



ACTUARIAL STANDARDS BOARD

**Actuarial Standard
of Practice
No. 16**

**Actuarial Practice Concerning
Health Maintenance Organizations and
Other Managed-Care Health Plans**

**Developed by the
Health Committee of the
Actuarial Standards Board**

**Adopted by the
Actuarial Standards Board
July 1990**

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July 1990

TO: Members of the American Academy of Actuaries and Other Persons with an Interest in HMOs and Other Managed-Care Health Plans

FROM: Actuarial Standards Board (ASB)

SUBJ: Final Version of Actuarial Standard of Practice: *Actuarial Practice Concerning Health Maintenance Organizations and Other Managed-Care Health Plans*

Background

Managed care health plans (MCHPs) accounted for a small proportion of total health care financing until the 1980s. The actuarial information related to them is much less abundant than for indemnity health plans. This standard supplements the general health insurance standards and deals with a number of considerations unique to or of greater significance for managed-care health plans.

In June 1989, the ASB requested that its Health Committee draft a standard of practice concerning such plans. An exposure draft of this proposed standard was released in October 1989 with a comment deadline of March 1, 1990.

Responses to Comments on Exposure Draft

Nine written responses were received. All respondents expressed support for the draft while offering points for clarifying or improving the document. All comments were carefully considered by the Health Committee and a number of changes were made to the draft as a result of this valuable input. The term *managed care health plans* (MCHPs) is now generally used throughout the standard, with the understanding that health maintenance organizations (HMOs) are a subset of MCHPs. The exposure draft had used the term *HMO* to refer to all MCHPs, but several respondents said this was confusing.

Several definitions were changed to be more clear, especially the definition of *MCHP*. Two more definitions were added.

The Background and Historical Issues section was changed slightly to clarify the increasing role of MCHPs.

References in the Recommended Practices section to the actuaries' inquiries of management were changed to make clear that they apply to both consultants and in-house actuaries. A recommendation that an MCHP's capital and surplus be considered when reviewing rates which assume improvement in utilization rates was strengthened.

A section was added which discussed health care budgets and how they can be used by MCHPs.

One respondent believed that the use of examples (in section 5) was inappropriate. The committee disagreed, believing that examples helped clarify the various situations described.

In addition, a number of changes were made throughout the standard to conform with changes described above.

The committee believes that none of these changes is substantive, and that a second exposure of the standard is not warranted. The standard is therefore recommended to the ASB as the final version.

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ACTUARIAL STANDARD OF PRACTICE NO. 16

**ACTUARIAL PRACTICE CONCERNING
HEALTH MAINTENANCE ORGANIZATIONS
AND OTHER MANAGED-CARE HEALTH PLANS**

PREAMBLE

Section 1. Purpose, Scope, and Effective Date

- 1.1 Purpose—The purpose of this standard of practice is to set forth recommended practices for actuaries dealing with health maintenance organizations (HMOs) and other managed-care health plans (MCHPs).
- 1.2 Scope—This standard is intended to provide guidance on several important areas requiring special consideration for HMOs and other MCHPs. It does not deal with issues generic to all health care plans, and it is not intended to be a comprehensive treatment of all items specific to HMOs and other managed-care health plans. This standard addresses several actuarial functions including rate adequacy, valuation of liabilities, financial reporting, and financial controls, and how these functions are affected by important aspects of MCHPs such as the transfer of financial risk to providers, the management of health care delivery systems, and multiple delivery systems and financial arrangements. It is the actuary’s responsibility to apply this standard taking into account other applicable actuarial standards of practice, regulatory or legislative requirements, and sound actuarial principles. This standard applies both to new plans and the ongoing assessment of existing plans.
- 1.3 Effective Date—The effective date of this standard is October 15, 1990.

