

**DOWNSTREAM RISK:
WHAT IS IT;
SHOULD IT BE REGULATED, AND,
IF SO, HOW?**

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Downstream risk exists with respect to HMO operations throughout the country. Despite the prevalence of the practice and some well-publicized problems in particular instances, most states regulate downstream risk little or not at all. Of the minority of states which do impose regulatory standards on the risk element, there is no consistent approach. The NAIC is studying the issue and the time is ripe for commentary and discussion.

In this article, downstream risk is defined and current regulation of the practice is discussed, the history of such arrangements and the nature of regulatory concerns are briefly addressed, and recommendations are provided which include discussion of the pros and cons of various potential regulatory responses.

What Is Downstream Risk and How Is It Currently Regulated?

As used in this article, “downstream risk” refers to the transfer, at a fixed price, by an HMO of the obligation to provide at least a portion of the benefits which the HMO has agreed to provide to its members. In its broadest sense, the term encompasses capitation agreements with individual providers, provider groups, independent practice associations (“IPAs”), physician management companies, and intermediaries. Arrangements where IPAs, physician management companies and intermediaries receive a fixed price but choose not to capitate providers fall within this definition of downstream risk, since the risk-shifting by the HMO which is the central characteristic is present, even if utilization risk is not undertaken by the providers. The term does not encompass arrangements where there is no transfer of utilization risk, such as situations where HMOs pay on a usage basis.

A core characteristic of downstream risk is the acceptance of financial risk by the provider or intermediary from an HMO, not directly from members of the public. The downstream risk entity does not offer its services to or accept money from members of the public. Rather, it deals with HMOs. This feature leads to important legal results.

Since the HMO is the entity which contracts with the public, it is exposed to the possibility the downstream risk entity will fail to perform. As the downstream risk entity is not offering its services to the public, most states do not consider that entity to be engaged in the HMO or the indemnity insurance business and thus it typically is not required to obtain licensure as either an HMO or indemnity carrier. In this majority group of states, the downstream risk entity is considered to operate under the umbrella of the HMO’s license and such control as is exercised over downstream risk is accomplished through regulation of the HMO. A very few states have a statutory approach requiring either that the downstream risk entity file for approval or that the HMO with which the downstream risk entity contracts secure prior approval of the proposed arrangement.

Why Has the Treatment of Downstream Risk Become an Issue Now?

The concept of downstreaming risk is well established and, in the context of the time frame in which HMOs have developed and grown, has a long history. The capitation services model utilized by many HMOs is based on one form of downstream risk – the shifting of risk from the HMO to the capitated provider. Downstream risk arrangements have also been used for physician groups, hospitals, and various specialized benefits.

While an HMO can downstream risk, it cannot downstream ultimate responsibility. When an HMO offers health benefits to its members in exchange for payment of premiums, it enters into a direct contractual relationship with its members. The members are not contracting with the various providers that they are entitled to utilize. If an HMO pays a capitation to a physician and the physician becomes unable or unwilling to perform, the HMO’s obligation to its members is not forgiven by that provider’s lack of performance. Unless the HMO can recover the capitation payment it has made to the non-performing provider, the HMO may end up paying twice for the same service – once to the non-performing provider and a second time to the provider who stepped in to fulfill the HMO’s commitment to its members when the first provider failed to perform. In this sense, downstream risk arrangements shift risk for

HMOs but do not completely eliminate it.

With individual providers, or even small groups of providers, the problem of provider non-performance does not usually have any material impact on access to care for members or the financial health of an HMO. Historically, not that many individual providers fail to perform at any given time. However, when the amount of risk transferred by single downstream risk agreements becomes material, the potential for problems becomes more pronounced. The problems with MedPartners and Harvard Pilgrim are illustrative. In each case, the failure of large downstream risk arrangements created care access problems for members and solvency risk for HMOs.

Against this backdrop, there are reasonable concerns whether downstream risk arrangements deserve more attention and, if so, what form that attention should take.

Recommendations

No responsible person can discount the need for study and a considered response to the challenges brought about by situations like those involving MedPartners and Harvard Pilgrim, although we also need to recognize that the existing system has dealt with these situations and others and has achieved good results. Continued access by consumers to the benefits which they have bought and the ongoing financial health of the HMOs that serve as a primary funding mechanism for much of the health care delivered in this country are at the core of regulatory responsibility.

Consideration of this issue is a good opportunity to focus on where regulatory attention and control are most effectively applied and to reflect on what kinds of activities the insurance regulatory system is expected and able to address.

If an HMO's overall exposure to downstream risk is minimal, no oversight is needed or appropriate. If, for example, a given downstream risk arrangement involves less than 5% of an HMO's revenue, that arrangement, by itself, neither needs nor justifies regulatory attention. If it does, then we may as well oversee where the HMO purchases its office supplies, too. At some level, being allowed to be in the HMO business implies a degree of latitude in attending to the details. Put another way, the purpose of regulation is not to protect the shareholders of HMOs or second guess the myriad small decisions that accompany any business enterprise. Regulatory concerns should concentrate on solvency, implementing public policy with respect to required coverages, consumer protection, compliance and similar core issues. The rest is up to the marketplace and the competitive process.

However, a single agreement which is beyond a certain threshold or the aggregate of all agreements for an HMO which, together, are beyond an established level become legitimate subjects for scrutiny. The resulting issue involves what kind of scrutiny to give and where to apply it.

The author suggests that the best approach is to protect against the potential problems of downstream risk arrangements through the regulation of HMOs and the application of increasing requirements depending on overall exposure. HMOs are already directly regulated. Existing laws provide the basis for requiring reporting of any arrangement or practice which a regulator believes may have impact on delivery of services to members or the financial health of the HMO, and the ultimate responsibility of deciding and justifying with whom it does business should rest on the HMO.

