
# Navigating "Downstream Risk" Arrangements

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Despite a segment of the industry that remains skeptical,[1] the number of fully functioning clinically integrated networks (CINs) and accountable care organizations (ACOs) in the United States has continued to grow even in the face of Affordable Care Act (ACA) "repeal and replace" efforts. Multiple factors are motivating this growth.

First, networks remain a powerful tool to align the interests of both independent and employed physicians. At least some of the exodus from private practice to employment by health systems has been caused by declining fee-for-service (FFS) income with limited access to other sources of income. By accepting some or all of the insurance risk for their patients, providers will have a more dependable way to maintain autonomy and professional integrity.

Second, well-run networks have demonstrated that they have the ability to improve the efficiency and quality of health care delivery and "monetize" the value they have created. Providers need a means to access the "bottom line" created by the more efficient use of health care resources as they see their incomes decline due to the FFS system giving way to value-based payments (VBP). Unless providers adapt to this changing payment environment, they will be unable to offset the costs of functioning in a VBP environment.

Third, without network participation, it remains difficult to enter into VBP arrangements with payers.

And finally, network participation provides some degree of protection from four key regulatory concerns: the Stark Law, the federal Anti-Kickback Statute, tax-exempt status, and antitrust law. In an effort to grant ACOs more latitude to achieve their intended objectives of delivering higher quality care at lower costs, federal agencies have designed a series of self-implementing waivers for the application of these laws in certain scenarios.

## Fundamentals of Risk Sharing

Risk transfer is a routine way for insurers to share or spread the risk they assume with others. Downstream risk is the transfer of a payer's responsibility to provide or pay for certain health care services to another entity, oftentimes a provider, which is similar to a subcontractor relationship.[2] In this scenario, the licensed payer acts as an upstream intermediary between the provider and the insured.[3] As a result, the downstream provider bears the risk of paying the cost of services that exceeds the fixed sum or capitation received from the payer.[4]

Downstream risk arrangements between health plans and providers first gained public attention in the 1980s and 1990s when health maintenance organizations (HMOs) and other managed care organizations began contracting with provider groups using a variety of risk-sharing mechanisms. Many such arrangements proved to be financially unsound because the providers entering those contracts were not prepared to assume the inherent risks. Operating without today's health care information technology nor having adequate solvency to assume any risk, full capitation and other global arrangements at the time were prone to failure.[5]

In 1995, the Health Plan Accountability Working Group of the National Association of Insurance Commissioners (NAIC) issued a memorandum to state regulators affirming that, if a provider organization accepts risk on a prepaid basis, it has entered the business of insurance and needs to comply with state insurance laws.[6] The NAIC considered advising states to regulate risk-bearing provider organizations universally, but that approach was rejected in favor of recommending the adoption of risk-based capital requirements that covered provider-sponsored organizations as well as other managed care plans like HMOs, and ultimately relieving risk-bearing provider organizations of regulatory burdens.[7]

In its 1995 memo, the NAIC did recognize an exception to its general recommendation: for provider organizations only contracting with one or more duly licensed health insurers for the provision of care to the insurer's enrollees. In those cases, the NAIC recommended that the health insurer remain "ultimately responsible" in the event the provider organization became insolvent or otherwise failed to perform under its contract with the health plan. This position has been adopted by a number of states.[8] The NAIC also distinguished traditional payment mechanisms that do not constitute the business of insurance, such as FFS payments, discounted fees, cost-plus reimbursement, and Diagnosis Related Group (DRG) payments.

In the ACA-era, downstream risk arrangements have regained importance.[9] Since payers must now use 85% (80% in small group contracts) of premiums collected to pay claims (known as the "medical loss ratio" or MLR), health plans have less economic incentive to serve as the underwriters of the claims risk under a policy.[10] By transferring some or all of the MLR to downstream providers, insurers can insulate themselves from losses and attempt to manage the non-MLR portion of the premium more profitably. What some industry observors have called "health insurance arbitrage" now places provider organizations like CINs and ACOs closer to the premium dollar. If a risk-bearing network can in fact do a better job of managing health care costs than an unorganized delivery system underwritten by a health plan, providers now have a way to "monetize" their investment in population health more directly than through any alternative payment arrangement.

