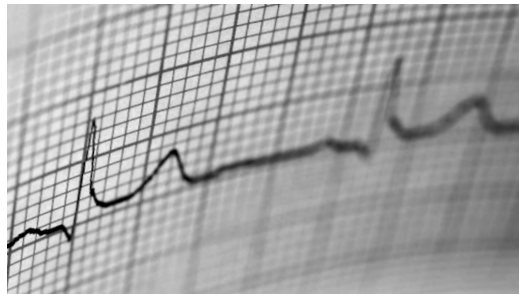


# Setting the Stage for Payment Reform: Updating New York's Regulations on Risk Transfers Between Health Plans and Providers



## **OFFICERS**

J. Barclay Collins II  
*Chairman*

James R. Tallon, Jr.  
*President*

John C. Simons  
Frederick W. Telling, PhD  
*Vice Chairmen*

Sheila M. Abrams  
*Treasurer*

Sheila M. Abrams  
Andrea G. Cohen  
Sally J. Rogers  
*Senior Vice Presidents*

Anne-Marie J. Audet, MD, MSc  
Deborah E. Halper  
*Vice Presidents*

Amanda A. Williams  
*Corporate Secretary*

## **DIRECTORS**

Michelle A. Adams  
Stephen Berger  
Lori Evans Bernstein  
Jo Ivey Boufford, MD  
Rev. John E. Carrington  
Derrick D. Cephas  
Dale C. Christensen, Jr.  
J. Barclay Collins II  
Michael R. Golding, MD  
Cary A. Kravet  
Josh N. Kuriloff  
David Levy, MD  
Howard P. Milstein  
Susana R. Morales, MD  
Robert C. Osborne  
Peter J. Powers  
John C. Simons  
Michael A. Stocker, MD, MPH  
James R. Tallon, Jr.  
Frederick W. Telling, PhD  
Mary Beth C. Tully

## **HONORARY DIRECTORS**

Howard Smith  
*Chairman Emeritus*

Herbert C. Bernard  
John K. Castle  
Timothy C. Forbes  
Barbara P. Gimbel  
Mary H. Schachne  
Allan Weissglass

## **United Hospital Fund**

The United Hospital Fund is a health services research and philanthropic organization whose primary mission is to shape positive change in health care for the people of New York. We advance policies and support programs that promote high-quality, patient-centered health care services that are accessible to all. We undertake research and policy analysis to improve the financing and delivery of care in hospitals, health centers, nursing homes, and other care settings. We raise funds and give grants to examine emerging issues and stimulate innovative programs. And we work collaboratively with civic, professional, and volunteer leaders to identify and realize opportunities for change.

# Setting the Stage for Payment Reform: Updating New York's Regulations on Risk Transfers Between Health Plans and Providers

Peter Newell

DIRECTOR, HEALTH INSURANCE PROJECT

Chad Shearer

DIRECTOR, MEDICAID INSTITUTE

Nikhita Thaper

RESEARCH ASSISTANT, HEALTH INSURANCE PROJECT

UNITED HOSPITAL FUND

November 2015

## Acknowledgments

This work was supported by the New York State Health Foundation. Support for the United Hospital Fund's Health Insurance Project is provided by EmblemHealth. We are also grateful to many individuals from the New York State Department of Financial Services and the New York State Department of Health, and to representatives of health plans and providers, who took time out of their busy schedules and generously lent their expertise and insights to this project.



Support for this work was provided by the New York State Health Foundation (NYSHealth). The mission of NYSEHealth is to expand health insurance coverage, increase access to high-quality health care services, and improve public and community health. The views presented here are those of the authors and not necessarily those of the New York State Health Foundation or its directors, officers, or staff.

Copyright 2015 by United Hospital Fund  
ISBN 1-933881-52-6

Free electronic copies of this report are available at  
the United Hospital Fund's website, [www.uhfnyc.org](http://www.uhfnyc.org).

## Introduction

In New York and around the nation, payment reform has emerged as a key strategy not only to control health care costs, but to improve the quality of care as well. A number of federal and state initiatives are encouraging the transition from fee-for-service reimbursement to value-based payments that tie providers' compensation to performance, including New York's Delivery System Reform Incentive Payment (DSRIP) program and related value-based payment (VBP) roadmap, the State Health Improvement Program (SHIP), and Medicare Accountable Care Organization (ACO) initiatives.<sup>1 2 3</sup> Commercial health plans are also seeking to realign incentives through accountable care contracts with providers.<sup>4</sup> The more far-reaching of these payment strategies involve the transfer of risk from health plans to provider groups or intermediaries, on the theory that providers will have strong incentives to allocate resources most effectively if they themselves are at risk for the quality and cost of their treatment decisions.<sup>5</sup> In this issue brief, we explore the policy and regulatory challenges such arrangements present.

The most well-known type of risk transfer is capitation, a fixed payment made to a health care provider in advance for each member, with the amount varying according to the services covered under the agreement. A newer generation of risk-transfer agreements, known as "shared savings" or "shared risk," may involve more limited transfers of financial risk. For instance, such an arrangement might retain underlying fee-for-service payments, but have specific spending targets for a given population that are reconciled at the end of a calendar year, allowing the provider or intermediary to earn a portion of any savings achieved, or requiring repayments if spending exceeds targets. All types of these increasingly common agreements raise a host of insurance regulatory issues. Determining

whether and how current rules governing these transactions—many adopted after a 1990s wave of experimentation with risk transfers that triggered some disastrous results—should be modernized is a front-burner issue for New York. Specifically, the Medicaid VBP roadmap has set a goal of having 50 to 70 percent of total managed care payments in agreements that are value-based and share risk with providers by 2020.<sup>6</sup> We seek to aid those efforts and tackle the matter more broadly and across insurance markets by developing a checklist of issues for policymakers, regulators at the Department of Financial Services and Department of Health, health plans, providers, and other stakeholders to consider.