Section 2. Definitions

While many terms are commonly used in the health care industry, there are generally no absolute definitions of terms which have been universally accepted or uniformly applied to HMOs and other MCHPs. Products tend to fall on a continuum rather than in discrete categories and integrated, multiple-option, and other hybrid plans further blur definitional distinctions. The following definitions are provided to clarify terms as used in this standard of practice. *Throughout this standard, the term MCHP is used to denote both health maintenance organizations, as defined in subsection 2.8, and other managed-care health plans, as defined in subsection 2.12.*

- 2.1 Capitation—The amount of money paid to a provider by an exposure-based payment system to provide certain health care services to an MCHP’s members. The payment does not vary on the basis of the number or type of services actually rendered. The verb *to capitate* is used to indicate the act of entering into such an arrangement. *Capitation* is also used to mean the total medical cost or premium per enrollee, though it is not used in this manner in this document.
- 2.2 Exclusive Provider Organization—An alternative delivery system which consists of a panel of providers (hospitals, physicians, or both) which are available to a group of subscribers on an annual election basis. If the subscribers do not utilize the services of participating providers “exclusively,” their benefits are significantly reduced and in some cases, there are no benefits.
- 2.3 Fee-For-Service—A method of reimbursing providers based on payment for each actual service rendered, in contrast to a salary or capitation payment basis.
- 2.4 Funding Arrangements—The financial mechanisms used to provide health benefits to covered individuals. They include insurance (either guaranteed cost or experience rated and minimum premium plans), which transfers financial risk to an insurance carrier; self-insurance, where the employer or employee group retains financial responsibility; and MCHPs where the financial risk is transferred to another financial security system.
- 2.5 Group-Model HMO—An HMO which contracts with one or more medical groups to provide services to members. Generally, most ambulatory care services will be provided at a site(s) owned or leased either by the group practice or the HMO. (Also known as *closed panels*.)
- 2.6 Group Practice—The delivery of medical services by three or more physicians formally organized to provide medical care, consultation, diagnosis, and/or treatment through the joint use of facilities, equipment, and personnel, and with income from the medical practice distributed in accordance with methods previously determined by members of the group. May be single-specialty or multi-specialty. (Also known as *medical group*.)
- 2.7 Health Care Budget—A management tool used to develop the MCHP’s financial and operating targets for a forthcoming fiscal year. The budget may include both financial projections, such as medical care costs, and operating expectations, such as utilization or enrollment targets. Some of the items in the budget may be used as risk-pool targets.
- 2.8 Health Maintenance Organization (HMO)—An organization which coordinates the delivery and financing of health care to an enrolled population. An HMO has the following characteristics:

- a. It is an organized system for providing or managing the delivery of health care services in a specified geographical area.
- b. It usually provides a comprehensive set of health care services.

For purposes of this standard, there are four types of HMOs: the group, IPA, mixed, and staff models.

- 2.9 Hold-Harmless Clause—A provision in a provider contract stating that the providers will hold the enrollee harmless for the payment of the cost of health care services for reasons including, but not limited to, non-payment by the MCHP or the MCHP’s insolvency. This provision alleviates the enrollee’s liability to providers.
- 2.10 Indemnity Plan—A type of benefit plan in which benefits are in the form of cash payments rather than services. The plan either pays the provider for services performed or reimburses the beneficiary for expenses after they are incurred. Most indemnity contracts set a maximum amount to be paid for covered services. Such plans are contrasted with prepaid health care plans.
- 2.11 Individual Practice Association (IPA)-Model HMO—An HMO which contracts with individual, independent physicians to provide services to members. Generally, the services will be provided at the physicians’ private offices; however, the physicians may work out of an HMO-owned facility.
- 2.12 Managed-Care Health Plan (MCHP)—A mechanism which integrates the financing and delivery of health care by the following elements:
 - a. Arrangements with providers to furnish health care services to covered individuals
 - b. Organized arrangements for on-going quality assurance and utilization review
 - c. Significant financial incentives for covered individuals to use the providers affiliated with the plan

Examples of such plans include HMOs and point-of-service products.

- 2.13 Mixed-Model HMO—An HMO which uses some combination of group, staff, or IPAs to provide services to its members. (Also known as a *network model*.)
- 2.14 Non-Indemnity Plan—Any type of benefit plan which provides benefits or services which are defined by some means other than reimbursement for expenses after services are performed.
- 2.15 Point-of-Service Product—A plan that offers at least two different levels of benefits, depending on the choice of provider selected by the insured at the time the service is

rendered. A higher level of benefits is available if the patient uses a provider designated by the plan. There may be required procedures to be followed in order to use the services of these designated providers; e.g., prior authorization to visit specialists.

