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Catastrophic Medical Excess Reinsurance Coverage and Claim Trends

By Mark Troutman

This article provides an overview of coverage and claim trends for managed care medical excess of loss insurance and reinsurance programs. For purposes of this article, reinsurance is considered to include provider excess of loss insurance.

COVERAGE TRENDS

Although there is a diverse mix of commercial, Medicare and Medicaid, including dual eligibles, health plans purchasing reinsurance protection, Medicaid risks are becoming more prevalent as state and federal governments expand Medicaid coverage to previously uninsured populations. In addition, states have transferred to health plans some Medicaid membership categories on which they historically have retained some or all catastrophic risk. These new Medicaid risks are often risk-adjusted with actuarial analysis of the capitation rate, but the sheer size of the new membership and the unknown new population health profile inherently bring material unknown risks to a health plan and its reinsurer.

The smaller the plan, the more likely it purchases reinsurance protection. The size and risk tolerance of the plan determine the deductible selected, which can vary over a wide range (see chart 1). A small but growing segment of coverage includes “sleep insurance” deductibles of \$2 million plus, which have been necessitated by the introduction of unlimited maximum benefits and the elimination of underwriting considerations in certain lines of business. Because of this unlimited liability, more and more reinsurance clients are increasing their maximum reinsurance limits. Although many insurance companies and health plans (HMOs) had unlimited liability prior to the Affordable Care Act, health care reform provisions make this a growing coverage trend (see chart 2).

CHART 1: DEDUCTIBLE

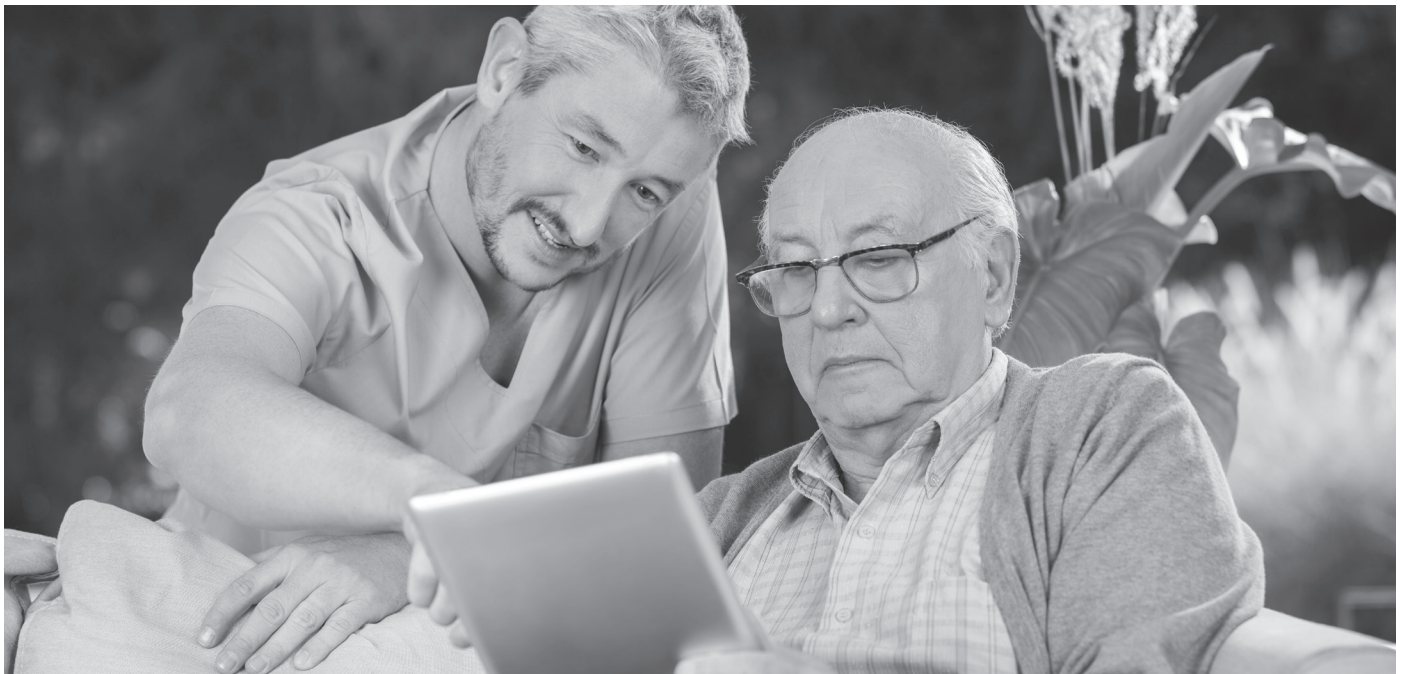
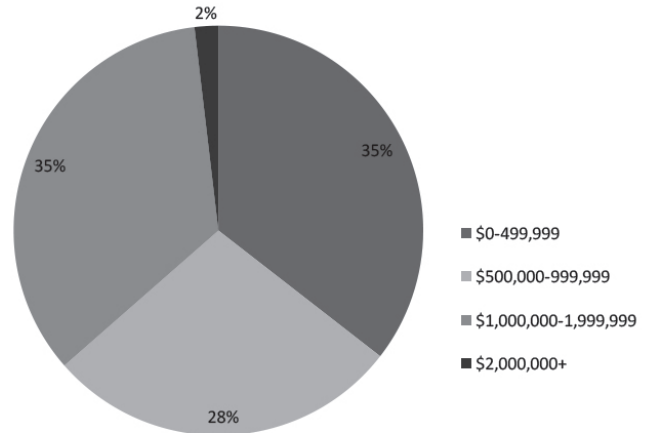
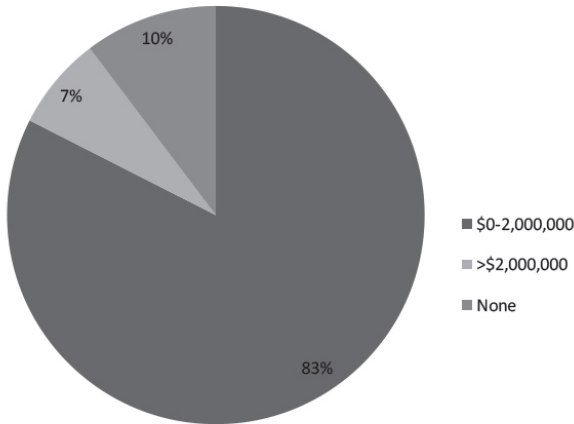
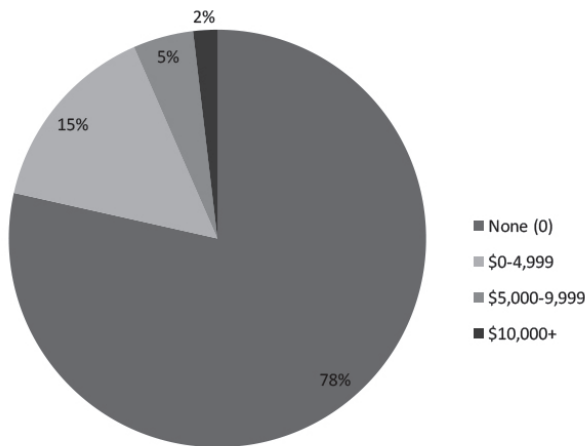


