



## What do Population Health Management, Captives and Reinsurance Have in Common?

One of the areas in the Affordable Care Act (ACA) with strong possibilities of “bending the cost curve” is the creation of the Accountable Care Organization (ACO). ACOs can place providers at risk in an integrated delivery system designed to transform the financing mechanism from volume-based to value-based financial incentives and reimbursements. Examples of financing changes from traditional fee for service medicine are bundled payment initiatives, patient-centered medical homes, Medicare shared savings programs and ACOs.

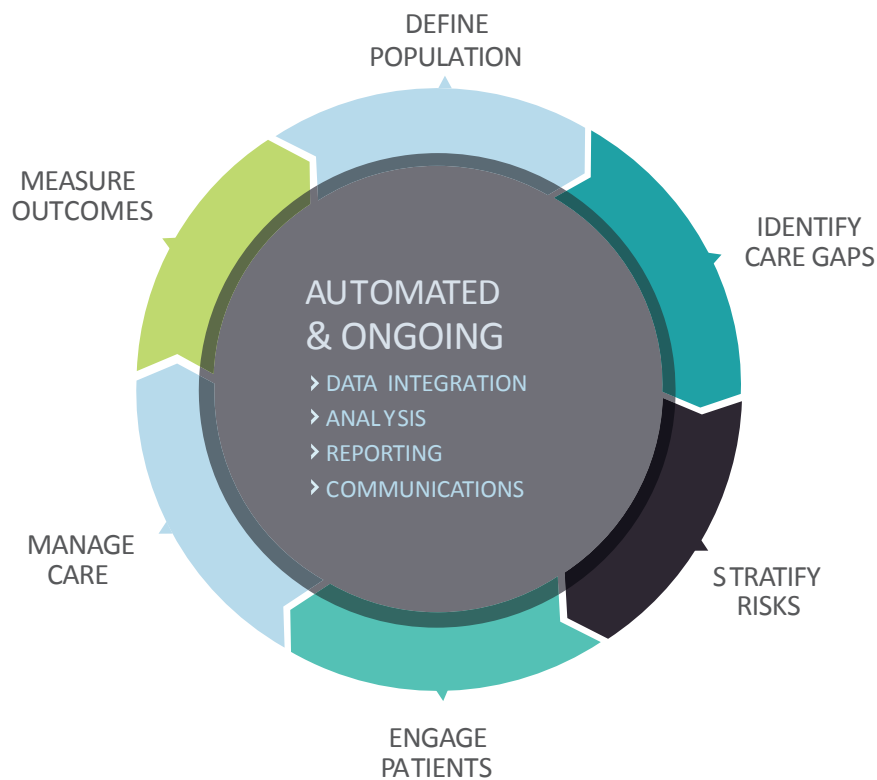
If an ACO is responsible for managing care for a given population, it must manage that risk. The primary means to do this in the ACO model is through population health management. This article discusses the positive risk management consequences of population health management to a provider entity directly responsible for managing a given population. Also touched on are the potential advantages of a partnership with a professional reinsurer capable of accepting and managing catastrophic medical excess of loss risk exposures which occur in that population. The ACO model will be successful if it manages the population’s health at the primary level and protects itself against catastrophic exposures through reinsurance coverage and managed care services at the catastrophic level.

The simple goal of population health management is to keep patients

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as healthy as possible and minimize the need for expensive intervention. It accomplishes this by implementing disease management programs for the highest risk and sickest patients, but also by employing wellness programs so others remain healthy.

## The Population Health Management Continuum



Source: Institute for Health Technology Transformation

### The Continuum of Care

Successful population health management relies upon the execution of six critical steps (see diagram: The Population Health Management Continuum):

1. Define the population – the ACO must understand the population for which it is responsible for delivering the full complement of medical care.
2. Identify the care gaps – the ACO must assess the current health status of the defined risk population and determine what health care needs are unmet.
3. Stratify the risks – the ACO must determine which patients are most likely to become sick and incur major medical costs and place the population in various subgroups to target medical services for specific health issues and conditions. Health surveys and predictive modeling are two tools to accomplish this objective.
4. Engage the patients – the ACO must engage patients to be their own advocates through various preventive, chronic and catastrophic health care management programs designed to monitor and maintain member compliance with all protocols and practices necessary to achieve high quality, cost-effective healthcare outcomes. When members assume joint responsibility for scheduling appointments, understanding treatment options and potential results, they become better healthcare consumers and better

patients. They also assume responsibility for reviewing health and wellness materials and maintaining the accuracy of their own personal health record. Various sub-populations will require different disease management programs. All sub-populations will benefit from wellness and preventive care.

