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THE ROLE OF REINSURANCE UNDER HEALTH CARE REFORM

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The discussion will review major elements of the reinsurance market as health care reform replaces traditional markets.

- What plans are carriers making to replace the profitable stop-loss coverages for small to medium-sized self-employers? As accountable health plan (AHPs) become full risk-takers, how will reinsurance needs change?
- As the market changes, how will reinsurers adjust to the needs of a new generation of risk-takers: physician/hospital organizations (PHOs); managed care organizations (MCOs); hospital systems; medical groups; informal associations of medical groups or individual physicians?
- What new risks appear to be involved in offering reinsurance to AHPs in health alliances? What will be the effect of including Medicaid eligibles, early retirees, and the low-income uninsured?
- How does the question of viable "health status adjusters" relate to perceived needs for reinsurance and sophisticated rating systems?
- How will new, risk-based capital (RBC) requirements for health plans with expanded guaranty funds at the state level affect client evaluation?
- What experiences have recently emerged that try to address reinsurance at the state level with major proposed reforms?

MR. HARRY L. SUTTON: My panelists include Evelyn Stravolemos and Mike Kemp. I'm also a panelist and will speak last. I'm going to talk about point-of-service (POS) reinsurance and a bit about the State of Minnesota and its views on reinsurance under universal health care. The first speaker will be Evelyn.

MS. EVELYN STRAVOLEMOS: The first question that comes to mind when discussing the role of reinsurance under health care reform is, what is the role of reinsurance? The traditional roles of reinsurance are to stabilize results and avoid catastrophic experience, and a new emerging role is to provide value-added services to risk-takers.

In this presentation, I will identify the risk taker, given various provider reimbursement mechanisms, and look at three current trends and their impact on reinsurance markets.

Table 1 shows various provider reimbursement mechanisms, in order of decreasing familiarity. The three risks that shift, based on the type of reimbursement mechanism are: first, the admissions risk; second, the length-of-stay (LOS) risk; and third, the charge/cost risk. As we move down the chart, the provider is assuming more and more of these risks.

TABLE 1
PROVIDER REIMBURSEMENT MECHANISMS

Familiar ↕ Unfamiliar	Reimbursement Mechanism	Risk Distribution		Primary Risk ↕
		Payor	Provider	Payor ↕ Provider
	Fee for Service	Admissions LOS Charge/Cost	Occupancy	
	Indemnity per diems	Admissions LOS	Charge/Cost Occupancy	
	DRGs	Admissions	LOS Charge/Cost Occupancy	
	Capitation	Overpay Risk	Admissions LOS Charge/Cost Occupancy	

The first reimbursement mechanism is fee-for-service; the only risk that the providers have under this scenario is occupancy risk, which is the risk that they will not be able to meet their overhead costs. The second reimbursement mechanism is indemnity per diems; with this, charge/cost risk is shifted to the provide. Diagnostic related group (DRGs) are the third reimbursement mechanism; here the LOS risk is also shifted to the providers. Finally, with capitation as the reimbursement mechanism, the providers have all the risks mentioned above, and the payors are left with overpay risk, which is the risk that they have been too generous with the capitation amount provided to the provider.

The first trend is that state regulators are supporting new risk-taking organizations that are offering fully insured coverage (see Table 2). I will give three examples of this trend. The first example is a hospital in rural Delaware, which was supported by the state to become a health maintenance organization (HMO) whose target market is low-income, employed, but uninsured people in this community. As this hospital does not have the resources to perform certain procedures, reinsurance is provided by John Alden for services delivered outside of the hospital.

The second example of this trend is "Tenncare," which has replaced Medicaid in Tennessee. Medicaid recipients must choose one of a group of designated HMOs for their health care. These HMOs pay low hospital per diems, which are mandated by the government. In pricing reinsurance for these HMOs, utilization is the issue instead of cost, because of the fixed per diems.

The third and final example also relates to Medicaid. In Florida, there is a state requirement that all Medicaid recipients be in managed care programs by 1995 and that Medicaid patients account for at least 5% of all commercial HMO memberships. Medicaid-only HMOs have grown in number from three to eleven in the past five

years; there are lower start-up costs for these HMOs due to lower capitalization requirements. The second is that managed care plans are being offered by providers that assume risk. Table 3 shows the impact of this trend on the HMO and commercial insurer and the provider.

TABLE 2
TREND 1: STATE REGULATORS ARE SUPPORTING NEW RISK-TAKING ORGANIZATIONS THAT ARE OFFERING FULLY INSURED COVERAGE

Risk-Taker	Impact on Risk-Taker	Impact on Reinsurer
HMO and Insurer	Competition from HMO look-alikes	More start-up reinsurance opportunities
Providers (hospitals and doctors)	Reduction of uncompensated care	More reinsurance opportunities

An example of this trend is a hospital system in Ohio that formed a PPO and a TPA to serve self-funded employers. Now this hospital system has bought an insurance company, which allows it to offer fully insured managed-care coverage.

TABLE 3
TREND 2: MANAGED CARE PLANS ARE BEING OFFERED BY PROVIDERS THAT ASSUME RISK

Risk-Taker	Impact on Risk-Taker	Impact on Reinsurer
Self-Funded Employer	Direct contracting with the provider	Increased focus on network evaluation
HMO	Start-up HMOs will provide competition	More reinsurance opportunities
Commercial Insurer	Joint venture opportunities between insurers and providers	New demand for product and value-added services
Providers	Providers are assuming risk for the first time	More reinsurance opportunities

In Table 3, we look at the three, traditional risk-takers: self-funded employers, HMOs, and commercial insurers, and the new risk taker, the provider. We see how the above trend impacts these risk-takers and, consequently, how the reinsurer is affected.

Self-funded employers, by directly contracting with the provider, will see greater control of both cost and utilization. They will also be able to build a relationship with the provider, which could result in improved service to employees.

