Own Risk and Solvency Assessment
Southeast Actuarial Club
November 19, 2014
Our Optum Mission

Helping to make the health system work better for everyone

• One of the largest health information, technology and consulting companies in the world

• The leader in population health management, serving the physical, mental and financial needs of both individuals and organizations

• The pharmacy management leader in service, affordability and clinical quality

• Market leaders within a dynamic health services market
Consulting | Our People

- 800+ Consultants exclusively focused in healthcare

- Experienced consultants, health plan leaders and operators, actuaries, IT leaders, clinicians, analysts and program managers

- We provide significant industry expertise, depth and breadth of capabilities

*Industry leading healthcare consultancy delivering broad scale and subject matter depth*
Discussion Outline

- What is ORSA? and Background
- ORSA Goals
- Regulatory Environment and NAIC Model Act
- Risk Categories
- Interested Parties in ORSA Evaluation Report Contents
- Challenges in the Healthcare Industry
- What Actuaries Should Know
- Company View of ORSA to date
- Discussion
What is ORSA?

• A realistic view of the risks a company faces due to its
  – Operations
  – Strategic decisions
  – External views of company (reputation)
  – Any other risks
• Holistic view of risk and not limited by formula (i.e., RBC)
• Application of Enterprise Risk Management principles
• NAIC has Model Regulation
• 11 states have approved legislation for 2015
• Has been embraced for Life and Casualty, not yet implemented for health insurance companies
ORSA Background

• Roots in Enterprise Risk Management – SOA Def’n of ERM
  “ERM is the discipline by which an organization in any industry
  assesses, controls, exploits, finances and monitors risks from all
  sources for the purpose of increasing the organization’s short- and
  long-term value to its stakeholder.”

Key elements:
– Discipline in any industry (including health insurance)
– Monitors risks from all sources
– To increase value to its stakeholder

• Would AIG have made different decisions about covering CDO
  (Collateralized Debt Obligations) had they thought ahead of the risks?
• Life / Casualty have embraced ORSA more readily than health
  insurance. They have much longer liabilities than Health Insurance
• Often performed by Risk Officer/Unit although a necessary need for
  actuaries to be involved
ORSA Goals

1. To foster an effective level of ERM at all insurers, through which each insurer identifies, assesses, monitors, prioritizes and reports on its material and relevant risks identified by the insurer, using techniques that are appropriate to the nature, scale and complexity of the insurer’s risks, in a manner that is adequate to support risk and capital decisions;

2. To provide a group-level perspective on risk and capital, as a supplement to the existing legal entity view.

Key Goal Elements:

• Each insurer identifies its relative risks
  ❖ Based on an honor system, no template and based on own review
  ❖ Introspective review incorporating internal and external factors

• Supports risk and capital decisions
  ❖ Helps drive strategic decisions; go into new endeavors with eyes open

• Supplements legal entity view
  ❖ Confidential by state law

NAIC ORSA Guidance Manual
Which Organizations are Impacted?

- Any individual U.S. insurer that writes more than $500 million of annual direct written and assumed premium

- Insurance groups that collectively write more than $1 billion of annual direct written and assumed premium

- Even if they are not required under regulation, smaller and mid-size plans can benefit from ORSA to gain a stronger understanding of the risks they face.
Regulatory Environment

• NAIC Model Regulations

• States Approving Model Regs for 2015:
  CA, IA, IN, ME, NH, PA, RI, TN, VT, VA, WY

• Frequency of filing: Annual

• Penalty for non-compliance:
  By regulation, suggested is a daily penalty with a cap

• State overview:
  Regulators will need to figure this out
Requirements of NAIC Model Act

- Risk culture and governance
- Risk identification and prioritization
- Risk appetite, tolerances and limits
- Risk management and controls
- Risk reporting and communication

**Describe ERM Framework**

**Assess Risk Exposures**
- Quantitative and/or qualitative assessment of risk exposure in both normal and stressed periods
- Details on risks identified along with assessment methods, key assumptions, risk mitigation activities and plausible adverse scenario outcomes

** Demonstrate Sufficiency of Capital**
- Group assessment of risk capital: current capital sufficient to meet identified risks
- Prospective solvency: future capital sufficient to support business plan

An ORSA summary report will need to be updated and filed annually with regulators.
Risk Categories

- Underwriting
- Credit
- Market
- Strategic
- Liquidity
- Operational
- Reputational
- Emerging

• Ability to meet profit objectives
• Ability to meet obligations to members, providers, or vendors
• How company will fare under different market & economic conditions
• Risks associated with an insurer’s future plans to expand, modify or diversify business
• Risk of not being able to meet financial obligations by selling assets
• Risk of loss resulting from inadequate or failed processes, people and systems
• Risks related to a tarnished brand or other intangible risk that may affect growth
• Risk for unknown events such as technological advancements, regulatory/legislative changes or unanticipated catastrophic events

• Risk categories may overlap!
## Multidisciplinary Team

What is the role of various units within an insurance company?

<table>
<thead>
<tr>
<th>Strategy &amp; Governance</th>
<th>Review strategic plans and risks associated in executing on these plans; review Board’s role in setting and monitoring strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underwriting/Actuarial</td>
<td>Review rating process, communication internally and to clients, process to meet profit objectives</td>
</tr>
<tr>
<td>Operations</td>
<td>Assess risk in areas such as billing, enrollment, claims adjudication, member and provider services, IT</td>
</tr>
<tr>
<td>Care Management</td>
<td>Evaluate effectiveness of medical management programs; ensure compliance with federal and state regulatory requirements</td>
</tr>
<tr>
<td>Legal &amp; Compliance</td>
<td>Ensure product compliance and internal testing of ORSA</td>
</tr>
</tbody>
</table>
## Key Stakeholders involved with ORSA

