

A Captive Audience for DPCs

Medical stop-loss captives seen as a promising way to elevate the value of direct primary care and help stabilize claim costs

Written By Bruce Shutan

Few would argue that direct primary care (DPC) provides better access to healthcare, but there's a dearth of credible data on the merits of this emerging approach. One potential obstacle is that there several different iterations of this solution, notes Dale Sagen, vice president and business development leader of QBE North America.

For example, some go by advanced primary care, others are virtual-based or have extremely low total patient panel counts and do house calls. "The question is, which ones are impacting the risk at a greater level?" he asks.



Dale Sagen

Some self-insured employers are using group captive insurance to segregate risk in order to identify if it's working over the long run, which Sagen says QBE's producer partners find intriguing. DPC is one of several newer applications for the medical stop-loss captive model. He says a group captive can serve as a rallying point for like-minded employers with a strong belief that DPC will reduce the risk they share and propensity for incurring catastrophic claims that often are a

problem in the medical stop-loss space.

On the surface, DPC appears to be a good fit conceptually for a medical stop-loss group captive. "From our perspective, the philosophy of the employer that sponsors direct primary care aligns with the stop-loss group captive because they're already thinking about risk mitigation," notes Don McCully, president of Medical Captive Underwriters. "Someone getting the flu who has direct primary care doesn't have to go anywhere else. They can get their treatments prescribed at home or go to an individual office because they have that relationship with direct primary care, and it will not, in most cases, develop into pneumonia."

MEASURING INTANGIBLES

However, there may be other roadblocks ahead to making DPC work in a captive setting. Mike Van Ham, SVP of health risk management at Captive Resources, LLC, notes that DPC is still a relatively new care delivery model that may not yet be widely accessible across all regions of the U.S. Another challenge is the difficulty quantifying the long-term value of DPC visits, specifically measuring the prevention of medical events such as a heart attack or chronic disease through more proactive care.

"How can you measure the conditions that never happened?" he asks, noting that while the return on investment may not always be immediately quantifiable, the value of proactive care is significant.



Don McCully

Still, those concerns pale in comparison to a system driven by misaligned incentives that's increasingly unsustainable. The marketplace is evolving, and Van Ham notes a growing dissatisfaction among traditional primary care physicians, including those working within larger hospital systems, who are willing to embrace an unknown and untested method of compensation based on monthly subscriptions rather than health insurance.

"If you talk to the physicians who started and own these direct primary care setups, they're actively stepping away from a transactional model where patient visits are limited to five minutes in order to meet revenue targets," he observes. "They want to return to the heart of practicing medicine. They want to get to know their patients, the holistic aspect of that person and truly build a relationship."

Over the long run, Sagen says the goal of many DPC-focused group captives is to use the ceded premium as an incentive to ensure that the covered population utilizes the enhanced primary care. He believes this model would have more of an influence over the course of a health plan member's treatment journey if a quality DPC operation is in place and steering patients to the appropriate care. This should reduce the risk of that group captive population over time.



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Mike Van Ham

Underwriters, however, are concerned about program utilization and lag time in appointments. Even if an employer is paying an upfront cost for DBP, Sagen says, sometimes health plan members still don't use the service and end up in the emergency room or an urgent care center.

Many times, not everyone is signing up or receiving an appointment in the first six months of access to a DPC practice because of a supply

chain issue or poor promotion, he says, noting the importance of incentivizing individuals to see their DPC doctor.

DPC physicians have a finite amount of time to meet with patients and, therefore, may have a limited ability to grow their practice to meet the needs of an employer and possibly the entire community, he says. A quick way to scale up a DPC operation is to utilize technology, but he fears it could dilute the quality of that risk-management solution.

ADVANCING PREVENTIVE MEDICINE

While frustration is mounting with a sick-care system that merely reacts to rather than anticipates illness, Van Ham says DPC builds on a back-to-basics approach that helps prevent problems from occurring and can stave off disease and chronic conditions. Many employers are seeing tremendous value in this proactive model.

He says regular checkups and preventive screenings from doctors who are unencumbered by time constraints can help identify early-onset diseases and conditions before they become a financial concern and undermine quality of life.

Where medical stop-loss captives can help elevate the DPC model is the fact that employers in these arrangements have a vested interest in always wanting to ensure they're improving clinical outcomes and lowering costs, according to Van Ham. "They're purchasing stop-loss in a more efficient way, and they're seeing the rewards and benefits



of doing that on an ongoing basis," he observes.

His team's focus is on the totality of medical spend, not just stop-loss spec hits – in other words, first-dollar coverage and using primary care to treat musculoskeletal disorders, cancer, diabetes, and other chronic conditions and diseases. They're also deeply involved in cardio-metabolic management, including the evolving GLP-1 space involving weight-loss drugs.

DPC not only lowers the cost to the member by making them more engaged with a physician but also reduces potential future claims that can't be priced in stop-loss insurance, McCully says. While noting that the DPC movement wants claims incurred from those doctor visits priced into stop-loss, he points to a disconnect "because we aren't looking at the frequency of claims as often or as granular as direct primary care requires," and that stop-loss is about anticipating costly catastrophic claims.

