that particular percentage or keep the carrier within that trend rate, it is probably going to be doing much better than what it did under the traditional fee-for-service indemnity-plan environment. With respect to the point-of-service formula that we might see, the trend rate will vary, depending on the level of the in-network use. So, for example, the trend may be 8% if the in-network use is 90% or more. But it may be 12% if the in-network use is less than 60%, or something along those lines. In many cases, a trend guarantee under a point-of-service product is tied to the level of network use. If it is not, then you as a carrier run a definite risk because of the potential trend variability from one year to the next. Also, with a point-of-service product we have to recommend that the trend rate incorporate the incremental increase in the in-network use in the next year, because, as many of our studies have illustrated, the in-network use increases over a period of time. You have to be careful that your percentage increase in the trend does not only reflect the increase due to past claims and they are then brought forward; it also needs that incremental component.

Now for some of the results of these rate and trend guarantees; for the most part, the concept is still new, or maybe the data is still evolving to see who's won. The first-year base rate is very important. The employer and carrier will go through all aspects of the arrangement. The base-rate target is established close to the end, once everything is fairly settled. At this point in time, it seems as though it's been better for the employer than the carrier in the earlier going, especially with rate guarantees. This is where perhaps a carrier did not make a very good estimate of what the base rates would be. Most of the carriers that have made estimates on a rate-guaranteed basis have not come out very well and for a subsequent three-year contract period have not continued the rate guarantee. In most cases, it requires a long-term commitment, usually a three-year, possibly a two-year commitment. I haven't seen anything in excess of three years. The base cost is very important in any of these arrangements. The base cost can be based on the past experience of that employer, adjusted for the effect of managed care. Identifying who's going to win or lose, obviously, depends on how that base cost is established and at what level.

Next I want to get into the risk-sharing arrangement that deals with the financial risk for incurred claim costs. These are the types of risk sharing arrangements we usually find under a self-insured arrangement. In most cases, however, the amount at risk for a carrier is limited to a certain percentage of its administrative fee, whether it be 50% or 100%. Once again, as you can probably imagine, the base target is very important in this situation. We usually observe risk bands around the cost targets, where the employer and the carrier share in those risk bands, based on a prenegotiated amount. Within these risk-sharing arrangements, the settlement is made on a retro basis, which is between three and six months after the fact.

Table 1 is expected to give you an idea of a typical risk-sharing arrangement. We can see that the expected claims are in the middle. The employer assumes the risk for that first risk band. And, as I indicated before, in the first year, that risk band may be

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expanded a little bit, because both sides are really uncertain of what's going to happen. Over time, these risk bands may be condensed, and then you'll see that the ultimate risk sharing is at the 125% level, where it is the aggregate stop-loss, and the reinsurer assumes that. But usually, there's 50% risk-sharing on the upside and downside between those different corridors. The results of risk-sharing is that the base target usually is set fairly conservatively, and, in most cases, the employer usually pays. Because the employer has usually paid, it may not think that this is such a great program. It may have lowered its cost over the previous program, but still it is paying more than what its actual claim costs are. And so now what we see is a trend toward one-sided arrangements, where (again, it doesn't hurt to ask) the employer asks the carrier to not share in any surplus that might emerge. In other words, the employer is not willing to share in any of the deficit of the program, but it wants to keep all of the savings. That seems to be a trend, and again, there might be certain contingencies of the nature of what I described before.

TABLE 1
Typical Risk-Sharing Arrangement

125%	Aggregate stop-loss (Reinsurer)
115% of Expected	Carrier at risk for 100% of excess over 115%*
105% of Expected	Carrier at risk for 50% of excess over 105%*
Expected claims	Employer at risk
95% of Expected	Employer at risk
85% of Expected	Employer pays carrier 50% of difference
	Employer retains all savings

*The actual amount of risk is limited to a designated percentage of the carrier's administrative fee (i.e., 25%, 50%, 100%).

Last are the performance guarantees. There are certain administrative services where expectations are identified for these administrative services, and then penalties are associated with the failure to meet some of these. This may involve claims, customer service, customer satisfaction, and network management. Under a performance guarantee, your penalties are limited to a certain percentage of the administrative fee, maybe in the range of 10-50%, somewhat dependent on the employer's objective. Also, the performance guarantees are independent of the claims' risk-sharing arrangement that might take place. As indicated earlier, there might be one or more of these arrangements in place. The risk is usually the greatest in the first year, because, again, you as a carrier don't know what to expect, but, also, there might be a heavier weighting on the implementation process; how well you get the cards out, how well you explain the program, and how well this program is communicated. But there's also additional expense to the carrier, because now it has additional requirements accumulating the administrative information and not just claims information. Table 2 gives you an idea as to how the percentage of fee at risk provides some ranges as far as the weight that may apply to these services. Some services carry more weighting

and, as you can see, the claim service, the data reporting, and the implementation carry much greater weight. Depending on the employer's objectives, customer satisfaction might be very high. But this is just to give you a general idea of the different weighting, and it may deal with telephone calls, answering the abandonment rates, how long it took to turn around the claim, the accuracy of claim payments, and what type of report there is in terms of settlement reports. Network management is also one that is becoming more and more important in dealing with the acceptability of that large employer's employees.