Due to the commercial insurers' joint ventures with providers, there will be a demand, possibly met by the reinsurer, for value-added consulting services to assist in contract formation, plan design, and risk-sharing arrangements.

The third trend is that integrated delivery systems are being formed in major metropolitan markets with incentives to accept global budgets. (See Table 4.) An example of this trend is an HMO in Florida that resulted from a joint venture between an insurance company and a group of PHOs, which have banded together. The integrated delivery system receives a capitated payment and then subcapitates the hospital, the physician groups, and the ancillary providers.

TABLE 4
TREND 3: INTEGRATED DELIVERY SYSTEMS ARE BEING FORMED IN MAJOR METROPOLITAN MARKETS WITH INCENTIVES TO ACCEPT GLOBAL BUDGETS

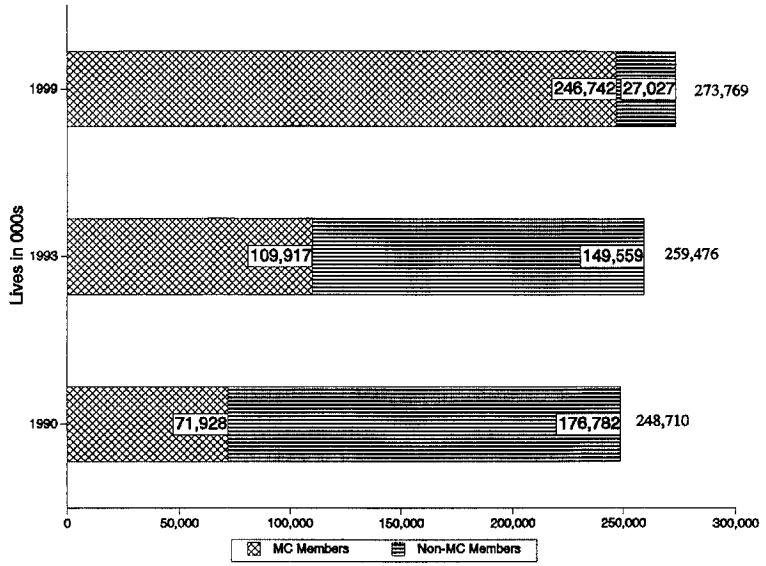
Risk-Taker	Impact on Risk-Taker	Impact on Reinsurer
Self-funded Employer	Some advantages of self-funding still exist	Little or no reinsurance needed
HMO and Commercial Insurer	Focus on selecting the best integrated delivery system and providing its marketing	Reinsurance needs decrease
Providers	Risk is transferred to hospital and physician groups	Both reinsurance and risk management services needed

When the risk-taker is the self-funded employer, the advantages of self-funding that still exist are that there are no benefit mandates and no premium tax. Reinsurance needs are minimized because the capitation amount is set in advance, and the employer no longer has the risk of adverse experience.

The role of the HMO and the commercial insurer under this trend is now that of marketer and administrator. Their risk will be for global results; hence the need for reinsurance decreases and can be categorized as aggregate results reinsurance, insolvency protection, out-of-area emergency coverage, and conversion. The providers are now subcapitated; they will need both specific and aggregate reinsurance.

Chart 1 shows how managed care plans (HMOs and PPOs) are covering a greater and greater proportion of the U.S. population; in 1990: 29%, 1993: 42%, and projected for 1999: 90%. With this trend, the financing of health care is merging with its delivery. The role of the reinsurer is to identify the risk-taker and to provide both traditional reinsurance coverage and value-added services to facilitate this merger.

CHART 1
TOTAL MANAGED CARE MEMBERS AS PROPORTION OF U.S. POPULATION



Source: Data from Marion Merrell Dow, Managed Care Digest: HMO & PPO Editions 1989–1993

MR. SUTTON: Our next speaker will be Mike Kemp.

MR. MICHAEL A. KEMP: Although I share with those of us in the health insurance industry an interest in the impact of health care reform on carriers, there has been very little analysis of the impact on reinsurers. I've been asking myself, what's the reason for that? I thought that maybe people weren't interested in reinsurance. I'm very encouraged by looking at the number of people attending this session.

When people have talked about health care reform in our market—the reinsurance market—they often say, what are you going to do after health care reform? I think there's going to be a strong role. Evelyn's touched on that. It's probably going to be the most exciting and challenging time in the reinsurance industry for medical reinsurers.

I will talk about how the current reinsurance market looks and how that will change as health care reform evolves. In order to understand the current reinsurance environment, just as in any market, you have to understand the customers. The current customers are commercial insurance carriers that are buying typically portfolio excess, specific stop-loss on their fully insured business. The other customers are self-funded employers. This is different from a reinsurance market, but a lot of stop-loss coverage that is delivered to self-funded employers is, in fact, driven by the reinsurance market. The final customer that we typically see today is the HMO. That is probably the fastest-growing segment of our market and one that will probably have the most likelihood of surviving in the future.

What are the products offered in the reinsurance market today? The first product typically offered, and the most popular product, is specific excess. This is the reinsurance coverage to protect against a catastrophic claim from a given individual over one year, a very common form of reinsurance purchased by commercial carriers, HMOs, and self-funded employers. A second product is aggregate excess, which is the coverage to protect from unexpected frequency of claims. That is typically restricted to self-funded employers.

Finally, quota share or proportional reinsurance may be involved, where the reinsurer is taking a proportionate share of each risk that the primary carrier takes. Right now that is primarily restricted to the commercial insurance carriers as they enter new markets or develop new products. There is often a desire to spread that risk with a professional reinsurer, to alleviate any capacity problems, develop some experience without taking the entire risk, and also to seek the professional advice of the reinsurer.