## Insurance Licensing and Regulation in New York

New York's insurance consumer protections begin with provisions that require entities taking on risk for certain contingencies to have sufficient assets to meet their obligations under an insurance contract. Insurance contracts are described as transactions under which one party agrees to confer a "benefit of pecuniary value" to another party "upon the happening of a fortuitous event,"<sup>7</sup> a broad definition that New York State Department of Financial Services (DFS) legal opinions refine on an ongoing basis.<sup>8</sup> In order to be licensed as insurers, entities must establish minimum financial reserves,<sup>9</sup> known as "capital and surplus" or "risk-based capital," and maintain adequate levels of reserves on an ongoing basis.<sup>10</sup> Capital and surplus requirements set by DFS for new insurers are based mainly on detailed projections of enrollment, revenues, and expenses. Reviewing the surplus amounts required for new insurers provides some context for the decisions policymakers will have to make when considering the regulations that will apply to providers taking on risk from a health plan.

For example, in 2013, newly licensed Oscar Insurance Company posted \$36 million in capital and surplus to support its entry into the insurance market in 2014; at the end of that year, the company reported enrollment of almost 17,000 members, with premium revenue of about \$60 million. A second new insurer, North Shore-LIJ CareConnect, is an example of the growing trend of health care systems that gain expertise in managing risk they accept from health plans, and then take the next step of obtaining their own insurance license. North Shore-LIJ CareConnect Insurance Company, formed by the major Long Island health care system, was licensed in 2013 with \$27.7 million in capital and surplus, and at the end of 2014 it reported enrollment of 11,700 members and premiums of \$44.5 million.<sup>11</sup>

Once insurance companies are licensed, their solvency is monitored in a number of ways. Insurers must maintain a minimum surplus based on a percentage of premiums they take in, and regulators use a formula known as “risk-based capital” to assess insurers’ surplus, based on the quality of their assets and the comparative level of risk to which they are exposed through insurance contracts.<sup>12</sup> Detailed quarterly and annual reporting of assets, liabilities, revenue, and expenses by insurers and HMOs allows regulators to closely monitor the financial condition of health plans.

Not all health insurers are subject to the same requirements, however. Health maintenance organizations (HMOs), certified by the Department of Health (DOH) under Article 44 of the Public Health Law, receive a limited exemption from DFS insurance licensing<sup>13</sup> as long as they follow a list of specific Insurance Law provisions governing health insurers, and are explicitly permitted to “require providers to share financial risk”<sup>14</sup> under their DOH certification. Similar to licensed insurer surplus

requirements, DOH rules specify that HMOs must build and maintain a contingency reserve of at least 12.5 percent of premiums, though reserves for mainstream Medicaid Managed Care business are set at 7.25 percent. In addition, HMOs must maintain a special escrow account “for the protection of enrollees” of at least 5 percent of the plan’s estimated expenditures to pay medical claims.<sup>15</sup>

## Cautionary Tales on Risk

The core of New York’s risk-transfer regulatory framework came about after a series of problems nationally and closer to home with risk transfers that were inadequately regulated, poorly conceived, or improperly executed—and in some cases, all three. California in the 1990s is often cited as the poster child for lax oversight of risk transfers. Despite an existing regulatory scheme that required licensure for entities accepting global risk from health plans, two large physician practice management companies became insolvent in the late 1990s. The market disruption that resulted left more than \$100 million in unpaid bills and affected more than 4 million health plan enrollees in California, leaving the State to clean up the mess amid protracted legal battles.<sup>16</sup> California’s aggressive response was a new regulatory scheme directly regulating risk-bearing physician organizations (discussed briefly below).

A similar failure prompted New York’s Insurance Department (before its reconfiguration as the Department of Financial Services) to promulgate its regulations governing risk transfers.<sup>17</sup> In 1997, HIP of New Jersey, an affiliate of the Health Insurance Plan of Greater New York, began making capitation payments of 91.5 percent of its premiums to Pinnacle Health Enterprises, a management firm, which in turn assumed responsibility for administering health care services to HIP of New Jersey’s 165,000

members. Within a year, however, New Jersey regulators were forced to take over the plan, as HIP of New Jersey's financial condition deteriorated rapidly, and more than \$120 million in unpaid claims piled up at Pinnacle, despite over \$300 million in capitation payments.<sup>18</sup>

Around the same time, Kingston-based HMO Wellcare of New York averted its own insolvency by selling its commercial business to another New York insurer and a stake in its Medicaid business to a Florida investor. The deal, however, required 50 hospitals to agree to settlements of 30 cents on the dollar for unpaid bills,<sup>19</sup> though New York lawmakers later provided a modest appropriation to offset some provider losses. Similar turmoil accompanied the 2007 failure of Community Choice Health Plan, originally organized by providers to serve Medicaid enrollees in Westchester County.<sup>20</sup>

New York regulations on risk transfers were adopted years ago, and to some degree they reflect the different roles different kinds of licensees played in the health insurance market historically, and the older, less sophisticated and complex contracting methods involving risk. Legislation adopted in 1996 to provide a regulatory framework for integrated delivery systems never took hold.<sup>21</sup> Modernizing these rules, or at least considering the need to do so, is an important task for policymakers and regulators as the delivery system evolves, as health plans operate through holding companies employing multiple licenses in a consolidated market, and as health care systems and providers take on new responsibilities and more financial risk. The policy decisions for this review require consideration of rules applying to different kinds of insurers and for different types of coverage, the similarities and differences in the approaches taken by DFS and DOH, the spectrum of risk-transfer agreements, the necessity and logistics of a transition period, and the adequacy of consumer protections as risk is transferred from health plans to providers.

