ISSUE ANALYSIS 97-1

ASSESSING MANAGED CARE CONTRACTING RISK

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This is the second Issue Analysis of the Healthcare Financial Management Association's Principles and Practices (P&P) Board. An Issue Analysis is written in response to the need for practical information on emerging issues in healthcare financial management. In order to expedite information to the industry, the P&P Board will prepare an Issue Analysis. An Issue Analysis is factual but not authoritative. It is not set out for public comment and provides the healthcare industry short-term assistance on emerging issues. Issue Analysis 97-1, Assessing Managed Care Contracting Risk, is an introduction to managed care concepts and terminology. The purpose of this P&P Board document is to provide guidance to healthcare financial managers entering into managed care risk contracts for the first time.

I. BACKGROUND

The healthcare industry is in an evolutionary period. Political consensus indicates that increases in healthcare costs can no longer sustain their current levels. Furthermore, reduced utilization of inpatient facilities and increased emphasis on ambulatory care is putting pressure on healthcare providers to change the way they deliver services. Providers, in turn, are striving to maintain market share and control costs through integration and managed care contracting. This evolution from independent healthcare providers in a fee-for-service environment to integrated delivery systems in a managed care environment creates the potential for significant financial risks to providers.

The transition to managed care and capitation, with its related assumption of high risk than traditionally required, has changed the nature of many healthcare providers from revenue centers to cost centers. Revenue for an integrated healthcare system is increasingly generated through the payment of a fixed amount per member per month (PMPM) for each covered life. Therefore, the focus is now on the provision of preventive healthcare services to ensure the future health of these covered lives while controlling the costs of care. The provision of inpatient services, professional care, outpatient services, and long-term care increases total costs to the system with providers at risk for the costs of care above PMPM amounts. Thus, while a fee-for-service environment encourages the use of referrals.

1. Terms defined in the glossary are set in boldface type the first time they appear.
and services, an unnecessary referral by a physician to another provider of care within a fully integrated healthcare system may be detrimental to the financial health of the healthcare system. (See Exhibit 1 for a comparison of the cost-volume profit models under the fee-for-service and capitation payment methodologies.)

II. PURPOSE

The P&P Board has prepared this document to help healthcare financial managers assess managed care contracting risks. It is intended to provide a basic understanding of managed care risk contracts from the provider's perspective; specifically, managed care plan structures and payment methods, necessary cost analysis, contract requirements, recording of related liabilities, and monitoring of contract performance. The document is intended for organizations that are not yet fully integrated but are presently going through this process.

III. TYPES OF MANAGED CARE PLANS

A. General Characteristics

Managed care can be defined as a system that integrates the financing and delivery of appropriate healthcare services to plan members by ensuring that services provided are necessary, efficiently delivered, and appropriately priced. A managed care plan can have a variety of structures and payment methods.

Managed care plans can be differentiated by several characteristics:

- The type of fee arrangements they have with participating providers to furnish a comprehensive set of healthcare services to members;
- Formal programs for ongoing quality assurance and utilization review;
- Financial incentives for plan members to use participating providers and procedures covered by the plan; and
- The size of participating provider panels.

The following is a description of specific managed care structures. It is important to note that as the managed care industry has matured, plan structures have borrowed characteristics from each other.

B. Preferred Provider Organization (PPO)

PPOs contract with independent healthcare providers (hereafter referred to as preferred providers), such as physicians, hospitals, home health agencies, and long-term care facilities, to provide services to plan members at negotiated rates. The salient feature of the PPO is that plan members are typically able to choose any provider, preferred or nonpreferred. However, they have financial incentives, such as reduced copayments or lower deductibles, to use preferred providers. Some PPOs enter into arrangements to spread the service risk to plan membership. Risk is typically spread by splitting in-network cost of care 90/10 percent between the PPO plan and the member. Out-of-network services usually involve a steeper cost-sharing arrangement, typically a 70/30 split.

Preferred providers agree to discount their customary fees in exchange for an opportunity to increase or retain their flow of patients. Discounts are based on the expected volume of business directed to the preferred provider and the effect of market competition. (See discussion of the secondary discount market, otherwise known as "silent PPOs," at section C.X.)

Payments to providers are made through traditional insurance or a self-funded plan. An insurer-sponsored plan combines a network of providers, utilization management programs, administrative services, and insurance. A self-funded PPO generally excludes administrative and insurance services. Employers may, however, purchase these services separately.

A self-insured employer may hire a third party administrator (TPA) to manage the healthcare benefits plan it has established. A TPA's responsibilities may include premium collection, claims processing and payment, and utilization review. TPA do not underwrite insurance risk; however, many insurance companies offer TPA services.

C. Exclusive Provider Organization (EPO)

An EPO expands the cost-management and volume-driving attributes of PPOs by providing services only if care is rendered by participating providers. This exclusive arrangement creates opportunities for larger discounts and tighter utilization controls. Typically, the panels of participating providers in an EPO are smaller than most PPOs. The small panel and the in-network requirement potentially lower member costs by steering a greater volume of business to the discounted provider network. EPOs are insurance products regulated by insurance laws while HMOs (see next section), because of the capitation payment methodology, are regulated by federal and state HMO laws.

D. Health Maintenance Organization (HMO)

HMOs provide medical and preventive healthcare services to plan members for a fixed, prepaid amount regardless of the amount of services actually used. Members must choose from the HMO's panel of participating providers. Generally, a primary care physician (PCP) serves as the gatekeeper for managing a member's medical treatment. HMOs either employ physicians directly or contract with physicians and physician groups for services. Although there are four common HMO models, as the industry has matured, these models have borrowed characteristics from each other, and mixed HMO models are now prevalent.

A key characteristic of HMOs is their physician arrangements. Staff model HMOs employ physicians and generally pay them salaries. Independent practice association (IPA) model HMOs contract with individual physicians in independent practice (or with associations of independent physicians) for a negotiated per capita rate, a flat retainer, or a negotiated fee per service. Group model HMOs contract with physicians who have organized as a partnership or corporation. Generally, the group negotiates a per capita rate, which it then distributes among its member physicians. Network HMOs contract with many physician groups, which are organized into single-specialty or multi-specialty group practices. The groups generally are paid a fixed monthly fee per plan member.

