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Reinsurance in the Evolving U.S. Medical Market

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Summary: This panel discusses the new customers, new forms of risk-sharing and new ways of reinsuring these risks. It also looks at the future in this rapidly changing market. Topics include:

- *How has the medical market evolved?*
- *Who are these new risktakers?*
- *What risks are they accepting?*
- *How are these risktakers purchasing reinsurance?*
- *What is the outlook for the future in this market?*

Mr. Michael A. Kemp: When the four of us were talking about this session, we figured that we probably had three different groups of people that would be joining us. The first group consists of people who really want to learn about the subject. The second group is those who are staying over the weekend and had nothing better to do, and the third group is those who were too late in getting a tee time.

It was very appropriate that the general session that started off the meeting dealt with change and the speed of change. That's really how this last session of the meeting is also going to be discussed. I can't think of a market in the insurance business that's undergoing such radical change as the U.S. medical market, and that

market on the direct side is producing corresponding changes in reinsurance and how we look at reinsurance. We've seen ongoing changes in the organizations serving this market, how the providers are forming different types of groups, and how risk is being shared, and all of those changes are driving changes in reinsurance.

We will be focusing on the providers and how they're taking on that additional risk, the changes going on there, and how they're reinsuring some of that risk in the form of provider excess. We have three panelists with us who have worked in this market in various capacities, and they will share some of their experiences and some of the factors that are driving this market, how the market is currently working, as the case may be, and also give some of their predictions and thoughts in terms of what the future might hold for the provider excess market. The first speaker will be David Wilson. Dave is the managing director of Apex Management. The second speaker will be Bruce Carlson, assistant vice president at Allianz Life Insurance Company. And third will be Walt Marsh, vice president of John Alden Risk Management Services.

Mr. David Wilson: One of the biggest things that's driving the marketplace right now is opportunities to make more money. This is particularly true when we start looking at some of the people who have capital to invest out there and just how they're employing it.

I'm going to touch on what I think is driving the market, some of the new products that we're seeing out there on the provider excess loss side, some new players and new ideas, and other changes, challenges, and opportunities. Then I'll make some predictions for the marketplace. Somebody asked me whether or not anybody would ever make money in provider excess loss. I think we will eventually, but it's going to be difficult. I think Walt's probably going to touch on some of those issues.

What's driving the market? Obviously, drivers include the growth of managed care (which is the major shift of indemnity coverages to HMOs and HMO look-a-likes) and also government initiatives on Medicare and Medicaid programs. There's a whole lot of interest at the state level in Medicaid programs and shifting them over to HMO-type vehicles to deliver care. That's not without its challenges to the providers and to anybody underwriting that business. On the Medicare side, for whatever reasons, providers are in a big hurry to get into Medicare risk, and if you actually look at the economics of it, it's not a really good deal for them. One of my guys was actually the head actuary for the American Association of Retired Persons operations at Prudential, and he went through an example of comparing fee-for-service revenue of the providers to what they actually get on a Medicare risk

contract, assuming it's a full capitation contract, and it's around 59 cents on the dollar. There's a little math behind getting there, but they really have to manage their act to be able to make money on that. Nonetheless, people are stampeding into it.

Then we have this other phenomenon. It has been happening for a while in California, and it's happening in the northeast now, and that's the shift of risk from the HMOs themselves to the providers through capitated contracts or through case rates. Some of our clients are large hospital systems, and we've been asked to look at various deals that are presented to them by the likes of U.S. Health Care and others. There's clearly an effort on U.S. Health Care's part to lock in profits. It's really not willing to give up too much of its profit for a full risk capitation deal. In fact, it becomes member brokers at that time. It's running the systems and running the marketing, but it's really washing its hands of all of the medical delivery aspects.

In terms of new products I think we're going to see some evolution. The typical product that's out there right now is specific. It's almost a hybrid between what I would characterize as traditional HMO reinsurance and some of the work in the employer stop-loss area in managed care plans, but it is evolving. It is breaking down into more and more pieces as we look at specialty subcapitation and things like that, but it is very traditional. In fact, most people who have been in the market for a while really believe providers need aggregate, but there aren't very many people providing aggregate.