TABLE 2
Services Subject to Performance Guarantees

Services	% of Fee At Risk*
Customer Service	5-10
Customer Satisfaction	10-25
Claims Service	20-30
Data Reporting	15-20
Implementation Process	10-20
Network Management	5-10
Overall Performance	0-5

* Fee at risk 10-25% of administrative fee

Finally, what's the future of risk-sharing? Well, employers are more attuned to the results of these new products, and there's less emphasis on the financial part of the arrangement and more emphasis on medical outcomes, medical management, or network management. The employer is making sure that the employees have accessibility, making sure that if its employees are in Podunk, Iowa, and it needed a network in Iowa, it would eventually expand into that general area. So there's a lot more emphasis being put on the network and on the accessibility.

Also, there is the business health-care coalition that's been organized in Minneapolis. A group of very large employers that have been put together, structuring most of their risk-sharing on the medical outcome of their employees and not necessarily so much on the financials. So that's an example of more things to come. Obviously, with this comes greater risk to the carriers, because carriers will be expected to do more but will not be allowed to charge greater administrative fees. And, obviously, there's always the uncertainty with the regulatory environment and with the health care reform and how ERISA will be handled in all of this with self-insured accounts.

MR. HARRY L. SUTTON, JR.: I can't resist commenting on a couple of Brent's remarks. One of the problems that we've seen in all that risk-sharing is the question of whether you're on a cash-flow basis for claims when you're ASO as opposed to accrual. I can't help think that many games are being played by switching from cash to accrual to cash, which sees very big bumps in the claims. We often don't discuss whether the guarantee's on a cash or an accrual basis. It is presumed accrual, but I think some are actually cash. Another interesting problem involves putting retention at risk. I don't know if the audience is familiar with retentions of 40 years ago and what they are today for a large group. My view is that the carriers doubled the retention and put half of it at risk.

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I'm coming from a different vantage point. I am not talking about HMOs and carriers that are owned by the same company. I'm talking about independent HMOs, trying to do a joint-business venture with an independent insurer and the amount of risk-sharing and types of arrangements and problems in functioning. I'm going to cover four elements; one is philosophical and the other three are work problems. Most of this comes from my own personal experience with my own company. I represent an insurer. I'm an underwriter and a rate developer for point-of-service plans. We have the best advice we can get. All five major consulting companies develop point-of-service rates for our HMOs, and then we tell them what we want. We're essentially a reinsurance company, so we are not a big primary health insurer, although I will discuss the experience that our clients have in dealing with them.

(POS) objectives. POS is a buzz word today, and there have been some very good meetings here, about the point of service. An earlier meeting with the employer from Winston-Salem made it clear that its ultimate objective was to get the membership of its big bank to go into the HMOs, where the cost would be less. The POS it offered its employees was more expensive than the HMOs that they offered, even though it had a \$400 deductible and so on. But there the HMOs and the POS were owned or controlled by the same carrier. The comment is, a number of big carriers view the POS as a permanent solution, and they have no interest in putting anybody in the network unless they gravitate there and it lowers the cost. I perceive them as willing to keep the POS system going indefinitely, and they claim that the POS is the cheapest system. I don't happen to believe that.

We tend to view the POS as a transitional solution in our dealings with HMOs. Earlier, the employer clearly said that POS is a transition. (It is a highly paternal, ethical, large bank.) POS should be higher cost, in our opinion, and generally speaking, where we offer it alongside the HMO benefit, we want to price it higher to get people, having both a financial and benefit incentive, to join the HMO ultimately, regardless if the benefits are so low that they reduce the price below the HMO. Our reason for going into the business is to eventually get everybody in the HMO, because we're interested in servicing the HMO with our reinsurance rather than pushing them into the fee-for-service business and writing part of that coverage, because we're really not in the fee-for-service business.

Just a short question related to this meeting: will a point of service be a good benefit plan in a Health Insurance Plan of California (HIPC) for small-group reform? If every provider in the community is going to be a choice, and all employees can choose which HMO or which network they are going to use, you really don't need a point of service. We don't know what the federal government will do. It's possible, having worked for a consulting firm that's encouraged big movement toward POS, rather than selecting HMOs and then keeping an indemnity, which may produce a problem with selection, that POS is really a creature of the big consultants as much as anything else.

Let's talk as if our objective is to joint venture with a contract between a carrier that can write indemnity and an HMO that can't. We'll talk a little bit about the legal problems with that later. Essentially I have seen nothing but huge problems with conflicting marketing objectives when you have a big insurance company dealing with an HMO. Now, if a little HMO is dealing with a big insurer that's going to go out

there and market whatever it wants, the insurer doesn't really care much for the future of the HMO, as long as it facilitates the insurer retaining its "market share" of the big employer accounts.