- 2.16 Preferred Provider Organization (PPO)—A group of health care providers (which may include physicians and hospitals) that contracts with a plan administrator or sponsor to provide certain health care services, usually at a discounted rate.
- 2.17 Prepaid Health Care Plan—A plan which provides contracted health care services to a group of persons covered by a prepayment program through physicians and possibly other providers who are paid to provide necessary care through fixed payments or payments according to methods which are determined in advance.
- 2.18 Primary Care Physician (PCP)—A physician who provides primary care; usually a family physician, general practitioner, internist, or pediatrician who provides a broad range of medical services and is generally the first point of contact for the patient. Primary care may be provided by obstetricians/gynecologists as well. The primary care physician may refer patients needing more specialized care to other specialists such as cardiologists, dermatologists, orthopedists, etc. Managed-care health plans frequently require the PCP to perform a gatekeeper function; that is, the PCP preapproves care by other providers if it is to be covered by the plan.
- 2.19 Providers—Individuals or organizations providing health care services, including doctors, hospitals, physical therapists, medical equipment suppliers, etc.
- 2.20 Risk Pool—A mechanism for sharing risk between an MCHP and its providers, usually defined by contractual agreements. Generally, actual medical cost experience is compared to budgeted amounts in the risk pool. A settlement divides the resulting surpluses or deficits between the providers and the MCHP in some manner.
- 2.21 Specialist—A professional provider whose practice is limited to a specific disease or group of diseases (e.g., rheumatology); part of the body (e.g., ear, nose and throat); age group (e.g., pediatrics), or procedure (e.g., oral surgery). Specialists may be board-certified, board-eligible, or otherwise specially trained through post-graduate residencies, etc., or merely self-styled.
- 2.22 Staff-Model HMO—An HMO which hires its own physicians. Generally, most ambulatory care services will be provided in an HMO's facility.
- 2.23 Uncovered Expenditures—The costs to the MCHP for health care services that are the obligation of the MCHP, for which an enrollee may also be liable in the event of the MCHP's insolvency, and for which no alternative arrangements have been made that are acceptable to the insurance or regulatory commissioner, director, or superintendent. This concept currently applies only to HMOs, because of statutory requirements.

- 2.24 Withhold—Amount of funds normally payable to providers that is held back (not paid out) for the purpose of funding a risk pool.

Section 3. Background and Historical Issues

Provision of insurance for health care costs through indemnity plans has been in existence for many years. A substantial body of actuarial knowledge and related publications has been built up regarding indemnity plans. Prepaid health care plans, HMOs and other non-indemnity vehicles for health care financing accounted for a small proportion of total health-care financing until the 1980s, and much less actuarial information is available for them. While many principles which apply to indemnity coverage also apply to prepaid plans, there are a number of considerations which are unique or have significantly greater materiality for non-indemnity plans.

Although some MCHPs have been in existence for a long time, in recent years there has been a significant increase in the number and types of MCHPs and introduction of new non-indemnity vehicles for health care financing. These ventures are frequently more thinly capitalized than insurance companies providing indemnity plans, making them more financially vulnerable. Many actuaries are becoming involved with these plans.

Applicable regulation and legislation are embryonic in many jurisdictions and actuarial expertise and literature are less available than for indemnity plans. Consequently, the actuary is required to exercise considerable innovation and professional judgment in a complex and rapidly evolving environment. This has led to significant variations in practice.

There has recently been an increase in the number and proportion of financially troubled non-indemnity plans, which may indicate inadequate application of sound actuarial practices.

This standard serves as a guide to actuaries dealing with non-indemnity plans by identifying several important considerations which should be taken into account. It addresses implications of the transfer of financial risk to providers, management of health care delivery systems, and multiple delivery systems and financial structures.

Section 4. Current Practices and Alternatives

Current practices are not tightly governed. Completeness and specificity of applicable government regulations vary widely by jurisdiction. The *Guides and Interpretative Opinions as to Professional Conduct* of the American Academy of Actuaries (AAA) provide broad conceptual guidance. Some particular issues are dealt with in:

1. Recommendation 10 of the AAA's *Financial Reporting Recommendations and Interpretations*: Statement of Actuarial Opinion for Health Service Corporation Statutory Annual Statements.

2. The standards of practice promulgated by the Interim Actuarial Standards Board and the Actuarial Standards Board, specifically:
 - a. Actuarial Standard of Practice No. 5: *Incurred Health Claim Liabilities*.
 - b. Actuarial Standard of Practice No. 8: *Regulatory Filings for Rates and Financial Projections for Health Plans*.