What they should really be concerned with is their ability to stay in business when they're taking on all this risk, and aggregate really does a more complete job of that, but there's just a myriad of problems in underwriting this coverage. Depending on the system you're dealing with, capacity could also be one of the problems.

There are some new entrants that are pushing financial-type products which revolve around aggregate-type coverage, and this is borrowing from a property and casualty-type coverage called finite risk. I don't know if it was created by Zurich, but it was certainly pushed by this company. I know that the Zurich folks are looking at ways of adapting it now to the provider excess loss marketplace. You have some of these traditional financial vehicles that the property and casualty insurers have been using, and there's a movement afoot to put these into provider excess loss and try to wrap the client in for much longer periods of time.

Through the early development of the provider excess loss marketplace, the product has basically been a commodity. I think what we're seeing now with finite risk-type products, and more and more interest in aggregate, is that it's going to be moving away from a commodity. It's going to be a custom fit to the individual situation.

In terms of who's out there doing this kind of business, we have traditional competitors plus new property and casualty entrants. There are a number of property and casualty firms that have initiatives in this area. There are some that are already active: General Reinsurance Corporation and American Reinsurance are two, and Zurich Reinsurance Centre is another. These companies are moving into this marketplace, and they're doing it for a lot of reasons. One of the biggest is the people these companies deal with. Many of their medical malpractice carriers want to get into the market. If they don't develop capabilities to put these people in the provider excess loss business, then they're going to potentially put their clients at risk, and somebody else will come along and get their toe in the door.

It is an offensive move as well. The property and casualty folks have been largely focused on the workers' compensation side of health care, which is just a relatively small percentage of what the total health care market is. So they're looking at it as a huge, growing, and changing market and one where technology is really coming into play in the way health care is being delivered. They have this concept that reinsurance is borrowing capital. It's just another way of putting up capital to take on risk. Their whole approach to the market is a lot more stochastic than the traditional health care actuarial approach would be. Any of the property and casualty folks that we've dealt with are much more into what is the standard deviation of the distribution we're using. I don't know that they're getting any better answers or have any better understanding of how variable it really is, considering it's such a moving target. Nonetheless, the approach they take is much more stochastic and heavily dependent on simulation.

One interesting thing that some of them are using right now is setting up venture capital pools to invest in new provider organizations that have some particular niche in the marketplace that they think is worthwhile. They're actually coming in with capital in two forms: capital as operating capital, getting these enterprises up and running, and reinsurance as borrowed risk capital to take on the risk. I think, as some of the large provider-sponsored networks (PSN)—if you're not familiar with it—drive more lives in, and as the marketplace starts to harden, what we're going to see is a move for some of the very large systems to move a lot of their provider excess loss needs out into their captives. The reinsurance game there is going to be working with the captive rather than being much closer to the first dollar claim.

Other changes in the marketplace. There is a real shift right now. Some of the brokers out there are definitely pushing commodity-style business. Some of the consultants are pushing custom fit business. That's a question that needs to be answered. I think it can be commodity for some situations, and it needs to be a custom fit for others, just depending on the situation. The market right now appears to be dominated by a few brokers, but it's spreading out. There are many more

people getting into the business. What we're also seeing is that underwriters need more support. There's a lot more data that are required to do a proper job in evaluating any of these risks, and underwriters typically aren't getting them and are having to make decisions with quite poor information.

When we talk about capacity in aggregate programs, I think we're going to see changes. I know there's at least one large pool out there that can actually take up to a $60 million deal in aggregate protections. For a very large system that needed a lot of protection, there is an option out there. In another session, we talked a little bit about super cap as another form of reinsurance which is like a high-end tertiary capitated network surviving on literally millions of members which, in effect, becomes another form of reinsurance. United Resource Network and its transplant program would be an example. I don't think Life Track's capitating yet, but it could. There are options out there. I think one of the things we're going to see is some of the high-end tertiary care medicine getting a little better organized and managed care arrangements with people that can drive membership into it. It's a real numbers game. You really need large numbers to make it work.