<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Board Members</strong></td>
<td>• Involvement in company strategy, future directions</td>
</tr>
<tr>
<td><strong>Senior Management</strong></td>
<td>• Impacts strategy, operations, general oversight of company</td>
</tr>
<tr>
<td></td>
<td>• Implement policy and strategy</td>
</tr>
<tr>
<td><strong>Managers &amp; Staff</strong></td>
<td>• Knowledge of daily activities.</td>
</tr>
<tr>
<td></td>
<td>• Helps uncover hidden risks</td>
</tr>
<tr>
<td><strong>Actuaries</strong></td>
<td>• Skilled in evaluating risk.</td>
</tr>
<tr>
<td></td>
<td>• Scenario test to put value to risk elements</td>
</tr>
<tr>
<td><strong>Regulators</strong></td>
<td>• Review and audit reports.</td>
</tr>
<tr>
<td></td>
<td>• Interact with company and staff</td>
</tr>
<tr>
<td><strong>Vendors</strong></td>
<td>• Provide services to company.</td>
</tr>
<tr>
<td></td>
<td>• Important for efficiency, accuracy, and confidentiality</td>
</tr>
</tbody>
</table>
Challenges for Health Insurers

- The revolutionary change that the healthcare marketplace is undergoing poses significant challenges for health insurers in understanding the risks they face.

**Enduring Business Challenges**
- Escalating Costs
- Public Perception
- Evolving Regulations

**Market Dynamics**
- Focus on Clinical Quality
- Medicaid Privatization
- Market Consolidation
- Consumer Health Revolution
- Operational Efficiency
- Health Benefit Exchanges
- Aligning Network and Incentives
- Payer / Provider Convergence

**Key Areas of Impact and Uncertainty**
- Position for success in a consumer-driven market
- Clinical quality, care coordination and network improvement
- Automation and administrative cost reduction
Actuarial Skillset to Perform ORSA Study

• Knowledge of internal workings of Insurance company
  – Identify key areas to explore
  – Ability to ask probing questions

• Knowledge of externalities that can impact an insurance company
  – Think outside the industry towards external forces that may impact company
  – Macro economics such as effect of unemployment on health insurance
  – Reputation of company, officers, Board, etc.

• Ability to think broadly to understand impact to company
  – Identify *Black Swans* i.e., rare and unexpected events that can have a major impact on company

• Modeling skills to estimate actual or opportunity costs to a company
  – Technical need to analyze and develop confidence intervals of financial impact

• Communication skills to convey key findings
  – Oral and written reports that provide insight and actionable results
How have company’s embraced ORSA

• Based on my discussions and observations:
  ➢ Larger company’s have been pursuing ORSA risks for at least a year. Actuary’s have been involved.
  ➢ Smaller company’s, actuaries have been less involved and offloaded to a risk assessment unit

• Unknowns on who is required to file?
  ➢ Is ORSA report required for a company operating in an ORSA state reporting up to a parent organization not required to file?
  ➢ Are quasi-State organizations (e.g., Medicaid) required to file?
  ➢ Can company’s apply for a waiver and under what conditions?
Company Resistance

• How to protect confidential information.
  – Valid concern, strategic plans are part of the evaluation
  – Regulators need to set up rules protecting release of information

• Some companies may not see the value of this report
  – Dedicating staff time and hiring consultants adds cost to the company
  – What insights will this produce? This is temporary and senior management should find value in the reports.
  – Only doing the minimum to satisfy a state requirement

• The reports are “squishy” at best and does not help with running of business
  – Having fresh look at business operations and strategic plans may avoid costly mistakes to company.
Discussion

Aka: Questions without Answers?
Agenda

• Price Transparency: Other Industries vs. Healthcare
• Complexities of Price Transparency in Healthcare
• The current state of Price Transparency in Healthcare
• The future of Price Transparency in Healthcare
Price Transparency: Other Industries vs. Healthcare Industry

Price Transparency in other industries

• Electronics Products
  – Flat screen televisions

• Furniture
  – Living room set

• Clothing
  – Suits and shoes

• Leisure
  – Hotels

**Key:** These are goods we can go look at in person or online and comparison shop. We can even review the quality and reliability of these products in consumer reports.
Price Transparency:
Other Industries vs. Healthcare Industry (continued)

• Price Transparency in the Healthcare Industry.

• Industry categories:
  • Medical products and devices
    – Durable medical equipment (crutches, braces, etc.)
    – Pacemakers, artificial knees and hips
  • Medical services
    – Hospital care
    – Physician care (PCP and specialist)
    – Other ancillary services
  • Prescription Drugs
    – Brand name
    – Generic
    – Specialty

• Key: For any of the above listed services, we are not afforded the opportunity to comparison shop, nor really assess the quality of the services or products provided.
Price Transparency: Other Industries vs. Healthcare Industry (continued)

*Why are other industries successful in providing Price Transparency vs. the healthcare industry?*

- In “product” based industries, the product is in a finished state ready for consumer use, and is on display in retail channels, for you to view, research and test, before buying.

- In many service based industries, the service you buy is someone’s expertise to help you get something done, or educate you about something.

- In healthcare, the products and services are provided to you or performed on you to improve your life. In many cases, these services are performed on you with some uncertainty around the outcome.
The Complexities of Price Transparency in Healthcare

• You are purchasing a service performed on yourself
• You cannot “Test Drive” most services performed on yourself
• Who is responsible for providing pricing information
  – Your health insurer if insured
  – Your employer via a third party vendor if your employer is self-insured
• Who plays the role of consumer advocate
  – How are the competing services evaluated for replacements or pacemaker inserts
• The price the Consumer really pays is a portion of the actual total service price based on the level of their health insurance coverage, which varies from person to person.
Price Transparency tools for consumers – What should they provide?

• Key elements of a tool
  – **Scope of tool**: Comprehensiveness of providers with information about in-network and non-network providers that covers price, quality and consumer ratings.
  – **Utility**: The ability of the tool to facilitate consumer decisions by being able to review comparisons of health care providers’ prices, quality, and care settings.
  – **Accuracy**: The extent to which consumers can rely on the provider, service, and benefit information.
  – **Consumer Experience**: Ease of use and easy-to-understand.
  – **Data Exchange, Reporting, and Evaluation**: Deals with claims data sharing adhering to all privacy laws.