There is an easy way to significantly reduce the risk of financial problems for downstream risk organizations. It involves a two-stage approach which provides greater regulatory scrutiny for downstream risk arrangements which are individually significant or in cases where the HMO's overall exposure to downstream risk is material and assures that a regulator sees new arrangements before they become effective.

The first stage: Require that an HMO report any downstream risk arrangement at least 30 days before it takes effect. Unless the circumstances bring the second stage into play, the new arrangement is permitted to go into effect, subject to ongoing reporting by the HMO which will indicate if the requirements of the second stage subsequently become applicable.

The second stage: If the payment under the proposed new arrangement (plus any other payments by the HMO to

the same downstream risk entity or other downstream risk entities under the same ownership or control):

- (1) Would involve a monthly payment which is in excess of 5% of the HMO's current monthly revenues; or
- (2) If the HMO's monthly downstream risk payments, in the aggregate, exceed 50% of its current monthly revenues, then the proposed new arrangement must be specifically approved before it takes effect.

In second stage situations, the regulator would need to be satisfied that the new arrangement adequately protects the solvency of the HMO before the arrangement is allowed to take effect. The burden for such a showing would be on the HMO. Such a showing might be based on the nature of the particular arrangement, the HMO's own finances, those of the downstream risk entity, the availability of a security deposit or other protective mechanism, or other factors.

Where approval is required because of the HMO's aggregate exposure to downstream risk, the scrutiny could extend to existing arrangements which involve payments to downstream risk entities of 5% or more of the HMO's monthly premium volume.

Where security is required in a second stage situation, the amount could be set as part of the approval process or there could be a formula (such as a sum equal to two months of payments from the HMO to the downstream risk entity). Where a security deposit is required, the compliance burden would be imposed on the downstream risk entity with compliance demonstrated by a filing by the HMO. Various permissible forms would be permitted for the security, and the downstream risk entity would be required to maintain the security on an ongoing basis, unless the requirement is modified by the regulator. Adjustments typically would be made each quarter, but would be required as often as monthly in the event of a 10% or greater aggregate change within a quarter. This would protect against the deposit becoming inadequate due to rapid increase in volume under the downstream risk agreement.

A required deposit could take the form of cash, a letter of credit (on the same form required for statutory financial statement credit for an HMO), or a bond from an admitted insurer. Risk transfers by an HMO to other admitted HMOs or indemnity carriers would not require the posting of security, but would still be subject to the requirement of at least 30 days prior notice to the regulator.

The entire process would occur in the context of the relationship between the regulatory agency and the HMO. The HMO would be responsible for initial and ongoing filings and for compliance with any requirements imposed.

In addition, regulators have general powers to safeguard HMO finances and the rights of members. Those powers would not in any way be reduced by the two-stage process outlined above. Under these general powers, if there are regulatory concerns about an HMO's downstream risk arrangements, a regulator could impose additional safeguards and requirements, as needed. However, the process above should make the requirement for such intervention infrequent.

Such a system:

- S Would be self-executing;
- S Could be implemented immediately;
- S Would not require licensing whole new types of entities
- S Would not impose on regulatory agencies the burden of creating, staffing, training and maintaining the expanded personnel rosters which would be required if a whole new type of enterprise, downstream risk entities, were to become directly regulated and licensed; and
- S Would provide regulators advance notice of all downstream risk arrangements and the opportunity to approve and impose specific requirements for significant new arrangements before they take effect.

The control would rest with the regulators, but the bulk of the work to comply would be done by the HMOs and the downstream risk entities with whom they choose to contract. Regulators could adjust the requirements, if appropriate, and could otherwise protect the public from this type of risk through regulation of the arrangements the HMO is permitted to make and the permissible structure of those arrangements.

Another benefit of policing the necessary protective requirements for downstream risk arrangements through the HMO regulatory function is that it avoids the complex and divisive issues that would arise if HMO and insurance

regulators were to undertake to regulate the entities which are involved with downstream risk arrangements. Do HMO regulators really want to regulate IPAs, capitation arrangements with providers in groups or practicing individually, or other downstream risk entities? Of course they don't. In some contexts trying to regulate such entities would cross over jurisdictional boundaries of the agencies which regulate the various professions and would also come perilously close to attempting to oversee medical practices. We don't want to go there. We just want to be sure that downstream risk entities do not have problems which will spill over onto members and HMOs. The suggested approach accomplishes that objective with a minimum of new regulation, staffing needs, and potential regulatory competition and complication.

The approach suggested focuses on the potential financial risks and minimizes the disruption to members in the event of a downstream risk intermediary failure.

It is beyond the role, or capabilities, of the HMO regulatory system to avoid all risk of failure for downstream risk entities and the service disruptions to members which inevitably result. We simply cannot guarantee that providers and downstream risk entities will succeed in business – but we can make sure that where there are significant downstream risk arrangements in place, funds will be available to permit HMOs to pay other providers to pick up the slack, if and when failures occur, and that if new sources of funds are needed to provide this protection to consumers, they will be generated by the downstream risk entities themselves, not by HMOs or the public.

The recommended approach:

- S Continues to permit members and HMOs to enjoy the many benefits of downstream risk arrangements;
- S Recognizes the cost-effectiveness and other advantages of such arrangements are far more typical than the problems which have sometimes arisen;
- S Protects the public against the risk which can occur; and
- S Accomplishes this result without the need for direct regulation of new types of entities, the delay, and the drain on resources such an effort would represent.