Let's discuss challenges and opportunities. At almost every health care session you go to, or at least the ones I've been to, the discussion always comes back to data. Data are rare. They are sketchy. There's some really good data, but they don't match what we're doing. We're always trying to do something with a moving target. Even if you have historical data on it, you really need to look at it more as a time series. The underwriting is tremendously complex. I had one guy I worked with in New York who used to call something like this vectors in n-space, but it really is a much bigger problem. To do a really good job you need to dig into a lot of detail; unfortunately, the information really isn't there sometimes to justify doing it.

Client systems are a challenge, even if they have a good system for paying claims, and even if they're capturing the right data. Are they on top of their game? How far behind are they? And are they just rushing to get claims paid and not capturing information that you can use for pricing and evaluating what you're doing later on? Provider systems are a different story. They're just not geared to support the kinds of risks that they're taking on right now. One thing we can say for sure is the market is expanding, and in terms of total dollars, just the necessary renewals alone should double the market every couple of years. We have the moving target deal. With any system that you underwrite, you're looking at it at a point in time, but if they're doing a good job, they should be moving along.

And one of the big challenges and something for which we've tried to use some simulation to get by is that providers really don't understand the risks they're taking

on, particularly if they've had anybody working with them to calculate a capitation rate. It's amazing how many of them get locked into a mind-set that a capitation rate is simple. I mean it's just utilization times the cost of the services being utilized. Unfortunately, there's a whole lot of variability in the cost of services as the risk moves around and also as the utilization changes. So there are many moving pieces there. They may actually not pay enough attention to the contracts they're signing, and be responsible for out-of-area situations, and just are not prepared to deal with it.

Anyway, I have some predictions for you. I think the market is going to begin to grow exponentially. I think it has the potential, in the long run, to really blow away employer stop-loss in terms of total dollars. There are many different variables there depending on how much combination is going on in the system. What you need to look at, particularly when you're talking about employer stop-loss in managed care plans, is basically the same information. But as you move from employer stop-loss to HMO reinsurance to provider excess loss, the level of detail keeps getting greater and greater.

I think the formation of PSNs is going to turbo charge the market. We're seeing that right now. Several states have initiatives to actually allow PSNs to do Medicaid business. Needless to say, insurance commissioners are concerned about whether or not this is a good thing. What kind of capital requirements are there? What kind of reinsurance should be mandated, or should they be in there playing a role? I think aggregate is going to, in the long run, become the key product. I think the large systems are going to, once the market hardens a bit, start using their captives. Once they get comfortable with the risk and the results, they are going to start using their captives to move some of the provider excess loss dollars out of the general system.

I think the product is going to evolve, certainly for the larger institutions that it would be applied to, to more of a financial vehicle. I think we can look forward to multiyear deals and something very much tied to relieving the strain on risk capital. I think property and casualty carriers could dominate. They're willing to throw a ton of money at this right now. They're spending a lot of money studying it. They're spending a lot of money in building tools to gear up to do it and investing in people. The have much at stake and access to much of the market through all the professional liability coverage that they do with physicians and hospitals and physician reciprocals, etc. I think that's going to be interesting to see develop over the next few years.

Mr. Bruce A. Carlson: Mike said we should talk about provider excess markets, but the term market has different meanings to different people. Intuitively, you

immediately think of the buyers of the product, and that would be the hospitals, the physician groups, and the ancillary providers. But there are other ways of looking at markets. If you talk to the brokerage community, for example, they think of the markets as the carriers or the managing general underwriters that are writing the product. They estimate that there are about 70 markets for this product. It's difficult to estimate the size of that market because it can be written either on a casualty or an accident and health form, and most companies writing it today are accident and health carriers using a casualty company's paper to write the product. So when you see a casualty paper being written, you're not really sure who the risktakers behind it are.

Another way of looking at the market is by the number of members who are receiving services under capitation arrangements. This is a convenient way of looking at a market because provider excess is typically quoted on a per-member-per-month basis, and if you know the total number of members, you can estimate the premium volume of the total market.

Still another way of looking at the market is by looking at the different ways this product is being distributed. I've identified about seven different distribution systems, and I'll talk about each of those, but before I get into that, I just wanted to touch on some regulatory aspects concerning provider excess. I've spent most of my time trying to get provider excess approved in the various states.