Let's talk about pricing in the current environment. The first question is, what are we pricing for? Right now what we're pricing for is a comprehensive set of benefits. We're reinsuring a broad spectrum of coverage, including all medical services, hospital, provider, and ancillary services. If we're covering a comprehensive benefit package, our pricing is on a macro level. We're pricing for all services on a combined basis. What do we use to price? Well, there's relevant historical data available, although some of us who are involved in the stop loss market may wonder if anybody is actually using it. When you have a specific risk that you're looking to place, you can evaluate the reinsured's experience. Commercial carriers' books of business have been fairly stable, and you can go back and look at their relevant experience in terms of setting a price for their coverage.

How do we underwrite our business today? The first and most obvious task is to review the primary insurance risk. What makes up this portfolio of insurance that we're going to provide excess protection on? What makes up this risk pool? Another layer of review is the primary insurance contract. What types of coverage? Most important, but less obvious, is a review of the primary risk-takers themselves. How well do they know their business? How well do they run it? Do they underwrite properly? Do they pay claims properly? That's probably the most important of the three reviews from a reinsurance standpoint.

What's going to happen when health care reform comes in? That's interesting because most people say that health care reform is going to come in one day and our lives are going to change the next. That will not happen. As a matter of fact, health care reform is happening as we speak, and we as reinsurers are having to respond to it on a daily basis.

Let's look at what health care reform may do to our current customers. Commercial carriers, which have been the bulk of what most of the analysis has involved, will have further consolidation. Smaller carriers will probably exit the medical insurance market, perhaps staying in through the delivery of ancillary products, so there will be a reduced need for reinsurance to commercial carriers as they consolidate and their risk pools grow.

Most of the health care reform proposals place some limit on what level of employers can remain self-insured. The Clinton proposal started at a 5,000-life level. That seems to be moving down somewhere between 100 and 1,000 lives. There will be a big restriction in the availability of reinsurance in the self-funding market because of the contraction of that market.

Finally, HMOs, as I indicated previously, will have a growing impact. However, in the long run, it's questionable whether that will continue to be a growth market for specific reinsurance.

Health care reform, though, introduces some potential new customers for reinsurance. The first is accountable health plans. These are the plans that everybody talks about in their various health care reform proposals, but they never really seem to be well-defined. There is still an open question in terms of what opportunities they offer for reinsurance. Accountable health plans may encompass any one of the three current customers, but they will be in a different form, and will operate under different rules. The current proposals for accountable health plans with mandatory alliances require risk adjustments between the various plans to adjust for the risk characteristics of the business they reinsure. If there is an accurate premium through risk-adjusters, is there a need for reinsurance? There probably will be a reduced need for reinsurance, because there will be some protection against getting an adverse risk pool up-front. However, there will still be some need for reinsurance to cover the potential statistical fluctuations in claims.

Today we see states that have introduced small-group reform, and they have introduced the state reinsurance pools. When they've introduced guaranteed issue, they've introduced state insurance pools to allow carriers to reinsure business they would not have taken on through their normal underwriting process. That's an up-front protection, but there is still a need for reinsurance going forward to protect their financial results from adverse risk.

The biggest, new potential customer that we see, which Evelyn mentioned earlier, is the provider organizations that, I believe, are going to be a major long-term market for reinsurance, and probably the biggest players in the whole, health care delivery system. With the current market and the current methods of transferring risk, the employer enters into an insurance contract with the insurance carrier or the HMO, pays premiums and, from that insurance carrier, or HMO, receives claims and services for his employees. In return for getting an insurance contract, they transfer the risk to the insurance carrier or HMO, and the risk resides there, thus creating the need for reinsurance. How is this market evolving?

We still have that first layer of transference of risk between the employer and the insurance carrier or HMO. What is happening today, and will continue to happen in the future at an accelerating pace, is that the insurance carrier or HMO will now transfer that risk on to a new entity. That new entity will be some form of a provider organization. It may be an individual practice association (IPA), an independent practice association, a multispecial group (MSG) of providers, a hospital, or a new emerging organization called a physician-hospital organization. That insurance carrier will sign a contract with that provider, thus transfer the risk down to that provider, paying a capitation and receiving medical services for that capitation. The risk will

now be transferred down to provider organizations. Therefore, we as reinsurers have to follow that risk and look at provider organizations as a new source of reinsurance.

How will this cause a refocus of our current products? In the specific excess product, there will be a shifting of the emphasis. The commercial carriers and HMOs, as their risk pools grow, or as they transfer risk onto the provider organizations, may have a reduced demand for specific coverage. They will, perhaps, buy very high catastrophic coverage or no coverage at all.

Aggregate coverage will probably take on new importance. New risk-takers coming into the marketplace, until they develop a comfort level with the taking of that risk, will be looking to protect themselves. The easiest protection for them in a new market is through an aggregate protection. The aggregate protection will also be very important because these provider organizations initially will not be well-capitalized. They will not have the high levels of surplus that an HMO or insurance carrier will have to protect themselves from a high number of claims and thus have the need for aggregate protection.

Quota share will also shift in emphasis. Again, as with the commercial carriers and HMOs, those risk pools will be growing. There may not be a need for quota share. However, where the quota share will probably come in is again with the provider organizations, similar in nature to the need for aggregate. As their risk pools start out, they will be relatively small. They will be looking to share some of that risk. They will not want to take it on all at once. Currently, providers do take capitation, they do take risk, but for the most part, unless they're salaried employees of a staff-model HMO, they may restrict the number of patients coming to them under a capitation model. What they try to do, if they have to provide an inordinate number of services under capitation, is simply shift some cost to their fee-for-service customers. As fee-for-service shrinks, and more of their practice comes under a capitation model, they will not have the capability of shifting that risk on to the fee-for-service, so they'll look to reinsurance to share some of that risk.