## Different Risk-Transfer Standards for Different Types of Insurers

Four major kinds of health plans provide comprehensive coverage in New York's insurance market, and they are usually described by the section of the Insurance or Public Health Law that governs their operations: **Article 43** Nonprofit insurers (e.g., Excellus BlueCross BlueShield); **Article 42** accident and health insurers (e.g., UnitedHealthcare and Aetna); and **Article 44** health maintenance organizations, which include both nonprofit HMOs (e.g., Capital District Physicians' Health Plan) and for-profit HMOs (e.g., Oxford Health Plans).<sup>22</sup> The Prepaid Health Services Plan (PHSP), a newer license initially created to serve only public programs, is really a kind of HMO license and includes both nonprofit plans (e.g., FidelisCare) and publicly traded companies (e.g., Wellcare). Currently, New York regulations vary somewhat based on the type of insurer involved, the type of transaction, the line of business, and the regulatory agency responsible for oversight. One task facing policymakers is determining the gains to be had in standardizing the treatment of risk-transfer regulation across these different groups of licensees.

DFS regulations on "Standards for Financial Risk Transfer Between Insurers and Health Care Providers" (Regulation 164)<sup>23</sup> apply to all four types of health plans in all lines of business, but are triggered only for transactions that involve larger, prepaid, full-capitation arrangements between health plans and intermediaries such as independent practice associations (IPAs) or health care providers. (In this report we refer to such intermediaries as provider organizations or risk-bearing entities.) Risk-transfer arrangements entered into by Article 43 nonprofit insurers and Article 42 accident and health insurers that do not meet the Regulation 164 standard for full capitation are not reviewed by DFS or DOH.



Only Article 44 HMOs are required to file detailed, publicly available reports<sup>24</sup> for each entity receiving capitation meeting Regulation 164 requirements. In 2014, HMOs reported over \$2 billion in such capitation agreements (see Appendix), though most were attributable to a single HMO, and the most common agreement reported by plans was for dental benefits. The reports provide a balance sheet for the risk-bearing entity, a statement of operations under the agreement, a description of any financial security deposit made<sup>25</sup> or the reason why no deposit was required, and a listing of other HMOs, insurers, PHSPs, or other entities with which the reporting risk-bearing entity contracts to assume risk. Article 42 accident and health insurers currently report only whether or not they have entered into risk-transfer agreements, and Article 43 nonprofit insurers do not report at all, except for “line of business” HMOs operated through the Article 43 license.<sup>26</sup> These requirements are summarized in Table 1.

Although all health plans are subject to DFS Regulation 164, regardless of license type, broader DOH requirements for agreements “that transfer financial risk for services to another entity” apply only to Article 44 HMOs and PHSPs, referred to as “managed care

organizations.” The DOH regulations classify risk-sharing agreements in five levels, and include arrangements that involve significant withholds, bonuses, and “post-paid” elements, in which the level of compensation to a provider organization is adjusted up or down based on contractual requirements.<sup>27</sup> Risk-sharing arrangements that meet Level 3, 4, or 5 definitions require the HMO to provide detailed information on the financial condition of the risk-sharing entity, and may also require the posting of a financial security deposit. DOH also reviews the management contracts that an HMO enters into with an IPA or other vendor, many of which involve the delegation of important functions, such as utilization review.

All told, while there is a degree of coordination between DFS and DOH in terms of the licensees they regulate, DFS requirements vary for different licensees, and the two agencies take different approaches to risk transfers. DOH casts a broader net, regulating risk-sharing arrangements beyond prepaid full capitation, but it requires less rigorous public reporting. DOH’s rules apply only to HMOs, while DFS’s rules apply to all types of health plans but to only one type of risk transfer: large, prepaid, full-capitation agreements.

**Table 1. Current Licensing and Risk-Transfer Requirements for Different Types of Insurers**

	<b>Article 44 HMOs and PHSPs</b>	<b>Article 42 Accident &amp; Health Insurers</b>	<b>Article 43 Nonprofit Insurers</b>
Health Plan License	DOH certified; exempt from some DFS rules	DFS license	DFS license
Prepaid Capitation Risk Transfers	DFS Regulation 164; detailed financial reporting required	DFS Regulation 164; disclosure required but not financial reporting	DFS Regulation 164; reporting required only for “line of business” HMOs
Shared Risk (not including prepaid capitation)	DOH Provider Contract Guidelines; review and requirements vary based on level of risk	No State review required	No State review required



Standardizing risk-transfer regulation for all health insurers is worth considering for a number of reasons. First, based on 2012 reporting,<sup>28</sup> Article 43 nonprofit insurers and Article 42 accident and health insurers accounted for more than half of both revenues and enrollment reported by all health plans. Adopting the same requirements for all health insurers would level the playing field, and reduce the chance that arrangements deserving scrutiny escape review solely because of the type of license. Uniform standards would also assist the agencies in coordinating their activities, streamline compliance for health plans and provider organizations, and make for a more efficient marketplace that is more hospitable to multipayer collaborations between health insurers and risk-bearing entities. With the diminishing importance of indemnity coverage, the offering of managed care products outside the HMO context, and health plans specializing in Medicaid now entering the commercial market, the distinctions between different types of health insurers that gave rise to different regulatory treatment are gradually disappearing, as is the rationale for maintaining them.

