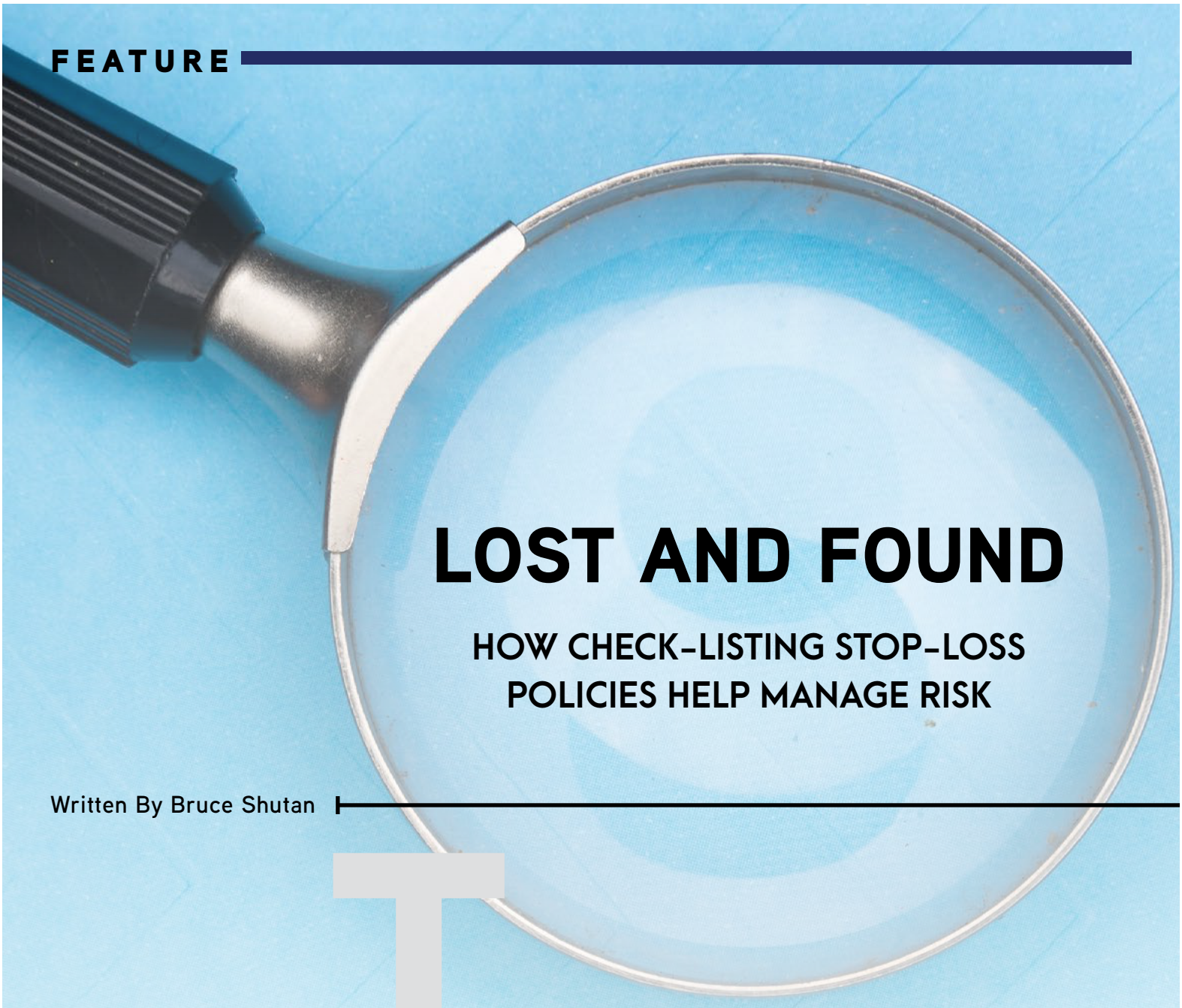


LOST AND FOUND

HOW CHECK-LISTING STOP-LOSS POLICIES HELP MANAGE RISK

Written By Bruce Shutan

There are plenty of do's and don'ts involved in stop-loss insurance in order to make it as efficient as possible. Whatever steps are followed, there's no shortage of basic and creative recommendations alike that can be made to achieve the best possible results.

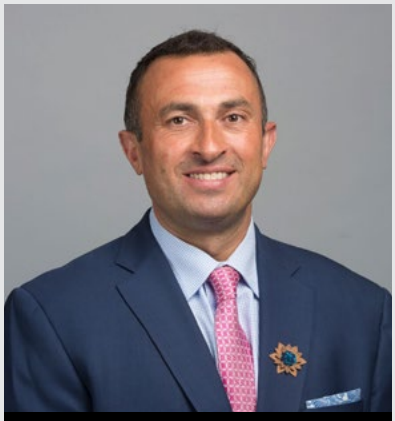
The top priority for any stop-loss contract is that there has to be built-in transparency over the price of care, according to Michael Meloch, president of TPAC Underwriters, Inc.

