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Medical Stop Loss Can Help You Adapt to the Changing Health Care System

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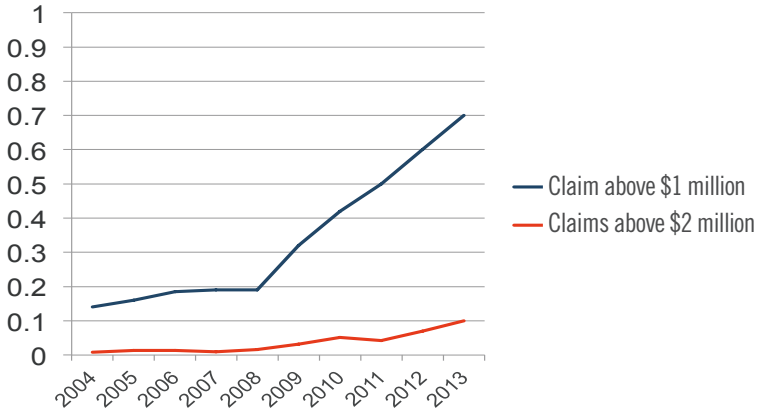
Health care plans across the country continue to face a number of financial threats associated with a growing frequency of high-dollar claims year after year. These high-dollar claims are driven in part by the increased use of advanced medical technology and the rising cost of intensive care treatments. It is estimated that the number of claims over $1 million has increased an average of 21.6 percent per year since 2005.

With the Patient Protection and Affordable Care Act's (PPACA) mandate to eliminate annual and lifetime coverage maximums for essential benefits beginning in January of 2014, plans' exposure to frequent high-cost claims will change dramatically.

Claims per 10,000 Members



Source: Munich Health North America November 2012 Newsletter.¬ 2012 and 2013 are projected by The Union Labor Life Insurance Company.

Scenario #1
Excluded Regimens and Treatments

Description: A claimant recently diagnosed with cancer had undergone a series of experimental chemotherapy regimens at a participating provider's medical facility. The provider had billed the claimant's insurance plan for each treatment and the plan owed the provider over $200,000 in service fees. The plan did not work with its third party administrator to review the claim's eligibility. Instead, it immediately paid the claim within the timeframe according to its contract with the preferred provider organization network. The third party administrator then submitted the claim to the stop loss provider on behalf of the plan to cover the excess cost.

Result: The stop loss provider denied the claim on the basis that the chemotherapy regimens provided were 'experimental,' for which coverage was excluded under both the plan's summary plan description and the stop loss insurance policy.

This loss would have been avoided if the plan and the third party administrator collaborated with the stop loss carrier prior to service, if known, or prior to paying the claim.

Scenario #2
Bill Negotiation

Description: The plan received a $100,000 hospital claim from a non-preferred provider organization facility. According to its summary plan description, the plan covered 60% of the cost for non-network in-patient hospitalization after the member met a $2,000 individual deductible and $1,000 individual confinement co-pay. The plan did not have an out-of-pocket maximum for out-of-network claims. The plan processed the claim according to the scheduled benefit without negotiating with the provider.

Result: Without negotiation, the plan's total liability was $58,200 and the member was responsible for the remaining $41,800.

If the plan properly negotiated the service fees with the provider, it could have received a 20% reduction on the total claim cost if paid promptly. The plan would have reduced its payment to $46,200, and the member would have been responsible for $33,800 instead of $41,800. Bill negotiation would result in savings for both the plan and its members.

Now that health care plans will have to manage high-dollar claims on a more consistent basis, many plan sponsors are looking to medical stop loss insurance (stop loss) as a way to maintain the financial viability of their plans and support their own cost containment strategies.

There are two common types of stop loss insurance. The first type is specific stop loss insurance, which protects against a large claim that exceeds a specific deductible in a policy period. The second is aggregate stop loss insurance, which protects the overall plan against claim expenses that exceed a certain threshold based on the group's expected claims rate per covered individual. Typically, a plan cannot buy aggregate stop loss insurance without having specific stop loss coverage.

But stop loss insurance isn't just a possible back stop to protect the financial assets of a health care plan. Many stop loss insurance providers have experience in handling high-dollar claims and can serve as a resource to help a plan resolve some of the administrative complexities associated with managing medical claims.

Here are three ways health care plans can work with their medical stop loss providers:

Collaborate with the Stop Loss Provider to Contain Cost for Overall Savings

Plans that have stop loss coverage seek protection from large claims that could wipe out their assets. The only way stop loss can help a plan contain costs and realize overall savings is if the policy works in conjunction with the plan's own cost containment program.

Part of a plan's cost containment measures is ensuring that expenses are justified when it receives a bill. This is particularly true for plans that have a preferred provider organization network agreement in place. Most network agreements are written to the advantage of the network administrators, not the health plans. There are plenty of opportunities in the claims process for billing errors and for some providers to take advantage of loopholes and provisions.