## **Regulating Risk Transfers Across Markets**

A second decision for policymakers is whether to develop different standards for risk transfers according to market segment (e.g., Medicaid, Medicare, or commercial, etc.), or to apply the same standards consistently across markets. Federal rules, for example, apply to risk sharing under the Medicare Pioneer Accountable Care Organization program,<sup>29</sup> and to Physician Incentive Programs (PIPs)<sup>30</sup> in the Medicare Advantage and Medicaid managed care programs. DOH contracts with Medicaid managed care plans specifically state that health plans must follow the federal PIP rules, which require health plans to make special reports and

ensure physician groups have stop-loss coverage in place if the incentive plan exposes the group to “substantial financial risk” due to the capitation arrangement, withholds, or bonuses.<sup>31</sup> Although Regulation 164 is not preempted by federal rules for Medicare Advantage coverage, DFS has taken the position that it is “apt” to treat a Medicare Advantage plan complying with federal solvency standards as meeting Regulation 164 requirements.<sup>32</sup>

On the one hand, adopting state regulations consistent with these programs promotes multipayer activities and keeps provider organizations and health plans from having to abide by two different sets of rules. New York’s ACO regulation and Medicaid managed care contracts already incorporate risk-related provisions from the federal rules.<sup>33</sup> On the other hand, federal ACO rules target the Medicare fee-for-service market, and, though federal regulators assumed many important insurance regulatory responsibilities under the Affordable Care Act, insurance solvency regulation is primarily a state responsibility. Federal rules focus less on the solvency of health plans or provider organizations than on protecting beneficiaries from underusing services because of the financial incentives that providers may have to limit care. In the event of a serious default by a provider organization taking on risk or related financial problems at an insurer, it is State officials and health plans that will be responsible for picking up the pieces, as they have in the past, with providers likely incurring losses when they are not paid contracted amounts for the services they already delivered, or absorbing payment reductions going forward.

On a state level, policymakers and stakeholders are developing standards and guidelines necessary to implement the vision outlined in the VBP roadmap for the Medicaid managed care program.<sup>34</sup> For Medicaid managed care

plans, New York Medicaid has a dual role, as a regulator with responsibility over health plans and providers, and as a payer of \$26.5 billion in managed care premiums with goals related to improving care, reducing costs, and improving population health. Whether this unique dual role justifies different rules for risk transfers under the Medicaid program is an open question. Solvency-related consumer protections are arguably more necessary for businesses and consumers paying premiums for commercial coverage than for the Medicaid program, where the State makes capitation payments to plans and enrollees pay no premiums; however, experience has shown that provider solvency problems can disrupt care for beneficiaries and splash back on taxpayers, other providers, and health plans. Harmonizing regulatory adjustments with federal rules and, as much as possible, applying those changes across insurance markets would help avoid potential market disruption associated with risk transfer to provider organizations, and allow New York to reap some of the same efficiencies as consistent standards for all licensees.

## **Which Risk Transfers Should Be Regulated?**

The next step in regulating risk transfers is determining the right mix of transactions that deserve regulatory scrutiny. As noted above, DFS's regulation 164 review is narrower, triggered only for larger prepaid full-capitation arrangements; its goal is to make certain that when a health plan prepays claims through capitation, the entity accepting that risk has the financial capacity to meet its obligations, so that the solvency of the insurer is not threatened. DOH's review under managed care contracting rules is broader, looking at all contracts, with a more detailed examination of those that transfer financial risk, calibrated by the perceived level of risk. Both agencies wisely distinguish between transactions under which provider organizations

are accepting risk for services they provide directly, and agreements in which an entity has responsibility for indirect or out-of-network services. In a direct service agreement, a health plan might reimburse a hospital provider in different ways, such as a flat per diem amount, or a payment based on a patient's condition rather than the length of the stay, such as diagnosis-related group payment. More detailed regulatory requirements, such as the posting of a reserve fund for out-of-network services, often apply to agreements that include risk for indirect services, since the risk-bearing entity has less control over services rendered by a provider not participating in the contract or arrangement.

Given the existing regulatory structure in New York, one possible approach would combine DFS and DOH thresholds into a single standard for risk-based transactions that merit attention from regulators and apply it consistently across all licensees and markets. Under this scenario, regulators would review risk transfers that fall within the range of the DFS-reviewed prepaid, full-capitation agreements at one end of the risk spectrum, as well as those reviewed by DOH with a lesser level of risk transfer (such as arrangements that involve a significant withhold or "post-paid" adjustment to a provider organization, rather than an upfront capitation payment). Coupling this new standard for risk transfers subject to regulatory review with a statement that these transactions do not fall within the Insurance Law definition of "doing the business of insurance," would eliminate regulatory uncertainty and provide a safe harbor for health insurers and provider organizations entering into innovative risk-transfer agreements.