Although it is not an actuarial standard of practice, the actuary should also be aware of the Statement of Position of the American Institute of Certified Public Accountants, *Accounting for Providers of Prepaid Health Care Services*.

However, current practices have varied considerably because of the absence of a single, specific actuarial standard of practice in this area.

Proper actuarial practice of necessity involves the use of significant professional judgment and interpretation regarding sound techniques and assumptions. The purpose of this standard is to identify some of the more important facets of MCHPs which should be considered when practicing in this area.

STANDARD OF PRACTICE

Section 5. Analysis of Issues and Recommended Practices

- 5.1 Transfer of Financial Risk to Providers—A significant characteristic which can differentiate MCHPs from indemnity insurance is the contractual sharing of responsibility for financial results between the MCHP and health care providers.

Four examples that serve to illustrate the main types of risk-sharing arrangements are as follows:

- a. Capitation contracts with a separate IPA corporation, multi-specialty medical group, or hospital.
- b. Capitation contracts with specialty provider entities such as a drug company or mental health services organization.
- c. Capitation contracts with primary care physicians plus financial incentives/risks that are a function of a primary care physician's management of inpatient hospital and/or specialty physician costs.
- d. A withhold of a portion of physician fees.

The actuary should determine the types and scope of these arrangements and their impact on health claim liabilities and rates.

- 5.1.1 Capitation Contracts with Providers—Some MCHPs capitate independent medical groups, IPAs, and hospitals and shift responsibility for processing and paying claims to these entities. Frequently, these entities have inadequate systems for monitoring financial results under their MCHP contracts and are under no requirement to submit claims data to the MCHP. A capitated entity could be financially insolvent for some time before the situation would come to the attention of the MCHP.

An important distinction to make regarding the type of physician organizations that assume financial responsibility under a capitation contract is the extent to which the organization provides the care directly, rather than through referrals to other physicians for care. Small physician groups that refer a large number of patients to other physicians, yet assume financial liability for that care under the terms of the MCHP contract, probably represent a larger risk of potential liability exposure for the MCHP than would groups that refer relatively few patients.

This distinction may also be important in the context of minimum statutory surplus requirements. These requirements are, in part, determined by the level of exposure for unpaid, uncovered expenditures. The actuary should carefully

consider the extent to which a capitated provider agreement includes liabilities for uncovered expenditures.

- 5.1.2 Stop-Loss Provisions—MCHPs that capitate providers as described above frequently incorporate specific stop-loss terms into the contracts to limit provider risk. The actuary should understand the basis for measuring amounts within the context of stop-loss clauses, and should determine that appropriate provisions are included in claim reserves and rates for any stop-loss features.
- 5.1.3 Supplemental Payments—Capitation contracts between MCHPs and provider organizations may include risk-sharing terms that make the MCHP’s cost partially dependent on actual claims experience, even though the provider organization has been reimbursed on a capitated basis. Such arrangements can either increase or decrease claim liabilities. Some common examples are contracts with drug companies, mental health organizations, and commercial laboratories. The actuary should consider the level of the capitation relative to reasonable projections of claims cost in establishing the projection of cost for rating purposes.

Occasionally, MCHPs make concessions in the form of retroactive supplemental capitation payments to capitated providers experiencing adverse financial results under their MCHP contract. The actuary should recommend that liabilities and rates include adequate provision for such actual or anticipated settlements which fall outside of the scope of the contract.

- 5.1.4 Financial Condition of Capitated Providers—The actuary should include in all MCHP claim liability and rate opinions a statement disclosing the actuary’s knowledge of all capitated risk contracts between the MCHP and provider entities. This statement should indicate whether the actuary has evaluated the financial position of the provider entities. The actuary should make appropriate inquiries of responsible persons regarding the financial condition of provider entities that assume financial risk through a capitation mechanism. The actuary’s statement should disclose knowledge of, and make appropriate provisions for, any financially insolvent provider entity that may have a material effect on the MCHP’s rates, reserves, or financial condition.

Some IPAs enter into capitation contracts with multiple MCHPs. In these cases, rarely will the actuary have access to information on the financial position of the IPA except with respect to the specific MCHP the actuary serves. The actuary should disclose in reserve opinions the existence of any IPAs with multiple capitation contracts and indicate whether the financial position of the IPA and resulting impact, if any, on MCHP liabilities have been evaluated.