With self-insurance, he adds, the objective is to pay known claims below the specific limit and use insurance for claims above the specific limit, which would be for catastrophic events. The impact of DPC on stop-loss may be indirect. For example, McCully says

a reduction in certain areas of claims below that spec will decrease the cost of an employer's aggregate coverage year over year.

"It will lower the overall cost of health insurance for the sponsoring employer who adds direct primary care," he says, "so renewals will be easier." DPC establishes a philosophy for employers who want to improve clinical outcomes, as well as have more productive and happier employees.

Granting 24-hour access to a DPC doctor with whom an employee can cultivate a one-on-one relationship is going to reduce emergency room visits,

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sick days and sick care in general because this proactive approach addresses health concerns in advance, according to McCully. The challenge is proving the preventive value of, say, catching a flu before it becomes inpatient pneumonia, but steering to a lower-cost location that in many cases provides superior outcomes results in significant employer savings.

USING HSAS TO PAY FOR DPC

Even with the promise of 24/7 access to a doctor, few employees are incentivized to spend an extra \$100 a month for DPC on top of payroll deduction, observes McCully, noting how 30 to 40 years ago, fully insured carriers started reducing reimbursements for primary care, which resulted in fewer of those visits.

But within the One Big Beautiful Bill Act passed over the summer, there's a provision that will allow health plan members to use a health savings account (HSA) to pay for DPC, which could serve to open up this model to a much wider population. The thinking is that an HSA contribution will serve as a stronger incentive for a health plan member to enroll in DPC, which is a taxable event for the employer and a benefit for the member.

Whether captives will be able to build out the DPC model in the years ahead, pressure will likely mount to achieve greater certainty in the captive space.

Given that the medical stop-loss market has hardened, more aggressive steps must be taken for captives to get a better handle on insurance risks, according to John W. Sbrocco, founder and program director of Virtue Health. For example, he says certain risk parameters and more risk sharing from the partners of self-insured health plans likely will be required for captive consortium programs to help stem losses.

"The claims are now so big that they cannot catch up to what's going on," he says of captive program managers, predicting the emergence of a more performance-based model. "But when you have risk in the game, you're going to have an incentive to jump on that claim and manage it the best you can." One such example would be monitoring the annual loss ratios of TPA and pharmacy partners in the program. ■

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for more than 35 years.



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Captives Eyed for Cell and Gene Therapy

As captive insurance grows in popularity across the self-insurance community, all eyes will continue to be glued to the way it's used for managing various costly claims that health plan sponsors are expected to struggle with in the future.

Mike Van Ham, SVP of health risk management at Captive Resources, LLC, believes the pharmaceutical and biotechnology space is ripe for expansion in the medical stop-loss captive arena as medicine increasingly incorporates advanced therapies.

He cites the rise of cell and gene therapies, alongside specialty drugs, which are reshaping treatment models and supplementing – or in some cases reducing the need for – certain traditional medical procedures. The challenge will be paying for expensive procedures, some of which he notes could be as high as seven figures, but also potentially curative.

For now, he points out that only a small percentage of the U.S. population is eligible for such therapies, and most stop-loss underwriters are able to underwrite the current risk. “But that said, the pipeline is not stopping,” he says, “so that risk is always going to continue to increase, and the likelihood of having that type of a claimant on your plan for any given employer is going to continue to increase.”

Don McCully, president of Medical Captive Underwriters, wonders how much premium self-insured employers have to add from their actuaries as gene therapies expand. “It may not work on a finite population where a single-parent captive is the best way for large employers to access captive solutions,” he says. It may be a viable solution to transfer cell and gene therapy in a safe place for, say, 10,000 or 15,000 health plan members, but he believes a more prudent approach would be for a consortium of stop-loss vendors to create an excess carrier that pools their covered lives as part of a collaborative effort that just focuses on this area.

An interesting component involving these treatments is addressing the curative nature of gene therapies. “What happens if you have a \$3 million therapy that guarantees a cure, and then you leave the plan, go somewhere else and get sick again?” McCully inquires. “I can't track it as a stop-loss carrier, and the other stop-loss carrier doesn't know that they're going to collect the next payment for the same therapy, but it really should benefit the person who paid the claim in the past, not the current claimant.”

Uncertainty also arises in other areas. For example, he reflects on how cell and gene therapies can be priced when each of these stealth-like products is so unique. In contrast, there are a finite number of human organs to transplant as part of a fixed indemnity program.

Whatever the case, Van Ham considers lasers a strategic lever and believes that as the market moves forward with more cell and gene therapies, there will be centers of excellence and other tactics that drive better outcomes and lower costs. The key is to make sure these design and solution strategies are part of the overall plan coverage.

“Many times, if you get better outcomes, you can identify better savings as well,” he says. “So, I think there's always going to be an opportunity to probably take a little bit off the sticker price on some of these treatments, and it just becomes a matter of using that lever strategically.” – Bruce Shutan