I will recite some anecdotes. There have been some of these that really just haven't worked. Prudential had a joint venture with Group Health in Minneapolis. Group Health wrote 95% of the account. Eventually, Group Health took over the claim payments, and then when Group Health merged with MedCenters and became an 800-pound gorilla on its own, Prudential was out. Prudential never really added much to it, because it never wrote any business. Prudential wanted to protect its share of the market. The HMO wanted to expand its share of the market, and the HMO went out and marketed, and eventually, all the people went into the HMO anyway. So, as a joint venture it was kind of a flop in my opinion. Now both those parties might disagree with that.

Regional weakness. Many big carriers have certain states, metropolitan areas, where they're traditionally very heavy. Just because it is a big carrier with \$25 billion of premium equivalents doesn't mean it is strong in Albuquerque, where the HMO is looking for a partner. The carrier might want to go there with the HMO because they both could develop business or have branches of a big employer.

For-profit status. Now one of the problems with the HMOs is that there are still a large number of not-for-profit HMOs. The IRS has come out with a ruling that if HMOs sell indemnity and make a profit on it, they could lose their tax-exempt status: 501(c)3, for example, in the case of Kaiser; 501(c)4 in the case of most of the other not-for-profits. Now the Blues do pay income taxes, assuming they earn any money, but HMOs that are not-for-profit have not yet been tarred with the same brush and required to pay taxes on their income. The powers that be in Washington, and Pete Stark and others, are appalled at the high profit margins of a number of the HMOs. Whether they provide care cheaper and better doesn't seem to be the point. If they make a profit, it sounds like it's bad. Many HMOs really are afraid to go into the indemnity business because they might jeopardize their not-for-profit status.

Who's going to market. Who's going to do the advertising? Many big carriers are not really in the small-group market. They all have some, but they're not in it in a big way, and yet the HMO's market may be smaller and have local employers. Can a big carrier make a decision in Oshkosh about whether to do a joint venture when its home office is 4,000 miles away in Florida or somewhere? It's really hard to get a decision out of a big corporation on a local issue. That's probably because, in my view, the big carriers think *macro*, and the HMOs think *local* and *micro*.

How do you measure results with a joint venture. We'll talk a bit about sharing risk. There may be a corporate mental block about trying things that are new and fighting over who's going to pay the claims. If you want to go back to 40 years ago, as Joe Moran and I do, the big Eastern carriers would never do business with the foundations in California, because the foundations set up their own claim-payment system, and the carriers felt that was their major function. I went to meetings out there, and there was no way that they would ever work with the foundations. The Pacific Coast companies did a lot of work with foundations and probably saved a lot of money.

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Small carriers. The question is, are they going to stay in the business? They aren't as sophisticated. They don't have the research staff. They aren't in tune quite as much with Washington, except for small-group reform and so on, through their trade association. They may or may not have the risk capital. They probably have easier decision-making. *It's local. It's going to be more of a true joint effort, because they may not have the expertise to do it, like the big carriers think they have.* The HMO may be market dominant. It may be more dominant in a market than the carriers. The carrier may be interested in selling life insurance and ancillary products to small groups, whereas, the big carrier does not have the same objective. There's no way the HMO is going to write life insurance on General Motors. The HMO is going to need administrative assistance in how to live with the contracts, and the smaller local carriers are more likely to be in small groups.

Carriers have taken a number of approaches in dealing with HMOs. Side-by-side joint marketing is not very successful because there's no risk-sharing. I know that in some instances a carrier has written small-group, regardless of size, alongside an HMO. One example was with Harvard Community Health Plan. I don't know if it still does it. I noticed the carrier had a huge loss it just wrote off. I don't know if that has anything to do with this business. A major Blue plan agreed to write side-by-side with a large HMO. If there was a five-life group and four went in the HMO, Blue Cross would take the last one at its community rate. Whether that was a smart move or made money, I have no idea; neither does either party.

An HMO POS with a self-insured employer lets the employer carry the risk out of network. That means the HMO has to be experience-rated, because the employer is not willing to pay both out-of-network claims and a true community rate to an HMO without knowing what goes on inside the HMO. That's often been a big problem for staff-model HMOs.

Shared administration. Who's going to do what? Who's going to market? Who's going to handle the billing? Who's going to pay claims and so on?

This is my conclusion: Generally, joint ventures with independent HMOs and large carriers have been a complete failure, and that's putting it kindly, I think. I can give you an example. The first one was Lincoln National and U.S. Health Care. U.S. Health Care has been a high flier in the over-the-counter market. It covers a couple of million people, has revenue of a couple of billion dollars, always makes money, and has 10% profit margins. *It could never get an answer out of Lincoln's corporate office about starting an HMO anywhere, so it sold the joint venture to Lincoln for \$100 million, which immediately closed down most of the HMOs.* U.S. Health Care came out all right, but was absolutely frustrated with dealing with the corporate mentality of an insurance company. That's, again, a superficial, biased, outside opinion.

With smaller carriers, it's hard to know. We've seen some examples where small carriers have bought and integrated with HMOs. *They somehow thought it would enhance their life marketing and other things.* Many carriers have gone into this, thinking they can sell life insurance, but it hasn't worked out that way, not if they don't get the whole group. Worker's compensation is a new field. Many people are

interested in that aspect. We've had some discussions with our own clients. It's going to grow rapidly.