E. Point of Service Plan (POS)

POS plans combine PPO-like elements of choice and HMO-like cost management features. Plan members select a PCP who controls referrals to specialists. At the time members need healthcare services, however, they always have a choice about whether to receive medical services in- or out-of-network. This option has made POS plans particularly popular, and many managed care plans now offer some form of POS product. If a plan member receives care from an in-network provider, the member pays little or nothing out-of-pocket (as in an HMO). Care provided by out-of-plan providers is reimbursable, but plan members must pay significantly higher copayments and deductibles.

POS plans use a network of contracted, participating providers. Total costs of a POS plan are higher than in HMOs due to the out-of-network benefits, but are lower than in PPOs because the in-network care is being authorized and coordinated by a PCP.

F. Direct Contracting

Employers, in some cases, contract directly with healthcare providers in an effort to actively manage healthcare benefit programs and reduce costs. Under direct contracting arrangements, employers (or their TPA) negotiate prices, register beneficiaries, manage utilization programs, monitor quality, and pay providers' bills without the added administrative costs of an intermediary insurance company. Risk-taking providers, in this case, benefit by getting predictable volume, guaranteed cash flow from monthly per-capita payments, and control of professional practices, including responsibility for utilization review and quality assurance.

Providers should consider several issues prior to contracting directly with employers. First, state law may require a risk-assuming provider organization to obtain an insurance license. The question of whether an unlicensed provider organization should be allowed to accept capitation payments from a self-insured employer that is exempt from state regulation under the Employee Retirement Income Security Act of 1974 (ERISA) is currently being debated in many areas of the country, so careful review of state law is required. Second, the creditworthiness of the employer should be evaluated to ensure that the contract is financially viable. Third, providers should consider any health concerns unique to a particular employer (for example, susceptibility to back injury or exposure to asbestos) and their financial implications. Fourth, the provider organization must have the necessary infrastructure in place, such as claims management, claims processing capabilities, and utilization and quality review functions, to be successful.

IV. TYPES OF RISK CONTRACTS

A. General Considerations

Healthcare providers may contract with managed care plans for risk-based payment arrangements, including per discharge, per diem, per case, per capita, premium-sharing, and other types of arrangements. These may apply to inpatient services or outpatient services. Each of these payment terms results in a different level of risk (see Exhibit 2). Each contract must be reviewed to ensure that the provider understands which services are to be performed within the negotiated rate. Services should be contracted very specifically, by CPT code or ICD-9 code, for example. Any services excluded from the contract should be specifically stated (pre-admission testing and post-discharge services should be addressed, for example). This level of detail will minimize the risk to the provider for changes in technology and in practice patterns. The following examination of each payment arrangement highlights the various types of risks in managed care contracting. These risks include: cost, contract, volume (or utilization), and demographic (or intensity).

B. Per Diem and Discharge Contracts

In both a per diem and per discharge contract, cost risk arises from services to an individual. The risk is created by the potential for the provider to underestimate the patient's utilization of services. The higher the utilization of services the greater the risk that the cost of these services exceeds the payment rate negotiated for each treatment or each discharged plan member. Providers should consider changes in utilization patterns when entering into managed care contracts. Providers do not benefit from a decrease in average length of stay, for example, under a per diem contract, but do benefit from the decrease under a per discharge contract.

C. Case Contracts

In a per case contract, the cost risk from services to individuals is combined with contract risk because the provider accepts the risk for not only the cost of treatment under its control, but often for the cost of treatment by all other providers in the treatment process. Appropriately crafted contracts, which include risk-sharing and consistent incentives among all providers, are essential to avoid financial danger under per case contracts.

D. Capitation Contracts

Capitation contracts involve volume (or utilization) risk, cost risk, demographic (or intensity risk), and contract risk. Providers face volume utilization risk if poor selection of contracts, improper incentives, or poor quality and case management
protocols result in high service volumes. Cost is another risk and may more often be the result of poor pricing rather than unexpectedly high cost. Risk can be minimized with thorough actuarial evaluations and the purchase of stop-loss insurance or reinsurance. Demographic risk arises from the effects of gender, age, occupational requirements (for example, heavy lifting versus word processing), and other factors that create a demand for higher-intensity services than was anticipated when negotiating the contract. Regardless of the success in minimizing controllable volume risk and cost risk, failure to carefully structure contracts for services with other providers and to carefully monitor utilization and outcomes can result in poor financial performance under capitation.

E. Premium-Sharing Arrangements

Premium-sharing or percent-of-premium arrangements are risk-sharing arrangements in which the payer (that is, the entity holding the HMO license) and the provider negotiate a portion of the premium dollars to be allocated to the medical expenses of plan members and to the administrative expenses of the plan. Both the medical and administrative portions can be paid to the provider. Alternatively, the payer can administer the plan by paying claims out of a pool of dollars and performing a reconciliation of actual claims and the agreed-upon premium share on a periodic basis. The reconciliation determines whether there is a surplus or deficit of premium dollars in the plan for the year. The provider and the payer contractually agree to the disposition of the surplus or deficit.

Providers assume more risk in percent-of-premium arrangements than in the other arrangements discussed in this Issue Analysis because the reimbursement for medical expenses is limited to the allocated portion of premium dollars. Additional issues should be considered as a result of the increase in risk. The contract should allow the provider or delivery system to control the spectrum of medical services covered and utilized by the members of the plan. In addition, if the total premium amount is paid to the provider to administer the provider or delivery system should be able to control the price paid to any subcontractors that provide services. Knowledge of the benefits available to members, any variations in the benefit plan, Federal or state requirements on the appropriate level of care, and the ability to monitor these factors is also vital. The underwriting and eligibility practices of the payer are critical to the success of this type of arrangement, and the provider should be familiar with these practices and be prepared for the types of members who could be covered. The potential number of members covered under this arrangement should also be considered; if the member pool is small, a costly case is less likely to be offset with revenue from the rest of the members, even with stop-loss coverage.