This criteria was published in the Catalyst Payment Reform Action Brief: “Price Transparency”, An essential building block for a high-value, sustainable Health Care system.
**The Complexities of Price Transparency in Healthcare**

(continued)

*A person’s benefits also determine what they “pay”*

<table>
<thead>
<tr>
<th>Example: Family Coverage</th>
<th>Person A</th>
<th>Person B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>3,000</td>
<td>5,000</td>
</tr>
<tr>
<td><strong>Maximum Out-of-pocket</strong></td>
<td>4,500</td>
<td>6,500</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>80%</td>
<td>70%</td>
</tr>
<tr>
<td><strong>Preventative Care Coverage</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Office Visit copay</strong></td>
<td>$30</td>
<td>$30</td>
</tr>
<tr>
<td><strong>Prescriptions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brand</td>
<td>$30</td>
<td>$40</td>
</tr>
<tr>
<td>Generic</td>
<td>$10</td>
<td>$10</td>
</tr>
</tbody>
</table>
# The Complexities of Price Transparency in Healthcare (continued)

<table>
<thead>
<tr>
<th>Sample Comparison Shopping</th>
<th>Scope of Services</th>
<th>Price Range</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Knee Replacement Surgery</strong></td>
<td>X-ray and interpretation</td>
<td>Artificial knee</td>
</tr>
<tr>
<td></td>
<td>Outpatient hospital setting</td>
<td>Follow-up physical therapy</td>
</tr>
<tr>
<td></td>
<td>Physician surgical procedure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Anesthesia</td>
<td></td>
</tr>
<tr>
<td><strong>Ear Tubes (Otitus media) (5 year old son)</strong></td>
<td>Physician visit</td>
<td>Follow-up physician visit</td>
</tr>
<tr>
<td></td>
<td>Outpatient hospital setting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician surgical procedure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Anesthesia</td>
<td></td>
</tr>
<tr>
<td><strong>Heart Surgery With Pacemaker Insertion</strong></td>
<td>Emergency room services (optional)</td>
<td>Pacemaker device</td>
</tr>
<tr>
<td></td>
<td>Inpatient hospital setting</td>
<td>Follow-up physician visits</td>
</tr>
<tr>
<td></td>
<td>Physician surgical procedure</td>
<td></td>
</tr>
</tbody>
</table>
Comparison Shopping Observations

• Considerations:
  – You will be paying no more than your out-of-pocket maximum for high cost procedures.
  – Your price paid will depend upon both your benefit coverage and the actual cost of the medical care.
  – Still difficult to really compare quality amongst your provider choices.
  – Comparison shopping for your healthcare procedure involves effort.
The Current State of Price Transparency in Healthcare

• Private Health Insurers

• Healthcare Industry Third Party Vendors
  – Cast light

• State Initiatives
  – Many states have taken steps to offer price transparency tools to the public
A Good tool might have the following steps:

- Since treatment costs vary by area, **Step 1** should identify your area. Typically, zip code is best.

- **Step 2**: Look up your desired treatment
  - 53 year old male, so I selected colonoscopy

- **Step 3**: An estimated cost for the colonoscopy comes up. More details are provided.

- **Step 4**: My search returned X physicians in my area having costs ranging from 500 to 1,200. It also gives me the cost for the affiliated facility for each physician listed.

- **Step 5**: When I click on a physician, I get a message about the cost of anesthesia services.
A Good tool might have the following steps (continued):

• **Step 6**: For the physician I selected, the tool gave me a list of 5 facilities the physician has privileges at, and the associated cost ranges, and whether the facility was a hospital or fee standing ASC.

• **Step 7**: I selected a facility and received my final estimate. Information covers:
  – Estimated treatment duration
  – The itemized cost for each service or procedure for this course of treatment
  – Total cost
  – Portion of cost paid by the patient and the health plan

• The final step was to print or save this cost estimate. This allowed me to go back and select other providers to get specific costs.
The Current State of Price Transparency in Healthcare (continued)

**Minnesota has a provider quality measurement website called www.mnhealthscores.org**

- You can search for clinics or select the one you currently use to see how it is graded.

- Once selected, you can select the types of care to be graded, such as diabetes care, vascular care, colorectal cancer screening.

- I selected my clinic and found the grading as follows:
  - Patient surveyed feedback: Below Average
  - Diabetes care-adults: Above Average
  - Vascular care: Average
  - Colorectal cancer screening: Average

- Reliability of information could be an issue as I noticed several clinics on the list were “non-reportable”.
The Current State of Price Transparency in Healthcare (continued)

41 Results for 'apple valley'

<table>
<thead>
<tr>
<th>CLINICS</th>
<th>PATIENT</th>
<th>DIABETES: ADULTS</th>
<th>VASCULAR CARE</th>
<th>COLORECTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>A-Z</td>
<td>Sort</td>
<td>Sort</td>
<td>Sort</td>
<td>Sort</td>
</tr>
<tr>
<td>Apple Valley Medical Clinic- Family Practice</td>
<td>BELOW AVERAGE</td>
<td>ABOVE AVERAGE</td>
<td>AVERAGE</td>
<td>AVERAGE</td>
</tr>
<tr>
<td>APPLE VALLEY, MN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appleton Clinic</td>
<td>AVERAGE</td>
<td>AVERAGE</td>
<td>NOT REPORTABLE</td>
<td>BELOW AVERAGE</td>
</tr>
<tr>
<td>APPLETON, MN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Associated Clinic of Psychology-Apple Valley</td>
<td>NOT REPORTABLE</td>
<td>NOT REPORTABLE</td>
<td>NOT REPORTABLE</td>
<td>NOT REPORTABLE</td>
</tr>
<tr>
<td>APPLE VALLEY, MN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BHSI- Golden Valley</td>
<td>NOT REPORTABLE</td>
<td>NOT REPORTABLE</td>
<td>NOT REPORTABLE</td>
<td>NOT REPORTABLE</td>
</tr>
<tr>
<td>GOLDEN VALLEY, MN</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
The Current State of Price Transparency in Healthcare
(continued)

Public Tools

• Based on information published by the Health Care Incentives Improvement Institute, many states have failing grades on efforts thus far in price transparency.

