SOCIETY OF ACTUARIES

Article from:

Health Section News

December 1998 – No. 36

Provider-Sponsored Organizations (PSOs)

by J. Patrick Kinney

As part of its efforts to encourage expansion of Medicare managed care, the Balanced Budget Act (BBA) provides a new avenue for Provider-Sponsored Organizations (PSOs) to contract with Medicare. New Federal solvency standards allow PSOs to seek a temporary waiver of state solvency requirements that may otherwise have precluded entry into the Medicare+Choice (M+C) arena. As a result, many organizations are studying their strategy for the Medicare marketplace, which may lead providers to prepare Medicare+Choice applications.

Among other things, this has given rise to new opportunities for health actuarial services. Health actuaries' professional expertise will allow PSO sponsors to understand and manage the new risks they are taking. In the preamble to the PSO solvency regulation, HCFA recognized the critical role that actuaries play in maintaining the solvency of risk-bearing entities:

> "PSOs should anticipate the need to utilize the services of qualified actuaries (e.g., a member in good standing with the American Academy of Actuaries) in (a) the preparation of financial plans consistent with the PSO's business plan, (b) the development of claim costs for the benefits to be offered by the PSO and (c) the analysis of claim liabilities and the necessary liquid assets to meet obligations on a timely basis. ... HCFA expects and, at its discretion, will ascertain that the information contained in the financial plan has been certified by reputable and qualified actuaries."

Clearly, the growth in the number and type of M+C risk-bearing entities offers opportunities for health actuaries. We can also work with employers to analyze the impact of new Medicare coverage choices for their retirees. Our particular skills will be called upon to help protect Medicare beneficiaries by contributing to sound financial management of a variety of new plans in the marketplace.

This article offers a broad discussion of potential effects of the new Medicare+Choice PSO plans on the Medicare marketplace. In an article of this nature, it is not feasible to discuss all the intricacies of the PSO regulations. Interested readers can explore the details for themselves at the HCFA Web site, www.hcfa.gov.

What is a PSO?

The BBA defines a PSO as a public or private entity that:

- is established or organized, and operated, by a healthcare provider or group of affiliated healthcare providers;
- provides a substantial proportion of the healthcare services under its Medicare+Choice contract directly through the provider or affiliated group of providers; and
- in the case of a group of affiliated providers, the providers share, directly or indirectly, substantial financial risk for the provision of services under its contract and have at least a majority financial interest in the PSO.

Plans sponsored by a variety of providers may meet this definition. Integrated delivery systems, large multi-specialty physician groups, hospital-based networks, and IPAs may be considering developing M+C plans. HCFA will determine, for each application received, whether the plan sponsor meets the detailed organizational requirements to qualify as a PSO. These requirements, contained at length in 42 CFR§422.350 of the M+C regulations, spell out criteria which qualify a plan as a PSO, including definitions of:

- Healthcare provider;
- Affiliated healthcare providers;
- Substantial proportion;
- Substantial financial risk; and
- Majority financial interest.

Through these definitions (and examples) HCFA emphasizes that providers must play a key role in a PSO, that providers must establish, organize, and control the PSO, and that providers must have a stake in the PSO enterprise by sharing in the financial risk passed to the PSO by HCFA.

What is Different for PSOs under the BBA?

Medicare+Choice plans are generally required to be organized and licensed under state law as risk-bearing entities in each state where they do business. For a PSO, however, the BBA provides an important exception.

Many states, in fact, have no specific regulatory authorization for a PSO as a risk-bearing entity. Other states impose differing standards for PSOs versus HMOs or similar managed-care organizations, while others may not distinguish between a PSO and an HMO for licensing purposes. The BBA allows a PSO to apply for a federal waiver of state solvency requirements, under certain conditions. However, PSOs will still be required to meet state consumer protection and quality standards.

The intent of the federal waiver is to facilitate the development of new Medicare+Choice PSO plans. The waivers are state-specific, and are limited to 36 months, or the end of the calendar year in which the 36-month period expires. By that time, PSOs are expected to meet solvency requirements under state HMO or PSO laws and regulations.

Another difference is that PSOs will be allowed to be smaller than other M+C plans. Minimum enrollment requirements have been reduced for PSOs to 1,500 for urban areas and 500 for rural areas, compared to 5,000 urban/ 1,500 rural for all other M+C plans.