F. Risk Pools

Risk pools, also known as withhold pools, are another type of risk-sharing arrangement. Risk pools can accompany any type of payment distribution method to providers. Physician hospital organizations (PHOs) often reimburse hospitals using a per diem payment with a withhold. Risk-sharing using withholds may be used between physicians and hospitals, among physicians only, or among all parties to the contract.

In a typical risk pool arrangement, a portion of the provider’s revenue is withheld and put into risk pools designated for primary, referral, and facility care. (An HMO, for example, will budget an annual amount for an inpatient services risk pool based on an estimate of hospital days per thousand members and a negotiated per diem rate. The HMO will then withhold 10 percent of this budgeted amount from the parties to the contract during the year.) Actual medical expenses for each type of care are tracked throughout the year. During a year-end reconciliation process, actual expenses are compared with the amount budgeted (amount paid to the providers during the year plus the withhold amount) and a surplus or deficit is calculated for each type of care. The surplus or deficit for each risk pool category is then shared with participating doctors, hospitals, and often the contracted health plan, based on predetermined conditions and formulas as outlined in the respective contract. Risk pools should be designed to reward the providers that have the ability to control costs through utilization management.

Parties to a managed care contract may also use risk pools to compensate providers for achieving patient satisfaction targets, quality indicators, and compliance with other contractual requirements. In this type of arrangement, a pool is created by stipulating that additional reimbursement will be paid to a provider that achieves certain quality improvement targets as defined in the contract. A risk-sharing program established by an HMO to incite an IPA to adopt quality improvements, for example, may contract to pay the IPA 3 percent of capitation for achieving a compliance ratio below 1.5 per 1000 members per year.

G. Risk Corridors

Risk corridors may be used in a risk-sharing arrangement to encourage participation in the contract. Risk corridors establish an upper and lower limit to the amount of reimbursement a provider can receive under a managed care contract. When establishing a capitation payment for physician services, for example, a PHO may contract to pay a basic per member per month (PMPM) payment to physicians that is adjusted for the number of members selecting the physician, demographics of covered members, specialty capitation and specialty referrals, and subject to a predetermined risk corridor. A lower corridor limits the risk of the physicians and a upper corridor limits the risk of the PHO.

A risk corridor limits the risk of the parties to the contract by providing a band around the reimbursement amount or an estimated cost target. In a simple arrangement, for example, a target reimbursement amount is predetermined. A band around the target amount is established; say, a threshold of 5 percent above the target amount and 5 percent below the target amount. At the end of the contract period, if actual costs fall below 5 percent of the target amount, the provider will receive an additional payment as reward for achieving cost savings. If, on the other hand, actual costs exceed the target amount, the provider will be contractually required to pay the plan.
V. ANALYZING CONTRACT COSTS

A. General

To understand the amount of risk assumed when contracting to provide healthcare services in a managed care plan, financial managers need to fully understand the costs of providing those services to plan members. Accepting a managed care plan's payment arrangement may cause a provider to incur costs for services that exceed reimbursements under the contract. Therefore, it is essential to evaluate the cost of contracted services before entering into risk contracts. This section discusses the common methods for analyzing contract costs.

Cost analysis begins by identifying the variability of the cost in relation to volume of service. Costs can be variable, semivariable, fixed, or semifixed. Financial managers must also determine whether the cost is directly traceable to a given service. Two methods, which incorporate the variability and traceability of costs, are used for contract analyses: fully allocated costing and marginal costing.

The choice of a costing method depends on several factors, including the competitive environment in which the provider is operating, the size of the contract, and the financial condition of the provider.

B. Fully Allocated Costs

Fully allocated costs include the fixed, variable, direct, and allocable indirect costs of providing services. Using fully allocated costs to price risk contracts should be the baseline when volume is determined to be fixed over the long run. Using fully allocated costs will allow provider risk-takers to minimize the risk of loss contracts.

The total cost outlay to the contracting provider during the premium period includes a number of different factors related to specific activities and settings (see Exhibit 3), and each activity and setting must control costs. The risk-taker must understand and manage the cost/benefit tradeoff between those levels.

C. Marginal Costs

Marginal costs are defined as the change in costs associated with a change in volume over time. Thus, costs that are fixed will not be considered under this approach. The provider can actually determine whether to treat a cost as fixed or marginal based on how the service is provided (see example below).

Marginal costs should be used as a base for pricing only when business is truly incremental over the long run. If business is not incremental, some portion of fixed cost will have to be considered to protect the financial integrity of the organization. Understanding marginal cost can influence operational decisions such as the hiring of a specialist physician versus subcapititating the services of a specialist physician. In this example, the hiring of a specialist is a fixed cost in the short run (that is, the provider must pay the specialist's salary regardless of volume). However, if the provider subcapititates, that would result in a variable cost in the short and long run because the subcapitated specialist may be paid a set PMPM rate based on volume. In this case, when volume increases, payments to subcontractors also increase.

D. Other Considerations

Both marginal and fully allocated costing are valid methods for evaluating contracts, but used alone, each has its drawbacks. A properly determined marginal cost may not be sufficient because even if all contracts are "marginally profitable," a risk-taker may inure a loss because fixed costs may not be recovered. Further, generally accepted accounting principles currently require contract losses, determined by the fully allocated costing method, to be accrued in the financial statements (see section IX.). Using the fully allocated costing method alone may cause the provider to reject a contract and lose an opportunity to increase its number of covered lives.

Because providers are accepting partial or complete financial risk for providing healthcare services to plan members, financial managers also must ensure that sufficient cash reserves are maintained to cover normal fluctuations in cash outflows due to random incidence of services required by covered members. Financial managers should also plan for the additional up-front administrative costs that may be incurred because of the contract (the provider's utilization review costs may, for example, increase significantly if the health plan has stringent utilization requirements).

Providers new to managed care contracting should consider negotiating contracts of one year in length until they have gained experience in determining contract costs. Financial managers must also negotiate contracts that budget a surplus in order to meet future capital needs and ensure continued operations.