• States with passing grades:
  – Colorado C
  – Maine B
  – Massachusetts B
  – Vermont C
  – Virginia C

• The full study with grading criteria can be found at the following link: http://www.hci3.org/sites/default/files/files/Report_PriceTransLaws_2014.pdf
The Future of Price Transparency in Healthcare

• Current state is evolving

• Health insurers will continue to improve the process due to customer pressure

• Entrance of technology companies looking to capitalize on a solution to the healthcare price transparency dilemma

• Regulatory requirements dictating the ongoing improvement of the price transparency tools offered

• Consumer Advocacy groups pressure to provide improved information as high deductible plans become the norm

• Improvement in quality outcomes and branding
Thank you.
Accountable Care Organizations
Dynamics of the Payer and Provider Relationship
• November 19, 2014
Introduction

• 2011:

According to HealthLeaders Media’s 2011 industry survey, 74 percent of hospital chief executives say that their organizations will be part of an ACO within the next five years. In addition, 16 percent of the respondents believe they already have the components for ACOs in place and 60 percent say they will have ACO components in place within the next five years.

According to HealthLeaders Media’s 2011 industry survey, 52 percent of physician group leaders said that their organizations will be part of an ACO within the next five years and 20 percent say they already have ACO components in place.

• 2014:

Results of the October 2014 NAACOS survey show that 66% of MSSP ACOs are highly unlikely or somewhat unlikely to remain in the ACO program. Only 8% are likely to sign a second contract with the remainder (26%) undecided.
What is an Accountable Care Organization?

• Collaborative structures populated by a set of provider partners, often in association with one or more Payer partners, who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their member populations
  
  o Latest attempt to generate medical value by:
    
    • Combining HMO-like structural components
    • Enhanced information technology
    • Greater financial risks and rewards for providers
    • Emphasis on care redesign processes
ACO Prevalence and Geographic Distribution

- 361 ACA ACOs (338 MSSP and 23 Pioneer) at beginning of May 2014
- 5.6 million Medicare beneficiaries in 47 states plus DC and Puerto Rico
  - 4.7 million MSSP
Accountable Care Organizations

The ACA established the **Medicare Shared Savings Program (MSSP, aka ACO)** as a new voluntary practice and payment model to serve traditional Medicare fee-for-service (FFS) patients beginning in 2012, primary goals:

- Better care for individuals
- Better health for populations
- Slower growth in costs

MSSP was designed to allow participating ACOs to share in savings if certain performance standards are met on quality of care and other measures.

**Bottom Line – ACOs are responsible for the quality and cost of care for the Medicare fee-for-service patients they serve and share in savings achieved**
Medicare Shared Savings Program ACO Characteristics

**General MSSP**

- ACOs separate legal entity, primarily “owned” by providers
- **Three** year contract
- Minimum 5,000 Medicare **attributed** beneficiaries
- Anti-trust issues (avoided/still persist)
- Two shared savings options
  - Track 1 – **no downside risk**
  - Track 2 – risk beginning **day 1**
- Technology challenges
  - Meaningful use
  - Reporting
  - Connectivity (EMRs, HIE)
Medicare Shared Savings Program Characteristics

High Level Financial MSSP

- **CMS** pays providers Medicare FFS rates
- ACO carries *administration cost/risk*
- ACO and CMS share savings/losses on *Parts A and B* only
- Based on ACO results (actual vs expected PMPMs) and chosen track, ACO will have three outcomes at the end of each performance year (lagged 3+ months):
  - Receive CMS payment (profit)
  - Pay CMS (loss)
  - Receive/pay nothing (subject to minimum thresholds)
- Payments subject to **maximum** profits/losses
- Up-front **financial guarantees** required for Track 2
But There’s More....

Program administered through CMMI

<table>
<thead>
<tr>
<th>Pioneer ACOs</th>
<th>“ACO-Like” Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Alternative to MSSP</td>
<td>• Commercial (fully insured and employer-sponsored)</td>
</tr>
<tr>
<td>• Developed for more mature risk taking organizations</td>
<td>• COOPs</td>
</tr>
<tr>
<td>- Integrated delivery systems</td>
<td>• Medicare Advantage</td>
</tr>
<tr>
<td>- Capitated providers</td>
<td>• Medicaid</td>
</tr>
<tr>
<td>• Pioneer ACO participates in more upside/downside risk than MSSP ACO</td>
<td>• Direct to Employers</td>
</tr>
<tr>
<td>• Initially only offered for 1/1/12 beginning date, CMMI released a new RFI December 20, 2013 for new...</td>
<td></td>
</tr>
</tbody>
</table>
ACO Business Model Illustration

PMPM Costs

- Difference between Baseline and ACO = Shared Savings
- Performance Period

Baseline/Unintervened Member Costs
- Shared Savings Split
- ACO Member Costs

Proprietary and Confidential. Do not distribute.
Requisites for a Successful ACO

California Health Care Foundation’s six requisites for a successful ACO:

1. Shared strategic vision that identifies the long-term goals of the ACO related to:
   a. Community health needs
   b. Provider capabilities
   c. State and Federal health polices

2. Shared hospital-physician leadership; transparent decision making; clarity of roles

3. Alignment of provider financial incentives to include cost, access, quality, and choice

4. Clinical and organizational infrastructure including coordination of medical care, financial systems, and information technologies

5. Sufficient capital and clinical/financial management capabilities to support taking on risk contracts

6. Trust and respect among ACO participants and clear channels of communication
Principles for ACOs

American Medical Association’s House of Delegates adopted the following thirteen principles for ACO’s:

1. The guiding principle that the goal of an ACO is to increase access to care, improve the quality of care and ensure the efficient delivery of care;

2. ACOs must be physician led (to ensure that medical decisions are based on patients’ versus commercial interests) and encourage an environment of collaboration among physicians;