How will the reinsurance of provider organizations affect us as reinsurers? What new things will we need to consider? First of all, we're going to need to consider new classes of risk that we have not had to consider before. One of these is Medicare. The government is rapidly trying to get Medicare enrollees into HMOs, under risk contracts. If health plans enroll Medicare members under risk contracts with providers, providers are going to be looking for reinsurance, and that is a new area for us.

A second involves Medicaid risks. Many of the states are setting up pilot programs and forcing Medicaid enrollees into HMOs. This is also a new area of risk for us, a currently uninsured population that we have no dealings with. And, the current uninsureds are the most difficult to evaluate. What impact will they have on our risk pools? How many of those are simply healthy lives that can't afford insurance, or choose not to pay, and how many are truly uninsurable who will subject the reinsurer to high risk?

Thus, we have new underwriting challenges. We're looking at a new market and new customers. Instead of reviewing the qualifications of the primary risk taker, the insurance carrier or HMO, we have to review the providers. How well do they do

their business? Their business is different than an insurance carrier's. They don't underwrite; they don't pay claims. There's a shift in the emphasis of the review to one of quality versus cost. We have to review the quality of that provider network and make sure that they can provide the proper level of care in a controlled fashion. We can certainly go for the lowest-cost network in looking for a good reinsurance prospect, but if enrollees go to the lowest-cost network, you still may have a disaster in terms of unmanageable claims.

Another new area of review is the provider contract. How is that provider taking on risk? Is it responsible for all care, only care given within the office, or is it responsible for specialist care? To what extent is it responsible for that care?

Very different, but probably a most important aspect of the underwriting review is the provider's financial incentives. Certainly under the capitation contract the incentive is to keep the cost and level of care as low as possible so that there is enough left over out of that capitation to enjoy the good life. However, in the reinsurance mechanism, the provider may be faced with the same incentives as in fee-for-service. The provider is potentially being reimbursed on a fee-for-service basis, so the underwriter has to be very careful in structuring the reinsurance contract not to build in the same financial incentives that the provider currently sees.

We have new pricing challenges in this market as well. Unlike our current products, there is a lack of relevant data. We're seeing new reimbursement mechanisms and new forms of managed care. The introduction of protocols and all these risk mechanisms is affecting how providers deliver care. The relevant data that we have used in the past are not directly applicable to this new risk. We also have to price at the micro level. The micro level is needed to price our reinsurance products for subcomponents of the comprehensive benefit package. Sometimes we need to price for the risk of the primary care provider. Other times we need to price for the risk assumed by a cardiologist. Other times we need to refine our pricing models and develop new sources of data to match these more refined levels of risk.

Finally, we need to price for different reimbursement mechanisms. We need to look at the impact of a given reimbursement mechanism on the way a provider uses reinsurance. Certainly, if the provider is being reimbursed through the reinsurance on fee-for-service, once it gets through that excess attachment point, it often will start to provide service as it does today. However, if reimbursement mechanisms are structured at a reduced level of reimbursement, possibly not covering the full cost, we have a more manageable risk.

In conclusion, the medical reinsurance market does have a role under health care reform. It's going to be an exciting role—one that I think will be very important in the ultimate development of how the health care insurance market looks in the future.

MR. SUTTON: I'm going to cover three things. First, I'd like to review the section of the Clinton bill that covers reinsurance. Then I'd like to talk about the POS end of the business. Finally, I will talk about health care reform in Minnesota, moving towards a universal health system, and the problems with reinsurance in the view of our state legislature.

I'd like to ask everyone how many people here have read the Clinton bill, all 1,400 pages of it? There's one hero, two heroes. We have distributed a copy of the section regarding reinsurance. I reassured my two co-panelists here that if something isn't specifically excluded in the bill, then you can do it!

Reinsurance in the Clinton bill is integrated into the section about health status adjusters (HSA). HSA relates to the pooling and internal rate adjustment of the health alliance when all individuals and small groups are pooled through AHP. In the Clinton bill, it includes employers less than 5,000 employees. The pool also includes individuals covered by Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), very-high-cost uninsurable pools, whatever that means, Veterans Administration (but if you ask the veterans, they won't do it, of course), CHAMPUS, and Native Americans. Nobody ever talks about those populations, but it's clear in this section of the bill.

Incidentally, one of my chief areas of concern in looking at the Clinton bill is coverage of early retirees; in effect, allows them to be covered nearly free for ten years prior to Medicare eligibility, with no funding, by shifting them into the health care alliance with federal reimbursement of the community rate. That is not mentioned in the section on HSAs.

The role of the HSA, and the reinsurance that's included, is a zero-sum game. Some carriers or HMOs will have to add to their premiums and submit money to a pool, and others will receive money from the pool and can adjust their premiums to produce a lower community rate for the Health Alliances or Health Insurance Purchasing Cooperation (HIPC).

The reinsurance is mandatory in Clinton's bill and controlled by the state. I think what we really have here is that the Clinton gurus didn't understand anything about HSA, particularly from the only model they had to go by, New York state small-group reform. Their text sounds exactly like New York state. You have a health status adjuster, and then you have lump-sum reimbursements for certain catastrophic claims. They don't get into much detail, but it's mandatory that everyone participate in it. It looks very much like medical reimbursement, which would be paid for by a flat tax per capita or percent of premium, as in New York state. This version implies that other reinsurance is forbidden.

However, the earlier, shorter 250-page version of the draft Clinton bill specifically said that you could buy reinsurance to cover fluctuations and costs that weren't fairly represented or accounted for by the health status adjusters. We assume that all forms of traditional reinsurance will probably be permitted, but we don't know for sure.

I would like to talk about POS coverage. A number of states are moving rapidly to permit HMOs to write indemnity. However, there are some real problems in some states. Texas, for one, is bound and determined that no HMO can ever pay an indemnity claim unless it is an emergency accident. You have legal or structural problems in whether an HMO or AHP could legally do this. It's not addressed in the bill.