VI. ROLE OF THE PHYSICIAN

Another factor in the cost analysis of a managed care contract is the practice patterns of physicians. In managed care plans, they are a critical factor affecting quality and costs. The quality and cost of care will be positively impacted by PCPs who are adept at managing patient care services (that is, knowledgeable about when to handle member cases themselves rather than referring to specialists and vice versa).

Providing timely and accurate feedback to physicians will help them understand how their practice patterns affect costs. Performance data will allow physicians to monitor their activities and compare themselves to best demonstrated national practices, as well as the performance of their peers. The data should contain enough detail to allow the physicians to differentiate clinical decisions.

Risk-taking providers will want to discuss some of the implications of their managed care contracts with their medical staff. Educating physicians about specific contracts and managed care principles relevant to their specialties will help physicians practice high quality, cost-effective medicine.
Medical case management (MCM) is critical in managing the risk-taking provider’s relationship with its physicians. The MCM staff is the liaison among the patient, his or her family, the physician, and the health plan. Many times these parties conflict. Therefore, it is essential that the MCM staff be seasoned, competent, and equipped with strong negotiating skills. If, for example, a health plan denies an admission, a member of the MCM staff must work with the patient and the physician to decide the next action.

Finally, physician incentive programs may be used to influence practice patterns. For example, the health plan could pay physicians a bonus for achieving certain quality indicators such as providing defined levels of immunizations or attending managed care seminars and training programs. In addition, the establishment of benchmarking and patient satisfaction targets may be used to incite physicians by providing an opportunity to earn additional compensation and gain professional recognition. The public has raised concerns about incentive arrangements that may deter physicians from providing patients with necessary care. Financial managers should, therefore, take care to ensure that incentive plans comply with Federal and state guidelines.

VII. CONTRACT ANALYSIS

A. Requirements

To quantify risk and set rates, contracting entities must have:

1. Actuarial capabilities to project the costs of the services to be provided and adjust these costs based on different risk factors, such as patient benefits covered, demographic mix, and selection.

2. Plan member demographics information, including age, gender, occupation, and family size of the population to be served.

3. Revenue stream data, including rates, number of plan members, length of contract, and copayments.

4. Benefits available to plan members. Obtain a copy of the basic plan offered to plan members and any variations to this plan, such as copay differences and limitations or expansions of certain benefits.

5. A definitive list of services to be provided by the risk-taking entity. Establish which services within the benefit package will be provided by the risk-taking entity and which will not. Note that an entity may be capable of providing services but still agree to exclude them from the contract.

6. Services to be obtained from outside sources. An entity should determine whether it can provide the services or whether it should subcontract with outside providers. If the entity decides to subcontract services, the terms of the subcontract should be obtained.

7. Marginal or fully allocated costs of services to be offered (see section V).


9. Reinsurance and stop-loss thresholds and related costs (see section VIII).

10. Utilization review processes and case management functions.

11. Outcomes monitoring capabilities.

12. Current cost experience of the plan members, if available. The best way to estimate costs is to obtain the past claims history of plan members.

See Exhibit 3 for a list of cost components for determining capitation risk.

B. Other Considerations

It is important to remember that in subcontracting arrangements, risk is not necessarily transferred to a subcontractor, as the risk-taker is ultimately responsible for providing contracted services. For that reason, it is important to carefully screen those parties involved as subcontractors. Risk can be passed to subcontractors, but this must be negotiated and clearly stated in subcontracts.

Financial managers should also be aware that there has been growing managed care activity in both the Medicare and Medicaid programs in the last few years. Managed care plans are committed to increasing their penetration of these markets as a means of achieving greater market share. The Medicare and Medicaid populations are often very different from those served by commercial payers; therefore, financial managers should give careful consideration to the demographics of these populations when evaluating Medicare and Medicaid risk contracts. In addition, the benefits covered by the Medicare and Medicaid programs may vary significantly from those covered by commercial plans. Providers should have the administrative abilities (for example, contract management systems) to differentiate between program benefits prior to entering into Medicare and Medicaid risk contracts.

VIII. STOP-LOSS INSURANCE

Most prepaid healthcare providers transfer some financial risk to insurance companies through stop-loss insurance. The threshold for stop-loss insurance is usually expressed as an amount per member per year. Stop-loss insurance can be purchased in many forms, including per diem or per case limits and annual medical cost limits at varying thresholds, depending on the level of risk the prepaid healthcare provider is willing to accept. See Exhibit 4 for a sample quote on medical services with PMPM rates at varying stop-loss levels.

Decisions on the type of stop-loss insurance required should be based on population demographics and historical trends. The threshold is typically determined with the help of an outside actuary. The level of the threshold depends on how much risk
the provider is willing to assume. To calculate the threshold, first project the medical costs of an anticipated number of claims over a particular threshold, such as $10,000. Then project the additional medical costs of an amount of claims over a higher threshold, such as $50,000. To decide how much insurance to purchase, compare the additional medical costs at the higher threshold to the additional cost of the stop-loss premiums at the higher threshold. These calculations should be performed using several years of cost data, such as five years, to be accurate.

IX. ACCOUNTING CONSIDERATIONS

A. General

Accounting guidance related to risk contracting is available through Chapter 13 of the AICPA Audit and Accounting Guide, Health Care Organizations (the guide); FASB Statement No. 5, Accounting for Contingencies, and P&I Board Statement No. 11, Accounting and Reporting by Institutional Healthcare Providers for Risk Contracts. The most recent of this guidance, the guide, was released in June 1996. Financial managers should also be aware that the AICPA is developing a statement of position (SOP) entitled Accounting for Certain Predetermined Health Care Arrangements. This proposed SOP will specifically address the accounting issues surrounding contractual arrangements that administer or transfer the risk for the cost of healthcare services for a predetermined payment, regardless of services rendered.