3. Physician and patient participation should be voluntary;

4. The ACO’s savings and revenues should be retained for patient care services and distributed to the ACO participants;

5. Waivers and safe harbors should be created to give flexibility to the patient referral and antitrust laws necessary to allow physicians to form or participate in ACOs without being employed by the hospitals or ACOs;

6. Additional resources should be provided to encourage ACO development in the form of financing up-front costs of creating an ACO;

7. ACO spending benchmarking should be adjusted for difference in geographic practice costs and risk adjusted for individual patient risk factors, and ACOs spending less than the national average per Medicare beneficiary should be provided an additional bonus payment so that organizations that have already achieved significant efficiencies are incented to participate;
American Medical Association’s House of Delegates adopted the following thirteen principles for ACO’s (continued):

8. The quality performance standards established by the Secretary must be consistent with the **AMA’s principles for quality** reporting;

9. An ACO must be afforded due process before it is terminated from Medicare for failing to meet quality performance standards;

10. The ACO should be allowed to use **different payment models**, and any capitation payments must be **risk-adjusted**;

11. The Consumer Assessment of Healthcare Providers and Systems Patient Satisfaction Survey should be used to determine whether an ACO meets the required **patient-centeredness** criteria;

12. Medicare must ensure that **electronic health record systems are interoperable**; and

13. If an ACO bears risk, it must abide by **financial solvency standards** for risk-bearing organizations.
Competitive Implications of ACOs

**Providers**

**Opportunities**
- Negotiating leverage for PCPs
- Payment for medical management
- Volume and margin stability
- Gain in market share for hospitals
- Enhance negotiating position for hospitals
- Data analytic development
- Direct contracting
- Ability for first movers and low-cost/high-quality providers to define brand
- Improve claims processing and eliminate obstacles to reimbursement

**Risks**
- Loss of volume if cannot position selves
- Economic returns do not equal utilization loss
- Small savings opportunity in already efficient markets
- Reduction in economic viability of hospitals
- Must develop a whole new set of capabilities

**Payers**

**Opportunities**
- Lower medical cost through more efficient utilization, lower unit costs and improved outcomes
- Ability to transfer financial risk
- Administrative cost savings through collectivization of providers and treatments (e.g. global payments)
- Ability to create new revenue streams through population health management, administrative services, and turnkey solutions.

**Risk**
- Marginalization in the marketplace
- Provider consolidation (or quasi-consolidation) will increase negotiating leverage of providers
- Central role that providers can play in establishing an ACO is a risk to Payers
- Dis-intermediation of payers
Accountable Care Competencies
## Accountable Care Developmental Competencies

<table>
<thead>
<tr>
<th>Performance-Based Payment</th>
<th>Physician Alignment</th>
<th>Patient Attribution</th>
<th>Financial Risk Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Resource Management</td>
<td>Leadership</td>
<td>Quality Improvement</td>
<td>Change Management</td>
</tr>
<tr>
<td>Multiyear Provider Partnership Contracting</td>
<td>Clinical Integration</td>
<td>Care Continuum Coordination</td>
<td>Population Management</td>
</tr>
<tr>
<td>Information Technology/Infrastructure</td>
<td>Patient Engagement</td>
<td>Internal/External Partnership Management</td>
<td>Legal Structure/Governance</td>
</tr>
</tbody>
</table>
ACO Capabilities Needed by Providers

- Technological infrastructure capabilities
- Risk management capabilities
- Care coordination, support, and wellness capabilities
- Sales and marketing capabilities
- Finance and business development capabilities
Payer Considerations

• Accountability to Patient Capabilities
  - Incorporate performance on patient experience metrics in financial incentives
  - Consumer-facing provider evaluation systems
  - Balance narrow networks and patient demand for open networks

• Care Redesign Capabilities
  - Development of a strategic plan for care design
  - Financial incentives for improving care practices
  - Provision of enabling capabilities for care redesign

• Organizational alignment capabilities
  - Risk of provider consolidation
  - Type of providers included in an ACO structure
  - Financial incentive design
Governance

Common questions leaders should take into consideration when designing governance structure:

1. Will physician “buy-in” to the model?
2. Will the model inspire trust and confidence in the ACO leadership team?
3. Is there appropriate accountability for ACO leaders?
4. Will the ACO be transparent?
5. Does the structure strike the right balance between sufficient checks and balances on the use of power and the authority to make decisive strategic decisions when the conditions warrant such action?
6. Is there enough power vested in the Governing Board to make the difficult decisions (e.g. terminating providers who do not comply with ACO standards developed by peers or terminating the hospital’s management company for poor performance) needed to achieve the overall mission of creating value for patients through higher quality care, lower costs and better service?
7. Does the model anticipate and manage potential conflicts of interest?
8. Does the model promote excellent communication at all levels of the ACO?
9. Will the ACO’s structure lead to a cultural transformation needed to respond to market changes in a competitive manner?
10. Is the foundation of the ACO governing structure designed in such a manner that the ACO can (i) evolve over time, (ii) respond competitively to new forms of reimbursement beyond just shared savings and (iii) attract commercial payers as opposed to Medicare alone?
Member Attribution

Goal is to determine which health care provider had the greatest opportunity to impact the health and health care costs for an individual.

Why is it important?

• Attribution and detail claims data time periods are not the same

• Creates unambiguous accountability for the provider for the overall health and health care costs

• Telling a doctor they have responsibility for a patient typically is not enough, may need to prove it!

• It can be leveraged to create proactive care initiatives and outreach

• Aligns incentives for coordinating care across providers to create a more positive experience for beneficiaries
Payer/ACO Payment Structure

“Risk Light”
- Simple gain-sharing based on medical claims expense with withhold upside

“Risk Light” Plus
- In addition to gain-sharing around medical claims expense, include quality improvement initiatives – e.g., readmission rate decrease, hospital-acquired infections rates, etc.

Shared Risk
- Sharing of gains and losses based on either medical expense target or split overall performance

Full Risk
- Provider organization assumes full risk for members assigned to ACO-affiliated based PCPs; ACO assumes all administrative functions
ACO Models
ACO Models

• Adapted Integrated Delivery System
  – Organized around existing integrated delivery systems that feature either a single entity that acts as Payer and provider or an association of providers with multiple care settings and employed physicians already affiliated with an external Payer.