## Providers and the Acceptance of Risk

Providers have been accepting some degree of payment risk since Medicare moved away from cost-based reimbursement in the 1980s. Not all of this risk is the same. Some VBP arrangements involve little to no true risk, such as shared savings with no downside risk,[11] CMS' comprehensive primary care initiative (CPC+), and many forms of pay-for-performance.[12] Other forms of VBP involve only limited risk, such as bundled payments,[13] shared savings with downside risk, and shared risk outside a pre-determined budget. Only capitation[14] and percent of premium arrangements place providers at true risk.

All compensation arrangements between payers and providers, other than those that are purely cost-based, shift some risk from payer to the provider; however, this is generally not the subject of state regulation. The best example is when a provider intentionally prices its services below the cost of delivering care to gain market share or achieve some charitable or public health objective. In contrast, when a payer (either a licensed insurer or self-insured payer) transfers insurance risk—the financial responsibility for a future loss based upon actuarial projections—there can be significant regulatory implications.

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## Assumption of Risk

As providers become more financially accountable for the quality and cost of care furnished to their patients, it is important to determine whether the assumption of risk associated with this accountability subjects providers to state insurance laws. If an ACO or CIN assumes "insurance risk," it may unwittingly fall within the purview of state insurance laws and be required to obtain a state insurance license and comply with the state's insurance laws and regulations. It is critical to carefully analyze state-specific laws to determine if the assumption of risk by an ACO or CIN implicates a state's insurance laws. Failure to

comply with such laws can result in significant monetary penalties, administrative fines, fraud or misrepresentation charges, and/or denial of future health insurer applications.

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Whether a provider assuming patient care risk becomes subject to state insurance law depends on: (1) how the provider is compensated for the services; (2) the nature of the risk being assumed; and (3) the nature of the party with whom the provider is contracting. The more downstream risk is associated with the payment of claims for services the provider does not have the ability to furnish, the more likely the ACO will be subject to state insurance laws.

Not only does the nature of the risk and overall structure of the arrangement need to be analyzed, but the laws, publications, and bulletins of the applicable state insurance authority also must be scrutinized to determine whether the activities of the provider network have implicated these rules. Some states have legislation specifically addressing ACOs or similar types of providers that assume risk.[15] Many states, however, do not have any laws addressing this issue. These states issue other forms of guidance on this subject, often in the form of agency bulletins.[16] Other states are unclear as to what state certifications are needed by an ACO that assumes insurance risk;[17] in these states, it is important to contact the state agencies directly for additional guidance.

If an ACO is not required to be a licensed insurer under state law, the ACO and its counsel still must be mindful of other state laws. For example, a majority of states have enacted some version of the NAIC's Third Party Administrator Law, which generally requires any person or entity that acts as an "administrator" or "third-party administrator" to obtain a certificate of authority from the state insurance commissioner.[18]

Risk-bearing entities should only take on the risk they can manage. Different patient populations will have inherently different costs. A critical aspect of understanding and managing risk is understanding the patients attributed to the ACO and the methodology used for attribution. Attribution can be handled in several ways. Organizations can be provided with a list of attributed members at the beginning of a performance year (i.e., prospective), at the end of the year based on patients' use of care during the actual performance year (i.e., performance year), or a preliminary prospective assignment methodology with a final retrospective reconciliation (i.e., hybrid).

Once an ACO fully understands its attributed patient population, it can then begin managing the health care of its population to achieve better outcomes and generate a return on the improved care. Applying risk stratification to the patient population based upon the patients' needs and then delivering the appropriate amount of care is the key step to unlocking value for all ACOs.

## Financial Obligations of an ACO

If a provider network determines it is subject to state insurance laws, it likely will be required to obtain licensure or certification. State laws that govern these types of licenses or certificates often impose financial solvency and additional capital reserve requirements that may be more burdensome for the typical provider network.[19] State insurance regulators' primary focus is to protect the consumers from the insurer's insolvency and from incentives to deliver inadequate care. As such, the state insurance requirements likely subject a provider network to administrative and financial requirements that cannot be shouldered without a capital partner, such as an insurance company. These additional requirements may include: improved IT security, additional administrative and clinical staff, and/or yearly filings that require specific computations for determining policy and loss reserves. A provider network required to obtain additional capital to comply with state insurance reserve laws would need to conduct an analysis of the laws impacting the raising of capital.