B. Accounting for Loss Contracts

According to the guide, a loss must be recognized when it is probable that the cost of providing future healthcare services (including maintenance costs) is greater than the total premiums (including anticipated future premiums and stop-loss insurance recoveries) for the balance of the contract period. “The estimated future health care costs and maintenance costs to be considered in determining whether a loss has been incurred should include fixed and variable, direct, and allocable indirect costs,” states the guide [paragraph 13.06]. For purposes of this evaluation, all contracts should be grouped in a manner consistent with the method used to establish premium rates. The guide suggests using “community rating practices, geographic areas, or statutory requirements” for purposes of grouping contracts [paragraph 13.06].

C. Stop-Loss Insurance

According to the guide, stop-loss insurance premiums are included in reported healthcare costs, and related recoveries are reported as reductions of costs in the financial statements. Receivables representing amounts recoverable from insurers are reported as assets in the balance sheet, reduced by appropriate valuation allowances. The nature, premiums, and effects of significant stop-loss insurance contracts should be disclosed in the notes to the financial statements.

D. Incurred But Not Reported (IBNR) Claims

Usually, accrued liabilities related to managed care contracting consist of claims reported but not paid and claims incurred but not reported (IBNR) by other providers. These projected liabilities can be tracked by the traditional loss development method (LDM), which forecasts future claim emergence patterns from past trends (see Exhibits 5A-5C).

Adjustments to LDM may be needed for seasonality, changes in claim processing and related backlogs, and significant demographic shifts in plan members. There are also various methods for analyzing low credibility months, including trending incurred claims PMPM, loss ratios, and credibility weighted LDM results.

Some of the common methods for computing IBNR accruals are: completion factor (lag schedule, see Exhibit 5A), number of claim months in reserve, and explicit reserve margin.

E. Other Liabilities

Not only must providers evaluate contract profitability and accrue losses, but consideration also must be given to the cost of treating plan members currently under care at fiscal period end. According to the guide, “if a provider of prepaid health care services is obligated to render services to specific members beyond the premium period due to provisions in the contract or regulatory requirements, the costs of such services to be incurred, net of any related anticipated revenues, should be accrued currently” [paragraph 13.02].

Providers should accrue amounts payable to other providers under risk-retention or bonus programs during the contract period. In addition, “costs that will be incurred after the contract is terminated, such as guaranteed salaries, rent, and depreciation, net of any anticipated revenues, should be accrued when it has been determined that a contract...will be terminated,” according to the guide [paragraph 13.02].

X. MONITORING CONTRACT PERFORMANCE

A. Information Requirements

In addition to traditional financial statements to monitor operations, concurrent medical utilization statistical reports should be developed. The reports generated should include daily census, inpatient days per 1,000 members, membership demographics, large cases, trended PMPM medical costs, lag schedules, IBNR calculations, physician profiles, customer service calls, late claims, rate schedules, grievance trends, and clinical quality indicators such as C-section rates and infection rates.

B. Audit Considerations

Financial managers should make sure that any information received from contracted health plans is verified. Providers should periodically reconcile payment
and eligibility information received from health plans with the original managed care contract. The payment and accompanying information should be audited on a regular basis to ensure that it is accurate and complete. The accuracy of payment amounts based on age, gender, and benefit plan, as applicable, should be verified. In addition, subtotals and grand totals throughout reports should be validated. If capitated payment is provided separately from eligibility information, details from both reports should be reconciled. If claims are paid out of a risk pool, providers should make sure the pool has been charged for eligible plan members and covered services only.

C. Other Considerations

Providers should also be aware that a secondary market has developed in which managed care organizations are selling and renting their networks of discount providers. This practice is sometimes referred to as “silent PPOs.” Payers have developed a means to pay discounted contract rates regardless of whether the patient is enrolled in a managed care plan and whether patients are subject to channeling mechanisms. This occurs when a managed care organization sells its list of contracted preferred providers either directly to other payers or to a broker who then sells the list to other payers.

Problems associated with secondary market discounts can be eliminated through contract negotiations that clarify the managed care organization’s ability to place the provider’s discounted rate in the secondary market. When an agreement is being negotiated, it is essential that the contract language be clear, with no room for broad interpretation by either party.

XI. INFORMATION SYSTEM CAPABILITIES

Information requirements for successful risk contracting have been discussed throughout this document. Risk-taking providers should examine their information system capabilities to ensure that they have the ability to access the information necessary to properly manage risk contracts. As discussed throughout this document, this information is different than that required by providers operating in a fee-for-service environment. Current systems may require significant capital investment to meet the needs of the managed care contracting organization. A list of information system capability considerations is included in Exhibit 6.

XII. SUMMARY OF CONTRACTING CONSIDERATIONS

Financial managers should consider many factors during the managed care contracting decision-making process. Although the following is not an exhaustive list, consideration of these issues during negotiations will minimize many of the risks inherent to the process:

1. Determine the types and level of risk the provider organization will assume under the contract.
2. Determine if the risk being assumed is appropriate for the organization.
3. Ensure the contract specifically states the services to be rendered by the provider organization, as well as the excluded services.
4. Obtain complete demographic information on plan members and analyze the marginal and/or fully allocated costs of providing the contracted services to those members.
5. Ensure that an adequate level of cash reserves is available to meet the fluctuations in cash flows that may result from providing contracted services.
6. Investigate state insurance licensure requirements prior to direct contracting.
7. Assess current information systems for the ability to provide the necessary information for managing the contracts, evaluating their profitability, and recording the necessary liabilities in the financial statements.
8. Provide participating physicians with timely and accurate performance data to facilitate the provision of high quality, cost-effective care.
9. Financial managers should periodically review the provider’s performance under the contract.
10. Contract terms should be monitored to ensure that the health plan has met its contractual obligations.
Exhibit 1: Provider Cost-Volume Profit Models

Fee-For-Service         Capitation

Dollars
Profit
Revenue
Costs
Costs
Revenue
Patient Services
Patient Services

Exhibit 2:
Forms of Payment Arrangements and Relative Risk

Fee for Service
Per diem, Discharge, Case*
Provider Lower Risk Higher Risk
Insurer Higher Risk Lower Risk

* The relative risk of per diem, case and discharge payment arrangements varies significantly depending on the type of service provided (i.e., obstetrics, open heart surgery, psychiatry).