Integrated relationships. Only three or four carriers are really doing this in the market that I'm in. We're essentially reinsurers and not first-line, first-dollar-coverage carriers. There is a rapid, growing interest in having somebody at least to front the risk for the HMOs.

Structural regulatory problems. Minnesota, for example, permits any HMO to write indemnity. I think Massachusetts permits an HMO to write a PPO benefit. Some of the state laws are fuzzy. Some of them don't have a law and permit HMOs to function independently. Other regulatory agencies don't like HMOs doing it, and they give you a hard time. In Minnesota, HMOs have a surplus requirement of 8% of revenue. If the HMO is writing indemnity, it has to have something like 25% or three months total expenses for the indemnity part of its business. In Minnesota, we're still the only state where all HMOs legally are not for profit, even though management companies make money like it's going out of style. You wonder where the money comes from.

But most states require a separate insurance contract. There have been several meetings here where we discussed this. Even if you're a carrier, and you own your own HMO, you may all have to offer separate contracts. One of the problems is, you may have to include all mandated state benefits in the indemnity piece, even though you're only trying to provide a very limited out-of-network benefit. Some states are really rigid. California will not permit any real risk-sharing, such as where the HMO will reimburse the reinsurer if the claims exceed net premium revenue.

Essentially, though, most states will permit very much like Brent was talking about, putting all or part of the HMO administrative fee at risk. That produces a kind of leveraging arrangement, depending on how the benefits are allocated. Of the states that permit this, probably 60% of them will permit a risk-sharing, and they don't ask very much about what goes on underneath.

Replacing a carrier. For most small employers these are carrier replacements, although occasionally, the POS is done side-by-side with another HMO or indemnity. That changes the rating structure and the selection aspects immensely. It's a very interesting actuarial exercise to figure out where everybody's going to go. One problem is that if a closed-panel plan is going to take over all the employees in California, who's going to cover the six people in Denver, or the six people in Florida or New York City, who does the employer's investment banking or whatever? So they need a straight indemnity plan. The employer has a choice of either the opt-out of a PPO-type benefit or a separate indemnity plan. But the opt-out frequency is often too low a benefit, because there are fat benefits if you go in the network. It generally requires a separate indemnity. In most cases, you can offer a fully insured PPO. Then the question is what risk-sharing arrangements you can make. You can have a side-by-side and then use the same network outside the HMO. We prefer that because we insure less business when we only insure everybody who's not in the HMO. We're talking, still, about a carrier replacement, however. The people who are not in the HMO are going to be high outside utilizers, such as the management of the company that wants no restriction where they get medical care. But the employer

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may also buy a low-option benefit plan. An insured PPO may not be legal for the HMO because most can't write insurance. I would guess maybe 10 or 12 of the major HMOs own insurance companies; many of them are shells. They will use this to get around some of the risk-sharing limitations.

COBRA, and conversions, and small-group reform. In New York State, we insure POS with a number of HMOs. We just said we can't write a case with POS that's less than 50 lives, so we opted out. I think if we could get New York State to agree that when we're writing a \$2,500-a-year leak-out benefit with a \$500 deductible, and we only sell it with the HMO, we could community-rate that with the HMO, and we might still be willing to write it in the small-group market.

Risk-sharing structure. We're essentially a reinsurance company. The company that I work for, which as of April 1 is called Allianz Life of North America, does not write any first-dollar medical coverage, except limited group conversions for HMO contracts. I think the reinsurance approach is best for an HMO. I'm biased again, because I'm looking at the way we operate with our reinsurance company, as opposed to an HMO working with a big front-line carrier. As a reinsurance carrier, we have no field force, the HMO does all the marketing, and it decides the benefit plans and what the employers need in its market, and we don't have a group field force out there that's going to be in conflict with marketing objectives.

There's also a negative to that. We don't do any first-dollar claims processing. The only business we do is through TPAs, so we'd have to train and audit the claims-processing system of the HMO or get it to hire a TPA to pay the indemnity part of the claims. We have to be sure that it knows what it is doing. Since we're a reinsurer, we don't have a law department to negotiate with all the small-group-reform states, so our tendency is to drop out of it because it's just too complicated to keep up. If it doesn't seem to affect us, we'll stay in. We're in California, but we're out of New York. We're trying to get an exemption for our POS-type products in California. We have an exemption for POS in Ohio, requiring a legislative correction bill. If you talk to the regulators, it doesn't make sense to regulate a \$10- or \$20-per-month premium for out-of-network benefits. It's only sold with the HMO as a part of the small group, but that doesn't mean the state won't obstruct it.

Complicated underwriting and rates. There are many risk elements: who will go out, who will go in, how good is the network, is it side-by-side, is there an indemnity plan alongside it? All those things are big questions. We have to audit the HMOs. We have to be sure that they're in compliance with their own rates. We approve the rates. When they write an employer group on POS, we try to be sure that the rates they sold are the same ones they're supposed to use.

State changes in reinsurance. The states are toughening up because they don't want carriers to go under, and carriers can go under because their reinsurance goes under.