• Virtually Integrated ACOs
  – Composed of multiple providers organizing in association with a Payer, who contributes the financial incentives that support collective accountability for patient health outcomes and the technological infrastructure used to connect the disparate providers.
  – Two variations:
    • Primary care-focused
    • Full spectrum

• Provider-Led ACOs
  – Composed of physicians, with or without hospital participation, and often they substitute Payers with third parties that provide support functions, such as middle office operations and claims.
ACO Models: Adapted Integrated Care Delivery

• First-mover advantage

• Characteristics of existing integrated care delivery systems that align with the goals of an ACO:
  – Strong in organization alignment
    • Partners
    • Governance
  – Experienced in management of medical risk
    • Comfortable with assuming a portion of the financial risk

• Payer support
  – Implementation of financial incentives aimed at supporting enhanced accountability for patient outcomes
    – Performance bonuses
    – Shared savings
  – Risk management
  – Data analytics
  – Disease management
  – Patient base
ACO Models: Adapted Integrated Care Delivery

<table>
<thead>
<tr>
<th>Provider Structure</th>
<th>Norton Healthcare/ Humana</th>
<th>Advocate/BCBSIL</th>
<th>Monarch HealthCare/ HealthCare Partners/ Anthem BCBS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Five hospitals and 12 clinics in Louisville, KY</td>
<td>Largest Integrated health system in Illinois, operating 200+ care sites across metropolitan Chicago, including 10 acute care hospitals, two children’s hospitals, four Level I trauma centers, a home healthcare company, and a large medical group</td>
<td><strong>Monarch</strong>: IPA with more than 2,500 independent, private practice physicians  <strong>HealthCare Partners</strong>: more than 1,200 employed and affiliated PCPs, and more than 1,900 specialists</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Population</th>
<th>Norton Healthcare/ Humana</th>
<th>Advocate/BCBSIL</th>
<th>Monarch HealthCare/ HealthCare Partners/ Anthem BCBS</th>
</tr>
</thead>
<tbody>
<tr>
<td>10,000 Humana participating members</td>
<td>250,000 PPO and 125,000 HMO members</td>
<td>50,000 Anthem PPO members in Los Angeles and Orange counties</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payment Structure</th>
<th>Norton Healthcare/ Humana</th>
<th>Advocate/BCBSIL</th>
<th>Monarch HealthCare/ HealthCare Partners/ Anthem BCBS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared savings between provider, Payer, and employers</td>
<td>• Limits on annual FFS rate increases with shared upside savings  • Total global risk for HMO products  • Shared upside and downside on per member/month based medical cost trend for PPO products</td>
<td>Shared savings with no risk in Year 1, transitioning to risk bearing</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Attribution</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Prospective</td>
<td>Prospective</td>
<td>Prospective</td>
<td>Anthem ETG method and Brookings-Dartmouth method</td>
</tr>
</tbody>
</table>
## ACO Models: Adapted Integrated Care Delivery

<table>
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<tr>
<th>Governance</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>• Participant in the Brookings-Dartmouth ACO Pilot Project</td>
<td>Savings measured by Advocate’s performance compared to other BCBSIL contracting network providers</td>
<td>• Participant in the Brookings-Dartmouth ACO Pilot Project</td>
</tr>
<tr>
<td></td>
<td>• Humana plans to continue developing more ACO models by partnering with providers in other regions</td>
<td></td>
<td>• HCP-Monarch-Anthem steering committee with topic specific subcommittees.</td>
</tr>
</tbody>
</table>

### Early Results/Progress

<table>
<thead>
<tr>
<th>Norton Healthcare/ Humana</th>
<th>Advocate/BCBSIL</th>
<th>Monarch HealthCare/ HealthCare Partners/ Anthem BCBS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identified areas of emphasis include:</td>
<td>• Targeting improvements in use of preventive screenings, tests, and vaccinations</td>
<td>In first six months of 2011:</td>
</tr>
<tr>
<td></td>
<td>• Better coordination in management of chronic illnesses</td>
<td>• Hospital admissions decreased 10.6%</td>
</tr>
<tr>
<td></td>
<td>• Appropriate use of generics</td>
<td>• ED visits decreased 5.4%</td>
</tr>
<tr>
<td></td>
<td>• Improved access to appropriate level of care</td>
<td>Five-year pilot launched in January 201</td>
</tr>
</tbody>
</table>

- Hospitals admissions decreased 10.6%
- ED visits decreased 5.4%
ACO Models: Virtually Integrated ACOs
Primary Care-Focused

• Collaboration between Payer and care provider(s)
• Emphasis on primary care interventions and preventive care
• Often built around existing patient-centered medical homes (PCMH) or existing pay-for-performance contracts.

• Strengths of this structure:
  – Governance
  – Primary care redesign potential
    • Strong care coordination and use of quality data

• Weaknesses include:
  – Limited range of care settings
    • Specialists and hospitals have little incentive to participate
    • Considerably more effort in aligning the ACO with external care settings and developing a payment infrastructure
  – Reluctant to take financial risk
    • Take on performance-linked bonuses but reluctant to enter into gain-sharing or shared savings arrangements that include downside risk
## ACO Models: Virtually Integrated ACOs
### Primary Care-Focused

<table>
<thead>
<tr>
<th></th>
<th>Carilion Clinic</th>
<th>UnitedHealthcare/Tucson Medical Center</th>
<th>Aetna Medicare Advantage</th>
</tr>
</thead>
</table>
| **Provider Structure** | 600+ physicians in a multi-specialty group practice and eight not-for-profit hospitals | • Large medical center and affiliated physician groups  
• ACO includes about 12 employed physicians and 50-60 independent physicians | Aetna-driven ACO model created with 36 participating primary care practices |
| **Patient Population** | 60,000 Medicare patients                                                          | Commercial, managed Medicaid, and Medicare FFS patients                                                  | 20,000 Aetna Medicare Advantage members                                                   |
| **Payment Structure**  | Shared savings and financial incentives for employed physicians based on cost and quality performance | • Shared savings  
• PCPs to receive monthly care coordination fee and bonus for performance based on clinical quality factors  
• Future might include capitation model | Performance (quality)-linked incentives for facilities and physicians |
| **Patient Attribution** | Unknown                                                                        | Retrospective                                                                                         | Unknown                                                                                 |
# ACO Models: Virtually Integrated ACOs
## Primary Care-Focused