## **Developing a Range of Regulatory Requirements**

Once the range of transactions meriting regulatory attention is defined, the next step is to delineate the type of intervention that strikes the

right balance between the desire to encourage risk transfers as a payment methodology, and the need to prevent unintended consequences. Other states have taken various approaches to regulating risk transfers. In Oregon Medicaid, Coordinated Care Organizations (CCOs) accept full risk through CCO entities that include a licensed health plan among the organizational affiliates. However, downstream risk-transfer payments to individual providers within the CCOs are still subject to the federally defined PIP rules.<sup>35</sup> California and Massachusetts have taken broader approaches that directly regulate risk-bearing provider organizations using a combination of licensing, adopted in Massachusetts, and reporting and solvency standards, required by both states, that must be met by certain providers that enter into risk-transfer arrangements with health plans.<sup>36</sup>

Regulatory requirements in place at DFS and DOH in New York involve reporting, evaluation of the financial capacity of risk-bearing entities, and, in some cases, the posting of financial security by the risk-bearing organization. Examples of these financial security requirements include proof of stop-loss insurance covering higher-than-expected claims experience, cash, bonds or letters of credit, or, most commonly, a financial guarantee from the parent organization of the risk-bearing entity. As is the case with defining when risk transfers are regulated, New York could meld a regulatory approach with these existing elements, but two main issues arise. First, this approach is largely transactional, and although health plans file templates covering similar transactions with multiple risk-bearing entities, significant resources are required to review each of a growing number of agreements. Second, although HMO reporting for DFS provides some information about the range of a particular provider organization's arrangements with other payers, there is a risk of not seeing the forest for the trees with a transactional approach. While a

single risk-sharing agreement between a particular health plan and a financially stable provider group may present no cause for concern, the same provider group entering into multiple agreements across different lines of business with multiple health plans might deserve greater scrutiny. California regulators are able to assemble a comprehensive listing of risk-bearing organizations, including their agreements with health plans and the number of participating physicians.<sup>37</sup> Reporting for HMOs in New York includes summary data for risk-bearing entities, which if expanded, could serve as the basis for a snapshot of a risk-bearing entity's arrangements with all health plans.<sup>38</sup> Whether to build on the current system of insurer-only licensing, or to create a new type of licensing for provider organizations taking on risk, is a fundamental issue facing New York policymakers.

## **What Transitional Rules Will Apply?**

The number of value-based accountable care agreements between health plans and providers is increasing dramatically. Blue Cross plans nationally reported \$145 billion annually in the year ending June 30, 2014—doubling the previous year's payments.<sup>39</sup> This proliferation of risk transfers that will predate regulatory adjustments requires careful attention. One issue is how to treat existing risk-transfer arrangements, including those governed primarily by federal rules, and whether they should be grandfathered or brought into compliance with new rules. A second issue is the timing of new requirements for risk-bearing entities. Regulation 164 in New York allowed provider organizations to phase in the accumulation of the necessary reserves, and the Massachusetts regulatory process involved a lengthy transition. Clear solutions to these transition questions will need to be developed in New York as well.

## Are Additional Consumer Protections Required?

New York has long been a leader among states in adopting consumer protections for enrollees in managed care plans through both insurers and HMOs.<sup>40</sup> These safeguards—disclosure, grievance procedures, “hold harmless” provisions that protect consumers from financial disputes between providers and plans, and appeal rights—provide protections to ensure that utilization and benefit determinations made by health plans are consistent with the policy terms and state regulations, and in consumers’ best medical interests (i.e., not related to health plan profit margins). Significant risk transfers to provider organizations will put these entities in the same shoes as health plans, as their own bottom lines will depend on utilization of services by enrollees attributed to them, in some cases involving care outside of their direct control. DOH regulations, in fact, specify that IPAs entering into management contracts with managed care organizations fulfill health plan statutory requirements.<sup>41</sup> An argument could be made that, just as health plans are ultimately responsible for services to members, they too are responsible for ensuring that consumer protections apply, even when capitation payments or other arrangements have been made with risk-bearing entities.

The agenda for a modernized regulatory scheme for risk transfers should include a review of current law and regulations to ensure first that any financial incentives for providers that could affect care are disclosed to consumers, and second that there is a clear path for consumers to challenge adverse decisions related to their care. This review could also include discussion of whether contractual provisions between health plans and risk-bearing organizations in capitation arrangements (such as “freedom of choice” provisions preventing the organization from impeding consumer access to the full health plan network) are adequate, or whether

additional protections are necessary. Continued access to these services is obviously important to consumers, but it is also helpful to smaller or less sophisticated providers, which might not have the capacity to enter into risk-sharing arrangements themselves.

## Helping Providers with Risk Transfers

While large multi-specialty practices, IPAs, and hospital-led integrated delivery systems may already be well positioned to enter into and manage risk-transfer agreements, many smaller providers will struggle to do so. Additional support beyond pure payment incentives may be necessary to enhance the capacity of providers to effectively engage in risk transfers. A state stop-loss program is one approach that has been suggested in the Medicaid context, although coverage is available from licensed reinsurers and from health plans, which often structure risk-transfer agreements to protect providers from excessive risk. DSRIP may provide some development resources to help providers prepare to accept risk transfers, but these and other providers may still require additional assistance from the State and plans with information technology, practice transformation, and technical assistance.

## Conclusion

The regulation of risk transfers between health plans and provider organizations is a complicated issue. Any updating of current rules must consider multiple, often competing priorities, account for a variety of existing state and federal regulatory schemes, and be flexible enough to apply to various types of existing arrangements as well as to new ones that are likely to emerge. The aggressive timetable in place for value-based payments involving risk transfers under New York Medicaid’s roadmap and various other efforts outside Medicaid add urgency and

complexity to these regulatory questions. Risk transfers can threaten a provider organization's solvency, with serious consequences, yet policymakers hope that value-based payments involving risk will at the same time bolster the financial condition of providers losing revenue as a result of reduced hospitalizations.