Reinsurance carrier pluses. We're not in the basic health insurance industry, so we don't compete with the HMO. Since we're not in the market, there's no incompatibility. Our objective is ultimately to transfer the total risk to the HMO. We just feel that the HMO can do a better job managing the indemnity, utilization, and everything else. There are real problems with the HMOs in dealing with their medical

group. If it's a narrow, closed panel, they don't like telling other doctors in the community how to function. There are many philosophical problems with medical groups controlling members when patients can go outside the group quality of care.

Protect the learning curve. Well, my favorite saying is, of course, that the last one willing to take a risk is an insurance company, and my employer is no exception. So we set rates that are quite conservative. We try to leverage our risk, whether it's the administrative fee against our risk, or trying to get as much money from the HMO as we can. Then when the experience works out and you get a pattern, the margin will shrink and the HMO will take all the risk. We and the HMO just don't know what's going to happen. We know the HMO market. We reinsure over 200 HMOs for catastrophic coverage, organ transplants, and we have 30 active clients with POS. The largest one will be \$100 million by the time we roll it all in this year. Our second largest one is \$40 million, which is a quota-share arrangement where we take the risk on two indemnity lines, a PPO and a straight indemnity. We share the risk bottom line with the HMO members in those same accounts.

For catastrophic claims, there is a dual benefit. As a carrier, we have our own provider contracts for organ transplants, and the HMO gets the advantage of those. Likewise, if the HMO has contracts with hospitals in its service area at 40% or 50% savings, we get the advantage of that also. Even though there is an out-of-network claim because the doctor is out of network, if it's one of the plan's contract hospitals, we still get the discount even though the patient may pay coinsurance.

We use almost every one of these approaches with one client or another. We have 30 very active ones. About 65 have negotiated contracts, but the HMOs haven't really worked out the selling and administrative arrangements yet. Some HMOs hire a carrier just to front and then reinsure 100% of the risk. We can quota-share with the HMO as a reinsurer, if the HMO does not have an insurance company, depending on the state regulations. If the HMO owns a carrier, it can write it with its own carrier and then we'll quota-share, reinsuring the direct writer.

Direct coverage. Our largest account is direct coverage with us for \$100 million, but it's 90% reinsured into the carrier owned by the HMO. That doesn't mean there is no risk.

Insured PPO versus insured out of network only. Let me talk a little bit about the leverage and how we try to protect ourselves from inadequate rates due to the difficulty of coming up with the estimated fee-for-service claim costs. Frequently we reinsure only the out of network, and the out of network may be only 10% or 15% of the total claims between in and out of network. And if we just leverage it by having a risk-sharing pool of 4% of the combined premium, and you look at 4% divided by what you hope is an adequate net premium of 10% for the out-of-network claims, you have a fair risk margin, as long as you're within 5% or 10% of the right number. So the carrier can be protected, as long as the state permits you to leverage that way.

When we're insuring the PPO, we have a different problem. We have, where it's legal, a line of credit with the HMO and a risk-sharing arrangement, where, if the claims go over a certain number they have to reimburse us. At some point we have

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all the risk over an aggregate stop-loss. But essentially we try to leverage against a small part of the risk.

Employer out-of-network ASO. We write specific and aggregate on this, and that's really an interesting problem. We've had some cases that are really hard to figure when you know there are two or three options with people shifting back and forth. How do you price an aggregate on top of something where you have no data of what happened the year before?

MR. MITCHELL J. GOODSTEIN: Much of the micro level I refer to in my remarks will be about what's happening here in Southern California. The micro level will be this population basin of about 20 million people. And there's an awful lot of this happening. Brent and Harry remarked about how employers and carriers are risk-sharing with each other, how carriers and HMOs are each sharing risk and that these arrangements involve rate guarantees, and trend guarantees, and quota shares, and reinsurance, etc. In addition, the HMO pays capitations to the providers. It's not real easy to integrate all of the risk-sharing arrangements between the employer, the carriers, and the providers. In fact, it's generally a mess.

Let me go through, maybe in a little bit more detail, some of the discussion points. Why do we have risk-sharing with providers? What types of risk-sharing arrangements are there? What kind of variations are there? And maybe the area that's most important to me is, what are the trends? What do we see happening, and where are things going?

When a carrier or an HMO shares risk with a provider, it wants to motivate the providers to control the costs by putting them at risk for the costs, by having them have rewards for controlling costs. From the provider's perspective, there is a tremendous trend developing that shows it truly sees the rewards for controlling costs. That's why many are starting to like capitation a lot. They can make money on the risk premium. There's another reason providers like these arrangements, and maybe it's the most important one: market share. By receiving a capitated risk, by being part of the risk-sharing, one thing that has to happen is that patients have to be assigned to providers. When that happens, providers get market share. It is becoming increasingly obvious to both doctors and, more recently, to hospitals, that this could be one of their keys to survival. When you construct, analyze, or negotiate a risk-sharing arrangement, there are many components to it, and there are different risks that are being transferred around.