The POS plan, as designed in the Clinton bill, is incapable of being used. The group of seven actuaries that did not bless the Clinton bill (but were accused of blessing it) wrote a letter saying that if the fee-for-service, out-of-network benefit required in the Clinton bill is the same as the indemnity plan, then it can't work.

A brief example may illustrate the reason. Suppose that the indemnity insurance by itself would cost $100, but the HMO is cheaper, at $80. That's even questionable under health care reform. The HMO must offer a point-of-service, and the out-of-network benefits must be the same as the indemnity. If you never intend to go into the HMO, you would have to pay $100 to the indemnity carrier. However, you would soon figure out that you could buy the indemnity coverage cheaper by buying a POS plan and going only out-of-network. Essentially the price will gradually move up towards the indemnity, but may never quite get there. There will be some financial incentives, if you need a new doctor, or a new specialty, to move into the network over time, but I think it will be gradual. Considering the financial incentives found in the POS market today to keep people in the network, the Clinton bill seems to be a nonstarter.

Some of the problems with the Clinton bill include the following. Because enrollees have the same benefits as in fee-for-service and can use any provider and because the state controls fee levels, there is little incentive to go in to the network. The fee-for-service carriers cannot negotiate with providers. It's the same in the Minnesota statute. In Minnesota, not only will the state set the rates for reimbursement on fee-for-service, but you can't even use your own utilization review (UR) system and you can't use your own PPO. Those are all out. Somehow the state thinks everything should be straight fee-for-service or managed by state rules. Because fee-for-service prices are set by the alliances in the local area (essentially by the state), this makes many people fear that alliances, as regulatory agencies, will set the prices that can be paid to providers. Will the providers who work in IPA models, or other models with fee-for-service, still give discounts to the HMOs? If fees are totally controlled outside HMOs, and there's no way of cost shifting, a likely solution is to raise your prices to the HMO or revert to total fee-for-service because providers may get a better price from fee-for-service than from HMOs. This depends on the prices that the state sets.

More generically, "any willing provider" legislation is a major problem for health care reform. I would guess 10 or 15 states have passed or introduced legislation involving any willing provider. It's a life or death issue for allied providers, psychologists, acupuncturists, and so on, whose services may not be covered if you have only closed panels or limited indemnity options. Allied providers argue that their services are more efficient, but nobody really knows in a macro framework whether including those providers lowers cost or is only additive.

Clinton has always said, no matter what plan you're in, you have your choice of physicians if you don't want to use one in the plan. This makes it obviously impossible to control cost or quality. You may as well be on fee-for-service with a single-payer system if everybody can go to whatever doctor they want to on demand, assuming they can get an appointment. Another problem with POS and "reinsurance" is technical. I mentioned before that the majority of states don't permit an HMO to write their own POS benefits. However, there have been major changes.

California has passed legislation to permit it. A number of other states that were initially adamant are now permitting it.

I will describe briefly my own company experience. I'm not an expert in reinsurance. I've been working with HMOs for 20 years, and we work in the POS business, wrapping indemnity products in joint ventures with HMOs. We sell an insured PPO in most cases with proprietary HMOs, and there is risk-sharing between the in- and out-of-area network costs. If it's profitable in aggregate, we share the profit. If it loses, we share the losses. Some states and some insurance departments don't permit this kind of an arrangement.

If there is a POS or PPO alongside an HMO, we may want to pool with the HMO experience with the same employer accounts. That means that the young people join the HMO and the old people stay in the PPO. We still have a combined risk pool that averages out more normally. Some HMOs don't seem to want to share the profitable part of the risk, but they're very happy that we would take most or all of the less desirable part of the risk.

We have many clients for whom we insure only the out-of-network portion of a POS plan. The difference between a PPO and a POS is small. The PPO is just one integrated plan where you have an innetwork and an out. The POS normally has the HMO as the in-plan network. The POS is normally an adjunct of an HMO, but a PPO may be just a very loosely affiliated group of providers. Now, Mike talked about evaluating the network. We do reinsure a few PPOs, but not very many. We have a very hard time knowing whether they really function or whether they're just trying to capture enrollment. They may save no cost, and their prices may not be very good. We have a network evaluator to look at that.

When we and the HMO combine as a carrier replacement, one of the problems that has come up, for example, in the California HIPC, involves how to cover employees of a relatively small company who don't live in the service area. They forgot this problem when they set up the HIPC in California. There may even be employees who may reside in California but are out of reach of any of the physicians of any of the health plans. We now have a number of clients for whom we write straight group major medical for employees residing out of the plan service area who are being enrolled under an HMO carrier replacement product. The eligibles may include people living in other states as well as those nearby, but outside the HMO local service area.

A dual-choice option is something we're working with. It's more like a triple option. We may enlarge the HMO network or have a separate PPO product with a completely different network from the HMO. If you have a small, closed panel, like a staff model, it's not very good for a POS, because with a very small network the leakage might be strong. It may require setting up a separate product, contracting with a local PPO, or even an IPA-model HMO to get a larger network to control the fee-for-service cost.

We write specific reinsurance, sometimes on the whole package, which would be the HMO and the POS, both in- and out-of-network. Other times we write the catastrophic coverage only for claims out of the network. The latter is difficult to administer. When people go out-of-network, there's less control on the fee-for-service

prices. As Mike said, we often have internal controls and limits on the per-diem hospital cost that we'll cover under the reinsurance contract. Again, we have to rely on the fact that the HMO or health care manager can intervene to try to prevent the people from going out of the network, particularly for a catastrophic-type medical service. On straight indemnity we typically pool the catastrophic claims into our own company, so we don't have a very small block of indemnity business with a 200% loss ratio. Essentially we're writing specific and aggregate on our own indemnity and reinsuring it into our other pocket.

Many of our HMOs now own insurance companies. They have problems, as they usually don't want too much capital in them. We work both ways. Sometimes we take the front risk and file our contracts. Other times they write the contacts, if it's legal, and reinsure part of the risk with us.