- 5.1.5 Primary Care Physician Financial Incentives—Primary care physicians occasionally have some level of financial interest in the variance between budget and cost for hospital inpatient and/or specialty physician costs for their group of MCHP patients. These arrangements frequently establish individual physician

settlements based on individual physician performance criteria. The MCHP's claim cost and liabilities are often changed as a result of incentives. Prospective rates may require a specific cost provision for expected incentive payments, based on prior or projected future experience. The actuary should determine whether rates and liabilities include adequate provision for contractual incentive payments.

- 5.1.6 Provider Settlements (General)—While the primary care financial incentive arrangements described above are a special case with unique features, most MCHPs utilize a risk-sharing arrangement that involves some year-end settlement process with hospitals, IPAs, medical groups, and/or other providers. These settlements may include amounts owed by the MCHP to the provider or vice versa.

In the case of amounts owed by the provider to the MCHP, the MCHP will either treat such amounts as an asset or offset such amounts against other liabilities. If the MCHP experiences losses, it may offset the losses with some or all of the amounts withheld from provider payments, to the extent of the liability established in the provider contracts.

In the case of amounts owed by providers to the MCHP when no contractual withholding provision exists, the actuary should consider the collectibility of such amounts, particularly if such amounts are netted from liabilities included in the actuary's review. In general, the actuary should consider the impact of year-end settlements on liabilities and rates.

- 5.1.7 Covered Liabilities—The actuary should be satisfied with the manner in which that portion of total liabilities which is allocated for unpaid, uncovered expenditures is included in all claim liability opinions filed with regulatory authorities. If the actuary is not so satisfied, this fact should be disclosed in the actuary's opinion. The actuary may rely on others to perform the allocation of liabilities for covered and uncovered expenditures, as long as the method used is reasonable and the results are consistent with the actuary's knowledge of the plan.

- 5.1.8 Experience Rating—Risk-sharing arrangements create special problems for the development of experience rates. One problem is the integration of the risk-sharing terms of provider contracts into the group experience rating method. Another may be substituting some measurement of claims experience within the rating method where a provider capitation exists. The actuary should assure that adequate provision has been made in experience rates for risk-sharing settlements, and that the rate method will produce adequate premiums to meet capitation commitments.

- 5.2 Management of Health Care Delivery Systems—One of the primary characteristics of an MCHP is the development of a health care delivery system and the attempt to manage the care within that system. Managing care involves providing health care directly or contracting with providers and intervening in the health care delivery process by setting

up qualitative and quantitative standards for the care delivered by those providers. The MCHP has the ability to affect the patterns of utilization of care, most notably hospital inpatient utilization. The MCHP contracts with providers by obtaining reimbursement agreements and by attempting to select providers who are cost efficient in the delivery of care or by changing patterns of treatment to a more cost-efficient basis.

The actuary should assist appropriate management personnel to assess the actual experience of the delivery system and to try to predict the future costs of the delivery system. Delivery systems continue to change as reimbursement arrangements, providers, and utilization management practices change.

5.2.1 Effect on Claims Liability—The potential to manage the delivery of care affects the process the actuary uses in setting outstanding claims liability estimates. There should be more data available to the actuary due to the presence of the utilization review monitoring system, which should provide information prior to claims actually being paid. For example, utilization review data should be available regarding the number of hospital days incurred in a month, or the number of specialty referrals. The actuary should be familiar with the provider contracts to ensure that the liability estimates take into account any risk sharing involved and special settlement provisions of the provider contracts. The process should take into account any expected or potential changes in the delivery system, such as changes in: provider reimbursement, the mix of providers being used, utilization review procedures, services which are capitated (therefore, not in the claims history), etc.

5.2.2 Effect on the Rate Setting Process—The degree of organization of the health care delivery system affects the actuary's choice of rating assumptions. While it is still very important to review historical experience, this experience may no longer be as good a predictor of the future as it would be without the presence of the delivery system. The actuary should review the potential for changes in such things as provider reimbursement levels, mix of providers, effectiveness of utilization review, capitation agreements, and use of non-plan providers.

The actuary should assist appropriate management personnel in assessing the risk associated with achieving projected changes in the delivery system. The actuary should include sensitivity analysis and/or comments, as appropriate, regarding the changes necessary to achieve the projected delivery system results. If significant delivery system changes are projected, there should be a statement of the risk involved and the steps to be undertaken to achieve the projected changes. This assessment is especially important for a new MCHP with little or no experience available.