Premium adequacy can be virtually guaranteed by using full capitation. If the capitation is a percentage of premium, such as 78% of the premium, and there's no guarantee as to what the premium is, the carrier has essentially transferred the risk of the adequacy of the premium over to the provider. If, for premium adequacy, the carrier pays the provider a per-member, per-month premium or capitation, then the carrier has the risk of making sure that the premium is sufficient in the first place. Risk is transferred for utilization of services, the cost of services, changes in the demographics, etc. If you pay a flat capitation amount for a family, then the provider is also on the risk for how large the family is. Maybe the most important thing is

unforeseen fluctuations. When a provider is capitated, what you really have from a carrier's perspective is an alternative source of capital to cover unforeseen fluctuations.

Many different types of risk-sharing arrangements exist. I will spend most of the time discussing capitation. The HMO can pay a fixed fee calculated by different formulas to the providers and pay fee-for-service payments with or without withholds. Hospitals can be paid per diems. Shared risk funds are established between medical groups and HMOs. Hospitals can be paid as per-case rates. In addition, providers can be capitated for a full array of services or just for primary care services.

The trend in this small population base that's based in California is toward full capitation. And the interesting thing about this trend is it's not being driven by the carrier or the HMO that wants to lay off the risk. Like Harry said, insurance companies are the last to take risk; well, so are HMOs. They might be even further down the list. This is being driven by the providers. In California, providers are demanding to take on the full risk. It's not being pushed upon them, which surprised me, quite frankly, when I got here, but that's what's happening.

I mentioned before that capitation can be paid in various ways. It can be paid as a percentage of a premium, a per-member, per-month amount by contract, by age, and by sex. Generally what happens, regardless of the basis for payment, when you take all the actuaries out of the room and the HMO and the provider are in the room, they have 20 different benefit plans, they have no data, and they don't really know what the right answer is. They're lucky if they take their revenue and they know that from their expenses. They know how many members were covered. They divide one by the other, and one negotiates for more, and the other negotiates for less. The basis of payment can be almost anything, and the outcome of the negotiation can be, too.

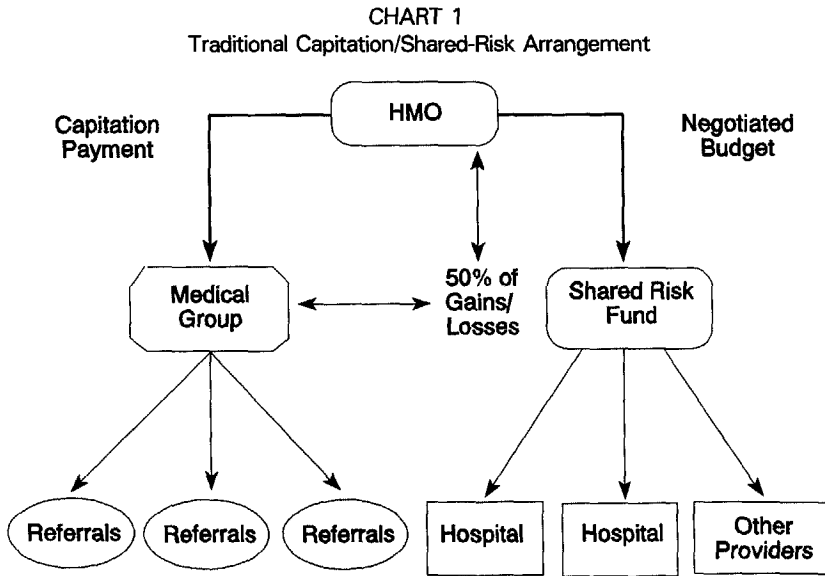
The point-of-service products, which both of our previous speakers spent a lot of time talking about, is where the real integration issues come into play. In California, we have some regulatory problems and I think some philosophical problems about point of service. The easiest way to do the accounting on a point-of-service product, especially when there's a large employer sharing the risk, is fee for service. It's easy to account for, but it's the worst thing for controlling costs, so you can count up the beans, but you get more beans to count. When you go into capitation, one way to pay the providers is to pay for in-network services only. One of the things that you find out about in-network capitation is, first of all, the providers have no incentive for out-of-network usage, so they might try to encourage members to go out of the network so they can make a lot of money on their in-network capitation. But maybe more importantly is this dangerous guess. You can guess 50% in network and 50% out of network or you can actuarially speculate 90% in network, 10% out of network. When you look at your projected cost between a 50/50 projection and a 90/10 projection, the total cost may only vary by 2-5%. But think of yourself as a capitated provider, getting the 50% capitation, when the in-network utilization is really 80%. The providers' costs can vary for that component by 60% when the total cost only varies 2-5%. So there are many structural problems for capitating for in-network. When you try to capitate for out of network, the providers shove it right back and say they don't want the risk for something they can't control. Also, the regulators step in and say they won't let you do it anyway. So point-of-service plans

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have not been growing here very much, and I think that's one of the reasons for lack of growth in many areas of the country.