I advise you to watch as the new health plan RBC rules unfold in the next six months. The way the rule stands in the draft, reviewed by the National Association of Insurance Commissioners (NAIC) this June, in order to take a credit to capital for ceding a quota share or other reinsurance, the reinsurer must have 200% of the authorized control-level RBC requirements. In other words, you can't take credit for reducing your capital needs by ceding to an HMO-owned insurer, if the entity you are ceding to doesn't have the required capital to support the risk it's taking. Either you will have to set up your own capital to match the deficiency, or the entity will have to beef up its capital.

There are a variety of risk-sharing arrangements, as you can imagine, anything from sharing a whole line of business to nonproportional for a subset of business. Even a large national employer might have a separate risk-sharing arrangement. There have been discussions to share risk, as major carriers do with large employers, by placing administrative fees at risk. We have to work carefully on these accounts to figure out how much risk we're taking.

A number of our clients are 501(c)3 organizations. They're very concerned about losing their federal tax exemption, and consequently, the perception is that they can't share risk on an annual basis. In other words, once the reinsurers' premium or our share of the POS premium is set and their premium is set, you can't share risk across that. If you have a long-term contract, you can readjust the share of the premiums that each party gets from year to year and hopefully keep the plan in balance.

To show you the size of the 501(c)3 problem, the largest prepaid plan is Kaiser, which had a gain from operations of $1.5 billion in the last two years. If Kaiser were to pay federal income taxes on that, you can see what a shock that would be to its system. Kaiser is very careful, for example, that it doesn't violate any law.

The Internal Revenue Service is presumably coming out with a ruling saying that if indemnity claims are less than 10% of total plan costs, you will have a safe haven. That also means that a number of not-for-profit HMOs are worried about hitting that 10% if they write a lot of POS or indemnity-PPO-type business. That means there's a tremendous demand to get a carrier to take the excess risk off their hands, so that essentially they quota share out to maintain their tax exemption.

Filing of more than one contract or certificate to be issued jointly to an employer is very complex, and insurance regulators often don't know what to do with it. Filing and getting approval of some of these forms is very difficult. In many states the indemnity has to comply with all the state mandates: in others it doesn't. Sometimes you have to negotiate with the insurance departments to make sure they think you've got enough benefits between both contracts. In addition, you don't want to duplicate benefits between contracts, particularly in something as hard to control as mental health. These are just a few of the problems with joint HMO/indemnity products.

Minnesota Care represents a kind of socialist state. The legislature really wants to have a single-payer system and there have been bills introduced to do that. The plan starts with the Children's Health Insurance Program (CHIP), which most states offer; it's a children's coverage as an adjunct to Medicaid. The federal program did not cover inpatient care, but it covered unlimited outpatient care, eyeglasses to make children ready for school, and their immunizations, and means to be sure that this happened. We had 30,000 or 40,000 children in that program before Minnesota Care started.

What the state did was to expand on that, permitting siblings of those eligible children to enroll for low premiums and setting up a more complete benefit plan that phased in hospital coverage after a year. Later the state provided full coverage for children, but only $10,000 for adults. The state subsidizes premiums based on income, but has run out of money already.

Of 90,000 people enrolled, most of them are children of low-income families, but some are the parents of those children, who later became eligible. There was a story about a family of six, husband and wife with four kids; they both worked and had a $28,000 income. The median income in Minnesota is $33,000 or $34,000 per family. They had to pay only $620 for essentially a full benefit boat, which is a relatively small part of their income. I realize that my kids are gone, so I don't remember exactly how much it takes to raise four kids, probably a lot. But if we subsidize everybody with incomes at that level to require paying only 2% or 3% of their income towards health insurance, we're going to have a huge subsidy system.

The fund sources available in Minnesota include the favored cigarette tax. The state tried to tax beer, but the blue collar workers got up and revolted and marched on the capitol. Five cents on a beer was not acceptable. The major source is a 2% provider tax. Jan Malcolm from Health Partners, who was on a panel yesterday, said it gives a nice circular feeling. In other words, you're financing the health care system by taxing the providers. You're raising the cost a little bit, but the same money is circulating within the system. Maybe that makes sense, and maybe it doesn't. At the beginning, the legislature told the providers they had to eat it, they couldn't add it to their bills. Now they insist they show it on the bill. The providers sued. In fact, the state taxes dentists, and dental service isn't even covered.

The state has a bunch of ideologues, including our Senator Wellstone (D—MN), who is co-sponsor of the Wellstone-McDermott bill, a single-payer, Canadian-type system. The ideologues like either the British system, which is a national health program where the government owns the hospitals and contracts with physicians, with

capitation or salary, or the Canadian system. There is a big philosophical leaning to the latter. In fact, after all the hassling with our 290-page bill, somebody introduced a bill to get rid of the whole system and put in a single-payer Canadian system, but nobody would vote for the taxes.

Essentially, we have an oligopoly in Minnesota. In the metro area, we have 2.4 million people, we have two HMOs with 600,000 members. We have another one with 200,000 or 300,000. After a few small HMOs have been added, essentially 60% of our total population, including Medicare and Medicaid, is in HMOs in the Twin Cities.

Many HMOs are vertically integrating. The HMOs are buying and owning hospitals. There is a proposed merger between the biggest hospital system and a large HMO, which would make a $2.5 billion health care company if it ever gets pulled off. Now there is a fear that they're becoming too big and powerful, and the state wants lots of little "Kentucky Fried" HMOs. In Minnesota they call them integrated service networks (ISNs). The legislature also wants community integrated service networks (CISN), or cooperative integrated service networks. These require decreased amounts of capital in order to get licensed under our law. The first version of the bill this year mandated that the state offer a reinsurance coverage to all the HMOs, which is a way of saying, if you've got a bunch of HMOs that don't know what they're doing, they're going to buy reinsurance at the same rate as the large HMO, because it would be one statewide contract for all HMOs, ISNs and CISNs, etc.