CHART 2: ANNUAL MAXIMUM



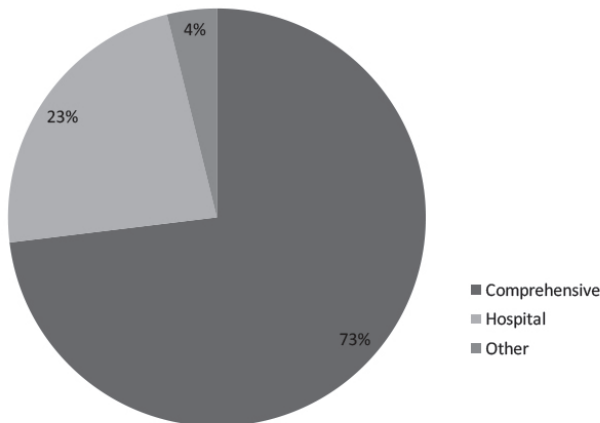
Another significant shift includes coverage with no inside limits on reinsurance reimbursement. Now 78 percent of Summit Re health plan clients purchase coverage with no average daily maximum (ADM) limitation. Previously, it was more common for reinsurance treaties to specify a maximum reimbursement per day (per diem), regardless of the actual billed and paid charges. Recall that the coverage feature was designed to encourage health plans and preferred provider arrangements to attempt to keep care in-network to the greatest extent possible, or to bring it back in-network at the earliest opportunity when it had leaked out-of-network. Notably, many plans purchase higher deductibles at the same time they eliminate this inside limit. This results in more predictable reinsurance reimbursements and price neutrality, i.e., a more consistent fixed dollar reinsurance spend year over year (see chart 3).

CHART 3: AVERAGE DAILY MAXIMUM



Comprehensive coverage is now predominant. The managed care excess of loss market was originally established on hospital-only coverage, as that reflected the majority of catastrophic claim costs many years ago. However, exposure to catastrophic losses is no longer derived primarily from hospital stays in this new health care environment. Specialty drugs and high cost therapies/procedures (regardless of setting) are driving this push to comprehensive coverage. Accordingly, 73 percent of all Summit Re clients now purchase comprehensive coverage which includes reimbursement for professional services (physicians and surgeons), drugs and other medical costs in addition to hospital costs (see chart 4).