The provider excess market today is virtually unregulated. The states can't seem to agree whether this is a casualty product or an accident and health product; in other words, is the event that generates the claim a health event or is it a financial event? In a telephone survey we conducted of the state regulators, we found about 27 of the states consider the product to be casualty and about 13 states consider it to be accident and health. Four states will allow it to be written by either casualty or accident and health carriers. Seven state haven't decided at all. In those states that haven't decided, I've seen this written on a surplus lines basis.

The states are struggling with how to deal with these new entities that are assuming risks? It's not just hospitals and physician groups. It's a lot of the ancillary providers as well.

One of the NAIC model regulations designed to address one class of providers is called the Prepaid Limited Health Services Organization Model Act. That model act regulates providers of single services, like dental, vision care, mental health and substance abuse, pharmacy, podiatric, and other limited services as they may be determined by the commissioner. It generally does not include hospital, medical, surgical, or emergency services, except as incidental to those single services. This

act does require a certificate of authority to accept risk and it has certain protections to guard against insolvency such as a certain amount of money on deposit, financial reporting requirements, and so forth.

A second piece of legislation that should be followed, and again this is proposed model legislation at the NAIC level, is out of the Health Plan Accountability Working Group, and it's called the CLEAR legislation. CLEAR stands for Consolidated Licensure for Entities Assuming Risk. It's a massive undertaking by the NAIC to get at how states are going to regulate these new entities that are assuming risk. It may take several years for this to get finalized. The CLEAR legislation grew out of the Model Uniform Licensing Act (MULA,) and it's really a grouping of seven model bills, three of which were adopted at the June 1996 meeting.

There are really no standards for the product at this time. When dealing with state policy analysts, they admit they don't understand it. Typically, they'd like to have a checklist that they go through when a carrier submits a product, and when everything's on the checklist they approve the product. They don't have that with provider excess, and they're trying to work with carriers to develop those checklists. Just the definition of a claim—whether you convert physician encounters via a resource based relative value schedule (RBRVS), MEDICAL DATA RESEARCH (MDR), or Health Insurance Association of America (HIAA) in order to generate a claim—that is still wide open. And there's generally no insolvency protection in these contracts as there is with HMO reinsurance.

Additionally we see few rules on the marketing of this product. States impose no minimum attachment points as they do with stop-loss. It's unclear with these various provider risk-sharing arrangements when they constitute the business of insurance, and a certificate of authority is required to transact business. There's a draft bulletin put out by the chair of the Health Plan Accountability Working Group that addresses this issue. That position, which has been adopted by many states, says that if the providers are accepting risk on a prepaid basis that would be full or partial capitation, then they're in the business of insurance, and they need appropriate licensure from the Department of Insurance.

Other types of risk-sharing arrangements like risk corridors, withholds, pooling arrangements, etc. may also constitute the business of insurance, but the bulletin gives little guidance on when states should regulate those types of arrangements. One exception, which is noted in this draft, is that if the providers are accepting downstream risk from a duly licensed carrier (that could be an insurance company or an HMO), then these providers are not in the business of insurance and do not need a certificate of authority. The theory there is that there's already one licensed regulated entity in the stream, and the insurance departments are going to hold that

entity accountable for providing the promised benefits to members. That would not be true in the case of a self-funded employer because they're not a licensed regulated entity.

Further work is now being done to clarify these other risk-sharing agreements and when they would constitute the business of insurance. On April 17, 1996, the American Association of Health Plans Managed Care Law Conference was held in Washington, and a paper was handed out that gave a conceptual framework for when these other risk-sharing arrangements would need to be regulated. There are two points made in this paper. One is that if the risk-sharing arrangement involves the assumption of incidence risk as opposed to pricing risk, and if the capitation assumptions or the risk-sharing assumptions rely on projections that not all buyers will require the service, then they should be regulated. Based on that analysis, you can look at the various types of risk-sharing arrangements and try to predict which are going to be regulated. A fee-for-service arrangement, global fees, case rates, per diem arrangements, and diagnostic-related groups probably will not be regulated because as the incidence or the utilization increases, so does the revenue stream to the providers. However capitation, percent-of-revenue, and other premium arrangements probably will be subject to regulation simply because as the utilization increases, the providers do not receive more revenue in the form of capitation. I think they will also begin looking at what types of services are being provided and whether or not the providers have control of those services. Referral services are typically outside of their control, and that's another trigger point that could lead to regulation.