We pointed out to the state that the biggest HMO of which I'm aware has a $500,000 deductible. When you've got a new HMO with 3,000 members, it's broke before it spends the $500,000, so that level of reinsurance wouldn't fit.

The state begged the question and said that if reinsurance is not available through the private market, through Mike or Evelyn or us, the state will mandate a coverage and maybe write it. The state seems to have backed off and proposes to pool the CISNs, perhaps excluding the bigger HMOs. Every HMO will have to convert to be an ISN to get into the state plan that includes governmental employees. The ISN must cover Medicaid patients and everyone included in the state plan in order to keep its license. HMOs could exist independent of the state plans, covering only large commercial accounts.

The capital requirements are interesting. The legislature talks about RBC according to NAIC (currently $1.5 million), and then one of the bills cuts the capital requirement to $250,000. The state allows a CISN with a capitated provider (like a hospital that will guarantee to provide coverage to all your members for six months for no premium, if the CISN goes bankrupt) to lower their capital requirement. They haven't looked behind this proposal to see whether the hospital has the capital to support covering a few thousand people free for six months.

The Minnesota legislature dislikes the power of the HMOs. We have a very ultra-liberal legislature. It doesn't understand how complex it is to set up, manage, and take risk. The legislators resent the power of the big organizations that already exist, who have spent 20 years to get where they are. Among other things, the state sets up a guaranty fund. The providers hold the patient harmless, but essentially the state

will tax the large HMOs to bail out the small ones if they have no capital and run out of money.

The enrollee is held harmless, but the guaranty funds pay off the providers, as in the Clinton bill. In any event, if the providers are going to be paid off, they may not manage medical care efficiently. Politically, physicians may be forced to join MinnCare, but with no incentive to function well. On the other hand, if physicians are too onerously controlled and their contracts limit their medical control, they may not join the plan. The object is to get all the physicians into something that's managing care, but not to make it so punitive that they're worried about losing lots of money. Surprisingly, some large HMOs think that's a good way to go, because the new CISNs will be so small. The established HMOs would rather pay the bail-out cost than have some more onerous tax to support the small HMOs.

Our rural hospitals, and we're not different from many other states, are in very bad financial shape. If they take a capitation risk as a Class I hospital and find an organ transplant case, they're going to have to buy it at some other facility. That could put small hospitals out of business, if they don't have reinsurance.

After we explained to the state how expensive it is to set up administration for a new ISN, it waived the data reporting required of everyone. The state waives audits until the third year. We suggested the state should audit in the first year and not wait until the third year, because the new players will be out of business if they aren't doing well in the beginning.

MR. JAMES R. HOREIN: Harry, you referred to risks that exist, and factors that influence the risk, at the time of insolvency. Would you speculate on the direction of those risks going forward and how they might change under health care reform?

MR. SUTTON: In the AAA committee on RBC, we haven't discussed much about the insolvency provision that is typical in HMO reinsurance. We really don't cover plan costs incurred prior to insolvency, except defined catastrophic claims. The typical reinsurance contract covers claims of people in the hospital until the date they're discharged. It provides continuing coverage for people who have paid a premium until the end of the period for which the premium was paid, e.g., for advance or unearned premiums.

In Minnesota, and in most states, the NAIC HMO model act has had very low capital requirements, because essentially all contracts with providers are required to have a hold harmless agreement. Essentially, when the plan stops operation, there is no liability for unpaid claims, except for noncontracting providers. In many cases, that risk is very limited. However, in the macro framework of health care reform, it's probably not likely that denying providers reimbursement will survive, because the Clinton bill itself says each state and the federal government will set up a guaranty fund to pay off the providers. They're thinking of indemnity insurance, and not the way that the HMO market has worked.

So, because of the hold-harmless on the providers, the insolvency coverage does not cover any debts incurred prior to the date of insolvency. Actually we don't pay unless the plan ceases operations. If the plan goes into rehabilitation and continues to

operate, there isn't any liability for the reinsurer except for catastrophic claims. Clinton thinks in terms of a guaranty fund and so do the commissioners.

I think it's a foregone conclusion that HMOs and all health care organizations will be part of a guaranty fund. In fact, our RBC requires setting up a surplus requirement based on the average assessments of the guaranty fund in the last three years. All proposals use a maximum of 2% of relevant premiums, which is the typical guaranty fund for life, health, and casualty insurance.

Consider one interesting change. If a big life company went insolvent, you may wind up with guaranty fund assessments against an HMO or Blue Cross; they would be part of a combined guaranty fund. That would be based on the percentage of the life company premium that happened to be health insurance divided by total insolvency expenses, if it was a multi-line company. The guaranty fund assessment would be added to health insurance premiums.

The former head of the NAIC was commissioner from Virginia, and dealt with an insolvency. He's been pushing for years to get HMOs into a guaranty fund. If the guaranty fund is there, why is there any need for a reinsurer to cover insolvency? One other element on insolvencies is that all HMOs in the same service area agree to take over the enrollees of the defunct HMO. No evidence of insurability is permitted, but there is confusion about payment of premiums.

Minnesota also has a very large uninsurable pool with 35,000 people. People who lose their jobs can go into that pool automatically at near-standard rates, a $500 or $1,000 deductible plan without any pre-existing conditions provision. It's also waived for people where an employer goes bankrupt with no mechanism for Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA).

I'm not sure what will happen with PHOs or health-provider organizations that may have medical expertise but no experience in terms of managing health care and that have very limited resources. We informed the State of Minnesota that if ISNs didn't meet normal capital requirements, we would not write insolvency protection.