Effective regulation must protect the health care system as a whole from financial risk that could undermine the viability of health plans and risk-bearing entities; it must protect health care consumers who might otherwise unknowingly be receiving care from provider organizations with financial incentives to limit services; and it must protect health plans and risk-bearing entities from burdensome reporting and financial

requirements that could raise the cost of doing business (thereby increasing premiums) and hinder their ability to focus on the broader goals of improving care and reducing costs. These are not hypothetical considerations; risk-transfer agreements that threaten solvency can have adverse consequences for health plans, provider organizations, and the people they serve. A recent California report provided details on nearly 100 risk-bearing organizations that had gone out of business since 2005; almost half had financial concerns.<sup>42</sup>

As New York considers regulating risk transfers in a way that balances these interests, it should consider the following goals in developing an updated regulatory scheme:

1. Harmonizing all types of risk-transfer regulation—and public reporting by plans and providers—so they apply equally across all types of licensed insurers (Article 42 accident and health insurers, Article 43 nonprofit insurers, and Article 44 HMOs and PHSPs), and providing for transparency on agreements already in place.
2. Standardizing risk-transfer regulations so that they apply, as much as possible, equally across all markets (Medicare, Medicaid, commercial), taking into account existing federal and State regulatory structures that cannot or should not be amended.
3. Defining a clear point at which the financial risk in any particular risk-transfer agreement rises to the level of requiring regulatory review and approval, including a clear definition of which types of agreements are subject to DFS versus DOH review, so that health plans, providers, and agencies, including those that audit payments for public programs, are all on the same page.
4. Reconciling to the greatest extent possible financial review criteria and documentation, post-review financial security vehicles, and ongoing reporting requirements across DFS and DOH regulatory schemes.
5. Reviewing current laws and regulations and supplementing them if necessary to ensure that consumers are adequately protected when treatment decisions are being made by providers or intermediaries that have taken on risk, along with traditional health plan functions.
6. Developing resources and technical assistance programs that explain the regulatory scheme and help provider organizations develop the capacity to effectively enter into and manage risk-transfer arrangements.

## Appendix

### Regulation 164 Capitation Payments by Article 44 HMOs, 2014

HMO	Total Capitation Reported	Number of Agreements
Aetna Health Inc.	\$6,170,186	4
Capital District Physicians' Health Plan	33,468,195	2
Catholic Special Needs Plan	5,026,227	10
Community Blue (HealthNow BCBS)	23,174,418	5
Empire BCBS Healthchoice HMO	10,168,898	5
Excellus BCBS Health Plan	195,448,729	2
HIP HMO	1,608,794,230	10
Independent Health Association	14,727,195	2
Managed Health Inc. (HealthFirst PHSP)	6,006,410	15
MVP Health Plan	18,449,044	4
Oxford Health Plans	3,135,712	1
Touchstone Health HMO	99,651,592	2
UnitedHealthcare	106,083	1
<b>Total</b>	<b>\$2,024,326,919</b>	<b>63</b>

Source: UHF Analysis of 2014 New York Supplements for HMOs.

Note: Total capitation and number of agreements are based on the definition contained in 11 New York Codes Rules and Regulations 101. HMOs reported \$11.2 billion in total medical payments in 2012, with \$1.8 billion through capitation payments. See Newell P and A Baumgarten. May 2014. *The Big Picture V: New York's Private and Public Insurance Markets, 2012*. United Hospital Fund of New York. <https://www.uhfnyc.org/publications/880980>