Exhibit 3: Cost Components for Determining Capitation Risk

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<tr>
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<th>Frequency</th>
<th>Cost per $</th>
<th>Projected Cost</th>
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<tr>
<td>Outpatient Surgery</td>
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</tr>
<tr>
<td>Skilled Nursing Facility</td>
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<td>Subtotal</td>
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</tr>
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<tr>
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<td>Office, Emergency Room</td>
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<td>Subtotal</td>
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<tr>
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<tr>
<td>Miscellaneous - Other</td>
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<tr>
<td>Profit</td>
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<td></td>
</tr>
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</table>

1. Annual rate per member
2. Frequencies will change based on age and gender bands
3. Cost to provider or purchase out-of-network
### Exhibit 5A: Cumulative Claims Received/Paid By Month of Incurred

<table>
<thead>
<tr>
<th>Month of Incurred</th>
<th>1 Month Following</th>
<th>2 Months Following</th>
<th>3 Months Following</th>
<th>4 Months Following</th>
<th>5 Months Following</th>
<th>6 Months Following</th>
<th>7 Months Following</th>
<th>8 Months Following</th>
</tr>
</thead>
<tbody>
<tr>
<td>August</td>
<td>$12,591</td>
<td>$31,439</td>
<td>$36,196</td>
<td>$37,459</td>
<td>$30,937</td>
<td>$40,256</td>
<td>$40,952</td>
<td>$43,023</td>
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<tr>
<td>September</td>
<td>15,464</td>
<td>29,842</td>
<td>30,987</td>
<td>32,397</td>
<td>34,477</td>
<td>34,925</td>
<td>36,135</td>
<td>36,200</td>
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<tr>
<td>October</td>
<td>18,907</td>
<td>33,291</td>
<td>35,380</td>
<td>45,180</td>
<td>45,581</td>
<td>46,068</td>
<td>46,068</td>
<td>45,387</td>
</tr>
<tr>
<td>November</td>
<td>15,824</td>
<td>32,421</td>
<td>39,855</td>
<td>40,613</td>
<td>43,805</td>
<td>45,737</td>
<td>46,298</td>
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<tr>
<td>December</td>
<td>14,437</td>
<td>34,518</td>
<td>43,409</td>
<td>47,421</td>
<td>49,147</td>
<td>49,401</td>
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<td></td>
</tr>
<tr>
<td>January</td>
<td>27,757</td>
<td>47,982</td>
<td>53,761</td>
<td>63,216</td>
<td>66,440</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>February</td>
<td>19,095</td>
<td>48,091</td>
<td>56,378</td>
<td>58,373</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>March</td>
<td>23,175</td>
<td>51,005</td>
<td>57,126</td>
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</tr>
<tr>
<td>April</td>
<td>22,674</td>
<td>42,849</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sum excluding the last month</td>
<td>$175,024</td>
<td>$308,228</td>
<td>$295,966</td>
<td>$266,286</td>
<td>$211,847</td>
<td>$166,986</td>
<td>$123,155</td>
<td>$79,158</td>
</tr>
<tr>
<td>Sum of all months</td>
<td>$208,734</td>
<td>$351,077</td>
<td>$353,092</td>
<td>$324,859</td>
<td>$278,287</td>
<td>$216,387</td>
<td>$169,453</td>
<td>$125,545</td>
</tr>
</tbody>
</table>

### Exhibit 5B: Estimate of Claims Received/Paid as Percentage of Total Incurred By Duration

<table>
<thead>
<tr>
<th>Month of Incurred</th>
<th>1 Month Following</th>
<th>2 Months Following</th>
<th>3 Months Following</th>
<th>4 Months Following</th>
<th>5 Months Following</th>
<th>6 Months Following</th>
<th>7 Months Following</th>
<th>8 Months Following</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims Received</td>
<td>$175,024</td>
<td>308,228</td>
<td>295,966</td>
<td>266,286</td>
<td>211,847</td>
<td>166,986</td>
<td>123,155</td>
<td>79,158</td>
</tr>
<tr>
<td>Claims Received</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Following Month</td>
<td>/351,077</td>
<td>/333,092</td>
<td>/324,859</td>
<td>/278,287</td>
<td>/216,387</td>
<td>/169,453</td>
<td>/125,545</td>
<td>/79,223</td>
</tr>
<tr>
<td>Percentage^1</td>
<td>49.9</td>
<td>87.3</td>
<td>91.1</td>
<td>95.7</td>
<td>97.9</td>
<td>98.5</td>
<td>98.1</td>
<td>99.9</td>
</tr>
<tr>
<td>Percentage^2</td>
<td>35.9</td>
<td>71.9</td>
<td>82.4</td>
<td>90.4</td>
<td>94.5</td>
<td>96.5</td>
<td>98.0</td>
<td>99.0</td>
</tr>
</tbody>
</table>

1. Ratio of claims received following month in %. 
2. Cumulative ratio in % (e.g., 35.9% = 71.9% × 99.9%).
### Exhibit 5C: Estimate of Gross Incurred Costs