MR. DARRELL D. KNAPP: I have a couple of questions for Mike. In your presentation you mentioned that you were having to review contracting arrangements to make sure the provider incentives weren't misaligned, as you negotiated provider reinsurance contracts. I was wondering if you could expand on what type of incentives you were seeing. Also, what sort of factors would you recommend a hospital consider when it's evaluating what sort of level of stop-loss reinsurance it needed under a capitation contract? It's a different aspect than the typical insurance company's experience, and I was wondering whether you or your organizations have looked at anything in terms of what sort of factors to examine.

MR. KEMP: To answer your first question, what I was getting at with the need to look at the reimbursement mechanisms is to make sure that the proper financial incentives are aligned. The purpose of the reinsurance is really to protect the income of that provider, not to allow it to gain from providing services. So the focus in looking at the reimbursement mechanisms under the reinsurance contract is to attempt to cover the cost of that provider that is providing a given service, not to

increase the profit potential for providing that service. It's a very difficult task, but that is the ultimate goal; so there is no incentive, once the reinsurance deductible is exceeded, to convert to a typical fee-for-service basis.

MR. SUTTON: I'd like to add something, too. In these various arrangements, which are partnerships, some of the partners try to be more equal than others. We've had situations where the HMO works to put too much risk on providers. Some plans buy reinsurance as a commodity, and they think if they don't make a profit on it, they made a bad bet. We may be estimating a specific coverage premium with a 50% or 60% loss rate, but if they don't get a 120% return from claims, they think that somehow they got a bad deal.

The reason we have to look at the contracts is that sometimes both the HMO and the provider are hunkering against the reinsurer. The most obvious example is, we're writing an HMO and we've got a $40,000 deductible on a specific coverage. The hospital changes its contract to provide $1,000 per diem until the gross charges exceed $40,000, and then it is a 5% discount. We've had HMOs lie to us about the nature of the contract. At times they won't let us see the contract; they just say they've got a $1,000-per-diem rate, and so we base our price on that. Then they come in with a $60,000 bill with a 5% discount.

I want to emphasize that the key is evaluation of the management capability of the HMOs, their ability to manage health care, and the nature of their contracts with providers. In our history we've forced them to change their contracts with providers to keep the reinsurance rates down. In other words, we think we've helped them indirectly to control their cost, by telling them how they should negotiate with hospitals, or getting in there ourselves to negotiate with the hospitals. We also have our own organ transplant network with negotiated fixed prices that, based on samples, are roughly at 50% off charges for select medical centers. We have about 30 centers nationwide, our own preferred network for various organ transplants. We work directly with the medical director of the HMO and facilitate arrangements with the medical director of the transplant center, often a time consuming process. Negotiating those medical deals is another way that we control the cost of our catastrophic reinsurance.

MR. KEMP: On your second question, which I believe was how to evaluate what deductible a hospital or a provider organization should carry, I think it's a very similar analysis to what we do with our current customers. You have to evaluate the level of risk they can take and the impact will be on their financial position if they have a certain level of claim. As Harry said, if you have a Class I hospital and it has to pay a $500,000 claim for an organ transplant, it will be out of business. You need to look at its revenue stream and capital structure and make that evaluation.

MR. SUTTON: From a purely practical standpoint, as we watch the business, there is a tendency to try to keep the premiums constant; so with inflation, HMOs tend to increase the deductible $5,000 or $10,000 a year, and that may offset the natural increase in premium rates. In our business, I would say that even though the number of members that we insure grows every year, the aggregate premiums don't change, but the deductible on the specific just goes up. Data to measure how rates are going to change with an increasing deductible is very important. Another problem is the

definition of cost limits for covered services. We frequently put in per-diem limits overall, or we may have per diems for intensive care, and a different per diem for routine care. This may vary by hospital. In other words, we have some very complicated contracts, based on what we cover, and based on the HMO contracts with the hospitals.

When dealing with HMOs, if they're small or new, we start with a low deductible because experience is hard to guess. We seldom go below $25,000 or $30,000 because we're swapping claim dollars. We do not desire to be in the claim business. We're only in the catastrophic (occasional claim) business. Some clients are very risk averse and want a low deductible. Typically when their enrollment grows, their deductible goes up, but it's not very easily quantifiable as to what the deductible should be. It's a guess from looking at how much surplus they've got and what would happen if they had a variation in claim frequency.

MR. ALLEN J. SORBO: You mentioned the possibility of quota-share treaties with a capitated hospital. This struck me as curious. I never thought it would evolve that way, although I guess I could conceive of a community hospital that maybe has 30% of its claims that must be referred to a bigger tertiary facility. Perhaps you want to quota share on that piece, which could be very risky for a smaller, community hospital. I was just wondering if you really think the market is going to head in that direction, or if you've already talked to hospitals about that type of an arrangement.

MR. KEMP: When I talk about having a quota share of a provider organization, it's really geared toward where I think we'll see this market evolving, in terms of the PHOs, the integrated networks really taking shape, like an insurance carrier or HMO. Providers are taking on risk. The structure will depend on how the regulatory environment evolves, but over time they will become their own little insurance companies, their own little HMOs, and they're not well-capitalized at this point. I think, initially to get into these markets, they will be looking for quota-share protection, and looking for a partner, as Evelyn said. They'll be looking not only for risk-taking capacity, but also for professional advice and a partner that is skilled in managing risk and helping them into this process.

MR. SUTTON: There's also another theoretical question about quota share. With HMOs, the federal and state statutes usually require them to take total risk, with defined exceptions, and you can't really have a quota share. When we joint venture with indemnity products, we frequently quota share that. We might take half the risk on a combined PPO/indemnity, sharing with the HMO, which in some states may not be legal. These products are new, and no one can accurately predict results, so we frequently quota share. When the HMO owns an insurance company it may write it and we almost always quota share or, if we front it and they reinsure it, we always quota share. We provide the specific coverage within that coverage to keep the experience more level than it would otherwise be.