## Endnotes

- 1 New York State Department of Health. Delivery System Reform Incentive Payment (DSRIP) program. [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/); New York State Delivery System Reform Incentive Payment Program Project Toolkit. [https://www.health.ny.gov/health\\_care/medicaid/redesign/docs/dsrip\\_project\\_toolkit.pdf#page=41](https://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_project_toolkit.pdf#page=41); New York State Department of Health Medicaid Redesign Team. June 2015. *A Path Toward Value-Based Payment: New York State Roadmap for Medicaid Payment Reform*. [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/docs/vbp\\_roadmap\\_final.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf)
- 2 New York State Health Innovation Plan. For background information, see [https://www.health.ny.gov/technology/innovation\\_plan\\_initiative/](https://www.health.ny.gov/technology/innovation_plan_initiative/)
- 3 Burke G. April 2013. *Moving Toward Accountable Care in New York*. United Hospital Fund. <https://www.uhfnyc.org/news/880899>
- 4 Pierson R. July 10, 2013. *UnitedHealthcare sees doubling of accountable care business*. Reuters Business News. <http://www.reuters.com/article/2013/07/10/us-unitedhealth-accountablecare-idUSBRE9690UY20130710>; Pizzi R. September 11, 2014. *Aetna expands ACO agreements in New York*. Healthcare Finance News. <http://www.healthcarefinancenews.com/news/aetna-expands-aco-agreements-new-york>
- 5 Damberg CL, ME Sorbero, SL Lovejoy, G Martsof, L Raaen, and D Mandel. March 4, 2014. *Measuring Success in Health Care Value-Based Purchasing Programs: Findings from an Environmental Scan, Literature Review, and Expert Panel Discussions*. Santa Monica, CA: RAND Corporation. [http://www.rand.org/pubs/research\\_reports/RR306](http://www.rand.org/pubs/research_reports/RR306)
- 6 New York State Department of Health Medicaid Redesign Team. June 2015. *A Path Toward Value-Based Payment: New York State Roadmap for Medicaid Payment Reform*. [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/docs/vbp\\_roadmap\\_final.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf). Payments to partially capitated managed care plans are not counted for purposes of the 50 to 70 percent goal.
- 7 New York Insurance Law Section 1101(a)(1).
- 8 New York State Department of Financial Services, Office of General Counsel, Opinion No. 09-02-02.
- 9 New York Insurance Law Section 4204.
- 10 New York Insurance Law Section 4310(d).
- 11 UHF analysis of New York Department of Financial Services' Reports on Organization for North Shore-LIJ Insurance Co., Inc. (July 19, 2013), and Oscar Insurance Corporation (June 25, 2013), [http://www.dfs.ny.gov/insurance/ex\\_index.htm](http://www.dfs.ny.gov/insurance/ex_index.htm); and New York Supplements to the Annual Statement for the year 2014, New York State Department of Financial Services, for the two insurers.
- 12 For data on 2012 surplus levels for New York health plans, see the Newell P and A Baumgarten. May 7, 2014. *The Big Picture V: New York's Private and Public Insurance Markets, 2012*, Table 2. United Hospital Fund. <http://www.uhfnyc.org/publications/880980>; for a description of risk-based capital standards, see National Association for Insurance Commissioners and the Center for Insurance Policy and Research. February 27, 2015. *Risk-Based Capital*. [http://www.naic.org/cipr\\_topics/topic\\_risk\\_based\\_capital.htm](http://www.naic.org/cipr_topics/topic_risk_based_capital.htm)
- 13 New York Insurance Law Section 1109(a).
- 14 New York Public Health Law Section 4403(c).
- 15 New York State Department of Health. Title 10 New York Codes, Rules and Regulations Part 98-1.11.
- 16 Brewster LR, L Jackson, and CS Lesser. February 2000. *Insolvency and Challenges of Regulating Providers that Bear Risk* [Issue Brief No. 26]. Center for Studying Health System Change. <http://www.hschange.com/CONTENT/56/>; California HealthCare Foundation. August 2002. *California Physician Group Solvency Standards*, prepared by CapMetrics. <http://www.chcf.org/publications/2002/08/california-physician-group-solvency-standards>
- 17 New York State Department of Financial Services, Office of General Counsel, Opinion No. 09-06-12.
- 18 *LaVecchia v. HIP of New Jersey*. 734 A.2d 361 (1999). March 5, 1999. Superior Court of New Jersey, Chancery Division, Middlesex County; *Smother's R and C Drew*. December 27, 1998. Failed H.M.O. *Exposes Shortcomings in a Changing Industry*. *The New York Times*. <http://www.nytimes.com/1998/12/27/nyregion/failed-hmo-exposes-shortcomings-in-a-changing-industry.html>
- 19 Moore A. May 24, 1999. *Hospitals sign off on deal to save WellCare Management Group*. *Albany Business Review*. <http://www.bizjournals.com/albany/stories/1999/05/24/story5.html?page=all>



20 New York State Attorney General, affirmation of an application for the appointment of a temporary receiver, in Board of Directors of Community Choice Health Plan of Westchester, Inc. Petitioners, for the judicial dissolution of Community Choice Health Plans of Westchester, Inc. Supreme Court of the State of New York, County of Westchester, Index No. 08/12630. February 10, 2009. <http://www.cchphealth.org/CourtDocuments/Document13/Affirmation%20of%20Attorney%20General%20re%20Appointment%20of%20Receiver.pdf>

21 New York Public Health Law Section 4408-A; Chapter 639 of the Laws of 1996.

22 For background information on New York insurance license structure, see Newell P and A Baumgarten. October 1, 2009. *The Big Picture: Private and Public Health Insurance Markets in New York*. United Hospital Fund. <http://www.uhfny.org/publications/880618>

23 New York State Insurance Department. Title 11 New York Codes, Rules and Regulations Part 101, also known as Regulation No. 164.

24 See, for example, Health Insurance Plan of Greater New York, Report #13, New York Supplement, 2014. In the course of our inquiry, the New York State Department of Financial Services indicated that reporting requirements for Article 42 accident and health insurance and Article 43 nonprofit insurers for the 2015 calendar year would be revised to include the same schedules required by Article 44 HMOs to capture financial statement information for risk-bearing entities.

25 Health plans and risk-bearing entities can use letters of credit, trust agreements, stop-loss insurance, funds withheld from reimbursement, or a guarantee by a parent corporation to satisfy financial security deposit requirements under Regulation 164.

26 The Article 43 nonprofit insurer license predated the creation of New York's law governing HMOs, Article 44 of the Public Health Law, so some Article 43 nonprofit insurers operate HMOs as a "line of business" of their Article 43 license.

27 New York State Department of Health. Provider Contract Guidelines for MCOs and IPAs.

[https://www.health.ny.gov/health\\_care/managed\\_care/hmoipa/docs/guidelines.pdf](https://www.health.ny.gov/health_care/managed_care/hmoipa/docs/guidelines.pdf); Department of Health Level 1 financial review applies to agreements between MCOs and providers with withholds and bonuses totaling less than 25 percent of total payment to the provider. Level 2 applies to risk transfers between MCOs and providers for a single service provided directly by the risk-accepting provider (e.g., primary care). Neither Level 1 nor Level 2 risk transfers require a demonstration of financial viability or financial security deposit. Level 3 applies to risk transfers from MCOs to providers (other than IPAs) for direct provision of multiple services, inpatient services, or withholds or bonuses exceeding 25 percent of total payment to the provider. A demonstration of financial viability is required for Level 3, but a financial security deposit is only required if that financial viability review reveals the provider has negative net worth. Level 4 is similar to Level 3, but applies to IPAs contracting with MCOs for risk transfer on single or multiple services. A financial security deposit of 12.5 percent of the cost of services at risk is required for Level 4. In Level 5, contracts that already fall in Level 3 or 4 but also include risk for services not provided directly by the risk-bearing provider must include an "out-of-health care provider network account" based on an estimate of the funds needed to cover those services. This is in addition to meeting the applicable Level 3 or 4 requirements.

