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MANAGED CARE UPDATE

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Introduction—This article provides an update on HMO market trends and reinsurance products and services supporting them.

A. HMO Market Trends

Several market forces have been affecting HMOs:

1. **Costs**—Average health care costs moderated in 2004. According to a Mercer Resource Consulting LLC study, the average cost of U.S. employer-sponsored health coverage rose 7.5 percent, to $6700 per employee. This is the lowest rate of increase since 1999. However, continued expensive advancements in medical technology, pharmaceuticals and the aging of the population continue to increase medical costs at a rate more than the change in the consumer price index.

2. **Product Design**—HMOs have offered more open networks and less management of care given the consumer backlash in the early part of the new millennium. This same Mercer survey also indicated that employers, in response, are raising employee cost-sharing with higher deductibles, co-payments and coinsurance features. Health Savings Accounts (HSAs) are being increasingly offered as part of a cost control solution. The number of members enrolled in HSAs has doubled to 1 million. The number of insurance companies providing HSAs has tripled to approximately 100. (*Source: America's Health Insurance Plans Survey*).

3. **Profitability**—The profit margin of the HMO sector improved in 2003. Average profit margins for the industry were 3.78 percent of premium versus 2.5 percent for 2002. The increased financial strength of HMOs is demonstrated by the rising stock prices of the big publicly owned chains. The financials are improving for various reasons: increased earnings potential, government expansion of Medicare / Medicaid opportunities and cyclical profitability. Further increases in profitability are being reported for 2004, although the majority of the earnings are concentrated in relatively few companies. (*Source: Weiss Ratings*).

4. **Market Share**—HMO market penetration is declining somewhat. The number of Americans enrolled in HMOs dropped to 69 million in 2004 from a peak of 80 million

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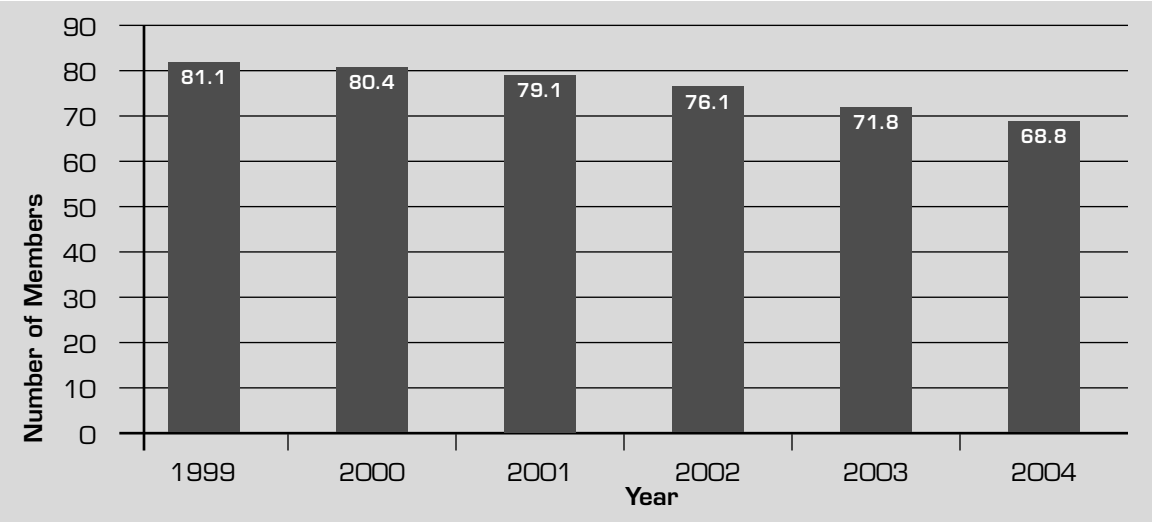
Figure 1: HMO Members (in Millions)



