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PROVIDER EXCESS INSURANCE CONTRACT CONSIDERATIONS

by Gregory G. Demars

Provider Excess is an insurance coverage offered to provider organizations that have a capitation agreement with a managed care organization. Provider organizations include hospital systems, physician groups, independent physician associations, physician hospital organizations and integrated delivery systems. The coverage is excess of loss in structure and protects the provider group from significant financial impacts caused by individual catastrophic cases. This article will attempt to educate a purchaser of provider excess insurance on the basic contractual structures and issues that should be considered when negotiating a contract.

Certainly key in any insurance coverage purchase is to first understand and determine what is going to be covered (covered services) and at what benefit levels. Concerning covered services, each provider group taking capitation has within its capitation agreement with the MCO, a Division of Financial Responsibility (DOFR). This matrix lists all medical services and supplies the MCO offers to its members and for each it declares whether the MCO or the provider group is financially responsible, or at risk. This document outlines each service/supply the provider group has committed to providing the membership of the MCO in exchange for a monthly capitation. An example of this is available on the section Web site. The DOFR document thereby drives much of the covered services discussion with an insurance carrier.

Like HMO reinsurance, a provider may choose to only insure a subset of total medical costs they are at risk for, targeting the drivers of catastrophic exposures. Usually the provider seeks coverage for all of the services and supplies they are at risk for per the DOFR. Due to this reliance on the DOFR to define the covered services of the provider excess contract, there must be significant rigor put forth in making this clear to all parties involved. Certain insurance carriers attach this DOFR to the provider excess policy and others translate the DOFR to a higher level risk matrix to be used within the provider

excess policy. The purpose of the translation or additional rigor is to take an additional step at time of purchase to make certain it is clear as to what the covered services are to avoid issues later.

The provider group may have many capitation agreements from multiple MCOs for multiple membership types. Membership types include commercial, Medicare and Medicaid lives with each often having unique DOFR's from the same MCO. Again it is critical that all are understood and clear in defining the covered services under the provider excess policy.

Benefit level considerations such as selecting deductible, covered services and coverage options should also include reviewing and monitoring changes in the following:

- Frequency and severity of historical claims at various deductible levels
- Risk profile of provider membership—size, type (Medicare, Medicaid or Commercial)

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- Risk tolerance and budget considerations of the provider group

- Risk mitigation mechanisms
  - o Provider contract structures
  - o Medical management and claim management programs

- Underwriting margin and results

- Financial strength and/or parent support

- Provider group mission and goals

Similar to HMO reinsurance, coverage options include deductible level, coinsurance, average daily maximums and limitations on specific services to name a few. These are tools that allow the purchaser the ability to balance the cost of the coverage with their organization's risk tolerance.

The remainder of this paper is a listing of terms and provisions commonly found in a provider excess policy with a general meaning for the term and typical parameters seen in the market. This information is not intended to provide a precise legal definition of each provision, but a general understanding.

First are common subsets of medical services and supplies defined in the policies that if desired may have unique coverage options or limitations relating to each:

Acute Care—A subset of medically necessary services where a member is a registered inpatient in a hospital, receiving care under the supervision of a physician and the care is not solely for rehabilitation.

Outpatient Care—Services and supplies provided to a member who is not a registered inpatient in a hospital.

Custodial Care—Services and supplies which are maintenance or to mainly assist in the activities of daily living.

Sub Acute Care—A subset of medical services and supplies where the care is primarily rehabilitative or restorative in nature.

Professional Care—Services and supplies provided by a health care professional which are not provided in a home setting.

The insuring clause of the policy generally states that the insurer will cover the coinsurance percentage multiplied by loss in excess of the deductible up to the policy maximum subject to any limitations. Following are brief summaries of these and other common benefit schedule terms and options.

Average Daily Maximum—A limitation on the average hospital inpatient expense per day that is covered under the policy. The average may be calculated for each period of continuous confinement or may be calculated over the entire provider year. These generally range from $2,000 to $6,000, but in some situations are unlimited. When part of the policy, it provides an incentive for the provider to negotiate strong provider contracts and bring care back into network when care is in a nonparticipating facility.

Coinsurance—The percentage of eligible benefits paid by the insurance carrier in excess of the deductible. Standard coinsurance is 90 percent.

Deductible—The amount of the loss incurred retained by the provider. These range from $10,000 to $75,000 for physician based coverage and $50,000 to $1,000,000 for hospital and comprehensive coverage.

Eligible Benefits—The medical services and supplies for which the insurance carrier has agreed to provide coverage under the terms of the policy.

Incurred—The date the service or supply is rendered or furnished by a provider.

Liability Period—The period for which claims must be incurred followed by the period in which

the claims must be both paid and submitted to the insurance carrier to be eligible for reimbursement. Common in the market is 12/18 coverage which means claims incurred during the 12-month coverage period and paid and submitted within six months after the end of the coverage period.

Loss—The amount of eligible benefits incurred subject to any applicable limitations or exclusions.

Maximum Benefits—The limit on the amount of total payment per claim which will be paid under the policy. These are often $1 million to $5 million per covered life per year or lifetime.

Run In—The loss incurred during a certain number of days immediately preceding the effective date of the provider's coverage with the current insurance carrier where such loss was not covered under the previous insurance carrier's Policy.

Run Out or Carryforward—The loss incurred during a certain number of days (e.g., 30-60 normally) at the end of the current policy period for which the deductible is not satisfied will be treated as if incurred during the next policy period.

Scheduled Provider Contracts—The provider may supply the insurance carrier with a written description of the financial terms of a hospital or physician contract and those terms are incorporated into the policy. Claims incurring expense at these providers will be held to the scheduled amounts included in the policy.

Other miscellaneous provisions include the following:

Exclusions & Limitations—Typical exclusions and limitations may include the following:

- Experimental procedures
- Expenses due to act of war
- Expenses payable from any other source
- Expenses not covered under the policy or underlying capitation agreement
- Expenses in excess of reasonable and customary charges

Experience Refund—This is an optional provision used to allow the provider a chance to participate partially in the experience of the policy if the provider excess experience is favorable.

Material Change—A change which requires notification and may result in exclusions of coverage, the termination of the policy or an increase in the premium. Significant changes in membership, ownership or provider contractual charge levels are common triggers for this provision.

Premium Provision—Premium is generally collected on a per member per month basis and is due on the first day of each month with a grace period of 30 days.

Notice of Claim—A requirement for the provider to report claims to the insurance carrier that either have a certain diagnosis or which reach a certain percentage of the provider's deductible.

Offset—The right of the provider or the insurance carrier to apply amounts owed by one party against amounts owed by the other party.

Reasonable and Customary—The charges for health care services which do not exceed the typical charge accepted by the majority of like providers in the same geographical area for the same or similar services.

Service Standards—The policy may include service standards for a policy and amendment issuance, claim payment accuracy and processing time. ✹

Editor's Note: An example of the DOFR document can be found on the section Web site at www.soa.org/files/pdf/excess-insurance.pdf.

Gregory G. Demars is executive vice president for H.C.C. Life Insurance Company. He can be reached at *GDemars@HCCLife.com*