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<th>UnitedHealthcare / Tucson Medical Center</th>
<th>Aetna Medicare Advantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brookings-Dartmouth to provide technical assistance for pilot setup</td>
<td>Based on a PCMH pilot financed by United with major employers such as IBM and Raytheon</td>
<td>Uses ActiveHealth’s CareEngine System to identify gaps in patient care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>United provides data and IT infrastructure</td>
<td>Aetna helped form the care team: doctor groups paired with specialists, hospitals, and community social services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dartmouth-Brookings provides “external manager” payment structure design</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Early Results/Progress</th>
<th>Anthem, CIGNA, United Healthcare, and Southern Health have expressed interest in partnering</th>
<th>Preliminary results:</th>
<th>Aetna began testing in 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>4.5% decline in necessary Emergency department visits</td>
<td>Nearly all participating medical groups met performance targets, including follow-up office visits within 30 days of discharge and two office visits per year for certain chronically ill patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>22.5% drop in unnecessary emergency department visits</td>
<td>Reduced acute hospital care by 43% compared to unmanaged Medicare Advantage members, according to a Commonwealth Fund study</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Some self-funded employers have expressed interest in joining</td>
<td>Health Affairs study revealed an increase in hospice election and a decrease in acute care services, estimated to reduce medical costs by 22% (compared to control group)</td>
</tr>
</tbody>
</table>
ACO Models: Virtually Integrated ACOs
Full-Spectrum

• Collaboration between Payer and broader spectrum of providers
• Markets that have progressive providers who do not want to move to fully integrated
• Payer’s role:
  – Infrastructure assistance
  – Financial incentives for performance (accountability)
  – Shared savings distribution model
• Strengths of this structure:
  – Enables more comprehensive and effective care delivery redesign
  – Higher savings potential
  – Includes full spectrum of care; Greater accountability for overall patient health
  – Inclusion of hospitals better enables transition to fully-functioning ACO and ability to take on greater financial risk (versus physician groups)
ACO Models: Virtually Integrated ACOs
Full-Spectrum (continued)

• Challenges of the full-spectrum ACOs include:
  – Leadership structure
  – Process designs to determine payment and savings distribution
  – Design decisions
    • Providers to include
    • Leakage strategy
  – Willingness to manage the total cost of care
## ACO Models: Virtually Integrated ACOs Full-Spectrum

<table>
<thead>
<tr>
<th>Provider Structure</th>
<th>CIGNA Collaborative Accountable Care</th>
<th>Dartmouth-Hitchcock Medical Center/Anthem BCBS</th>
<th>Blue Shield of CA/Catholic Healthcare West/Hill Physicians</th>
</tr>
</thead>
</table>
|                    | Large primary care groups, multispecialty groups, and integrated delivery systems of physicians and hospitals | • DHMC is New Hampshire’s only academic medical center  
• 900-physician group practice, with strong background in ACOs | CHW: large hospital system  
Hill Physicians: large physician multi-specialty group practice |

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</thead>
<tbody>
<tr>
<td></td>
<td>Various products, including PPO</td>
<td>Anthem members</td>
<td>Approximately 40,000 California state employees in greater Sacramento</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payment Structure</th>
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<th>Blue Shield of CA/Catholic Healthcare West/Hill Physicians</th>
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</table>
|                    | • Bonus for meeting performance targets (quality and lower costs)  
• Eventually expected to move toward two-sided gain sharing | Dartmouth-Hitchcock to manage cost and quality of care | Shared savings |

<table>
<thead>
<tr>
<th>Patient Attribution</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Retrospective, based on CIGNA analysis of which PCP last treated the patient</td>
<td>Unknown</td>
<td>Prospective. Initiated a program to identify and enroll patients who have gone out-of-network</td>
</tr>
</tbody>
</table>
# ACO Models: Virtually Integrated ACOs

## Full-Spectrum

<table>
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</tr>
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</table>
| • ACO enabled by CIGNA  
• CIGNA provides claims data and informatics to identify high-risk patients, funds nurses for outreach programs, and produces management reports  
• Provider practices to determine care redesign opportunities |  
Anthem and Dartmouth-Hitchcock to collect and analyze data to “identify and implement efficiencies and improvements in healthcare delivery” |  
Hill and CHW are collaborating on alternatives, including pursuing evidence-based approaches to therapy and treatments prior to recommending surgery |

### Early Results/Progress

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>CIGNA expecting savings from efficiencies, however results and not yet available</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
• Dartmouth-Hitchcock has earned $13M to date in the Medicare Physician Group Practice Demonstration, the model for ACOs |  
Early results include:  
• Added 2,500+ members since open enrollment  
• 30% reduction in readmissions  
• Reduction in average length of stay by 0.72 day  
• 7.6% reduction in ER/Urgent Care admissions  
• 15% reduction in total bed days |
ACO Models: Provider-Led ACOs

• Payment reform not typically a priority due to lack of Payer involvement
  – Typically a FFS structure
• Focused on capturing shared savings without necessarily sharing gains with Payers
• Future trend may include acquisition and consolidation in order to form physician-led ACOs
• Greater focus on care delivery improvements
  – Strength of this design as providers tend to have better insight into care process inefficiencies and physician practice motivators.
• Obstacles include:
  – Organization expertise and bandwidth around traditional Payer functions
    • Management (financial, network, medical)
  – Attribution
  – Evaluation of care outcomes
  – Significant organizational effort in governance and partner selection
ACO Performance Thus Far