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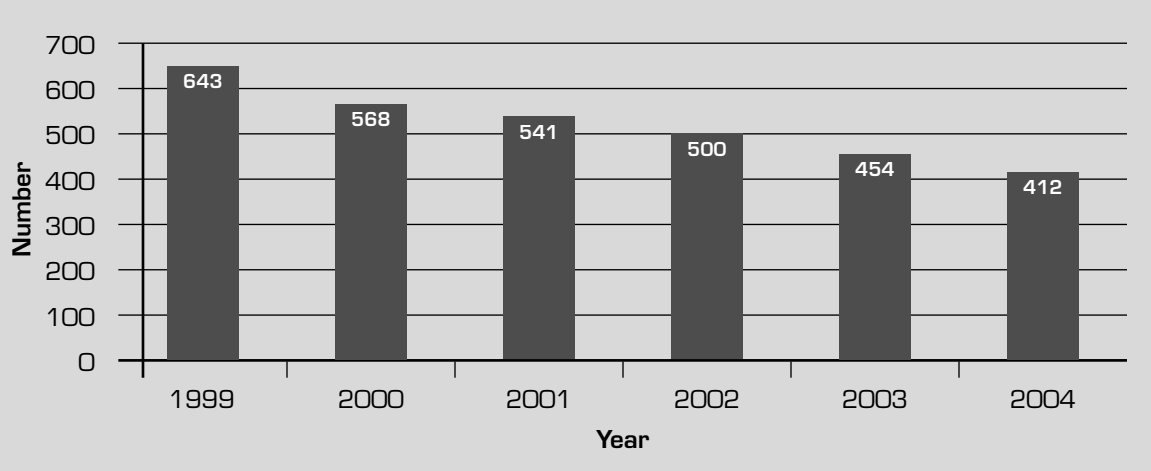
in 2000 (Source: Interstudy Publications). PPOs have picked up the slack as they provide a broader access and greater flexibility than HMOs, but usually at higher cost. PPOs now cover 109 million Americans. Table 1 on page 23 demonstrates the decline in HMOs membership.

5. **Provider Contracting**—More provider contracts are designed to provide pay for performance to efficient providers. Managed care companies increasingly design programs to steer patients to high quality, low cost providers in the environment of "managed care lite." The Centers for Medicare & Medicaid Services (CMS) has begun a new demonstration project to test financial incentives, which reward quality improvements. Providers have gained more contracting strength due to consolidation in the hospital market. This allows them to negotiate higher increases on per diems, percents of billed charges or other managed care contracting arrangements with payers.

6. **Consolidation**—The merger-and-acquisition activity of the major health care chains continues to shrink commercial and Medicaid plan reinsurance opportunities. Publicly held corporations strive for growth to achieve economies of scale, expand their market penetration in various geographic areas and demonstrate revenue and earnings growth to their shareholders. Most of the publicly held corporation health care chains buy little, if any, reinsurance. There have been over 100 HMO acquisitions the last 10 years by major chains such as United Healthcare, Anthem/Wellpoint, Coventry, PacifiCare, Humana, Cigna and Health Net. There has also been a flurry of M&A activity by major Medicaid chains such as Molina and Centene. These two companies alone have engaged in 10 transactions in the last 18 months. Table 2 demonstrates the HMO market consolidation (*Source: Interstudy Publications*).

7. **Government Programs**—At the same time that the traditional reinsurance market is contracting, however, there is some expansion in Medicare and Medicaid HMO reinsurance opportunities as the state and federal governments continue to privatize these programs in a perennial effort to control costs. The 2003 Medicare Modernization Act increased government reimbursement significantly to managed care plans. In 2005, Center for Medicare & Medicaid Services (CMS) received nearly 150 new health plan organization applications to offer services to Medicare Advantage beneficiaries through

Figure 2: Licensed HMOs



new Medicare Advantage HMOs and Medicare PPOs. Over 100 current Medicare Advantage HMOs are also increasing their service areas. (*Source: CMS Medical Affairs*).

The effort to provide high-quality, cost-effective healthcare with broad access to providers continues in this segment.

B. Reinsurance Underwriting and Coverage Trends

The most important trend affecting the traditional HMO reinsurance market is the continued industry consolidation previously described. This causes the HMO excess market to be a small, mature market where reinsurance opportunities are trending downward. This follows from the continued consolidation of HMOs through M&A activity as well as from very small HMOs going out of business. Such plans occasionally cease operations due to a provider hospital owner capital constraint, or a desire to focus on maximizing revenue across payers rather than using an HMO as a distribution channel for their services. Due to the consolidation in the market, reinsurance competitors must "steal" business from each other in order to grow. This places pressure on reinsurer margins and essentially makes it a buyers' (i.e. soft) market. This increased competition in a declining market is offset somewhat by the expansion of government programs described here.

The relative increase or decrease in the entire market depends upon the future consolidation trends and the consistency of government policy regarding privatization of government health care liabilities in Medicare/Medicaid programs.