I put together a checklist of things to consider to analyze a risk-sharing arrangement. How are the payments being made, capitation, per diem, etc.? What services are covered? Are AIDS cases part of a pool? Are transplants part of a pool? Are they covered? How will we measure gains and losses? If you capitate a hospital or you have a semicapitation where you share risk with a hospital under a budget, you still need a basis for discovering whether there's a loss or a gain, so you still may need things like per diems. How much will I get if there's a gain? How much will I get if there's a loss? Are there any stop-losses on the risk-sharing arrangement? Are there any aggregate stop-losses? How do we settle up the funds?

I'm going to just give you two examples. One is a traditional arrangement and the other one is becoming more frequent. Both are group-model or network-group-model style risk-sharing arrangements. I think the first one especially works almost as well for an individual practice association (IPA) arrangement (see Chart 1). It's just got the details now.



On the left side, the HMO pays a capitation to the medical group. The medical group is then responsible for all professional services, all physician services, lab services, and x-ray services. It pays the referral bills. It processes the claims. It cuts the contracts with the referral specialists. Those contracts could be fee for service between the medical group and the referral specialist. They could also be capitation between the medical group and the referral specialist. The rates can vary from 100% of the fee down to Medicaid levels. In southern California, the rates for referral specialists are down to Medicaid levels where capitations are designed to produce the equivalent of

Medicaid levels. And the reason you can negotiate such a low result, or maybe a reflection of it, is just in this diagram. The referral specialists are at the bottom of the food chain. That's what happens down there. You get the least amount of money, and it's under control of the medical group.

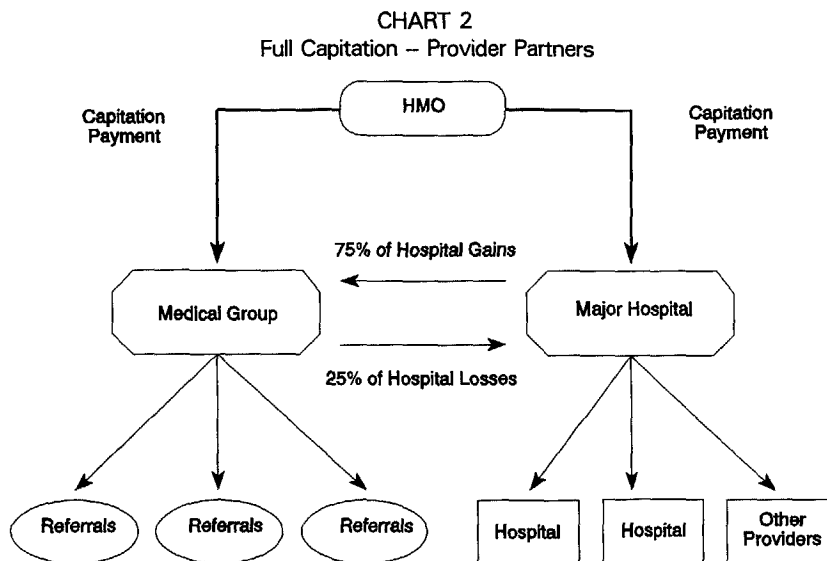
On the right side, the HMO and the medical group mutually agree upon a budget. Here it's called the shared-risk fund, and it's the budget to fund all of the nonmedical group capitated cost, mostly inpatient hospital. And out of that fund for accounting, draw payments are made to hospitals' per diems, case rates, etc. Payments are made to some of the ancillary providers, and then at the end of the year, the results are calculated and it's determined whether the fund had a surplus or a deficit. I have 50% of the gains and losses being shared between the medical group and the HMO. If there is a loss the medical group doesn't pay it to the HMO anyway, because it is in so much financial trouble it can't afford it. And then the HMO forgives the loss, or carries it forward, or somehow the deficits never get paid anyway. So some people have just cut through this and said to just drop the losses. The regulators in California are telling everybody to drop that loss side, saying they will not allow a medical group to be put in financial jeopardy for a hospital claim, even though that was in the scope of services they provided. So the regulators are pushing the arrangements to be one-sided. And the one-sided arrangements I'm seeing are more like 0% sharing for losses and up to 99% for gains. And the message behind that is, who's driving the system here? The physicians are the ones driving the system. They're the ones really managing the cost.

In terms of trends, another thing is the up-and-coming risk-sharing arrangement (see Chart 2). I took the first diagram and eliminated the shared risk fund and substituted it with a real hospital. The HMO pays the medical group a capitation. The HMO pays the hospital a capitation. The HMO gets out of the way completely. The HMO does the marketing, counts the people, and collects the premium. As a team, the medical group and the hospital go eyeball to eyeball with the HMO. They say to give them the money and go away and they'll take care of the work while the HMO markets and administers. Then the medical group pays the referral bills as before. The hospital pays the bills to the other hospitals, which are less frequently used. This is a very interesting strategic position now. The hospital is a payor of other hospitals. Then they do an accounting of the gains and losses. That means they meet a measurement system underneath, which is usually per diems, to measure the capitation the hospital receives against the utilization of the services. And the medical group and the hospitals split the money.