• MSSP ACOs (Performance Year 1)
  o 53 of 204 (26%) MSSP ACOs had shared savings
    • 4 of the 53 (8%) did not successfully report quality measures and will not receive their shared savings
    • 52 ACOs had spending below their benchmark but did not reduce spending enough to qualify for shared savings
    • 99 experienced spending above their benchmark with one owing CMS $4M
  o Net program shared savings of $301M
  o MSSP ACOs improved on 30 of 33 quality measures

• Pioneer ACOs
  o Performance Year 1
    • 13 of 32 Pioneer ACOs earned shared savings totaling $77M
    • One owed money back to CMS
  o Performance Year 2
    • 11 of 23 Pioneer ACOs earned shared savings totaling $68M
    • Three owed money back to CMS and three deferred the calculation until the end of PY3
  o 19 of the original 32 Pioneer ACOs remain for performance year 3
Legal Considerations
Key Legal Issues Related to Payer/ACO Payments

• Federal Antitrust Laws
  – Can ACO participants jointly contract with Payers?
    • Single Entity
    • Financial Integration
    • Clinical Integration
    • Exclusivity
  – Price-fixing risk in negotiating rates with private Payers, including Medicare Advantage plans
  – Not an issue with Medicare FFS ACO, because Medicare sets FFS payments and no negotiation by ACO providers

• Representative State Law Issues: HMO/Insurance/TPA Licensing Laws and Corporate Practice of Medicine Laws
  – Corporate Practice of Medicine
  – HMO/Insurance/Managed Care Contracting Laws

• Stark Law
  – Governs physician self-referral for Medicare and Medicaid
  – Waived for Medicare Shared Savings Program participants

• Antikickback Statute
  – Prohibits offer or receipt of compensation in exchange for referrals or services reimbursable under Medicare or Medicaid
Federal Anti-Trust Laws

• If providers in ACO are not competitors or are considered a single entity, they are incapable of violating price-fixing prohibition

• If providers in an ACO are competitors and are not considered a single entity, then they must demonstrate sufficient financial integration or clinical integration through which they can operate as a single entity for antitrust purposes

• If insufficiently integrated, ACO must use unwieldy and ineffectual “messenger model”

• Financial Integration
  – Capitation
  – Percentage of premium
  – High withhold
  – Bundled payments

• Clinical Integration
  – If competing physicians are not financially integrated (i.e., FFS with upside only), must be clinically integrated
  – Four FTC advisory opinions; three favorable
Representative State Law Issues

• Corporate Practice of Medicine
  – Most states still have laws that prohibit, to varying degrees, the “corporate practice of medicine” ("CPOM"), which generally prevent unlicensed lay entities from employing physicians or otherwise contracting with physicians to furnish medical care.
  – CPOM laws may limit the flexibility of physicians and non-physicians to structure ownership and employment arrangements of an ACO unless licensed as a managed care organization or hospital may employ physicians under state CPOM law.
  – Some states with strong CPOM laws (e.g., California, Nevada, and Texas) even prohibit hospitals from employing physicians, but have laws permitting nonprofit “medical foundations” to engage physicians (e.g., in medical group) indirectly to provide medical care.
  – “Friendly Physician” or “Management” models in CPOM states will require careful regulatory analysis to minimize regulatory risk.
Representative State Law Issues

- **HMO/Insurance/Managed Care Licensing Laws**
  - National Association of Insurance Commissioners ("NAIC") determined in 1990s that a health care provider receiving capitated-type payments assumes insurance-type financial risk
  - In most states, capitation is permissible under state insurance/HMO law for state-licensed HMO’s “downstream” providers, within the scope of their medical/health licensure, for services provided to that HMO’s members
  - Capitated or Other “Downside Risk” Payments?
    - In a number of states (e.g., California, Colorado, Illinois, New Jersey, New York, Ohio and Pennsylvania) an ACO is prohibited from assuming capitated or other substantial financial risk, unless the ACO is licensed by the state to assume such financial risk or falls within an exception.
    - ACO that direct contracts with self-funded ERISA plan is not shielded from state insurance/HMO licensure and regulation by ERISA preemption, which applies only to plan itself. [See Hewlett-Packard Co. v. Barnes, 571 F. 2d 502 (9th Cir 1978)]
      - Congress could preempt state insurance/HMO laws for Medicare capitation, but PPACA does not appear to do so.
Representative State Law Issues

• HMO/Insurance/Managed Care Licensing Laws (continued)
  – Examples of State Managed Care Laws that May Apply to ACOs include:
    • California’s Knox-Keene Act
    • Colorado’s Division of Insurance Regulations
    • Florida’s Definition of Fiscal Intermediary Service Organization
    • Illinois’ PPO Regulations under the Health Care Reimbursement Reform Act of 1985
    • New Jersey’s N.J. Stat. §§ 17:48H-1 et. seq.
    • Ohio’s Rev. Stat. Chapter 1751
    • Pennsylvania’s Department of Insurance Regulations
  – Applicability of state insurance/HMO/managed care laws will depend on precise payment structure
    • Global capitation/percentage of premium
    • Capitation only for services that capitating provider is licensed to provide
    • Risk corridors (10-15% or 50%?)
    • FFS combined with withholds (10-15% or 50%+)
    • FFS with upside shared savings bonus (not regulated)
    • ACO contracts with private Payer or Medicare Advantage Plan vs. self-funded employer
Representative State Law Issues

- HMO/Insurance/Managed Care Licensing Laws (continued)
  - In some states (such as California, Ohio, and New Jersey), providers that lack a state health plan license may not capitate or assume substantial financial risk other than under contract with a licensed HMO, and then only for services within scope of provider's licensure.
  - In those states, an ACO may still engage in direct employer fee-for-service contracting as permitted by CPOM (including case rates and other bundled pricing) but is prohibited from being paid on a capitated basis or otherwise assuming substantial financial downside risk unless the ACO holds the required state HMO, PPO or insurance license.
  - Must review state insurance/HMO managed care law carefully before structuring ACO
  - Note: If ACO is not a licensed health plan and is delegated TPA functions (e.g., claims adjudication), ACO may be required to obtain a state third party administrator (“TPA”) license
•Thank you!