<table>
<thead>
<tr>
<th>Months of Incurred</th>
<th>Cash Claims To Date</th>
<th>Accrual Factor</th>
<th>Estimates Incurred</th>
<th>Number of Enrollees</th>
<th>Capitated Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>October</td>
<td>$46,387</td>
<td>0.999</td>
<td>$46,433</td>
<td>5,940</td>
<td>$7.82</td>
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<tr>
<td>November</td>
<td>46,298</td>
<td>0.980</td>
<td>47,243</td>
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<td>7.62</td>
</tr>
<tr>
<td>December</td>
<td>49,401</td>
<td>0.965</td>
<td>51,193</td>
<td>6,500</td>
<td>7.88</td>
</tr>
<tr>
<td>January</td>
<td>60,440</td>
<td>0.945</td>
<td>70,307</td>
<td>8,100</td>
<td>8.68</td>
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<tr>
<td>February</td>
<td>58,573</td>
<td>0.904</td>
<td>64,793</td>
<td>8,250</td>
<td>7.85</td>
</tr>
<tr>
<td>March</td>
<td>57,126</td>
<td>0.824</td>
<td>69,328</td>
<td>8,250</td>
<td>8.40</td>
</tr>
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<td>April</td>
<td>42,849</td>
<td>0.719</td>
<td>59,595</td>
<td>8,450</td>
<td>7.05</td>
</tr>
<tr>
<td>May</td>
<td>33,710</td>
<td>0.359</td>
<td>93,900(^3)</td>
<td>9,750</td>
<td>9.63</td>
</tr>
<tr>
<td></td>
<td>$400,784</td>
<td></td>
<td>$502,792</td>
<td>61,440</td>
<td></td>
</tr>
</tbody>
</table>

The IBNR accrual is calculated as follows:
- $502,792 = estimated claims to be incurred
- $400,784 = cash claims to date
- $102,008 = IBNR

Capitated expense PMPM: \(\frac{502,792}{61,440} = 8.18\)

Note: August and September are assumed to be complete and therefore omitted from the table.

### Exhibit 6: Suggested Information System Capabilities for Administering Risk Contracts

#### Enrollment and Eligibility
- Demographic information
- Benefit plan details
  - Copayments and deductibles
- Cost experience of plan members

#### Revenue and Cost Data
- Revenue and payment tracking
- Fixed and variable costs of specific procedures
- Indirect costs
- Claims lag schedule
- IBNR calculations

#### Claims Processing
- Contract terms for reimbursing providers
  - Services provided under subcapitation arrangements
- Claim rules, e.g., screening duplicate claims
- Referral control

#### Utilization Management
- Daily census reports
- Inpatient days per 1,000 members
- Physician profiles
- Referral rates
- Clinical quality indicators
GLOSSARY

This glossary contains definitions of terms used in this document and in the field of risk contracts:

Capitation contract
A contract with a payment methodology in which the provider is paid on the basis of a fixed rate per eligible member for a continuum of services, regardless of the actual number or nature of services provided. Revenue is earned in the period that plan members are entitled to healthcare coverage (see P&P Statement No. 11).

Case contract
A contract with a payment methodology in which the provider is paid a fee for all services related to a specific episode, typically triggered by a hospital admission. The fee is intended to cover all services required to treat the patient for that episode, regardless of the provider or setting. Revenue is earned by the provider over the period of treatment.

Community rating
An insurance rating method in which the rate schedule is established for all members in a geographic area.

Completion factor
The completion factor approach is based on a report format commonly referred to as a “claims lag triangle.” The claims lag triangle consists of a matrix of paid claim totals, with month-of-service along one axis and month-paid along the other axis. An example is included in Exhibit 5A. The data assumes a triangular form because claims are not paid before the service occurs. Patterns can be discerned which will offer guidance as to what proportion of a given experience period’s ultimate claims cost is still outstanding at any time. A claims lag triangle report should include sufficient history so that claims payment activity associated with a given month of service completely disappears in virtually all cases. Usually, this will require an 18- to 24-month triangle. The calculation of completion factors will take into account more than one experience period (e.g., multiple years) to predict future patterns. Claims lag triangle reports should be rerun and reexamined at least once a quarter to detect changing patterns.

Contract period
The period for which premium rates are fixed by contract (typically one year).

CPT code
Current procedural terminology. A classification system of terminology used for coding, describing, and reporting medical services and procedures. The system was developed by the American Medical Association.

Credibility weighted LDM
A method of determining outstanding claims liabilities whereby the results of the completion factor approach and the loss development method are weighted and combined.

Direct costs
Costs that can be directly traced to an individual patient’s care.

Discharge contract
A contract with a payment methodology based on discharges. The provider is paid a predetermined amount for the inpatient stay typically based on a patient’s diagnosis. Revenue is earned and costs are incurred on a prorated basis over the period the patient is an inpatient. Medicare utilizes this methodology with diagnosis-related groups (DRGs).

Exclusive provider organization (EPO)
A more restrictive form of the preferred provider organization (PPO), in which enrollees are required to use a network of participating providers. Patients who use out-of-network providers must pay the entire cost out-of-pocket.

Explicit reserve margin
An amount a risk-taking provider may add to the estimate of its unpaid claims liability as an additional margin (reserve) for unpaid claims. (For example, assume it is the risk-taking provider’s standard practice to add an explicit reserve margin of 10 percent. If the risk-taking provider estimates its unpaid claims liability to be $1,000, it will record a total unpaid claims liability of $1,100.)

Fee-for-service
A payment methodology based on actual services performed. The payment can be based on the provider’s charges, reasonable charges determined by the payer, or some contractually determined discount rate based on charges (discounted fee-for-service) or a negotiated fee schedule. Revenue is recorded when the service is provided.

Fixed cost
A cost that remains unchanged in total for a given time period despite wide fluctuations in volume and that becomes progressively smaller on a per unit basis as volume increases.

Fully allocated costing
A costing method generally used in determining whether a loss has been incurred and in pricing contracts when volume is determined to be fixed over the long run. The costs used in this method include fixed, variable, direct, and allocable indirect costs.

Gatekeeper
A primary care physician (PCP) or nonphysician practitioner who is responsible for managing a patient’s medical treatment. Because the PCP or nonphysician
practitioner is the patient's initial contact for medical care and makes all referrals for specialty, ancillary, and hospital services, he or she controls healthcare utilization and costs.

Group model HMOs
An HMO model that contracts with physicians in large, multi-specialty medical groups.

Health maintenance organization (HMO)
An organization or group of related entities providing healthcare services to an enrolled population for a predetermined fee over a fixed period.

ICD-9 code
International Classification of Disease, 9th edition. A standardized coding system consisting of a listing of diagnoses and associated identification codes. The ICD-9 coding system is used by physicians and other providers for reporting diagnoses of covered persons on claims.

In-network
Refers to healthcare services provided by a panel of participating providers that have contracted with a managed care organization.