Another coverage trend among HMOs currently buying reinsurance is a movement towards higher deductibles and higher average daily maximums. This is a natural trend in an inflationary environment. An average daily maximum (ADM) is a per diem inside limitation on reinsurance claim reimbursement. It maintains an aligned economic interest between the reinsurer and the HMO regarding health care claims which exceed the reinsurance deductible. From a pricing perspective, increasing the deductible lowers premium rates while raising the ADM increases premium rates. Doing both in combination often results in relative premium neutrality and higher coverage efficiency as a larger percentage of claims over the chosen deductible are reimbursed instead of being limited by the ADM. In fact, some HMOs are now looking for coverage, which has no such inside limits. Different carriers will offer such coverage with various underwriting guidelines. The reinsurance contract with no ADM limitation is much more expensive than one with a reasonable ADM limitation (sometimes two times more expensive). The exact magnitude of difference depends upon plan experience and provider contracting arrangements.

It's still very important to keep apprised of all of the particulars of a given state Medicaid program. Some states take back certain high cost claim risks in Medicaid populations and others don't. The eligibility requirements of any state-provided reinsurance protection affect the size of the external reinsurance market. Furthermore, underwriters need to be aware of what risks are moving in or out of their exposure base as the government program provisions change.

Some reinsurers are beginning to add additional exclusions and limitations in their agreement to move costs back to the managed care plan. Some are more obvious than others. An example would be limiting organ transplants to two per member or imposing an average daily maximum even to a diagnosis related group (DRG) payment arrangement. It is important for the purchaser to ensure an "apples-to-apples" comparison of benefits for various reinsurance proposals when comparing rates.

General inflation for hospital inpatient reinsurance coverage has been roughly 9–10 percent. Outpatient facility drugs have trended higher at 10–12 percent. All of these trend rates have additional leverage as the deductible increases, but are subject to change in the per diem provider contracts as well as outlier provisions, which revert a per diem or DRG contract to a percent of billed charges.

What items do buyers take into consideration in their purchasing decision? Benefits and rates are far and away the key consideration. Claim service and reinsurer financial strength are a distant second and third. There is little impact in the buying process

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from reinsurer capabilities such as managed care vendors (*e.g.*, transplant networks) or ancillary product solutions (*e.g.*, employer stop loss, group life or out-of-area medical programs).

THE RELATIVE INCREASE OR DECREASE IN THE ENTIRE MARKET DEPENDS UPON THE FUTURE CONSOLIDATION TRENDS IN THE INDUSTRY AS WELL AS THE GROWTH OF MEMBERSHIP IN PRIVATE PLANS ACCEPTING GOVERNMENT HEALTHCARE LIABILITIES IN MEDICARE/MEDICAID.

Another reinsurance trend is the increase in coverage features, which have some form of swing rate, aggregating excess corridor or other alternative premium funding method. Each of these attempt to give some cash flow advantage to the client while trading upside and downside risk with the reinsurer. It's particularly hard to compare these provisions among carriers on many of these product permutations. These features may seem to reduce an insured's reinsurance costs; however, when they need protection, these provisions actually add to their costs and load an additional margin. Caveat emptor.

One knows the market is softening when one sees two-year rate guarantees and products with no ADM being offered more prevalently, particularly by brokers. These were major contributing factors to the last soft HMO reinsurance market of 1998–1999.

Brokers—Brokers still control 20–25 percent of the market, notwithstanding the fact that the Elliott Spitzer investigation has shed a new light on brokering activities. The HMO reinsurance market is still segmented into companies, which acquire business through brokers and those reinsurers who write business directly with the HMO. This could be done through their own employees or by contracting with managing underwriters. More and more plans are willing to solicit direct market bids in addition to the bids they receive from retail brokers. Otherwise, they are limiting their access to several of the major HMO reinsurance markets.

Regulatory—The ongoing broker/reinsurer practices inquiry led by New York Attorney General Elliott Spitzer is primarily focused on certain major property and casualty carriers in national brokerage firms. In addition to focusing on contingent commission arrangements and bid-rigging, some of the more severe forms of financial or finite reinsurance are under close scrutiny. It's unclear whether or not the same kind of scrutiny will be applied to the life and health reinsurance marketplace and the smaller fish in the pond. The investigation is still a work in progress, and most HMO reinsurance brokers who were accepting contingent commission arrangements from reinsurers have ceased doing so.

