HMO Excess Reinsurance Treaty Considerations

By Mark Troutman

This article addresses issues of importance to HMO excess reinsurance purchasers when negotiating a reinsurance treaty.

Reinsurance is a budgeting tool to avoid the impact of catastrophic claims on financial statements. In addition to providing coverage for unpredictable catastrophic claims, HMO reinsurance can provide coverage for insolvency/continuation of benefits risk which is often required by state regulatory requirements. Reinsurers may also offer access to managed care vendors to mitigate severity and frequency risk of catastrophic claims (e.g., transplant centers of excellence, neonatal case management, discounts of high-end pharmaceuticals or provider discounts on out-of-network claims).

The most important consideration in the reinsurance purchasing decision is the type and level of benefits to be reinsured. The proper risk analysis by the plan or in conjunction with its reinsurer will address the following considerations:

1. What is predictable risk versus unpredictable risk?
2. Where is the health plan at greatest risk for catastrophic claim?
3. What is the appropriate reinsurance deductible for the health plan?
4. What covered services should be reinsured?
5. Which hospitals facilities (contracted or non-contracted) have the greatest impact on the reinsurance program cost?

6. What reinsurance limits, explicit and implicit, are being utilized to control the cost of reinsurance and shift costs to the plan?

In contrast to other medical excess covers, HMOs often only reinsure a subset of total medical costs. For example, the plan may only reinsure hospital inpatient services, since they are the primary drivers of catastrophic claims. Or, the plan may purchase comprehensive coverage including other medical and professional services. These types of services would include such items as prescription drugs (including blood and blood products), physician charges, durable medical equipment and supplies, ambulance services, outpatient facilities, mental health and chemical dependency services.

In selecting deductible and coverage options, administrators of health plans should consider the following:

- Frequency and severity of claims at various deductible levels
- Geographical locations of contracted providers and provider contract characteristics (e.g., discounts from billed charges, DRGs, etc.)
- Member type and risk profile of plan membership
- Risk tolerance and budget considerations
- Plan size
- Underwriting margin and results
- Plan mission, financial strength and parental support
- Effectiveness of the plan’s managed care programs

A primary differentiating factor in HMO excess contracts is the presence of “scheduled” and “unscheduled” facility charges for hospitals. These may be called by other names such as approved or non-approved. A reinsurance treaty recognizes the provider contracts that the HMO has negotiated and delivers higher reinsurance benefits when medical care is provided in scheduled facilities. In addition to higher coinsurance reimbursement levels, the treaty may waive or reduce inpatient average daily maximum limits or per diem limitations on reinsurance reimbursement as well. Most HMO reinsurance agreements have some form of maximum per diem reimbursement, often called an “average daily maximum.” Including an average daily maximum limitation provides an incentive for the plan to negotiate strong provider contracts and to bring care back into the health plan’s network when care is being provided in a non-participating facility.

Reinsurance coverage is typically for all population bases insured by the HMO-Commercial, Medicare and Medicaid (if applicable). A reinsurance treaty may include service standards for a treaty and amendment issuance, claim payment accuracy and processing time. Since most agreements fall into the one-year, cancelable coverage category, there are no provisions for recapture in the event of a ratings downgrade by the reinsurer.

HMO Excess Reinsurance Terms

The following is a listing of terms commonly found in an HMO excess reinsurance agreement with a general meaning for the term. This information is not intended to provide a precise legal definition of each term.

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.

Average Daily Maximum—A limitation on the average expense per day that is covered under the agreement. The average may be calculated for each period of continuous confinement or may be calculated over the entire agreement year.

Coinsurance—The percentage of eligible benefits paid by the reinsurer in excess of the deductible.

Continuation of Benefits—Additional coverage which is usually provided, if applicable, in an amendment for primary plan benefits in the event of insolvency of the plan.

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

Deductible—The amount of the loss incurred retained by the plan.

Eligible Benefits—The medical services for which the reinsurer has agreed to provide reinsurance coverage under the terms of the agreement.

Experimental—Medical services which are not currently considered as standard, effective practice by the medical community at large.

Exclusions & Limitations—Typical exclusions and limitations may include charges for which the plan is not liable, fines or punitive damages, extra-contractual damages, salaries paid to employees, professional liability and the like.

Fixed Procedural Fee—A predetermined, all-inclusive fee for a described healthcare procedure.

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

Liability Period—The period for which claims must be incurred, paid and submitted to the reinsurer to be eligible for reimbursement (e.g., 12/18 = claims incurred during the 12-month coverage period and paid within six months after the end of the coverage period).

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

Material Change—A change which requires notification to the reinsurer and which may result in exclusions of coverage, the termination of the agreement or an increase in the premium.

Maximum Benefits—The maximum reinsurance reimbursement that will be paid under the agreement.

Medically Necessary—Services that are necessary for the treatment of an illness or injury with demonstrated medical value and are recognized by the medical community as being appropriate for the condition diagnosed.

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

Offset—The right of the plan or the reinsurer to apply amounts owed by one party against amounts owed by the other party.

Outlier—An inpatient hospital confinement that exceeds a predetermined length of stay or cost as defined in the applicable provider contract.

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

Per Diem—A fixed, all inclusive per day charge for health care services.

Professional Care—Services and supplies provided by a healthcare professional that are not provided in a home setting.

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

Run In—The loss incurred during a certain number of days immediately preceding the effective date of the plan's coverage with the current reinsurer when such loss was not covered under the previous reinsurer's agreement.

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

Scheduled—The plan supplies the reinsurer with a written description of the terms of a hospital contract and those terms are incorporated into the agreement.

Step-Down Facility—A facility which provides a lower intensity of care than an acute inpatient hospital. Such a facility may be a sub-acute facility, a skilled nursing facility, a hospice, an inpatient rehabilitation facility or the services may be provided in a home setting.

Subacute Care—Care that is primarily organized for patients with rehabilitative and/or medically complex needs who require physiological monitoring. Services are focused on functional restoration, maintaining a stable medical condition, or avoidance of complications.

Swing Rate—A premium rating mechanism whereby the rate may increase or decrease depending upon the loss experience, subject to a minimum and maximum rate.

The following is an example of HMO excess reinsurance coverage for a plan.

Covered Members:	Commercial Medicare Medicaid
Covered Services:	
	Inpatient hospital services Outpatient facility services Subacute facility, inpatient rehabilitation facility, skilled nursing facility, hospice and home health care agency services Prescription drugs
Exclusions:	Ambulance services Durable medical equipment and supplies Professional services Inpatient mental health and chemical dependency services Outpatient mental health and chemical dependency services Organ donor services Organ procurement services
Deductible:	$300,000
Loss Limitations:	
Average Daily Maximum:	$3,000, based on the number of days of each continuous hospital confinement

Subacute facility, inpatient for rehabilitation facility, skilled facility, hospice and home health care agency services:	$750 per day, 30 days per agreement period for all categories of services combined
Prescription drugs:	$250,000 per agreement period

Coinsurance:

Transplants:	
Scheduled facilities:	90%
Unscheduled facilities:	60%
All other services:	90%

Maximum Reinsurance Benefit:

Per agreement period	$2,000,000
Per lifetime	$2,000,000

Deductible Carry Forward: 31 days

Liability Basis: 12/18

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