Conditions for Federal Waiver

HCFA may grant a waiver of state licensing requirements if a state:

(1) fails to act on a PSO's state license application within 90 days (the 90-day period may begin any time after the enactment of the BBA);

continued on page 13, column 1

Provider-Sponsored Organizations
continued from page 12

(2) discriminates against a PSO by imposing material requirements, procedures, or standards not generally applied to other entities in a substantially similar business or requiring the PSO to offer any product other than a Medicare+Choice plan;
(3) denies a PSO's license based on solvency standards that differ from the federal standards, or documentation or information requirements that differ from federal requirements; or
(4) refuses to accept a PSO's application and has notified the organization in writing that it will not accept its licensure application.

For the first three conditions, the organization must have applied to a state for "the most closely appropriate" license or authority. HCFA expects that for most states the most appropriate license available will be an HMO license, although this may change as states adopt PSO or modify current licensure laws. HCFA requires documentation of the circumstances leading to the PSO's eligibility for a waiver, including evidence of appropriate application to state authorities and the state's denial or failure to act.

The fourth condition is designed to save both the state and the organization time and resources by allowing the organization to go directly to HCFA for a waiver rather than submit a lengthy pro forma application to a state with no chance for approval. It would be wise for a PSO to coordinate with state regulators before attempting to apply directly to HCFA under this provision.

Federal Solvency Standards

Once a federal waiver has been approved, PSOs applying to offer M+C plans will be required to meet federal minimum solvency standards. These standards were developed by a negotiated rulemaking committee consisting of representatives of government, professional, and industry associations.

Solvency standards and reporting requirements differ for the initial start-up of a PSO, and for ongoing compliance during the M+C contract period. (The accompanying table on page 15 shows a brief summary of the solvency standards. Full details may be found in 42 CFR§ 422.370. These regulations are available on the HCFA Web site www.hcfa.gov.)

The rulemaking committee discussed whether to include, among the factors considered in setting the ongoing net worth amount for PSOs, the authorized control level capital requirement derived from the NAIC Health Organization Risk-Based Capital (RBC) Formula. Although the RBC formula is designed to be used by states to monitor the financial viability of state-regulated managed care plans, it has not yet been adopted by states in setting the minimum net worth amount requirements. The committee agreed that HCFA should consider adding the RBC authorized control level factor to the ongoing net worth amount requirements after evaluating whether the RBC formula is a valid indicator of Medicare PSO solvency and after considering the manner in which states have regulated managed-care plans using the RBC authorized control level. In 1999, after PSOs have begun to operate and report financial data, HCFA plans to issue a notice requesting comment on adding this factor to the net worth calculation for PSOs. As part of HCFA's normal data collection process for all M+C plans, HCFA expects to be collecting information necessary to perform the RBC calculations.

PSOs must submit detailed financial plans including:

- marketing plans;
- statements of revenue and expense;
- statements of sources and uses of funds;
- balance sheets;
- justifications and assumptions supporting the financial plan; and
- statements of the availability of financial resources to meet projected losses.

In addition to balance sheet assets, financial resources identified to fund projected losses may under certain conditions include guarantees, letters of credit, or other binding capital contribution agreements. PSOs must also maintain insolvency deposits.

Actuarial expertise is required in the preparation of financial plans, especially in the areas of claim cost development and the analysis of claim liabilities in light of the necessary liquid assets to meet obligations on a timely basis.

Marketplace Effects of PSO Regulations

The BBA includes significant reductions in the growth rates of Medicare fee-for-service payments to providers, particularly hospitals. Many providers may consider forming a PSO to recapture some of the anticipated loss in Medicare revenue. Medicare beneficiaries may be attracted to PSOs sponsored by well-known hospital or physician groups with strong reputations for quality services. Providers may find participation in a PSO attractive as a mechanism for both retaining and capturing new market share. To the extent that PSOs succeed in attracting members from among the healthy aged population, capitation payments may become a growing revenue source.

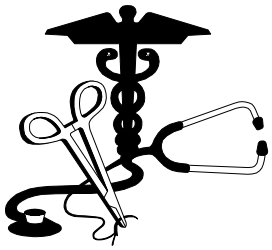
Entering the Medicare managed care market is not without risk. In particular, many hospitals and integrated delivery systems considering the PSO option will need to equip themselves to accept and effectively manage care in a full risk arrangement. Despite the relaxed enrollment requirements and federal solvency waiver, PSOs will function very much like HMOs. They must develop or acquire the infrastructure needed to accept and manage risk.