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## What Providers and Their Counsel Need to Know Before Engaging in Risk Contracting

Providers and their counsel need to consider the following prior to entering into a risk-based contract.

First, the providers need to know what they will be responsible for. Whether through capitation, percent of premium, or other risk-sharing mechanism, the provider needs to know what risk will fall on them as opposed to the ultimate payer.

Second, providers must fully understand the elements of the MLR. This could include: carve-outs for certain expenses (e.g., certain specialty services, prescription drugs); cost of quality of care programs; individual physician incentive payments; pharmacy rebates; incurred but not reported claims (IBNR); and stop-loss and reinsurance.

Third, providers must know if the risk-based payment is adequate to support the infrastructure costs of this type of arrangement including claims administration, IT, and accounting personnel.

Finally, since most CINs and ACOs were not initially structured to accept risk contracts, providers must know what organizational and strategic changes are required to take on downstream risk, and counsel should carefully draft the contractual agreement to reflect such changes. Things to consider when drafting the contractual agreement include: state and federal regulations; ownership and governance; management and staffing; data sharing; regulatory reserve requirements; and cost of new or improved IT systems.

With the assistance of counsel, as well as financial and IT consultants, provider networks can position themselves to enter into sustainable downstream risk arrangements and keep the benefits of VBP for their participating providers and their patients.

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## Endnotes

1 *See* D. Butts, Jr. & V. Gursahaney, *Turning Skeptics Into Believers: Why ACOs/CINs Are Still a Good Idea*, Becker's Hosp. Rev. (Oct. 3, 2014).
2 Douglas J. Witten, *Regulation of "Downstream" and Direct Risk Contracting by Health Care Providers: The Quest for Consumer Protection and a Level Playing Field*, 23 Am. J.L. & Med. 449, 455 (1997).
3 *Id.* at 464.
4 G. Benjamin, *Managed Care and Downstream Risk: Placing the Provider and the Patient At-Risk*, Physician Executive (May-June 2000).
5 *See* M. Glabman, *Downstream Without a Paddle*, Managed Care (Dec. 2000).
6 NAIC Health Plan Accountability Working Group, Memorandum and Model Bulletin to Insurance Commissioners, Aug. 10, 1995.
7 NAIC Risk-Based Capital for Health Organizations Model Act (2009). It is important to note that, although influential, NAIC is not a legislative body and each state is free to accept or reject its recommendations.
8 *See, e.g.,* Colorado Division of Insurance, Bulletin No. B-2.3 (listed in the index as B-2.03) (May 8, 2007) [hereinafter, Colorado Bulletin]; Oregon Department of Consumer and Business Services, Insurance division, Bulletin Insurance 96-2 (Apr. 1996) [hereinafter, Oregon Bulletin].
9 *See generally* T. Bartum, ACOs and State Insurance Laws, ch. 12, *The ACO Handbook: A Guide to Accountable Care Organizations* (Am. Health Lawyers Ass'n 2015).
10 45 C.F.R. § 158.210.
11 A shared savings program (the most common today being the Medicare Shared Savings Program (MSSP)) aims to encourage coordination and cooperation among providers to improve the quality of care for beneficiaries and reduce unnecessary costs. A shared savings program rewards an ACO that lowers their growth in health care costs while meeting

performance standards on quality of care. A shared savings program does not incur downside risk if the structure is set up so that the provider only participates in the savings and not the losses associated with the program. Section 1 of the MSSP program, for example, allows an ACO to participate without subjecting themselves to downside risk; however, they may only share in up to 50% of the savings. *See* American College of Physicians, Detailed Summary—Medicare Shared Savings/Accountable Care Organization (ACO) Program (Nov. 15, 2011).