Brokers, managing underwriters and reinsurers are subject to a wide variety of licensing and compliance requirements. Companies are advised to make sure that their brokers, consultants, reinsurers and reinsurance intermediary managers and reinsurance intermediary brokers have all the required licenses and approvals to conduct business in their state. Some states recognize reciprocity when the entity has a similar regulation and license in their home state. Others require additional filing and licensing requirements in addition to the reciprocity provisions.

Provider Excess—The early part of the new millennium was highlighted by poor profitability on these arrangements where HMO risk had been shifted to capitated providers. Several carriers have exited the market, and there have been no significant new entrants. In general, the number of reinsurers appears to have stabilized, and they are achieving their target profit margins. Most providers, which continue to receive capitation have demonstrated the infrastructure to manage risk and to negotiate the appropriate capitation rate. Many of the past players who took capitation first and asked questions later took a bath. Rates have increased significantly, and liberalizations in terms and conditions have moderated (*i.e.*, a hard market). This is welcome relief to provider excess carriers who had significant losses in that line in prior years.

Carve-outs—There are no significant changes in purchase of neonatal or transplant carve-out products. Plans purchasing such carve-outs often have inadequate medical management capabilities or

provider contracts of their own. They are looking to replace uncertainty with certainty, as with any reinsurance premium, but on a first dollar quota share basis rather than excess of loss. Transplant carve-out market is estimated at $50 million of premium with URN, a subsidiary of United Healthcare, being the largest player due its acquisition of SRI. Distribution is through a wide variety of sources including direct sales, brokers, TPAs, managing underwriters and carriers.

Catastrophic Claims/Managed Care Vendor Trends—There are three main trends in this area:

1. Organ transplants are still limited by the supply of organs. There is still a significant waiting list for organ transplants.
2. There continues a rising rate of multiple births. Increase is due to advances in and greater access to fertility therapies and an older age of childbearing.
3. Many HMOs offer disease management programs themselves or through disease management vendors. Typical programs target asthma, diabetes, cardiovascular disease, chronic obstructive pulmonary diseases and maternity as well as end stage renal disease. Most disease management claims do not reach the catastrophic claim level.

A recent survey by Summit Re of its managed care clients regarding what types of managed care vendors they currently have in place produced the following results:

1. All clients have some form of utilization management, consisting of pre-authorization for admissions and certain other services in concurrent review of inpatient admissions.
2. Disease management programs are primarily internally developed and focus on the diseases most prevalent within the particular health plan. The sophistication of the program is varied as well as the degree of the outcome reporting. A few plans have a specific end stage renal program and more are planning to do so in the future.
3. Almost all clients have contracts with pharmacy benefit managers, which may include reduced pricing for high-cost specialty pharmaceuticals or they have contracts with separate companies for those drugs. The contracts provide discounts off of average wholesale prices of the drugs. Some companies also include supplies and home nursing (when medically indicated) as a part of the contracts.
4. The majority of the clients access some form of network for transplant services such as United Resources Network (URN).
5. About half have some form of out-of-network repricing capabilities. Pricing negotiations are done internally for some health plans or are contracted out to a national PPO /repricing vendor.
6. Approximately 25 percent of the clients have contracted with a neonatal intensive care unit (NICU) management vendors.

Figure 3: Managed Care Programs

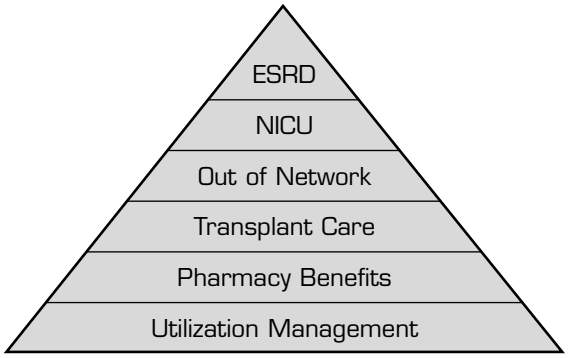

Figure 3 indicates the prevalence of various types of programs offered by managed care plans.

Conclusion—From a reinsurer's perspective, there are positive and negative aspects of the current managed care reinsurance marketplace. It has consolidated and softened somewhat, but still has plenty of opportunity for knowledgeable, disciplined reinsurers. As some trees fall and are cleared away, other trees are planted. The relative increase or decrease in the entire market depends upon the future consolidation trends in the industry as well as the growth of membership in private plans accepting government healthcare liabilities in Medicare/Medicaid .✺

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