

How to Drop an Insurance Company

By Tom Necela, DC

One of the most common questions I get from consulting clients and seminar attendees is in regards to my advice on dropping a problematic insurance plan. The issues that have led to this dilemma are virtually the same across the board: low reimbursements, high hassle factor (usually in the form of paperwork), slow payments and payers who don't meet contractual obligations.

In general, the doctor asking the question typically feels that a plan or plans are more trouble than they are worth. Certainly, these insurance companies have gone above and beyond the expected norms for the industry and have exhibited chronic patterns that indicate substandard practices.

As a result of these repeat offenses, the good doctor is usually annoyed with some recent problem and decides they have had enough and that something needs to be done. The question then remains: How exactly do you go about deciding which insurance plans to participate in and which to terminate?

At a recent seminar, I revealed my tried and true method of determining which plans you should keep and which plans you should fire. Be forewarned: Accepting or removing provider status should have little to do with philosophical arguments about a particular payer's stance on chiropractic (although this may add more fuel to your fire) and should be approached with the due diligence associated with any major business decision. My recommendations to drop a plan amount to just that. If participation on a particular insurance plan makes poor financial sense, a strategic approach to the issue may actually dictate that *not* being a provider may be of greater financial benefit to your clinic than being one.

After all, like it or not, you are in the business of providing chiropractic services. Many times, joining particular insurance companies makes sense as a business decision because (in theory) we provide the insurance plan and members a discount on our services in exchange for access to their patient list. When the financial discount is too steep, payments are repeatedly delayed in excess of industry standards, or the number of hoops we need to jump through to receive payment is too great, it may no longer be a fair

exchange for doctors to continue as providers.

Please note: I am certainly not advocating you drop all insurance plans and go to a cash-only practice. There is not a week that goes by that I don't receive an e-mail from a doctor who is struggling to find profitability in that model. I am not stating one model of reimbursement is better than the other. What I am trying to convey is that if you participate in third-party reimbursements, you need to monitor the associated contracts, fee schedules and policies to make sure this is a worthwhile endeavor.

Before I reveal my methods of determining which plans to consider dropping, here's a short list of what *not* to do:

- Don't base your decision to participate on a single EOB that has made you upset based on the way it was paid.
- Don't drop a plan without calculating the true value of what nonparticipation will cost you.
- Don't forget to inform the insurance company of your decision in writing.

The decision to drop an insurance plan should be based on carefully calculated, rational business principles. Fortunately, you have the single best tool to help you make that decision in your hands at this very moment: your 1099. Since your 1099 records the total payments you have received from a single payer in the previous year, you can use it to calculate their value. First, rank all your 1099s in order from highest payments received for 2008 to lowest. Consider the bottom (lowest) handful of payers to see which insurance companies to potentially drop. You may be tempted to stop there and drop the lowest payers immediately. However, take the next few steps to see why it may be important to continue.

Calculate the total value per patient for each of these low payers by determining the total amount paid divided by the total number of patients seen for that plan in 2008. For example: ABC Insurance Company paid you \$5,000 last year. You have 100 patients on ABC plans. Therefore, your total value per patient for ABC is \$50 per patient. XYZ Insurance Company also paid you \$5,000 last year. You have 125 patients on XYZ; a total value per patient of \$40.

In some cases, the numbers may be spread apart enough for you to make a decision immediately. For example, if a particular plan pays \$5,000 for the year but only has two patients, it may be a keeper. If an immediate winner/loser does not emerge because the numbers are too close, then calculate the total value per visit. Divide by the average number of visits each patient had.

For example, ABC Insurance has a total value per patient of \$50 and patients on ABC plan visited the office 1,000 times. There were 100 patients on the ABC plan, so that's an average of 10 visits. So, a \$50 total value per patient divided by a 10-visit average = \$5 value per patient visit. XYZ Insurance, on the other hand, has a total value per patient of \$40 for 125 patients. XYZ patients saw the doctor 500 times: an average of four visits per patient. A \$40 total value per patient divided by the four-visit average = \$10 value per visit.

So, in our examples, XYZ actually saw a greater number of patients, but in fewer visits to achieve its total payment of \$5,000. In other words, XYZ paid a higher total-visit value than ABC.

If things are still close, use "hassle factor" emotions. If you still can't decide, bring in emotional factors to help make a choice on whether to stay on the plan. In other words, does the plan require lots of paperwork that effectively lowers the value of your claim? After all, every time you or a staff member has to write a report, appeal letter or medical-necessity explanation, it's money you are not being compensated for and work you have already done. Are there good-quality patients on this plan, or do the patients not quite fit the demographic of those patients who love and appreciate your work the most? Are there other hassles about dealing with this plan that just make life difficult, such as poor customer service, repeated processing errors, delays in authorizations, etc.?

The good news is many of the decisions can be done before you ever need to get emotionally involved, but if need be, use the hassle factor to further confirm your participation or withdrawal from a particular plan.

If and when you decide not to participate in an insurance plan, consider that you must inform the insurance company in writing and that most plans require a 60- to 90-day notice. Make absolutely sure you have calculated correctly and estimated the true costs for dropping this plan. Then, if you are convinced that nonparticipation is a sound business decision, go ahead and give them the boot. This is certainly not an issue to take lightly. However, if more chiropractors (and other physicians) routinely evaluated their participation, they would likely uncover the "rotten apples" that give the good insurance companies a bad name.

Congratulations - it's time to celebrate! Why? Because you have now taken steps to declare that your time and expertise are valuable, and that you are not willing to tolerate someone (or some insurance company) placing arbitrary limits on them. And you have taken concrete steps toward achieving better profitability by removing barriers to do so.

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