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Pricing Issues Resulting from Budget Setting and Stoploss in ACO Arrangements

By Anthony Rubiano

More emphasis has been placed on Accountable Care Organizations (ACOs) and similar provider risk-sharing arrangements due to health care reform. These new contractual arrangements pose challenges for actuaries involved in budget setting and stoploss pricing.

For purposes of this article, an ACO is an arrangement between one or more providers and an insurer (or governmental payer such as Medicare) to manage the financial and clinical aspects of covered members' health care. In many respects ACOs are like HMOs—in that the provider is accountable for population health of their member panel. However, in an ACO a patient doesn't necessarily choose a primary care physician. They often can go to their provider of choice, subject to the terms of their coverage contract with the insurer—as in a PPO. The insurer determines which provider is attributed the responsibility for each member's care, based on individual claims patterns.

As providers take on risk, they will be interested in stoploss insurance (sometimes called provider excess insurance). This protection could be separately purchased from a third party stoploss insurer, but in this article I assume it is included in the terms of the ACO arrangement. At the beginning of the year, a budget for total claims costs may be agreed upon by the insurer and the provider. If the provider can control the costs to an amount below the agreed-upon budget, the insurer and the provider would share in the savings. Since providers may not be able to manage the costs of high claimants, or be financially responsible for these costs, they may include stoploss in their contracts with insurers. The ACO will be held accountable for reducing the costs of the patient while still maintaining a high standard of quality. However, there will be low frequency/high severity claims that will skew results and "muddy the waters" as to whether the ACO is having a positive effect on the patients' claim costs. So, the ACO will pay a premium (which lowers their budgeted amount). In return, the amounts above the stoploss threshold for high claimants are taken out of the experience data when comparing budget to actual results.

This article will consider several issues arising from ACO budgeting and pricing of stoploss coverage, including:

1. attribution of members;
2. claim carve outs;
3. ambiguous stoploss terms;
4. providers gaming the system and
5. credibility of data.

Attribution of Members

When underwriting a group, it is often important to understand the experience of the members in the group compared to the experience in the overall population. When setting budgets for providers who will be accepting member risk and pricing the associated stoploss insurance, it is important to be able to determine the experience of the members attributable to that provider compared to the rest of the population. Attribution is also extremely important in monitoring the provider's experience compared to its budget.

In an HMO arrangement, it is easy to determine which members are attributable to each provider since the member actually has to choose a primary care physician. However, in ACO arrangements, the member does not formally select a primary care physician. A decision needs to be made regarding to which provider a member is attributable. A physician's office may have a list of members who have visited it throughout the year. From that provider's perspective, those members should be on its attribution list. However, those members may also have seen other doctors, and/or may not want to continue to go to that provider. From the member's standpoint, that provider may no longer be the provider of choice. And from the insurer's perspective, there may be many physicians that the member visited, all of whom have had an impact on the member's health and claims costs.

The insurer needs to consider several things when developing attribution lists:

1. Partial vs. Full Attribution: Will a member's experience be fully attributable to a provider or only part of the experience? If members are considered to be fully attributable to a particular provider then attribution lists should be mutually exclusive (i.e., there should be no overlap in the lists). In any case, the total member months (and claims) should be equal to the sum of member months (and claims) that are attributable to each provider plus those that are unattributed.

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Anthony J Rubiano, ASA, MAAA is associate actuary at Excellus BlueCross BlueShield in Rochester, N.Y. He can be reached at *anthony.rubiano@excellus.com.*

2. Quantity of visits: It may be true that the physician who was visited the most may have the biggest impact on the member's health. If the physician is not doing much good for the patient—hopefully the patient would change physicians. However, if a physician were to drive the utilization, the member could potentially have a large number of visits with little effect to his health.

3. Recency of visits: In some cases, a member might be assigned to a physician based on the most recent visit.

4. Members with no claims: These members could be unassigned. However, the unattributed experience will include members with no claims. If providers are only attributed members with claims, their population could look sicker than the general population. The attribution of members with no claims might be determined based on historical data, geographical, or volume of claims.

The analyst might consider applying the claims-based attribution logic to the HMO population. Since HMO attribution is otherwise positively and clearly defined (the member selects his provider), this can provide insight into how the attribution logic works—and identify false positives and false negatives.

Claim Carve Outs

Another important issue that actuaries need to consider are claim carve outs. When measuring the effect that an ACO is having on claims, the provider may wish to exclude certain claims such as:

- claims that they have little control over;
- claims excluded for religious reasons (e.g., abortion services);
- conditions which are not normally treated within the provider's hospital system (such as burns and trauma).