Although not easily attainable, he believes it's headed in the right direction thanks in large part to the No Surprises Act and transparency-in-coverage rules. If true transparency came to the marketplace, he believes medical costs would plummet by 30%. "The average bill that gets sent off from a provider is 500% of Medicare," he laments.

As part of that equation, it's also critical to know how much all of the entities involved are earning from rebates that should be going to the employer or employees. "Are you charging me a percentage of savings? Are you charging me a PEPM? Are you charging me a percentage of the premium? What are you making off of our plan, Mr. Broker, Mr. Underwriter or Mr. Whoever?" Meloch asks, adding that "there are so many hands in this health care pie. It's just ridiculous."

REVEALING CAVEATS UPFRONT

Third-party administrators play a critical gatekeeping role in helping slice up reasonable coverage for self-insured employers. Adam Russo, Esq., CEO of the Phia Group, LLC, says that first and foremost TPAs need to work with preferred stop-loss carriers so that they can offer better pricing and actually get claim reimbursements for their self-insured clients.



Adam Russo

He also believes that even if they're not the ones bringing in the carrier, they should proactively make available a disclaimer document that establishes complete transparency and helps manage expectations.

That effort, for instance, could caution health plan sponsors against expecting reimbursement from a certain carrier based on the result of a third-party claim review. It also would hold the TPA harmless if the carrier in question was chosen and that was indeed the outcome.

"All employers and brokers need to do is actually know what their risk is before they sign the contract," he explains. "If they did that, TPAs wouldn't be losing employers due to stop-loss issues. Bottom line is if you tell people ahead of time, 'if these types of things happen, you're not going to be reimbursed with that policy,' and if the group says they'll still do it, then they can't get mad at you six months later when they're not reimbursed. It's all about the right partnership, total transparency and getting that loyalty back between the TPAs and the stop-loss community."

The reason Russo is so passionate about employing simple stop-loss checks and balances is that the scenario he describes is one of the top reasons a self-funded group goes back to being fully insured or an administrative-services-only firm wherein none of these conflicts ever arise.

If those employers make a claim, then he says it gets reimbursed in the ASO environment. "But we have more bad policy language out there now than I've ever seen in my 20-plus years in the industry," he observes. "It's not even close.

"Their definition of experimental and investigational, or a hazardous activities exclusion, might be very different than yours," Russo continues. "Also, don't just believe it when you hear plan mirroring. I have seen claims not reimbursed by stop-loss carriers even when there is so-called mirroring by them stating the plan didn't follow the terms of its own plan document and instead the plan followed the network contract. That's why you have to read the stop-loss policy to see what the actual definitions say and then get real world examples. The biggest issue is probably discretionary authority. There's language in policies that grant the stop-loss carrier the right to interpret the terms of the plan document independent of the plan administrator's actual interpretation."

It's important to engage the services of a benefits broker who's knowledgeable about the stop-loss space, can collaborate with the carrier's underwriting team and make recommendations, notes Andrea McNamara, SVP of technical underwriting for QBE North America.

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Andrea McNamara

But a key industry trend is complicating matters. With some experts across the brokerage and consulting community retiring and newer producers not being as familiar with the benefits of unbundling services for self-funded plans, she says losing institutional memory can be daunting.

The fact is that broker partners need to know the stop-loss claims team's reputation, turnaround time, accuracy of their claim payments and ability to help with cost-containment negotiations, McNamara explains.

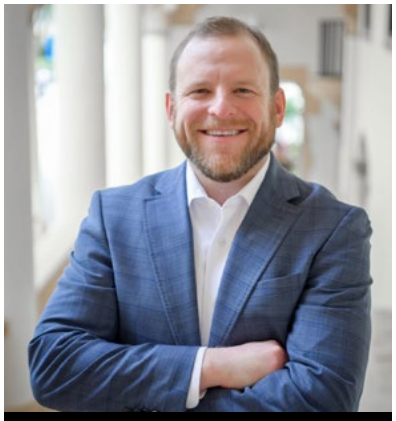
Regarding this last point, some carriers are poised to go that extra mile.

"We have a dedicated cost-containment specialist who works out of our claims department," she reports, as well as a risk management team of registered nurses – most of whom are certified case managers.

LASERS VS. CARVEOUTS

Mindful that there could be claims payable under the plan document that aren't covered under the stop-loss contract, which has narrower language, it's always good to ensure that the two documents mirror one another, opines Scotty Campbell, senior vice president with Stealth Partner Group, an Amwins Company.

"I think it should be pretty cut and dried that either the claims is payable by the plan or it's not," he says. "And if you don't think it is, then it's up to the TPA to prove it to us. I like shifting the responsibility to the TPA because you're paying them to administer this."



Scotty Campbell

The most common causes of this disconnect include haggling over the definition of experimental medical procedures and medical necessity, as well as usual, customary or reasonable charges.