5. Manage the care – the ACO must focus on evidence-based protocols and practices when it employs preventive, chronic and catastrophic case management programs specifically targeted to the various sub-populations identified.

6. Measure the outcomes – the ACO can't manage it if it doesn't measure it! The ACO must focus on quality and evidence-based outcome protocols and determine areas of success and areas of needed improvement.

Because the distribution of health risks changes continually, this population health management process must be continuously employed. If effective, the ACO will then be a healthcare financing and delivery model which successfully accomplishes the triple aim of healthcare reform: to improve the patient care experience, to improve the outcomes for health populations and to lower the per-capita cost of care.

### Catastrophic Claims Risk

With many health systems forming or acquiring their own health plans, assuming more risk from payers via ACO contracts and even directly contracting with employers in a narrow network strategy, protection from catastrophic medical claims becomes imperative. Although most health systems and ACOs are comfortable assuming risks for a given patient population, the vast majority still prefer risk protection for the catastrophic

claims such as traumas, transplants, premature births and hemophilia.

Health plans and health systems with an affiliated captive insurance company already have an effective risk management tool at hand. Although the existing captive may have been formed to cover malpractice or professional liability risk, it may have access to capital that would allow it to assume additional types of risk, such as provider excess of loss and/or employer stop loss risk. The captive as the final risk-bearing entity will need to develop the following skill set or contract with a strategic business partner to do so:

1. Identify risks the health system is assuming from payers via ACO risk contracts, employers via direct contracting, their own employee benefit plan or their own health plan.
2. Develop risk placement strategies for each.

3. Provide fronting services, if necessary, that allow ceding risk to the captive.
4. Price and administer stop loss coverage on all medical risks placed into the captive.
5. Provide medical case management support for catastrophic claims in network and out of network.

The following diagram outlines one such medical excess of loss reinsurance program involving ACO risk ceded to a captive.

### What Options Exist with Regard to the ACO Purchasing Provider Medical Excess of Loss Coverage?

1. Purchase “pass-through” coverage from the health plan providing the capitation.
2. Purchase provider excess of loss insurance from the

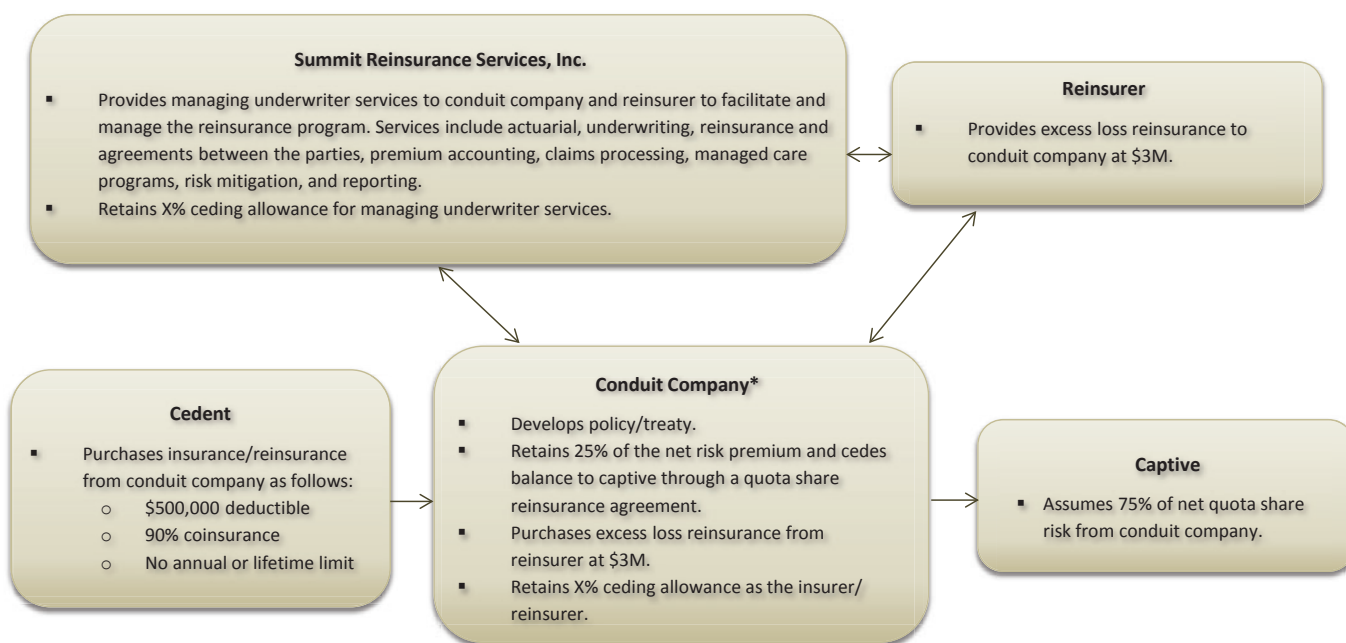
insurance marketplace if permitted by the health plan.