I want to talk a little bit about markets now from the buyer's standpoint. First, the buyers are not individual physicians. They're more intermediaries, groups, individual practice associations (IPAs), and so forth, and it's typically those organizations that are capitated with the individual providers are paid on a fee-for-service or some scheduled basis.

This market began long ago with the ancillary service providers—home health care, mental health, substance abuse, durable medical equipment, laboratory, vision care, and so forth. They were being capitated and felt they needed some protection. That was a tough sell because there's little catastrophic risk with these ancillary service providers, and, as Dave mentioned, most of the provider excess was sold on a specific-only basis. Typically, at the end of the first year, if there's no claim, the providers might decide they don't need the coverage, and so your persistency is poor.

The hospital market, based on my talking with various writers of this product, probably generates a little more than half of the provider excess premium today.

That's a tough market. It's typically dominated by the brokers who tend to turn it into a commodity-driven, price-sensitive sell.

On the physician group side you have multispecialty and single specialty physician groups. There are about 610,000 physicians in the U.S. with 210,000 of those organized into roughly 19,000 groups. The American Medical Association's definition of a group is three or more physicians who are formally organized as a legal entity in which business and clinical facilities, records, and personnel are shared. Income from medical services provided by the group are treated as receipts by the group and distributed according to some prearranged formula.

So that gives you some feel for the size of the physician group market. Of those 19,000 groups, about 70% are single specialty, 22% are multispecialty, and about 8% are family or general practice. However, if you look at it by the number of physicians, the multispecialty groups dominate with over half of the physicians being a part of a multispecialty group. What we're seeing is most of the provider excess being written today is written on multispecialty groups, but there's increasing interest from the single specialty groups, particularly those that have catastrophic exposure—cardiac surgeons, for example.

HMOs have been a market for provider excess for some time. They have a relationship with the provider groups. They're a market in two different senses. One, they could simply be a broker providing lead generation to the carriers who then write the product directly on the provider groups. Second, the providers can actually pass the excess risk back to the HMO through the capitation arrangements, and then the HMO cedes it to the insurance carrier through its HMO reinsurance arrangement. This latter approach is common, particularly in states that have not yet decided what the product is and won't approve it, or if a carrier hasn't received state approval for its product.

More often, however, we're seeing the providers going direct to the carrier market and not working through the HMO for a couple of reasons. I think, first, they believe, and rightfully so, that the HMOs may be retaining part of the premium, and they're not necessarily getting the best deal, so they want to shop the market. More importantly, many of the provider groups today are receiving capitation arrangements from a variety of health plans, and they're looking for one global provider excess contract that will cover all of those capitation arrangements.

A physician hospital organization (PHO) is another market that was originally thought to be hospital/physician joint ventures that would develop products to market, take risk, and so forth. With maybe one exception we haven't seen any PHOs develop and market an insurance product. Rather, these joint ventures

simply deliver services and assume risk and thereby have a need for provider excess. We are beginning to see some funds being capitated where an HMO would capitate a fund, say, and then out of that fund it would pay its providers on a fee-for-service basis. The surplus from that fund would then be split at year-end between the HMO and the provider groups. Both parties desire to protect that fund with provider excess insurance.

When we see those kinds of arrangements it's questionable whether you're reinsuring the HMO or whether you're insuring the providers, and whether you need an HMO reinsurance agreement or whether you need a provider excess agreement. As Dave was saying earlier. there is a blurring between the provider excess market and the HMO reinsurance market.

I tried to give you a sense of how many physicians there were in physician groups, but you really need then to convert that into how many of those are capitated because that'll give you a better sense of what the excess market is. A 1995 survey showed that about 76% of primary care physician contracts are capitated. Specialists are less capitated at 45%. Ancillary providers are less yet at 34.7%, and hospitals are the least capitated at 33.8%.

