PHYSICIANS TURN TO CAPTIVE SOLUTION

Michael A. Schroeder of Roundstone Insurance explains why physicians are turning to captive solutions following the implementation of ACA

Physicians have long been a leading innovator in the captive marketplace. In part out of necessity, many physicians turned to the captive market in the 1980s and early 2000s for a viable alternative to the standard medical malpractice market. Price, control, coverage and, in some cases, availability, encouraged physicians to form captives that flourished through aggressive practice and claim management strategies.

Today, many of these captive trailblazing physicians are once again looking at a captive as the solution for their current business challenges. Business challenges? The Affordable Care Act (ACA) or healthcare reform presents most physicians with many challenges. Compensation for services, quality care definitions and incentives favouring large integrated provider organisations are part of ACA, which in turn cause today's physician to worry about much more than medical malpractice.

An example of ACA's disconnect with a physician's practice is the failure of the insur-

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ance regulations to objectively reward quality physician care. Who knows if and how one is rewarded when a physician does a good job and practises in such a fashion as to limit readmissions and escalating health costs? How does healthcare reform's impact on fixed cost insurers through community rating distinguish between those physicians applying quality low-cost care and those running up the tab to enrich their bottom line? Fast answer, it doesn't and so physicians delivering quality care are marginalised when their patients are covered by a fully insured or fixed cost insurer. What about plan designs such as high-deductible plans that match a physician's health and wellness efforts? No, these too are limited by much of the rules now imposed by ACA on the fixed cost insurance market.

Provider health plans

If the door is shut on physicians trying to apply cost reduction strategies to the fixed cost commercial market, what can be done? After all, if physicians have invested time and money to rework their care in a direction focused on quality and efficiency, it seems illogical to not apply these efforts in the commercial insurance group market.

Fortunately, innovation in the captive insurance market is finding its way to physicians once again. This innovation is being delivered in the commercial group market under the name 'provider health plans'. These new plans overcome the obstacles found in the fixed cost insurer market and enable all the great quality care efficiencies to be applied in the commercial group market. Problems with keeping track of savings, identifying cost-effective providers, and rewarding quality directly, objectively and efficiently are removed with these new plans. Community rating is inapplicable. Plan design creativity is unencumbered with the capability to align provider and buyer incentives.

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What is this stealth solution that is taking the provider market by storm? The self-funded or stop-loss group captive (the "medical captive"). Yes, the old reliable physician insurance solution, known as the "captive", is once again resonating with physicians, especially large primary care physician groups. And, why not? Captives worked well for physicians when they confronted the medical malpractice crisis of the 1980s and early 2000s.

The medical captive solution enables physicians to offer their community a health plan immediately. No regulatory red tape. They can offer a commercial market health plan where quality physician care can be objectively monitored so cost savings and efficiency is not a guess or lost to a third-party insurer. Cost savings arising from quality care can be measured quarterly if not monthly under the medical captive approach. A physician's effective care and innovative cost containment ideas receive real time feedback.

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The self-funded chassis the medical captive is built upon also delivers benefits over the traditional fixed cost insurance market. The post ACA insurance environment includes community rating and restricted plan designs; however, self–funded insurance programmes avoid these potholes. As long as the medical captive is the financing vehicle being utilised by the provider health plan, the disconnect between ACA's quality initiatives and the commercial insurance market is resolved.

Who benefits?

Many primary care physician groups are attracted to the medical captive as a form of physician sponsored health plan for several reasons. First, narrow networks are gaining ground as a viable solution for keeping medical expenses under control. Employers and employees are now receptive to the notion of limiting choice to the local provider in exchange for a lower price. This is good news for a physician group that is looking for traction with local employers. The physician-sponsored narrow network is an approach that is simple to implement with the medical captive. Physicians competing with existing hospital-focused health plans of the fixed cost variety now are looking to add the medical captive as a competitive choice.

Larger integrated service physician groups sit in a similar place to many hospitals in their quest to retain and grow their customers. Offering a health plan with a capitated physician service component is easily accomplished with the medical captive. Physicians can quickly distinguish their practices from the rush of hospitalists with a health plan that incorporates much of their treatment philosophies. The flexibility of the medical captive built on a self-funded platform enables creativity in plan design and buyer incentives that mesh nicely with efforts by physician practices directed at reducing high-cost diseases. Measuring the effectiveness of physician practice efforts at cost control is readily verified by reference to the medical captive underwriting results. It's not hard to understand why larger integrated physician practices are quickly moving to the medical captive as part of the solution for reinventing healthcare delivery.

Common ground

Everyone agrees with the objective of lowering the cost of healthcare. Not everyone, however, agrees or understands what goes into the cost of healthcare. Most consumers do not see what it actually costs to receive a medical procedure or purchase a medicine. This is because many do not directly pay for or see the cost of the care, but rather the buyers pay a fixed cost or premium and then enter a buffet of healthcare providers. Cost efficiency is a low priority and is only mentioned at renewal time or when the overall price trend for the fixed cost interferes with the buyer's budget. ACA was created with the objective of changing the incentives surrounding the purchase of healthcare. We may disagree on whether it does so in the most effective manner but we should be able to go back and agree with the initial motive for the law – lower healthcare cost.

We should also be encouraged that physicians are innovating through captives, not just with their medical malpractice exposures but now with the financing of their care. If healthcare reform is encouraging physicians to form new healthcare financing mechanisms that offer objective and immediate feedback on quality care, we are starting to reach a shared objective.