Providers should identify what additional operational expertise they will need to manage risk. Then they must decide whether to buy, build, or partner with other organizations such as management services organizations, Third Party Administrators, or Managed Care Organizations (MCOs) for those services. PSOs will need to fully evaluate and understand the implications of outsourcing certain functions, such as claims processing, utilization review, marketing, and/or membership services versus conducting these functions in-house. Providers should also evaluate the impact on existing payor relationships if the PSO is perceived as a direct competitor.

continued on page 14, column 1

Provider-Sponsored Organizations
continued from page 13

As a result of the requirement to provide a "substantial proportion" of healthcare services, PSOs will have to be much broader in scope of services and network providers than just hospital or physician services, potentially requiring strategic alliances and/or joint ventures with other providers in order to meet the PSO definition. For non-rural PSOs, not less than 70% of Medicare services must be delivered directly through the health care provider or group of affiliated providers responsible for operating the PSO. For a rural PSO, the minimum is 60%.



As the PSO marketplace continues to evolve, it is critical that PSO sponsors understand the implications of the M+C regulations, and their own responsibility for compliance. Hospitals, physician groups, MCOs, and their financial and actuarial advisors will see much activity during the next few years.

Implications for Medicare Beneficiaries and Employers

The PSO provisions of the BBA are part of an effort to increase the managed care choices available to Medicare beneficiaries. Other provisions of the Act provide for annual communication to beneficiaries regarding the specific plan options available in their area. Some areas will see a proliferation of Medicare+Choice options. Like the former Medicare Risk HMO plans, many of the PSO plans will offer extra benefits designed to attract seniors, often at reduced or no cost to the beneficiary. Some PSOs may be sponsored by local hospitals whose favorable reputations could attract seniors who had been reluctant to join traditional HMO plans.

Employers concerned about the high cost of their post-retirement medical plans may look forward to the advent of more attractive M+C options. Those with significant presence in local markets may actually be able to encourage the formation of PSOs by local providers.

An unintended side effect of increasing choice may well be increasing confusion on the part of Medicare beneficiaries and the employers who offer M+C plans to their retirees. Health actuaries and benefit consultants may find additional opportunities to assist employers in navigating through the new Medicare+Choice world.

Conclusion

With change comes opportunity. Health actuaries are professionals participating in an ever-changing health care marketplace. As traditional areas of insurance focus have given way to rapidly growing managed care, we have evolved to meet the needs of HMOs, PPOs, POSs, MCOs, and others. With the new focus on PSOs, our profession is ready to provide expertise to an even broader audience.

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Health Section Lunch

With the skyscrapers of Manhattan in the background, Health Section members enjoyed lunch with Tom Corcoran (1998 Section Chair), Jim Murphy, SOA Vice President, Health, and guest speaker Daniel Zismer.

continued from page 14

TABLE 1
Summary of Federal PSO Solvency Requirements

	At Initial Application	Ongoing Requirement
Minimum Net Worth Requirement	$1,500,000 at start-up. HCFA may reduce the net worth requirement by up to $500,000 if the PSO has available to it an administrative infrastructure that HCFA considers appropriate to reduce, control, or eliminate start-up costs associated with the administration of the organization. Aspects of such an infrastructure could include office space and equipment, computer systems, software, management services contracts, and personnel recruitment fees.	The greater of: (1) $1,000,000; (2) 2% of annual premium revenues up to the first $150,000,000 of annual premiums and 1% of annual premium revenues on premiums in excess of $150,000,000; (3) an amount equal to the sum of 3 months of uncovered healthcare expenditures as reported on the most recent financial statement filed with HCFA; or (4) an amount equal to the sum of: • 8% of annual healthcare expenditures paid on a non-capitated basis to non-affiliated providers, and • 4% of annual healthcare expenditures paid on a capitated basis to non-affiliated providers, plus • annual healthcare expenditures paid on a non-capitated basis to affiliated providers. (Annual healthcare expenditures paid on a capitated basis to affiliated providers are not included in the calculation of net worth requirements.)
Cash or Cash Equivalents	At least $750,000	$750,000 or 40% of Minimum Net Worth
Healthcare Delivery Assets	Admitted at depreciated GAAP book value	Admitted at depreciated GAAP book value
Intangible Assets	May be up to 10% of Minimum Net Worth if a PSO keeps less than $1 million in Cash & Equivalents, or uses the administrative infrastructure reduction (Up to 20% otherwise)	May be up to 10% of Minimum Net Worth (Up to 20% if at least $1 million or 67% of Minimum Net Worth is kept in Cash & Equivalents)
Deferred Acquisition Costs	Not admitted	Not admitted
Subordinated debts and subordinated liabilities (e.g. withholds)	May be excluded from liabilities for purpose of determining net worth	May be excluded from liabilities for purpose of determining net worth
Liquidity	Current ratio of 1:1 or better	Current ratio of 1:1 or better