Interstudy estimated the percentage of HMO enrollments served by capitated providers, and you can use these data along with average per-member-per-month premiums to get an estimate of what the size of the total market is today.

To date, most provider excess has been written on commercial, Medicare, and Medicaid populations of HMOs. We're beginning to see other types of populations generating a need for this product. One example is a large health plan being capitated by the state Medicaid program to provide care for its acquired immune deficiency syndrome (AIDS) patients. We are writing provider excess for that health plan just for those AIDS patients. That is a well-defined population where clearly the risk is catastrophic, and it's a new twist to an old product.

Another way of looking at the market is by the distribution methods. It's difficult to market direct because you need to have the relationships with the groups. The direct relationship is ideal, however, because then you get the underwriting information you need. You don't have to work through a broker or intermediary, and when it comes time to adjudicate the claim you have that direct relationship. We prefer to write direct as much as possible.

Reinsurance intermediaries have redefined their role in the last few years. Traditionally, they brokered risks between insurance companies and reinsurance companies, between reinsurance companies and retrocessionaires, but in the new world

order where you have different entities taking risk, they're brokering between the new risk-taking entities and the insurers writing provider excess. We've seen a lot of activity in this area, but not many sales. However, it's interesting how they're redefining their role in this new world order.

The next is the casualty brokers who already have the relationships with the provider groups. Either they're providing the medical malpractice or the professional liability. They dominate and control most of the market today.

TPAs are also getting into the market because many of the provider groups don't have the systems to capture the encounter data and convert them into a claim. They need those encounter data to get a feel for what their costs are so they can renegotiate their capitations at year-end. They also need the data to build up a claim so they know whether or not they have a reinsurance reimbursement at year-end. Those TPAs are in the same position to place provider excess as they are with stop-loss. We already talked about HMOs and the dual role that they play in the provider excess market.

Physician practice management companies are acquiring physician practices and acting as the back room providing a myriad of services. They're in an ideal position then to place the provider excess insurance product for those physician groups. The consulting actuaries are in a similarly, but somewhat less, ideal position. There's a conflict between an actuary making a recommendation and taking commissions, but we've seen at least one example where they've set up a marketing organization to provide the provider excess insurance to the capitated provider groups that they've been working with.

What's the outlook for the future? Dave was optimistic that it's a growing market. I think in the near term that's true, but long term much is going to depend, first of all, on the consumer reaction. Historically, physicians have been reimbursed on a fee-for-service basis where their incentive is to perform more services, and that's where we saw the double-digit inflation in medical costs. Under capitation the incentive is to perform less services, and you're seeing a lot of litigation today against HMOs because of those incentives.

The provider action is interesting as well. Many physicians feel they've always managed the risk, and so they welcome taking risk. Others are not so keen on capitation. I think, in the long term, what they're going to need to be concerned with is how diligent are those HMOs in underwriting the membership to which they will ultimately provide the services. It goes beyond the three types—commercial, Medicare and Medicaid—but within each of those categories are they diligent in their underwriting and doing all that they can with pre-existing conditions and

actively at work and whatever the small group reform regulations will allow, or are they just out writing as much risk as possible and pushing that off to the provider groups?

Last, I think the regulators' reaction is going to be important. This could be a very bright future if the states accommodate the product and set reasonable reserve requirements. However, a few prominent insolvencies could lead to overregulation and kill the market.

One bright note, and I'll give a little plug here. There's an association that is starting up called the Provider Excess Loss Association for provider excess carriers, and, if any of you are interested, you can talk to Dave about that. There is an opportunity now for the industry to clean up the act, to set some standards so that this doesn't get too out of control and we don't end up with a few, very large insolvencies that could result in overregulation.

Mr. Walter C. Marsh: Mike started off by talking about change and how fast things are moving. Here's how fast things are moving. Many of you are probably looking at getting into this market. We've been in it. We're on the way out. That's quick. We've had an interesting experience at Alden.

Dave made a presentation yesterday. I don't know how many of you got a chance to see that, but it was an excellent presentation. Many of the things I'm going to cover here he covered yesterday. I'm going to give you a few war stories, a few pointers, and a few pitfalls to avoid based on our experience.

