Purchasing Provider Stop-Loss May Save Your Capitation Bottom Line

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If you are about to sign your first capitated contract or if you are an established physician organization, what about your Provider Stop Loss? It is often overlooked by most physician organizations and it is extremely important to your overall survival.

First, what is Provider Stop Loss or reinsurance? It is insurance coverage which the physician organization or hospital purchases in order to protect itself from catastrophic claims generated by its capitated patients. In the event that a severe catastrophic claim occurs in a capitated setting, the provider has an outside insurer reimburse a defined amount of money after a per patient deductible has been met.

One problem with this product is that it has multiple names. Often you will find people thinking they are discussing two different products without knowing that they are talking about the same thing. Here are some of the many names that are used throughout the industry with regards to this product:

- Provider Excess of Loss
- Stop Loss
- Provider Stop Loss (PSL)
- Stop Loss Reinsurance
- Provider Excess
- Capitated Stop Loss
- Reinsurance
- “That Stop Loss Stuff” (My favorite - actual quote attributed to a prospect we worked with)
The term that we use most frequently in the industry is Provider Stop Loss (PSL). As the name indicates, it’s coverage for a provider of healthcare and it stops losses.

Here is an example of how the coverage might work on a particular claim:

- Premature baby who has $42,000 of eligible charges (based on RBRVS) billed by a neonatologist to the physician organization responsible for that member.
- Physician organization pays the claim to the neonatologist and submits the stop loss claim to its Provider Stop Loss insurer.
- Policy will pay 100% of RBRVS after a $10,000 deductible is met by the physician organization.

Example:

<table>
<thead>
<tr>
<th>Eligible Claim:</th>
<th>$42,000</th>
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<tbody>
<tr>
<td>Less Deductible:</td>
<td>($10,000)</td>
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<tr>
<td></td>
<td>$32,000</td>
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Recovery paid by insurer to Physician Organization

This is how the coverage works. However, what does this really mean to a Physician Organization? Many people feel it should cover the total cost of all catastrophic claims. In a sense it often does, especially for physician coverage, but that really isn’t the big picture. The big picture is the following: If you are a capitated physician organization your macro accounting looks like this:

TOTAL CAPITATION REVENUE

\[ \text{Minus} \]

CLAIMS AND ADMINISTRATIVE EXPENSE

\[ \text{Equals} \]

Profit or (Loss)

Please note: This equation is missing a key ingredient - the Provider Stop Loss reimbursement, which for many of our customers has made the difference
between a profit and a loss. We consulted with a physician organization that had a terrible year in terms of catastrophic claims. If it weren’t for the reinsurance that was designed by our firm, they may not be in business today. Here is what their year-end looked like. (Please note we’ve changed some of the particulars so it doesn’t reflect any individual group.)

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<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>$3,900,000 in claims paid</td>
<td>$4,200,000</td>
<td>Capitation Revenue</td>
<td></td>
</tr>
<tr>
<td>$120,000 Provider Stop Loss Premium</td>
<td>$528,000 Provider Stop Loss Recovery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$480,000 Administrative Overhead</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$4,500,000 Subtotal Out</td>
<td>$4,728,000 Subtotal Credit</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$228,000 Total Profit</td>
<td></td>
<td></td>
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</tbody>
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As you can see, this group’s expenses exceeded its revenue, but the Provider Stop Loss bailed out a bad year. This illustrates how PSL can make a significant difference to the margin of the provider.

Most providers, as I indicated at the beginning of this paper, overlook the provider stop loss component and take what the HMO gives, I mean sells them as part of their capitated contract. I crossed out the word “give”, which is how the HMO presents it to you, but in most cases the HMO doesn’t give you anything - they sell it to you. I’ll show you more on this later.

You can buy this coverage privately through a Provider Stop Loss broker who represents many credible insurers. There are many advantages to this, which we will explain later.

The last option is to totally self-insure your catastrophic claim and not buy Provider Stop Loss. This is probably the most foolhardy thing we’ve seen in the industry. Now, self-insuring a defined amount of risk is one thing, but to totally insure all catastrophic claims is playing Russian Roulette... one bad year may be your last.

