

OPERATING IN A VALUE-BASED AND AT-RISK ENVIRONMENT

Since the emergence of managed care in the 1970s, the healthcare industry has been slowly transitioning from fee-for-service payment models to those more tied to quality of care. As this trend has progressed, providers face increasing levels of uncertainty by entering into risk-bearing contracts with payers known as capitation agreements. These capitated agreements present attractive upsides like experience refunds and less desirable downsides like the risk of catastrophic claims. Recognizing this significant exposure for providers, the Centers for Medicare and Medicaid Services (CMS) has declared that a stop loss mechanism must be included in all capitation agreements to protect provider assets when catastrophic situations arise.

THE REINSURANCE SOLUTION

Providers who engage in these at-risk capitated contracts with health plans need protection from catastrophic claims. Provider stop loss reinsurance steps in to cover claims that exceed the capitated payments over a certain deductible level. Procuring stop loss reinsurance is complex and it's in the provider's best interest to explore the commercial market rather than relying on the coverage already included in individual health plan contracts.

KEY CONSIDERATIONS

HEALTH PLAN STOP LOSS

Multiple payer contracts: complexity and lack of economies of scale

Often vague, one-sided terms and conditions in favor of the health plan

Low deductible level / traditional approach to retaining risk

Limited availability of ancillary services

No data management intelligence to benefit the provider

VS.

COMMERCIAL MARKET

Consolidation of contracts under one master policy achieves consistency and ease of administration

Market-based competition drives savings and defined coverage specifications which reduce uncertainty

Exploration of alternative risk financing options and higher deductibles often leads to increased cash flow

Obtain access to bill review, transplant networks, cancer management networks, out-of-network provider management and pharmacy vendors, among others, in order to reduce the severity of catastrophic claims and thus, the overall cost of risk

Examine advanced data management and population health analytics to increase decision-making insight and market negotiation leverage

THE PROCESS

1. DISCOVERY

We will host a discovery meeting to learn more about your organizational and stop loss-specific objectives. We'll also agree on a timeline and begin the information-gathering process.

2. ANALYSIS

In addition to the capitated contracts and the Division of Financial Responsibility Matrix (DOFR), gathering plan membership and claims experience is necessary to engage the team in further analyzing the risk and creating a full market submission.

3. CREATING THE CARRIER REQUEST FOR PROPOSAL (RFP)

Submitting membership and claims analytics along with the raw data allows for more effective negotiation with carriers by speaking their language and appealing to their technical nature.

4. REINSURER NEGOTIATION

A comparison of competitive alternatives will grant negotiation leverage with carriers to ensure the provider group gets the best coverage efficacy for the best rate considering current market conditions.

5. BINDING COVERAGE

Following a team oriented approach to selecting the most favorable program that fits the provider best, coverage is bound and all contingencies are satisfied.

6. IMPLEMENTATION MEETING

The meeting will be held at the provider's office to introduce the reinsurance partner, review reporting requirements and answer questions.

7. ONGOING SERVICE

Throughout the year, the team consisting of the broker, provider and reinsurer work to manage high-value claims and ensure the provider receives the most favorable experience refund following the reporting period.

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