Actuaries can help specify the definition of excluded claims, with some knowledge of claim coding. For example the provider may want to exclude claims related to "trauma." First of all, how is "trauma" coded in the claims? Will it be determined by a set of DRG's, ICD9 (ICD10) codes, or CPT codes (or some combination of these)? Will only the claim on that date be considered, or will follow up claims associated with that claim be excluded also? How will these associated claims be identified? This may require collaboration between the actuary, coders and clinicians.

An insurer may decide to exclude the claim and all claims within a set time period of the claim. A drawback from this method is that other claims that should be included may overlap with this time period.

Another method that can be used is to exclude the entire member from the study for the year that an excluded claim occurs. But suppose a member has a claim that is incurred toward the end of the year. Since claims associated with the original claim may span across the two years, should this member also be excluded from the following year? Complications could arise from the decision that is made.

Alternatively, claims to be excluded could be defined according to episode grouper software. However, there could be a lag in identification of claims related to specific episodes, potentially delaying settlement of the ACO risk-sharing arrangement.

Ambiguous Stoploss Terms

A lack in clarity in allocating the amounts above the threshold can result in confusion. The provider may want the stoploss amount allocated across different service categories, depending on which types of providers are included in the ACO arrangement.

For example, suppose the desired annual stoploss thresholds were:

- hospital inpatient claims greater than $75,000
- hospital outpatient claims greater than $75,000
- comprehensive claims over $75,000

Suppose a member had hospital inpatient claims = $85,000 and hospital outpatient claims = $85,000, and other claims of $10,000.

How might this be interpreted?

One analyst may view the stoploss for hospital inpatient would be $85,000-$75,000=$10,000, the stoploss for hospital outpatient = $85,000-$75,000 = $10,000, and the comprehensive claims stoploss would be equal to $10,000 (since total claims are greater than $75,000, all of the "other" claims would be covered.) So the total reimbursement would be $30,000.

Another analyst might view the total claims equal to $85,000+$85,000+$10,000=$180,000. The stoploss above the comprehensive threshold would be $180,000-$75,000 = $105,000. He might then allocate the stoploss as 41.67 percent inpatient ($49,583.33), 41.67 percent outpatient ($49,583.33) and 5.56 percent other ($5,833.33)—the percentages equal to the magnitude of each category divided by the total amount of claims.

Often contracts are made by individuals who aren't actuaries. Sometimes details in the contract are left out. So when it comes time for the actuary to make a decision, different interpretations of the author's wording may be possible. It's important for actuaries to be involved when the ACO contract is written, to consider details that could avoid ambiguity.

Another thing to consider is that providers may try to experiment with different stoploss thresholds for different service categories in order to maximize the value that they get. This may be good for the provider (and perhaps even theoretically correct) but the cost of this to an insurer can include:

- complex contracts (with ambiguity of calculation)
- extra work to administer the contract
- opportunities for errors

So the actuary should consider these costs before agreeing to such an arrangement.

Providers Gaming the System

Providers have better knowledge of their patients than actuaries. While providers may not always be able to control the members who are on their attribution list, they may be able to control the utilization and the costs of those members. They may also be able to alter utilization and cost to meet their budget at the expense of the members.

So, the arrangement should include quality measures to ensure that the provider doesn't sacrifice quality to receive any shared savings. Quality is hard to define and measure; it isn't necessarily linked to increased utilization any more than the bonuses are linked to decreased utilization. Therefore it's important for the actuary to make sure that the base data used to produce the budget is carefully analyzed. For example, if an actuary risk-adjusts the data, he should have a good understanding of how the risk scores are produced. In addition, it is important to pay particular attention that the data used to produce the budget parallels the experience used to measure the bonus. Also, the bonus that is paid out should in some way be tied to quality. Perhaps a simple system would be to apply a quality factor between 0 to 100 percent to the potential payout, where 100 percent represents ideal improvement in quality and 0 percent represents a decrease in quality. The insurer and ACO provider(s) should develop clear definitions of quality and quality measurements. Something else to consider regarding quality is whether an improvement (or worsening) of experience for a provider is actually due to the provider's influence or some other external factor(s).

Credibility of Data

Credibility affects all pricing, so I only mention this briefly. Stoploss insurance typically uses high thresholds. The supporting data is often scarce (low frequency/high severity claims). This is an opportunity for actuaries to apply knowledge from core actuarial exams to determine if the data they have is credible enough to use. This is also a consideration for the ACO claims experience data as well as the quality data.

Conclusion

ACO arrangements provide another way of contracting with providers. However, because additional money can be paid out when the provider meets the quality and/or financial goals of the contract, the actuary must be careful in setting the budget and determining the stoploss rates. An undervalued stoploss rate may leave the insurer with inadequate funds to cover large claims. Inflated budgets will overstate the shared savings. Therefore, these issues should be carefully analyzed, and risks to all parties understood. ■