CHART 4: COVERAGE TYPE

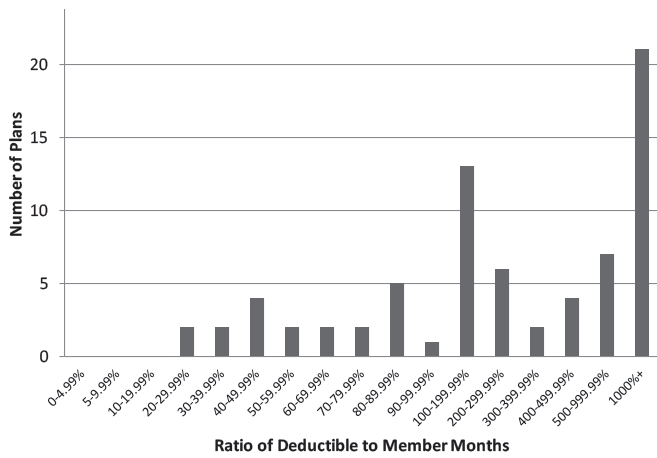


Health plans had historically purchased reinsurance protection for various “step-down” facilities and treatments venues such as skilled nursing facilities, sub-acute care, rehabilitation facilities, home health care and hospice care, subject to various limits such as \$500/day for 30 days. It is more common now for step-down facilities to have no separate reimbursement limits and to be treated the same as any other claim.

Risk tolerance per health plan will vary for an assortment of reasons. Plan size, coverage type, maturity of the plan, financial strength, access to capital, and underwriting margins (targeted and actual) can affect risk tolerance. One measure of health plan risk tolerance versus risk exposure is the ratio of deductible divided by health plan annual member months. The larger the ratio, the more risk tolerant is the health plan. The attached chart demonstrates this ratio for a wide variety of health plans reinsured by Summit Re (see chart 5 on page 16).

A significant mix of provider payment methods still exists, such as diagnosis-related groupings (DRGs), discounted fee for service arrangements and per diems (all with or without outlier provisions). The reinsurance industry has seen minimal activity, however, in “bundled payment” reimbursements, that is, in providing some form of aggregate stop-loss protection on the ade-

CHART 5: MOST FREQUENT RATIOS



quacy of bundled payment reimbursement. There is currently a small but growing number of requests for aggregate stop loss on capitation funds.

The following charts illustrate distributions of claims by diagnosis, based on reinsured claim amounts paid (Source: Summit Re claim payments). The largest catastrophic claims are still pre-term births and congenital anomalies, hemophilia, transplants, traumas and burns, complications of various procedures and