If you don’t believe this, consider that all insurance companies, for the most part, purchase insurance to protect themselves from catastrophic risk. This includes
insurers that earn more in a day in interest income than the average physician organization grosses in a year. Everybody buys stop loss/reinsurance.
Besides the risk aspect to totally self-insuring catastrophic risk, what about your professional liability exposure?

A patient needs a referral to a specialist. For some reason the Primary Care Physician and his physician organization delay in getting the patient to a specialist. The patient is later diagnosed with cancer, which spreads quickly, and she dies. Later the family of the patient sues the physician and the physician organization stating that if the patient had been referred to a specialist immediately there would’ve been a better chance of the patient surviving the cancer.

The family’s attorney finds out in discovery that the physician organization has some financial challenges and further, totally self-insures all its catastrophic claims with no Provider Stop Loss Insurance. That’s all the motive that the attorney needs to show that the physician organization acted out of pure financial self-interest and ignored the patient’s care. Therefore, never totally self-insure from a risk and liability standpoint. It does not make sense.

Anyone who receives capitation as his or her total payment for delivering healthcare needs Provider Stop Loss. This includes Primary Care Physicians and specialists. If you’re a physician signing a capitation agreement with anyone, make sure that you have Provider Stop Loss.

A deductible is the defined dollar amount, per patient per year, that you are willing to self-insure until you require the insurer to reimburse you for a catastrophic claim. Obviously, the lower the deductible, the higher the price of the coverage. Most physician organizations will want deductibles between $10,000 and $20,000 for Commercial and Medicaid Members.

Coinsurance is the percentage that the insurer will reimburse you, once an eligible claim exceeds the per patient per year deductible.
⇒ You have a $20,000 eligible claim
⇒ $10,000 deductible
⇒ 90% Coinsurance
⇒ $20,000 Claim
⇒ ($10,000) less deductible
⇒ $10,000 gross recovery
⇒ 90% multiplied by \textit{coinsurance}
⇒ $9,000 Net recovery

The purpose of coinsurance is for you to share in the risk with the Insurer once the deductible has been met. The belief of many Provider Stop Loss insurers is that once the deductible has been met on a catastrophic claim, you as the physician organization will do nothing more to manage the claim. But, by having you self-insure ten percent (10%) of the claim in excess of the deductible, the insurer feels that you will more actively manage the case until it is complete.

The purpose of this coverage is to reimburse the actual payment that you make to your providers after the per patient deductible is met. The top three reimbursement schedule options for coverage are:

- RBRVS
- McGraw-Hill
- CRVS

You want your coverage to be based on whichever of the above schedules you use for your Providers.

The coverage period is the time you have to submit a claim and the period of time the policy will cover your claim. Most PSL contracts cover your membership for a 12-month policy period. At the end of that 12-month period you either have 90, 120 or in some cases 180 days to report any claims that were incurred in your policy year. If you know your claims department isn’t as efficient as you would
like, try to get a longer reporting period. Many providers lose tens of thousands of dollars due to the cut off period on claims reporting.

- Policy is effective 1/1/97
- 90 day reporting period is utilized
- Covers all claims incurred through 12/31/97
- At the end of the 31st, you will have 90 days to submit any claims that were incurred during that policy year that were not reported to the insurer

- 12/15 - Claims incurred in a 12-month policy period and reported in 90 days.
- 12/16 - Claims incurred in a 12-month policy period and reported in 120 days.
- 12/18 - Claims incurred in a 12-month policy period and reported in 180 days.

There are essentially two key areas that a physician organization should consider in evaluating its risk and therefore coverage for PSL:

Non-contracted - meaning a physician that neither has a contract with you nor will sign one with you, but is a specialist that you need to have in order to provide total care to the members that are part of your physician organization.

Contracted risk - meaning any provider that you have a discounted schedule agreement with or is capitated.

