

Women want to be seen and heard

By Genie James

How important is the female consumer to your practice? The answer is quite interesting if you follow the dollars.

According to a report by the Boston-based consultant firm, Marketing to Women, women make 75 percent of consumer healthcare decisions. In addition to their clout regarding healthcare purchasing decisions for their families, satisfied female customers have the potential to be sources of recurring revenue for physicians.

As baby boomers age and women's life expectancy continues to stretch beyond men's, women are customers whose loyalty can pay

dividends over decades. Both economic and demographic factors should foster a serious focus on women's health as a component of any aggressive business strategy.

For healthcare professionals who are willing to embrace a new model for caregiving, there's much to gain. There is most definitely a customer in the marketplace, the customer knows she is a customer, and the customer knows what she wants.

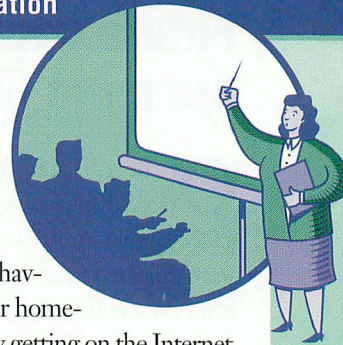
The female patient appears to be no longer satisfied with the status quo of traditional medical treatment. What this means is that the savvy female patient is entering into her relationship with her medical provider as a participant and a team player. She comes into an examina-

tion room having done her homework first by getting on the Internet, researching her symptoms, exploring holistic approaches to care, and checking her physician's professional track record and quality rating.

Despite the fact that women are a major economic force in healthcare, research shows that women consumers have become increasingly *dissatisfied* with what has traditionally been available. Today, what women want can be distilled down to three critical elements:

- ◆ Education and information about their health.
- ◆ Convenient diagnostic and clinical services.

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“The female patient appears to be no longer satisfied with the status quo of traditional medical treatment.”

—Genie James

Reinsurance: Establishing a physician safety net

By Sue Lyn Schramm

The evolution of managed care has seen a steady shift of insurance risk onto the shoulders of physicians. Capitation, especially global capitation, gives providers responsibility for absorbing the costs of caring for their patients. In today's healthcare market, even the best-managed practice can't hope to cover the worst eventualities.

To smooth out the peaks and valleys of outlier cases, physicians can turn to reinsurance. Sometimes, reinsurance is called stop-loss cov-

erage because it stops the bleeding from high-cost losses after a certain point is reached. Thus, reinsurance is a way for physicians to protect themselves from having a single case destroy their profitability.

Surveys of providers have shown that this kind of protection is underused, especially by those who are least likely to have the resources to cover catastrophic cases. Physician groups, even those taking full professional risk, are sometimes shockingly casual about buying stop-loss coverage. According to a survey of capitated physician groups in mar-

kets with more than 10 percent managed care penetration, 25 percent of healthcare administrators do not know what protection they have against outliers, and 90 percent of capitated specialists have no reinsurance at all.

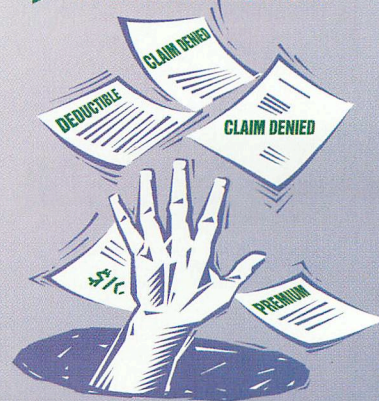
Reinsurance coverage is complex, and rates are subject to many variables. Weighing the benefits of a variety of policies will mean making judgments about the trade-off of coverage vs. premium price. In addition, the reinsurance coverage you select depends on your own resources for reserves to cover high claims.

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Reinsurance features

Some of the main features of reinsurance policies include :

- ▶ Per case vs. aggregate coverage
- ▶ Reinsurance deductibles
- ▶ Contract period
- ▶ Reimbursement maximums



Reinsurance *continued from page 1*

Reinsurance is a business riddled with jargon that is bound to intimidate those unaccustomed to dealing with insurance underwriting.

Your reinsurance needs will vary according to organization size, internal resources, the size of the population at risk, the complexity and variety of your health maintenance organization contracts, and the services for which you are at risk.

Following are brief descriptions of some of the main features of reinsurance policies.

► Per case vs. aggregate coverage

Coverage can be packaged in a few different ways. Among the most important distinctions is whether protection is *per case* or *aggregate*.

Per case coverage, sometimes called *specific coverage*, is written to cover catastrophic cases on an individual basis. After reaching a certain deductible level, it protects physicians from further losses.

Aggregate coverage offers protections from the effects of all losses combined. Physicians must track claims up to a predetermined point, then may make claims against the aggregate excess policy for amounts in excess of that point. Coverage might kick in at 125 percent of expected claims, or a similar level set by the reinsurer's actuaries. At-risk practices may purchase both per case and aggregate coverage at the same time, but usually select one or the other.

pense of those at the bottom.
American Medical News, July 26, 1999

Exaggerating symptoms

Almost 40 percent of physicians say they have exaggerated patients' conditions to insurance companies to make sure the patients have coverage for needed treatment or hospitalization, according to a survey conducted by the American Medical Association.