3. Purchase no protection and self-insure the exposure to catastrophic medical claims.

Excess of loss protection is usually purchased by the ACO to eliminate the exposure to catastrophic medical claims from any single member for which the ACO is at risk. Without this protection, the ACO is at risk of the medical claims exceeding the capitation premium by a substantial amount through outlier claims through no fault of the provider. In the new era of unlimited claim liability in most situations, this coverage is paramount.

It is common for a health plan that is capitating ACO providers to offer to retain the risk for claims incurred per member above a chosen dollar claim level. This is often called “pass-through” reinsurance coverage since the risk protection for catastrophic claims in the capitated population is passed through to the provider

## Medical Excess of Loss Conduit Reinsurance Program



\*Issues insurance policy to cedent for provider medical excess or HMO/health plan reinsurance treaty for HMO/health plan medical excess. In some situations the reinsurer also acts as the conduit company.



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from the health plan providing the capitation. In this way, the providers are incented to arrange for all medical care per member, but to not worry about random and unpredictable catastrophic claims, both in network and out of network.


It is important to understand if the ACO is at risk from one or more payers. This will affect its decision-making on how provider excess of loss insurance is purchased. If a provider entity is receiving capitation from a single source (government or commercial payer), that capitation source may be best able to offer protection against catastrophic losses. Any such protection from the capitation source does not normally provide coverage against catastrophic exposures to individuals other than for members capitated by that one entity.

Potential benefits of buying medical excess of loss as “pass-through” from



the health plan include a competitive premium with reduced expenses and profit charges, simplicity of premium and claim payments, ease of implementation and ongoing management, compliance with “PIP” regulations, transparency in rate and education on coverage options.

The provider can accept global risk (for all claims) or risk for any specific set of medical services that are expressed in the capitation agreement. The capitation



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agreement will usually have a section which outlines the Division of Financial Responsibility (DOFR) between the payer and the provider ACO.

Physician Incentive Plans (PIP) that place the physician groups at substantial financial risk are regulated by CMS regulations. The health plan and delegated provider ACO must comply with these regulations and limit the exposure to individual claims to specific levels as shown in the following PIP table:

<b>Panel Size</b>	<b>Single Combined Limit</b>	<b>Separate Combined Limit</b>	<b>Separate Professional Limit</b>
1-1000	\$6,000	\$10,000	\$3,000
1,001-5000	\$30,000	\$40,000	\$10,000
5,001-8,000	\$40,000	\$60,000	\$15,000
8,001-10,000	\$75,000	\$100,000	\$20,000
10,001-25,000	\$150,000	\$200,000	\$25,000
>25,000	None	None	None

The panel size can take into account the total at-risk membership (Commercial, Medicaid and Medicare) the ACO provider may have from other payers. There is varied compliance with these PIP regulations which have not been changed for institutions since their inception (e.g. imposing an aggregating specific deductible for the entire member population in addition to the per member deductible is perhaps subverting the prescribed PIP coverage requirements). New PIP guidelines may be forthcoming from the Centers for Medicare and Medicaid Services (CMS) later in 2016.

## Medical Management Support

One of the services also potentially offered the ACO provider in such a catastrophic claim reinsurance arrangement is additional managed care claim management resources. These can be categorized as follows:

1. Care management – interface with health plan case managers to provide case-specific research and consultation, including validation of diagnosis and disease progression, evidence-based treatment options, outcomes research and access to clinical expertise.
2. Comprehensive medical management evaluation – full scale evaluation of utilization management, case management and disease management programs and processes, procedures and benchmarks for the ACO. This includes analysis of communications and workflows between utilization management, disease management and case management departments and how they might improve. Benchmark comparisons are made to standard (e.g. Milliman) care guidelines.
3. Cost management – additional support for complex bill analysis, provider contract analysis and negotiation of in-network and out of network claims including national PPO access and pharmacy benefit management programs.

In conclusion, as ACO arrangements multiply, effective risk management strategies and tools exist to protect and support the ACO in its mission. ■

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