Contracted care is the part of your risk that you should be the least worried about. If you have a contract with a provider, at least you know what your unit costs are.

Non-Contracted care can be your worst nightmare, because a provider can charge you anything they want when you utilize them.

A plastic surgeon received a referral on a weekend for a child with severe third degree burns on over 90% of her body. This plastic surgeon was extremely efficient and used all the state-of-the-art treatments available to burn victims. Further, this plastic surgeon had no contract with the physician organization and in
fact, there was no love between him and that particular physician organization. After the physician had finished treating the young child for an extended period, he submitted his bills for $300,000 to the physician organization. Obviously the physician organization was extremely upset and tried to negotiate with the plastic surgeon, who only wanted his money. The case went to court, and it was determined that the referral was made and therefore the physician organization must pay the bill. Unfortunately, this physician had inadequate provider stop loss coverage for its non-contracted care and only received a few thousand dollars from its policy. For all non-contracted provider claims you should try to get the PSL insurer to give you a percentage of the amount you actually pay. If the physician organization had 100% of the actual paid amount with a $10,000 deductible, this catastrophic claim picture would have looked a little better on their bottom line.

\[
\begin{align*}
\text{\$300,000} & \quad \text{Paid Charges} \\
\text{\(- \text{\$10,000}\)} & \quad \text{Less Deductible} \\
\text{\$290,000} & \quad \text{Sub-total Billed Charges} \\
\times 90\% & \quad \text{Multiplied by Coinsurance} \\
\text{\$261,000} & \quad \text{Reimbursement to physician organization}
\end{align*}
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The thing that every physician organization has to be extremely concerned about is its non-contracted care. If there is a specialty for which you cannot get a contract, make sure that you have very good PSL coverage based on the amount you pay for this non-contracted care.

Conversely, your contracted coverage should be reimbursed on the contracted rates you pay to your providers (i.e. CRVS, RBRVS or McGraw-Hill Schedules).

The HMO will provide this type of coverage to you as part of your capitation agreement. While there are many disadvantages, there are very few advantages to this approach.

- **Premiums are often higher than you should pay.** This is because the HMO offers this coverage to all of its providers. Therefore, you are thrown into a risk pool with every provider with whom they have a contract. The problem with this scenario is that if you are good at managing your risk, and
have excellent claims experience, you are being charged for the other providers who are not as good as you are. Further, the HMO tries to make the administrative burden on themselves as simple as possible, so they overcharge on the premium rates to make sure their overall pool is profitable.

- **Coverage flexibility is not offered by the HMO in most cases.** In general, they will give you an option of one or two deductibles with a single reimbursement formula. If you are a very large provider, who does not need as much Provider Stop Loss, you are often buying too much coverage, because the deductible options are too low. Conversely, if you are a small provider, the deductibles may be too high. Again, the HMO is attempting to come up with a generic program to make it as easy as possible on themselves to administer.

- **Limitations in the coverage are often not spelled out by the HMO in the capitation agreement.** If you buy this coverage privately from an outside insurer, you are usually given a detailed policy document that can be anywhere from ten (10) to thirty (30) pages. In your average capitation agreement, there is usually very little reference to limitations or exclusions. The limitations or exclusions are often found after you’ve submitted a claim and you are expecting reimbursement back from the HMO.

- **Claims turnaround.** Since the HMO is creating a generic product for all of its providers, it often will not reimburse your claims until the end of the year or even several months after the end of the year. This slows down your cash flow and limits the contribution that Provider Stop Loss can make to your overall profit margin.

- **Renewals can often yield higher prices for stop loss than your individual group should pay.** At the end of the year, most HMOs look at the overall claims experience for the Provider Stop Loss that they have been offering. At that time, they estimate a rate increase based on the experience of the entire group. Again, you can be paying for the mistakes of other providers that may
not be as effective at managing care or may be exposed to greater catastrophic claims than you are.

- **Provider Stop Loss is often used as a negotiating tool by the HMO when they contract with you.** Often, they will use more favorable terms for the Provider Stop Loss in order to get you to accept lower capitation rates.