The AMA's national sample of physicians showed that "physician deception of third-party payors is prevalent and may be rising," according to AMA investigators. The forms of deception included exaggeration of severity of patients' conditions to avoid early discharge from hospitals, changing billing diagnoses to help secure services, and reporting symptoms that the patients did not have in order to obtain coverage and treatments.

Reuters Health Information, June 29, 1999

► Reinsurance deductibles

Reinsurance coverage begins at the stop-loss point. Even after reaching that point, however, coverage is usually subject to a deductible. Reimbursement covers costs in excess of the stop-loss point, minus the deductible amount. Appropriate deductibles vary. Physician groups taking full professional risk without the inpatient component will have much lower deductibles than physician groups that are globally capitated providers.

Even under global capitation, deductibles vary with the structure of the coverage: It may combine the claims costs of physician and hospital services, or it may split the two. If split, per case coverage for the inpatient portion might have a deductible of as much as \$150,000, while the physician portion deductible might be set at \$25,000.

Longer stays for new moms

New mothers are staying in the hospital about half a day longer than they did in the mid-1990s, when insurance companies cut childbirth stays to 24 hours and sparked an outcry about "drive-through deliveries."

A government study says the trend began before a federal law requiring insurance coverage of 48-hour childbirth stays went into effect last year, thanks to a few state laws that already were giving women longer stays.

Physicians say 24-hour stays are often long enough for healthy women with uncomplicated vaginal deliveries who are having their second babies. But first-time mothers, who generally have longer labors and more questions about newborn care, often need a second day.

Modern Healthcare, June 21, 1999

MCP

► Contract period

Policies usually are written for a one-year period, but providers must be careful to understand the reinsurer's definition of which claims fall into consideration for coverage. In the case of provider excess loss coverage, reimbursement is often made only for claims that are both incurred and paid within the contract period.

A typical contract basis is "12/18 paid." In other words, the contract covers claims incurred within 12 months and paid within 18, giving the physician an extra six months after the policy ends to make claims against its reinsurance. Some policies may be written to cover claims on a "12/18 reported" basis.

While "paid" means the physician must have paid the claim during the runout, "reported" means the physician only has to report the claim to his or her reinsurance carrier. This is a much richer benefit for the physician, since it permits claims for all catastrophic cases merely reported within the overhanging months, or "runout" period. This is a crucial distinction since cases using outside specialists or resources frequently involve delays in processing payments.

► Reimbursement maximums

Even reinsurers try to limit their liability for coverage, and most policies have maximum reimbursement limits. A common maximum for per case coverage under global capitation is one million dollars per member per year. A policy also may have an upper limit for the total payout for all cases in a contract period. Higher limits result in higher premiums.

Of much more concern to providers who are at risk for inpatient costs are the limits for per diem reimbursement for out-of-area hos-

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News & Notes

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Impact of report cards

Following its release of quality and service data on medical groups last fall, PacifiCare of California found that high-scoring groups attracted significantly more new enrollees than low-scoring groups.

Encouraged by these preliminary findings, the HMO will repeat the experiment and expects to find report cards can strongly influence patient choice at the physician practice level.

For years, large employers and business coalitions have given employees report cards summarizing clinical and service quality for health plans. When combined with economic incentives to join better-rated plans, those rankings have resulted in huge shifts in market share, with plans at the top gaining at the ex-

Reinsurance *continued from page 8*

pital stays. If an enrollee requires hospitalization outside the network, the provider carrying out-of-area risk must pay for those medical costs. Many reinsurance policies set a daily maximum for charges they will cover, with the limit often as low as \$3,000.

Because out-of-network hospital services will be billed to providers at full-charge rates, complex cases can rapidly surpass reinsurance maximums. Providers accepting full risk should be very wary of per diem maximums, because if they are set too low, they can defeat the whole purpose of reinsurance for catastrophic cases.

Note that reinsurance can't save physician practices from poorly ne-

gotiated managed care contracts. It doesn't replace the need for carefully set capitation rates or adequate claims reserves. But in the event of a catastrophic case, reinsurance can prevent the worst consequences.

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Importance of the per diem maximum

Consider the following case: A globally capitated provider has an enrollee who suffers a burn accident out of state, requiring a hospital stay of 120 days. Because of the intensive care required for the patient, the average per diem charge is \$9,000, even after a 20 percent discount is granted to the provider covering the patient. Thus, the total charges billed to the provider are \$1.08 million.

Here's an example of how the variations in reinsurance coverage affect the provider's benefits. The provider's reinsurance has a \$75,000 deductible, after which the reinsurance policy provides 90 percent coinsurance reimbursement for costs. If the policy carries a \$3,000 per diem maximum, reimbursement is calculated like this:

$120 \text{ days} \times \$3,000 = \$360,000$ allowed claim
 $\$360,000 - \$75,000$ deductible = \$285,000 covered
 $\$285,000 \times 90\%$ coinsurance = \$256,500 reimbursement paid to provider
 $\$1,080,000 - \$256,500 = \$823,500$ still the responsibility of the provider

If the provider system had purchased a policy with no per diem maximum, it would have been much better off:

$120 \text{ days} \times \$9,000 = \$1,080,000$ full charges
 $\$1,080,000 - \$75,000$ deductible = \$1,005,000 covered
 $\$1,005,000 \times 90\%$ coinsurance = \$904,500 reimbursement paid to provider
 $\$1,080,000 - \$904,500 = \$175,500$ paid by provider

Source: Evergreen Re, Minneapolis, 1997.

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