It may be difficult for an MCHP to reduce utilization levels in a short time period and the actuary should consider all appropriate factors when assessing the likelihood of success. Changes in provider reimbursement may be more predictable in managed care than in indemnity insurance, since an MCHP's

management has some control over the rate of change. However, improvements in utilization review effectiveness are more difficult to predict. The actuary should comment regarding the capital and surplus available to the MCHP if the premiums are based on a level of effectiveness not likely to be reached until the end of the rating period or later.

5.2.3 Changes in Mix of Providers—The actuary should consider the effect of any material changes in the mix of providers making up the delivery system, such as changes in the following:

- a. Makeup of the primary care specialties, e.g., general/family practice, internal medicine, obstetrics/gynecology and pediatrics
- b. Hospitals used
- c. Referral specialists used
- d. Enrollee satisfaction with providers
- e. Subspecialty make-up of providers

Even if the arrangements with each individual provider do not change, changes in the mix of providers within any of the above categories could cause significant changes in medical costs.

5.2.4 Effect on Data Monitoring—The degree of organization of a delivery system affects the data monitoring/experience analysis needs. Provider contracting typically requires data to be available in much more detail than in an unmanaged system—both by type of service and by type of provider. This detail is necessary to be able to estimate the impact of projected changes in the delivery system, and to determine whether the projected changes occurred. For example, if the MCHP expects to be able to sign a capitation agreement for laboratory services, it is important to know what the existing laboratory experience is, and what percentage of services will be included in the capitation to be able to estimate future laboratory costs under the capitation agreement. After the capitation agreement is implemented, fee-for-service laboratory payments are added to the capitation cost to determine total laboratory costs.

Data monitoring is especially important when future rating assumptions provide for changes in the effectiveness of the delivery system. For example, if it is assumed that a change in primary care physician financial incentives will reduce x-ray and laboratory utilization by 10%, then data should be available to measure utilization rates before and after the change in financial incentives, on a consistent basis.

The actuary should determine whether the MCHP's monitoring systems produce reliable data in the amount and type of detail necessary to support the plan's operations. The actuary should recommend to management the type and frequency of data to be collected and whether changes are needed in monitoring systems.

5.2.5 Basis for Claim Reports—The actuary should determine the basis for claim amounts reported by the MCHP in claim lag reports or experience reports; namely, whether claims are stated gross or net of various items such as provider withhold coordination of benefits, reinsurance, provider stop-loss, discounts, etc.

5.3 Multiple Delivery Systems and Financial Structuring—One factor unique to the MCHP industry which can greatly complicate the analysis of historical cost information and the projection of future costs, which are the basis for premium rate and claim liability development, is the existence of combinations of the following types of health care delivery and financing mechanisms within a single MCHP:

- a. Staff model clinics employing full-time salaried physicians with negotiated fees for non-staff physician specialties
- b. Capitated primary care physician arrangements with modified fee-for-service for specialty services
- c. Capitated professional services arrangements with IPA organizations and/or medical groups
 1. Where the MCHP administers underlying fee-for-service payments, or
 2. Where the MCHP delegates administration to the IPA or medical group
- d. Modified fee-for-service for all professional services
- e. Capitated ancillary service arrangements which apply to some or all provider groups within the MCHP

For the purpose of experience analysis, data complications can arise either from a combination of some of the types of reimbursement systems within the same MCHP or because the MCHP has changed from one type of reimbursement to another at some point during the experience period.

If several IPAs or medical groups are capitated within a network structure, it is common that the capitations are individually negotiated and are likely to include differing scopes of services between IPAs and medical groups.

In many instances, the MCHP's data systems have not yet reached a level of sophistication to distinguish clearly the costs associated with each type of arrangement.

Thus claim summaries could include different scopes of services for the segments of the covered population associated with different types of delivery and financing systems. It is also possible for claim summaries to include a combination of (1) fee-for-service claim payments which represent the MCHP's own liabilities and (2) fee-for-service claim payments made by the MCHP on behalf of an IPA, which are actually the liability of the IPA.

- 5.3.1 Scope of Services by Contract—When dealing with mixed-model MCHPs, the actuary should understand how the MCHP's data systems have dealt with pertinent issues such as those outlined above. When data ambiguities do exist, the actuary should ensure that any assumptions made are reasonable and/or that any limitations due to the unreliable or incomplete nature of the data have been noted and accounted for.