- There aren’t many advantages to buying PSL from the HMO, unless you are one of those providers who have extremely bad claims experience. In that instance, you probably can’t get less expensive PSL from the HMO, since you are in a pool where others are helping to offset your costs with their good experience.

This is universally the best option for buying this type of coverage. The only exception would be as indicated above.

- **Coverage is often 30-50% less expensive than buying from the HMO.** If you are a larger group with very predictable experience, the savings can be even greater if that experience is good.

- **Since you are dealing with an outside vendor and insurer, they will pay your claims as you submit them.** In fact, you can get a claims payment performance that guarantees payment within thirty (30) days of submission.

- **Administration is easier since you will have one Provider Stop Loss policy for all of your HMO agreements.** If you have your coverage with multiple HMOs, you have different submission requirements for claims with each HMO, and you may even have different deductibles for each HMO agreement. By buying one policy with one set of terms for reimbursement, deductibles and coinsurance, you simplify your claims submitting system.

- **You can design the coverage, within reason, anyway you want.** Meaning, you can have any deductible, any coinsurance or any reimbursement formula. As long as the coverage is reimbursing the actual cost of your claim, most insurers will be flexible.
• Tracking your claim is much easier because you have only one entity to whom you are submitting claims, as opposed to multiple HMOs. This way you do not lose track of any claim submissions.

• If you use a broker who specializes in this product, their service staff will be a great assistance to you in both submitting and following up on your claims. Our company often becomes the “back room” for many providers in term of Provider Stop Loss claims submissions. This can often limit the amount of overhead you have to use in order to get your claims submitted and paid in a timely manner.

• If you use a PSL broker/specialist, you will gain access to multiple insurance markets. This means that you can get various rate and term options, ensuring the best possible deal.

• You will have flexibility in your coverage period. Many of the HMOs will give you a limited period of time at the end of the year in which you can submit your claims. Most Provider Stop Loss brokers will do the same, but you will have flexibility as to how long of a period you have at the end of the year in which you can submit your claims. The HMO will not be this flexible. Again, the HMO is attempting to create a very generic program.

If you buy this coverage from a non Provider Stop Loss broker or work with a broker who is learning on your account, you may buy inadequate and/or over-priced coverage.

Criteria for choosing and finding a provider stop loss brokerage

• Do they specialize in healthcare? Of those who will solicit you, 99.9% do not, and therefore they are still learning the product. If they say that they do, ask for a client list and make a few calls, to their clients.

• Do they have a dedicated service department that will help you submit your claims, track those claims and will intervene on your behalf to ensure that you
are reimbursed in a quick and efficient manner? This is one of the most significant values that a Provider Stop Loss brokerage offers.

- Make sure your broker has Errors and Omissions Insurance! We’ve come across many so called PSL brokers who try to sell Provider Stop Loss and do not possess an Errors and Omissions Insurance policy. Ask for a copy of your broker’s policy and review it to make sure that they have at least two million dollars worth of coverage or more. The reason being, if they make a mistake, you will have to pay for it. There will be nobody for you to pursue, unless you want the brokerage’s assets.

- They should be able to show you at least three to four quotations from various insurers. They should be able to recommend one insurer and tell you why you should buy the insurer they are recommending. Beware of insurers who give you a spreadsheet with every quote. These are people who do not know what they are doing. You want to work with someone who knows how the insurance company works in terms of paying claims, who understands the exclusions contained in their policies, and knows what the track record of the insurer has been with other mutual clients.

- A good broker will possess a dedicated customer service department who will help you submit all of your claims. You might want to speak with this person(s) before you make a decision on a broker. You may even request that they accompany the broker to meet with you.

- Throughout the year, as you add more HMO agreements, you will want to make sure that the service person knows how to get them processed. This will include following up with you to get the necessary paperwork and ensuring that the new HMO agreements are properly added to your policy. Again, do not undervalue the benefit of a good service department at your chosen brokerage. It can make your life easy or extremely difficult.