When a plan receives a bill— regardless of how large the claim is — it is the plan's ultimate responsibility to ensure that the claim is paid accurately and on time even though these duties are frequently out-sourced to a third party administrator. It is imperative that plans and their third party administrators apply pre-payment bill reviews and audits to ensure the appropriateness of billing and standards of care.

When a claim qualifies for stop loss coverage, it is usually because it is beyond the plan's claims expense threshold. If available, plans can utilize the resources provided by their stop loss provider as an integral part of their own cost containment strategy. Utilizing these resources will help to mitigate common billing errors and eliminate ineligible charges. In some cases, the stop loss provider can help plans negotiate prompt payment discounts with its network provider in lieu of auditing to avoid payment delays and help ensure a smoother claim process.

Ensure Uniformity and Consistency of the Summary Plan Description

The summary plan description (SPD) describes the terms and conditions of the group plan such as eligibility, when coverage starts and ends, the schedule of benefits, continuation provisions, covered benefits and plan exclusions. Because plan members and covered dependents base health decisions on what the plan covers, it is essential that the language provided in the SPD is simple, precise and easy to understand.

This same rule applies to a plan's medical claims administration. The claims administrator must adhere to all conditions on the plan's SPD. If they do not, the plan may face higher than expected claim costs, possible claim denials by their stop loss insurance provider and potential litigation.

Scenario #3
Excluded Coverages

Description: A claimant, who drove under the influence of alcohol, was injured in a car accident requiring emergency medical surgery and hospitalization. He later faced misdemeanor charges. The plan language excluded services resulting from an injury or illness caused while committing or attempting to commit a felony. On the other hand, its stop loss policy excluded coverage for claims resulting from injury or illness caused by an illegal act on the part of the insured.

Result: Because the insured was only charged for a misdemeanor, the plan covered the claim. Since the cost was well over the plan's coverage limit of $200,000, the plan submitted the excess loss for stop loss insurance reimbursement. However, the stop loss insurance provider denied the claim because of the discrepancy in the definition of what coverages are excluded.

Scenario #4
Updating Summary Plan Description

Description: A claimant underwent a liver transplant for which the plan paid up to the extent of charges less any preferred provider organization discounts. The plan removed any coverage limits on the benefits provided as mandated by the Affordable Care Act. The plan verbally communicated the unlimited coverage to its members during the open enrollment session, but neglected to update its summary plan description, which defined a maximum coverage limit of $100,000 for transplant services.

Result: Because the plan did not update its summary plan description, the stop loss provider only considered the charges up to the $100,000 defined maximum and was therefore, made responsible for the loss over the $100,000 limit.

Scenario #5
Coordination of Benefits 'Birthday Rule'

Description: A 10-year old boy, who was diagnosed with End Stage Renal Disease (ESRD) for the last 25 months, was covered under both parents' health plans and Medicare as of January. By December, the claims totaled over $360,000 in doctor's visits, diagnostic tests and hemodialysis treatments. The father's plan paid all claim expenses. After applying all eligible discounts, the total cost was about $330,000. The plan submitted the excess loss of over $180,000 to its stop loss provider after reaching its specific stop loss deductible of $150,000.

Result: Because the 10-year old boy's mother's birthday was on January 2, 1978 and his father's birthday was on February 2, 1976, the father's stop loss insurance provider denied the claim. According to coordination of benefits' 'Birthday Rule,' the mother's plan should have been the primary payer during the plan's 30-month coordination of benefits period from January through May after which time Medicare was to become the primary payer.

In addition, it is equally critical that plans update their SPD to include any required PPACA mandates and update their stop loss providers with a current version of the SPD. It seems basic, but too often, the lack of uniformity and consistency of the SPD can result in significant losses.

Understand and Enforce Coordination of Benefits to Avoid Overpaying Claims

Accurately assessing whether a particular plan is the primary or secondary payer is the first step in avoiding claim overpayments and denial of stop loss coverage. The primary payer will cover a majority of the claim costs and any unpaid portion will be the responsibility of the secondary payer. Coordination of benefits should be considered and enforced when a plan member or any of their dependents are covered by more than one health plan, by Medicare, Medicaid or TRICARE.[ii]

If a plan covers a claim as the primary payer in error, its stop loss provider will deny any overpayments made by the plan outside of the coordination of benefits rules.

Conclusion

The rise in large claims combined with increases in annual maximums and unlimited lifetime maximums will have a tremendous impact on self-funded plans and those who have a fiduciary duty to protect them. Plan sponsors that work closely with their stop loss provider and take a strategic approach to managing claims with their third party administrators and network providers are best positioned to ensure its financial interests in a changing health care market.

(Endnotes)

i Phillips, R.T., Potenza, N., Sabol J., Thomas, A. (November 2012). Confidence Amid Uncertainty. Munich Health North America Newsletter Fall 2012

ii Federal and/or state health care programs are generally always the secondary payers to the employer's health plan.

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