The actuary should be fully aware of the scope of services being capitated under each type of contract and should know the proportion of the MCHP's membership associated with each arrangement, in order to interpret properly the available experience reports when using the reports for determining rates or liabilities.

Example—Consider an MCHP which began by paying physicians on a modified fee-for-service basis based on direct contracts with each physician. The MCHP later piloted a primary care capitation reimbursement model with a group of physicians which covered 20% of the MCHP's membership. It also contracted with a large multi-specialty group to provide all professional services for a fixed, per-member capitation rate. The multi-specialty group was responsible for payment of any professional services provided to its MCHP members by non-group physicians. Twenty-five percent of the MCHP's members had selected the multi-specialty group as their primary care provider.

In analyzing historical cost experience, the MCHP was not able to separate claim payments made on behalf of members covered under each type of reimbursement system. Claim reports were available for the entire MCHP which summarized the number of services, net payments, and dollars withheld by several types of professional services (e.g., office visits, inpatient visits, diagnostics laboratory, surgery, etc.).

The actuary should understand the scope of services covered by the primary capitation arrangement and recognize that claims summaries would not include the primary care services delivered to 45% of the MCHP's members. Further, the claims summaries on non-primary care professional services as defined in the multi-specialty group arrangement would include services to only 75% of the MCHP's membership. Hospital services and other services not covered by either arrangement would be included in the claim summaries for all of the MCHP's membership.

- 5.3.2 Change in Membership Mix—In cases where significantly different costs exist between the various health care delivery and reimbursement structures, including point-of-service products, the actuary should consider the likelihood of a change in the proportion of the MCHP’s membership being served by each structure between the experience period and the projected rating period based on the MCHP’s business plan for the next year, and the reasonableness of the business plan.

The actuary should recognize the impact on medical cost trends of the increase in the proportion of the MCHP’s membership which would be associated with the higher cost delivery system when determining rates or liabilities. The actuary may also want to discuss a more complex rating structure with management which would attempt to recognize on a group-specific basis the proportion of each employer group likely to be selecting each of the delivery systems.

Example—Consider an MCHP which started out its operation by building its own clinics to serve its membership. As the MCHP matured, it desired to expand to adjacent service areas by contracting with established physicians in private practice on a modified fee-for service basis in order to allow for faster expansion with less initial capital investment. While historically the membership associated with the fee-for-service delivery system had been insignificant, half of the MCHP’s growth for the upcoming year was expected to come from the newly serviced area. It also appeared likely that the new fee-for-service system would cost 15% more than the more closely managed staff-model system.

- 5.4 Capitation Paid to a Provider—When providing an opinion regarding the appropriateness of a capitation paid to a provider, the actuary should specify all information which would be considered relevant in a premium rate opinion.
- 5.5 Health Care Budget—The MCHP may be using a formal budgeting process to establish both its performance targets and its financial projections for the next fiscal year. The actuary should be aware of and play a role in creating the major assumptions used in constructing the budget, particularly the assumptions involved in medical cost and utilization. The actuary should also exercise care in the use of such budget information, since it may incorporate unrealistic targets set by the plan’s management, and it may also be difficult to explain rate filings which differ in their assumptions from those used in such a budget.

Section 6. Communications and Disclosures

- 6.1 Statements of Opinion—The actuary should include in all MCHP claim liability and rate opinions a statement disclosing the actuary’s knowledge of all risk sharing contracts between the MCHP and providers, as described in subsection 5.1.
- 6.2 Other Health Standards Apply—Actuaries practicing in the area of MCHPs and other prepaid plans should be aware that, to the extent not superseded by this standard, Actuarial Standard of Practice No. 5, *Incurred Health Claim Liabilities*, and Actuarial Standard of Practice No. 8, *Regulatory Filings for Rates and Financial Projections for Health Plans*, apply to the actuary’s practice.
- 6.3 Deviation from Standard—An actuary who uses a procedure which differs from this standard should include, in the actuarial communication disclosing the result of the procedure, an appropriate and explicit statement with respect to the nature, rationale, and effect of such use.
- 6.4 Other Disclosures—Other disclosures specified in this standard are described in subsections 5.1.4 (Financial Condition of Capitated Providers) and 5.1.7 (Covered Liabilities).