- You should be able to get periodic reports from your broker, highlighting what claims have been submitted, paid or are pending. If there are any claims outstanding, the broker and the brokerage service person should be
aggressively working on your behalf to resolve any claims issues between you and the insurer to your satisfaction.

- You need a broker who is very knowledgeable and who thoroughly understands Managed Care and this insurance product. We have come across numerous prospects who later became customers, whose brokers sold them a Provider Stop Loss Program by representing the coverage inaccurately. Unfortunately, the provider doesn’t discover this until it’s too late, which is, at the time of the claim. If you pick a good Provider Stop Loss broker, who is a specialist in this field, you can rely heavily on that broker’s experience when it comes to deciding on coverage design and which insurance company to utilize.

When Buying the Coverage from an Insurer, You Should Consider The Following:

- Get a specimen contract from the insurer. Your claim will not necessarily be paid in accordance with the quotation that your broker presents. An experienced Provider Stop Loss broker will give you the specimen contract, which you should review thoroughly. You should pay special attention to the “Exclusions Page”, and ask your broker questions. If your broker has difficulty answering your questions, you may not have picked the right broker. The “specimen” is your policy, so read it carefully.

- Give the insurer whom you are considering, three claims examples and ask them to adjudicate those claims. You might be surprised by how you thought the coverage should work versus how it actually will work.

- Contact the insurer’s claims reviewer that will be paying your claims. Call that person and find out how savvy they are about paying claims. In most cases, if you are dealing with an experienced Provider Stop Loss broker, he’ll be able to set up a conference call between you and the claims reviewer at the insurer.

- Request that the insurer include a claims payment performance guarantee in your policy. This means that if you submit an eligible and complete claim, the
insurer will have thirty days to pay the claim. In the event they do not, there will be an interest penalty. This way you are assured that all of your claims will be paid quickly.
What many providers do is send out their request for a quote to every broker that has ever sent them a piece of mail on the subject. If you use the above criteria that we’ve indicated, the majority of brokers that have solicited you are still in the learning stage, and aren’t who you want to work with.

Further, by sending requests for quotations to multiple brokers including those who know what they are doing and those that do not, you are going to “flood” the insurance market with duplicate submissions going to the same insurer. The underwriter at the insurance company will see that none of the brokers who are involved have control over the account and subsequently will be in no position to negotiate. If you do not allow the broker(s) you work with to possess the ability to negotiate, you are essentially limiting your opportunity to get the best price for this product.

The underwriter will feel that he/she will have a great chance of obtaining your account since there are so many people trying to sell his/her product. Consequently, the underwriter will not give you the best deal. They will quote the “off-the-shelf” rates and you will pay full retail rates for your coverage. Thus, it is best to select one or two brokers to work with. If you pick two, allow them to select the top markets that they work with. Again, these would be markets that they have at least a dozen or so customers with and a minimum of $1,000,000 in premium.

We’ve reviewed many of the aspects of how this coverage works. The key points to remember are as follows:

- Buy only from a brokerage that brokers this product as the majority of its business. Do not assume that a large brokerage firm with a fancy marketing brochure knows a great deal about Provider Stop Loss Insurance.

- If you choose two brokerages, allow each firm to have their choice of insurance companies with whom they will exclusively work on your behalf. You do not want duplicate submissions going to the same insurance company. You will not get the best deal, and you will take away your brokers’ ability to negotiate.
• Ask a lot of questions of both your Provider Stop Loss broker and the insurer that you plan to select. Ask for claims examples, so that you know what you are purchasing, and read the specimen contract.

• Get 90% of the amount paid for non-contracted care in your PSL policy.

• Stop buying this coverage from the HMO. Go find a capable Provider Stop Loss Broker and buy this away from the HMO. There are very few providers who have not saved a significant amount of money by purchasing this coverage away from the HMO. You will save between 30%-50% and your administrative burden will be greatly reduced.

• Realize that each and every dollar that you can get to contribute towards your margin, including Provider Stop Loss claims, may make the difference between a losing year and a profitable one.