Incurred but not reported (IBNR)
Incurred but not reported liabilities reflect costs associated with healthcare services that have been incurred during the financial reporting period but have not been reported to the healthcare provider until after the financial reporting date.

Indirect costs
Any cost, other than direct costs, associated with the provision of healthcare services. Examples include administrative overhead and plant and equipment.

Independent practice association (IPA)
A professional corporation or other legal entity serving as a contracting vehicle between physicians and HMOs or other payers. An IPA contracts directly with an HMO and subcontracts with individual practitioners to provide services. The providers will ordinarily continue in their existing individual or group practices.

Integrated delivery systems
A local or regional healthcare network which provides a full range of services for all aspects of health care for patients in a defined geographical area. This network may consist of separate affiliated entities, independent unaffiliated entities that participate in a network through a series of contractual arrangements, or a combination of these two scenarios.

Loss development method (LDM)
A method of determining outstanding claim liabilities whereby the claims already paid are divided by a factor indicating the assumed percentages of estimated claims paid to date. The method is predicated on the assumption that future claims payments will emerge in a pattern similar to that indicated by recent experience.

Loss ratio
An indicator used by insurers as a way of measuring the amount of benefits returned to policyholders. The loss ratio compares an employer's actual claims experience to the premium paid. For example, a low loss ratio indicates a "good" claims experience for a given period, and also shows that the premium collected was more than required to fund the actual claims and provides for administrative costs and margin. A high loss ratio shows that claims required more of the premium for the given time period and left little or nothing for other costs or margin.

Maintenance costs
Cost of maintaining enrollment records and processing collections and payments.

Marginal costing
Marginal cost is defined as the change in total costs associated with a change in volume over a period of time. The marginal costing method of cost analysis includes marginal costs only.

Medical case management
The process of developing a medical treatment plan for achieving the best patient outcome while utilizing healthcare resources in an efficient and cost-effective manner. The medical treatment plan involves the coordination of care to be provided by the payer, the provider, and the patient's family in an effort to determine the most appropriate treatment for the patient.

Network HMOs
Network HMOs contract with many physician groups organized in single-specialty or multi-specialty group practices.

Out-of-network
Refers to healthcare services provided by nonparticipating providers (i.e., providers that have not contracted with a managed care plan).

Participating providers
Refers to a provider who has contracted with a managed care plan to provide medical services to plan members. The provider may be a practitioner or a medical facility.

Per diem
A payment methodology for inpatient care based on a flat rate, regardless of the intensity of services provided on that day. Revenue is earned as a result of a patient occupying a bed.

Per member per month (PMPM)
A unit of measure used by prepaid health plans to describe utilization payments. PMPM may relate to either revenues or costs expressed in terms of each plan member for each month that the member is enrolled.
Physician hospital organization (PHO)
A legal entity formed and owned by one or more hospitals and physician groups primarily for the purpose of obtaining managed care contracts. The PHO performs the marketing, negotiating, and contracting functions necessary to obtain the managed care contracts. Physicians accept managed care patients in accordance with a professional services agreement with the PHO while maintaining ownership of their practices.

Point of service plan (POS)
A health plan option that allows members to use either in-network or out-of-network providers. If members select out-of-network providers, they must pay higher copayments and/or deductibles.

Preferred provider organization (PPO)
An arrangement whereby a third-party payer contracts with a group of medical care providers to furnish services at discounted rates in return for a certain volume of patients.

Prepaid plan
A type of health plan in which a defined set of services are provided for a fixed, periodic payment made in advance by or on behalf of each covered member in the plan.

Primary care physician (PCP)
Physicians designated as responsible for providing primary care services, including evaluation and treatment of patients and decisions regarding referrals for specialty care. “PCP” generally refers to physicians who are in family practice, general practice, general internal medicine, pediatrics, and sometimes obstetrics and gynecology. See also definition of “gatekeeper.”

Reinsurance
A type of insurance that is purchased by primary insurers from secondary insurers to protect against part or all of the losses the primary insurer might incur in honoring the claims of policyholders.

Risk corridors
Term used to refer to setting an upper and lower limit on the amount a provider will be reimbursed for services. The corridors limit the risk of the applicable parties.

Risk pools
A risk-sharing arrangement in which a percentage of a provider's payment is withheld by a health plan and placed into a special account until the actual cost of medical services provided has been determined. During a year-end reconciliation process, budgeted amounts are compared to actual amounts and a surplus or deficit is calculated. Surplus funds may be distributed among providers at the end of the period based on pre-determined conditions and formulas.

Semifixed cost
Costs that change with changes in output. The change in costs are not proportional to the changes in output. A semifixed cost might be considered variable or fixed, depending on the size of the steps relative to the range of volume under consideration. An example of a semifixed cost is staffing expense.

Semivariable cost
Costs that include elements of both fixed and variable costs. An example is utility costs.

Staff model HMOs
An HMO that directly employs physicians.

Stop-loss insurance
Refers to reinsurance for risk-taking providers that limits the provider's financial risk if the cost of care exceeds a predetermined limit.

Subcapitating
A method of transferring risk from a capitated provider to a subcontracting provider. The payment arrangement can be either a flat amount or specific PMPM amount to provide services, thus transferring the risk to the subcontracting entity. The subcontractor may contract for a specific service, such as a Skilled Nursing Facility or ambulance, or for a clinical specialty, such as cardiovascular services or psychiatric services.

Third party administrator (TPA)
An independent person or firm that contracts with an employer (typically self-insured) to perform the administrative services of an employee health plan or managed care plan. These services generally include premium collection, claims processing and payment, and utilization review. The TPA does not underwrite insurance risk.

Utilization management
Programs, protocols, and procedures which ensure that patients receive the necessary services in the appropriate settings.

Variable cost
A cost that changes in direct and continuous proportion to changes in volume.

Withhold
The percentage of a provider’s payment that is withheld under a risk sharing arrangement (called a risk pool or a withhold pool).
SELECT BIBLIOGRAPHY


1996-97
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