CHART 6: CLAIMS BY DIAGNOSIS-MEDICARE

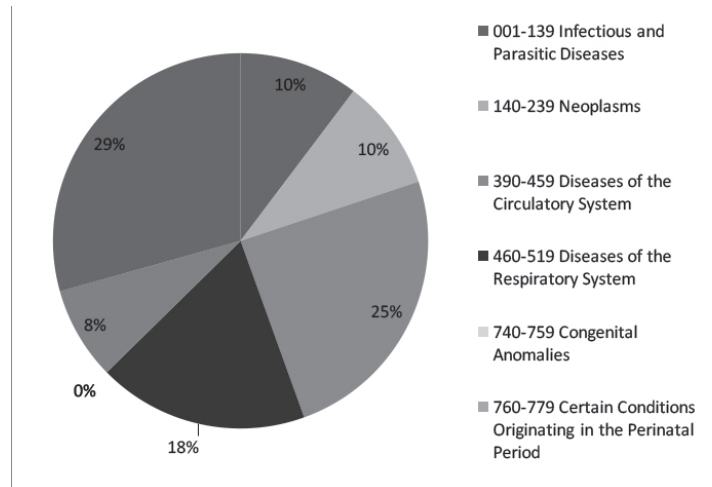


CHART 7: CLAIMS BY DIAGNOSIS-MEDICAID

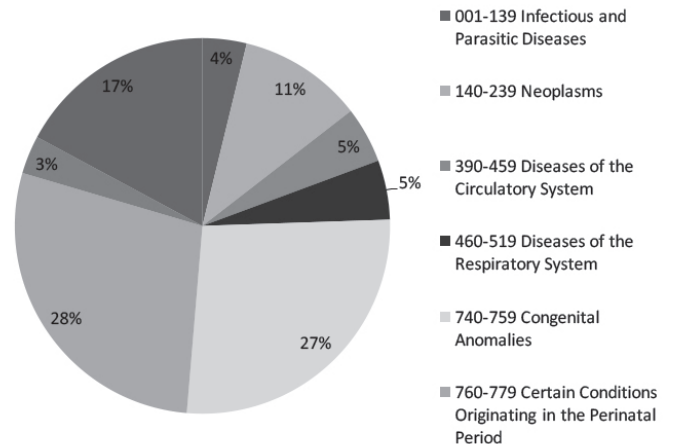
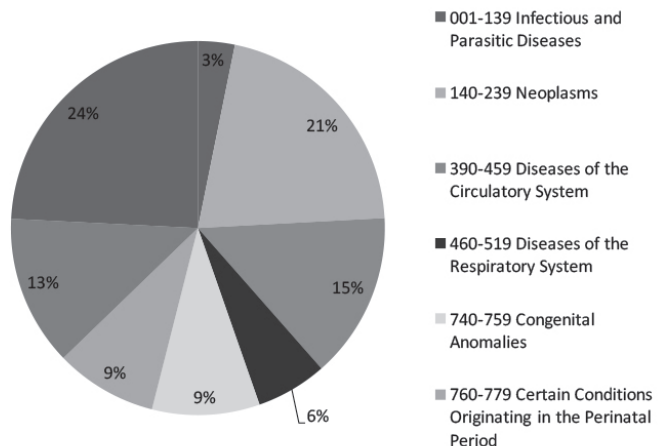


CHART 8: CLAIMS BY DIAGNOSIS-COMMERCIAL



cancer. The mix varies based upon the population being reinsured (commercial-Medicare-Medicaid) (See charts 6, 7, and 8).

COST CONTAINMENT SUPPORT

To help mitigate claim frequency and severity, the reinsurer often makes available to its health plan clients a variety of internal and external medical management services. These are designed to offer cost savings primarily through appropriate care management that is focused on clinical outcomes. Examples of these types of programs for managing catastrophic claims include the following:

Consultative Case Management	Assistance with catastrophic cases, research on rare or unusual clinical situations, suggestions for alternate care options.
Transplant Management Program	Access to credentialed (centers of excellence) and non-credentialed facilities for transplants.
Congenital Heart Disease Network	Access to centers of excellence for the treatment of congenital heart disease.
Cancer Services Network	Access to centers of excellence for the treatment of complex cancers.
Kidney Management Services	Access to dialysis centers. Renal case managers work with clients to maximize cost effectiveness of chronic kidney disease treatment.
Neonatal Management	Resolving key issues that impede progress, while accelerating care when appropriate and offering evidence-based solutions.
Physician Consultation	Specialty consults, second opinions, and hospital bill audits.
National PPO Network	Medical assistance/cost containment via PPO networks and claim re-pricing.
Provider Negotiations	Direct provider negotiations with provider sign-off.
Forensic Review	Identify inappropriate levels of care, non-covered services, experimental treatments, errors and unbundling. A course of care is reconstructed to identify gaps between care provided and billed charges.
Claim Recovery	Post-payment claim recovery services related to coordination of benefits, Medicare eligibility, judicial judgments and claim payment verification.
Specialty Pharmacy	Medication management and support services for patients with serious and chronic conditions.
Pharmacy Benefit Management (PBM)	Maximize relationships with PBM vendors.

WHAT'S NEXT

Health care reform continues to bring new challenges and opportunities. The industry is now familiar with the structural provisions offered by Centers for Medicare and Medicaid Services (CMS) known as the 3Rs: reinsurance, risk adjustment and risk corridor. Designed to partially mitigate the risk associated with covering new populations, these protections were intended to be limited in scope and duration, except for the risk adjustment mechanism. Reconciliations for 2014 coverage in 2015 have now been completed for these well-intended, but complex provisions. Although they accomplished many of their objectives, there was considerable uncertainty regarding the risk adjustment transfers, as well as some surprises such as the partial funding of the risk corridor and the demise of several co-ops.

A recent Summit Re client survey of the problems and opportunities of key reinsurance decision-makers highlighted the following issues as the most critical ones currently facing their organizations:

1. Declining reimbursements, risk adjustment payment cuts, minimum loss ratio constraints, financial uncertainty regarding the 3Rs.
2. Provider risk contracting strategies. Capitation is becoming more prevalent, primarily with Medicare risks as large national regional chains demonstrate desires to share risk with provider groups through capitation.
3. The high cost of specialty drugs.
4. Whether to expand into new markets such as employer stop loss, the exchange, dual eligibles and special needs populations.
5. Capital constraints and capital allocation.
6. Regulatory compliance.

These are interesting and challenging times for all. Reinsurance is still a versatile tool in a health plan's enterprise risk management plan which addresses these critical issues. ■



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