With the devil lurking in those detail, Campbell cautions that self-insured plan sponsors can be left holding the bag with hundreds of thousands, if not millions, of dollars owed on claims. Moreover, he notes that lasering high-cost claims can widen any gap between the plan document and stop-loss contract, which also raises a philosophical debate about the merit of this approach.

Rather than laser out these claims, his recommendation is to carve out big-ticket items across the entire continuum of care, which also will avoid arbitrary decision making. "I always want no new lasers with the renewal rate cap whenever I can get it just because there are so many expensive ongoing maintenance medications out there," Campbell explains.

"If you're to 300 employee group humming along for a decade spending $3 million a year on health care, then somebody pops up who's on a million dollar a year orphan drug," he continues, "that can literally bankrupt your company."

But that's not to say there's no value in lasers, he hastens to add, describing them as "an effective risk-management tool." With only 20% of covered lives ever even hitting the laser amount – usually because of cancer treatments or transplants – Campbell believes there

are times when it's worth rolling the dice. "If you take your 50% rate increase, we 100% know you're going to pay that money no matter what," he says, "but if we have a laser, you only pay the claim if it happens, and if you do, 100 pennies on the dollar go to pay that claim, whereas if you pay $1 premium, only 75 cents out of $1 goes to pay claims the other 25% is overhead. So I'd rather have the employer keep the money."


Michael Meloch

Prudence and good stewardship invariably will be tethered to plan design. For example, a plan that's steering health plan members toward higher costs will serve as an impediment. "Mayo Clinic is great if I have acute lymphoblastic leukemia, and I'm in Minneapolis," Meloch says, "but is it the best option if I need knee replacement?" Better choices may involve the Surgery Center of Oklahoma, which made its mark in 1997 as a transparent-priced center of excellence, a facility in the Cayman Islands or elsewhere, he notes.

Another suggestion Campbell makes is having 12 months of a tail for contract periods before or after unscheduled surgeries for an added layer of protection against a worst-case scenario. The underlying plan document 99% of time will allow providers to submit a claim 12 months from the date of service, he says, noting how it's a standard practice in network agreements that the BUCAHs ink with various facilities. Without a 12-month tail and stop-loss protection, he says there are usually facility claims that are complex and have a big price tag that leaves the client exposed.

The issue recently arose with BlueCross BlueShield of Western

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New York, which he says served as both the TPA and network for a 100-employee municipality client in rural upstate New York. "They administered this $2 million claim for a hemophiliac baby and auto adjudicated it down to $58,000, then the provider, which does a twice-year audit, realized the problem, submitted it to BlueCross Blue Shield, and they agreed it should be $1.2 million," he reports.

But by the time that happened, it fell outside the stop-loss contract and was payable on the plan document according to the network agreement that the client signed when they rented that network. Without the stop loss, he says the city faced bankrupt. While acknowledging the need for technology, Campbell stresses the importance of having a human review and red-flag any questionable high-cost claims.

The way the marketplace is structured raises a larger issue about the degree to which bundled vs. boutique services are the best approach. Bundled service providers whose clear advantage is scale are good if they care about how much it costs the employer and employees, Meloch points out. But he believes those organizations are nearly extinct and the model has become a monopoly as prices continue to rise.

"There's one large carrier in the South that has $4 billion dollars with a 'B' of unallocated surplus," he says. "That's not going to premium. That's not going toward reserves. That's not going toward anything. Where did that come from? Premiums from employees and employers. These entities have become so large and control a majority of the marketplace that they're just accumulating premium. At least organizations that are for-profit pay taxes. If I ran a not-for-profit HMO, could I actually make more money? It's very possible."

FACING DOWN RISING COSTS

Increased use of specialty drugs, along with cell and gene therapies, to treat the growing number of chronic conditions, comorbidity factors and rare diseases in the U.S. makes due diligence on stop-loss insurance more important than ever before.

Cell and gene therapies are expected to double in the next two years and triple in the next three years after that. In QBE's 2022 A&H Market Report, the insurer estimates that more than one million people will receive such treatment by the end of 2034.

"The number of drug therapies that cost over $1 million annually is exploding," McNamara reports, noting how a large segment of the U.S. population is on maintenance drugs for serious chronic illness that are permeating society. Indeed, a recent report by Sun Life found that million-dollar claims per million covered employees rose 15% in the past year and as much as 45% between 2019 and 2022.

Given this backdrop, it's inconceivable that any self-insured employer would roll the dice by forgoing stop loss, though some large organizations have done so in the past. "When you tally up all your dependent lives, that's a lot of hooks in the water for cell and gene therapies, and going bare is not a good idea," she says, cautioning against the prospect of taking on an unlimited risk just to save on the stop-loss premium. As a result, she notes that more large self-insured employers that have traditionally gone bare are now electing to purchase stop loss to mitigate against the increased severity of these kinds of risks.

A knowledgeable broker would help educate their client to explain that a stop-loss policy is designed to pay for projected claims that are simply unknown. Noting that it's a small price to pay for peace of mind, McNamara says "that's what you're paying them for." ■

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for more than 30 years.