You'll notice Chart 2 doesn't show equal risk-sharing. If there's a gain, the hospital forks over 75% of the gain to the medical group. It doesn't happen, but if there's a loss, the medical group would give 25% of the losses to the hospital. Again, the point is, even though the hospital has now been elevated on this diagram to being an equal partner to the physicians, the physicians are still driving the arrangement. A physician medical group will never stop hounding a hospital administrator if they have to give the hospital money. It always has to be the other way around. Every new arrangement that I am seeing cut in California between HMOs, hospitals, and physicians that's not the same as the arrangement from the year before, is one of these. The medical groups and the hospitals are getting into partnerships with each

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other asking for full health capitations and telling the HMO it isn't needed for anything but delivering the patient.



There are also legal reasons for this. If you left it completely up to some of the medical groups, they'd say to just give them a complete capitation for both the medical care and the hospital care, and they will pay the hospitals just like a referral provider. Knox-Keene, the California enabling legislation for HMOs, won't allow that. So this is the trend in risk-sharing arrangements. If you think about this trend in the context of the employer risk-sharing arrangement Brent talked about and the joint ventures between carriers and insurance companies that Harry talked about, it is totally incompatible. The HMO hands over a capitation and that's it, so how do you measure gains and losses, etc.? You don't.

Just to finish up with the trends, integrated delivery systems are developing. There are hospital/physician partnerships, physicians owning hospitals, hospitals owning physicians, foundations owning both, something where it's an integrated delivery system. Once you have an integrated delivery system, they're taking the risk for all health care. I think it's redefining the roles or better defining the roles of the parties that are in the risk-sharing arrangements. The HMOs don't manage care. They are called managed-care organizations. They end up not managing any care. They arrange for the management of the care with the providers, but the providers manage the care, and the providers take the risk for managing the care. The HMOs become, maybe going back 20 or 30 years, the intermediary. "Just make sure the administration happens, and we'll do the rest." It's a step forward or backward, I don't know which. The providers take on the role of health care management, which makes sense, because they're providing the health care. So they take care of the management of the health care and they have the risk.

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There are tremendous battles for market share, and the risk-sharing arrangements are tied completely to gaining market share. Capitations are the way to access ownership of a patient. And the financial arrangements are driving the relationships between the hospitals and physicians, although sometimes I think the relationship between the hospitals and physicians is driving the risk-sharing arrangement. I don't know which one it is, but they're tied together.

MR. FRITZ: Mitch ignored the fact that there are still some staff model HMOs out there where the HMO is really taking the risk, but then the staff models also provide the health care.

MR. GOODSTEIN: John works for a staff model.

MR. FRITZ: As you can see, we could have probably gone on forever talking about this topic and really gotten into much greater detail. We tried to cover some of the overall topic, to give you a flavor for the issues.

MR. SUTTON: Mitch, we now have an HIPC in California. I'd like to get some reaction to how you think your HMO is going to function. Why did you decide to go or not go in the HIPC? If you know, how are you going to relate to it? It's voluntary, but it's not the true managed-competition model recommended by the Jackson Hole Group.

MR. GOODSTEIN: I'd also invite John to answer the same question, because his organization also joined the local HIPC. It will be interesting to hear John's answer, because I think we probably joined for different reasons. My company is, first of all, very new and young. It has very little, if any, market share, and it has a target market of small groups. Within the environment of the HIPC, I will have precisely equal marketing exposure to companies like Kaiser, which has eight million members, while we have 2,000 members. So it's a marketing opportunity of a lifetime for a young start-up company. Plus, because of the legislative climate, we felt that given the choice of being in or out of it, we'd better be in it, because we don't know what will be coming next. Harry taught me a lot, and one thing he did teach me was to be scared to death of the risk that's about to come, but we did it anyway. John, how about you?

MR. FRITZ: It was not an easy decision for us. We didn't decide until almost the last minute whether we were going to go in. I think the thing that finally tipped the scale toward us going in is the fact that the barriers to getting out are not as great as the barriers of getting in, once you've opted not to go in. So now that we supposedly have a full complement within the HIPC, it will be very difficult for new players to come into the HIPC. At least that was our understanding. The risks can't be minimized, obviously, because as it's structured, we need a high and a low benefit design, each based on the HMO's community rate. It has to have a reasonable relationship to any street products that the same carrier might be marketing. For those of you who are not familiar with the AB1672 legislation here in California, it requires the carriers to set their rates within a band of 80-120%. The HIPC rates are supposed to be set at 100%, and the carrier is not allowed to vary rates, depending on the risk taken. You just take on all comers at the rate that you file with the HIPC. Of course, for the street product, you can vary that rate between 80% and 120% of

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the filed rates. Within two years, this will go to 90-110%. I think we'll feel a little bit more comfortable in the HIPC when we get down to the 90-110% range for street rates, so we expect some adverse selection initially. I'd say that probably the lower priced plans are maybe somewhat more at risk than those that are at the higher end. But it is going to be an interesting experiment. I think that the other factor that caused us to go in is that the whole country seems to be moving toward managed competition, and from an overall political standpoint, we felt that it was the right thing to do. We felt that being in the HIPC was almost like our HMO was getting some kind of a good housekeeping seal of approval.