28 Newell P and A Baumgarten. May 2014. *The Big Picture V: New York's Private and Public Insurance Markets, 2012*. United Hospital Fund of New York. <https://www.uhfny.org/publications/880980>

29 Affordable Care Act, Section 3021 for the Pioneer Accountable Care Organization Model; Centers for Medicare & Medicaid Services, Center for Medicare & Medicaid Innovation. Pioneer ACO Model. <http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/index.html>


30 Code of Federal Regulations, Title 42, Section 422.208. Physician incentive plans: requirements and limitations. <http://www.gpo.gov/fdsys/granule/CFR-2002-title42-vol2/CFR-2002-title42-vol2-sec422-208>

31 New York State Department of Health, Medicaid Managed Care / Family Health Plus / HIV Special Needs Plan Model Contract, March 1, 2014; 42 Code of Federal Regulations 438.6(h)—Contract requirements. 42 Code of Federal Regulations 422.208—Physician incentive plans: requirements and limitations, and 422.210—Assurances to CMS. The New York Medicaid Managed Care contract at page 192 specifically requires plans to comply with the federal Medicaid managed care contract requirements on Physician Incentive Plans at 42 CFR 438.6(h) and both of those refer back directly to the Physician Incentive Plan requirements in the federal Medicare Advantage rules at 42 CFR 422.208 and 422.210.

32 New York State Department of Financial Services, Office of General Counsel, Opinion No. 09-06-12.

- 33 New York State Department of Health. Title 10 New York Codes, Rules and Regulations, Part 1003.5—Medicare-Only ACOs Sharing Losses; New York State Department of Health. Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract, March 1, 2014. [https://www.health.ny.gov/health\\_care/managed\\_care/docs/medicaid\\_managed\\_care\\_fhp\\_hiv\\_snp\\_model\\_contract.pdf](https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv_snp_model_contract.pdf)
- 34 New York State Department of Health, Medicaid Redesign Team, Regulatory Impact Subcommittee. [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/regulatory\\_impact.htm](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/regulatory_impact.htm)
- 35 Oregon Health Authority. January 1, 2015. Oregon Health Plan Amended and Restated Health Plan Services Contract for Coordinated Care Organization. [http://www.oregon.gov/oha/OHPB/docs/2015\\_CCO\\_Model\\_Contract.pdf](http://www.oregon.gov/oha/OHPB/docs/2015_CCO_Model_Contract.pdf); Oregon Health Authority. Physician Incentive Plan Disclosure Form. <http://www.oregon.gov/oha/healthplan/CCO/Physician%20Incentive%20Plan%20Disclosure%20Form,%2010-1-2014.docx>
- 36 Code of Massachusetts Regulations, Title 211, Section 155.00—Risk-Bearing Provider Organizations. <http://www.mass.gov/ocabr/docs/doi/legal-hearings/211-155.pdf>; Massachusetts Office of Consumer Affairs & Business Regulation, Bulletin 2014-05; Guidelines on Submitting Filing Materials Relative to the Certification of Risk-Bearing Provider Organizations Under Chapter 176T of the General Laws and 211 CMR 155.00, Issued August 15, 2014. <http://www.mass.gov/ocabr/insurance/providers-and-producers/doi-regulatory-info/doi-regulatory-bulletins/2014-doi-bulletins/bulletin-2014-05.html>; California Department of Managed Health Care. Senate Bill 260 Regulations Summary. <https://www.dmhc.ca.gov/LicensingReporting/RiskBearingOrganizations/SB260Regulation.aspx#.Ve87EhFVhBc>
- 37 California Department of Managed Health Care Solvency Board. Risk-Bearing Organizations Statement of Organization. <http://wps0.dmhc.ca.gov/ProviderReports/statorg.aspx>
- 38 See for example, Parts C and D, Report #13, for HIP Health Maintenance Organization New York Supplement, 2014.
- 39 Jaspen B. October 27, 2014. Blue Cross' Move from Fee-for-Service Medicine Hits \$145 Billion. *Forbes*. <http://www.forbes.com/sites/brucejapsen/2015/10/27/blue-cross-move-from-fee-for-service-medicine-doubles-to-145-billion/>
- 40 Chapter 705 of the Laws of New York, 1996, and subsequent enacted legislation. For a summary, see the Department of Financial Services, "Your Rights as a Health Insurance Consumer," available at <http://www.dfs.ny.gov/consumer/hrights>
- 41 New York State Department of Health, Management Contract Guidelines for MCOs and IPAs. [https://www.health.ny.gov/health\\_care/managed\\_care/pdf/mgmt\\_contract\\_guidelines.pdf](https://www.health.ny.gov/health_care/managed_care/pdf/mgmt_contract_guidelines.pdf)
- 42 California Department of Managed Health Care. November 13, 2014. *Summary of Risk-Bearing Organizations No Longer in Business* [PowerPoint]. <https://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/FSSB/rptdeclineRBOs.pdf>



 **United  
Hospital Fund**

*Shaping New York's Health Care:  
Information, Philanthropy, Policy*

1411 Broadway  
12th Floor  
New York, NY 10018  
(212) 494-0700  
<http://www.uhfnyc.org>

ISBN 1-933881-52-6