12 This is considered a non-risk reimbursement payment method because the health care provider is not subjected to downstream risk if the performance goals are not met; rather, they are only rewarded for high-quality performance. *See generally* CMS CPC+ Payment Methodologies (Feb. 2017), *available at* https://innovation.cms.gov/Files/x/cpcplus-methodology.pdf.

13 The risk is considered "limited" because a typical bundled payment reimbursement plan assumes more risk than a simple pay per service structure; however, it is not as susceptible to risk as a "lump sum" payment structure.

14 The providers in a capitation payment model are exposing themselves to downside risk should the cost of care exceed the predetermined amount per patient; thus, the provider is exposed to full downside risk in this structure.

15 **Colorado**: Colorado law allows providers to conduct business collaboratively in provider networks, such as an ACO. The law further states that if the ACO is engaged in the business of insurance then the ACO must have a certificate of authority from the Colorado Division of Insurance. The law states that even a capitated payment structure does not automatically make an ACO an insurance carrier, but rather the commissioner of insurance must evaluate the standards to be used when determining what qualifies an ACO as an insurer. *See* Colo. Rev. Stat. § 6-18-302. The Colorado Division of Insurance published a bulletin which clarifies what activity rises to the level of insurance carrier. *See* Colorado Bulletin, *supra* note 8.
**Texas**: Texas law provides that an entity that arranges for or provides to enrollees on a prepaid basis a health care plan, a limited health care service plan, or a single health care service plan is an HMO. Therefore, any ACO that provides services based on a prepaid structure is considered an HMO. *See* Tex. Ins. Code. Ann. § 843.002. Per the statute, all HMOs must obtain a certificate of authority to conduct business. Tex. Ins. Code Ann. § 843.071.
**New York**: New York has statutes that discuss ACOs and say they may enter into reimbursement payment arrangements that incur risk, such as full or partial capitation, as well as other payment methodologies (subject to regulations issued by the Commissioner of Health). *See* N.Y. Pub. Health Law, art. 29-E, § 2999-q(6)(a). However, the law is silent as to under what circumstances an ACO needs to register as an insurer and thus state insurance law should be reviewed as well in this instance.

16 **Colorado**: Even though Colorado has laws that pertain to provider networks, they still have previously issued bulletins to clarify the state's position. In 2007 the Colorado Division of Insurance issued a bulletin that stated "[t]he transfer of risk for consideration, such as capitated contracts for the provision of health care services, constitutes the transaction of insurance business and subjects the entity assuming the risk to relevant insurance regulatory requirements." *See* Colorado Bulletin, *supra* note 8.
**Oregon**: Oregon's Insurance Commissioner issued a bulletin concluding that a "capitation, fixed or 'global' payment, or any similar arrangement" between a health care provider and a purchaser of health care services constitutes an insurance transaction. *See* Oregon Bulletin, *supra* note 8.

17 For example, in **Michigan** the Office of Financial Regulations (OFIR) is the state agency that regulates Michigan's insurance companies. If an ACO is considered a "health plan," then they would be required to obtain certification as an insurance entity. *See* Mich. Comp. Laws § 500.7001–7004. It is unclear based on the definition of "health plan" whether a provider network would qualify as a health plan, and Michigan has yet to pass additional legislation aimed directly at governing ACOs. Accordingly, it is unclear whether or when a provider network would be required to obtain appropriate licensure and the OFIR should be contacted on a case-by-case basis to ensure proper compliance.

18 **Tennessee**: Tennessee law provides that "[n]o person shall act as, or hold out to be, an administrator in this state, other than an adjuster licensed in this state for the kinds of business for which the person is acting as an adjuster, unless the person holds a license as an administrator issued by the commissioner." Tenn. Code. Ann. § 56-6-410(a) (2011).

19 **Georgia**: In Georgia, a provider must be licensed as a "provider-sponsored" health care corporation to accept full risk, which comes with a $1 million solvency requirement. *See* Ga. Code Ann. §§ 33-20-3 and 33-20-13 (2016).
**Kentucky**: Kentucky requires provider networks that accept insurance risk to be licensed as Provider Sponsor Integrated Health Delivery Network, which requires initial capitalization of $1.5 million dollars. *See* Ky. Rev. Stat. § 304.17(A)-310.