I'm going to try to cover the marketplace, give analysis of provider contracts (a critical element), discuss coverage design (also critical), claims, and a few miscellaneous underwriting points.

I disagree with Dave, I don't think the marketplace is as large now as we initially anticipated it was going to be. It may be that it's going to become large. It may very well grow exponentially in the future. I do know that when we originally went into this market, we had a relatively well-designed business plan and that the market right now is not nearly as large as we anticipated. I'd say it's probably around $125–150 million.

Panelist: I think it's probably double that.

Mr. Marsh: Did you say double that?

Panelist: The potential is much larger.

Mr. Marsh: I don't know. Maybe the potential's much larger. The growth has been a little bit slower than we anticipated, although you'd probably get some different opinions from people. There are a large number of players. I can name 30 or 40 right off the top, and I've heard people say there are as many as 60–70 different players out there. Some people have found niches out there where they have not dealt with the brokers as much. We ran into a broker-driven market. Because of that it was very soft. I think it's beginning to harden a bit, but I believe it has a ways to go.

Let's discuss a few miscellaneous topics. First, Dave talks about the providers naivete. They are, in some ways, naive, but in other ways they are sophisticated, especially in California. There are certain hospital administrators that are very sophisticated.

Second are the captives. We did write a number of captives. There's the Sutter System in the Bay Area of San Francisco, the Salas System, and some other systems. They do have big property and casualty captives. They issue all their medical malpractice and other property and casualty coverages through them, and when this market starts to harden, they'll want to consolidate their entire system and run all the provider excess through the captive.

ANALYSIS OF PROVIDER CONTRACTS

This is one of the areas that really makes this line of business so much more difficult than the stop-loss market. If you remember, in the stop-loss days you had to talk about being able to analyze the plan document so you could determine the coverage. This is what you were reinsuring. You have a situation where you could have 8–10 different organizations, HMOs, or managed care organizations or provider health organizations, that are capitating a particular hospital or a particular IPA. Each one of these contracts can be different. If you don't know what's out there, you can really get snake bitten, and as we move on a little bit further, I'll show you a couple places where we were bitten. You really need to analyze each of these contracts separately. Initially, I think you need to involve somebody who really knows an awful lot about the different types of services that these folks can be financially responsible for. I'd recommend involving your medical director. If you have any people in your organization who do contracting, you might want to get them involved. Also include your claims personnel. You need to develop a good analytical approach along with guidelines and procedures to analyze contracts.

You're going to need to develop a matrix of financial responsibility, and you'll need to do this fairly quickly so you can evaluate these arrangements. If you don't do this, you're going to run into the practical difficulties of being able to do a quick turnaround on a quote or a request for proposal (RFP). You must be able to develop

a procedure so that you can accurately analyze these arrangements fairly quickly. What are they responsible for? What can they cover? And what do they have special arrangements for? By special arrangements, consider what they have as far as arrangements for referrals. For instance, this large hospital system was having trouble with cost associated with premature infants and they subcapitated the children's hospital that was in the same area. These are the kind of things you need to know if you're going to be able to price this coverage and do it well.

The following are some of the things that you might want to look for when you're going through these contracts.

Subcapitation

We ran into this situation where the system was a large one. It had both hospitals and physicians and it had subcapitated a lot of the services, and it didn't think that we should have to cover subcapitated services because there was no risk to the organization for them. Maybe the group of people it was subcapitating might have a risk and might want to purchase coverage separately, but we don't.

Drugs

We had a situation on more than one occasion where we had an IPA that happened to bear the financial responsibility for pharmaceuticals or drugs, and nobody paid any attention to it until the claims started coming in. Do you know what chemo-therapy costs? I would say that you need to load about 20 points for that.

Emergency Facilities/Outpatient Facilities

We had another group of physicians that had responsibility for the facility charge for hemodialysis from one HMO, and even though Medicare has a separate status for the end-stage renal category, there is an 18-month period before somebody can get into that status, and during that 18-month period they can run up large bills.

Risk Pools

That's another situation we ran into where we had another hospital system, and we had the provider excess for one of the hospitals that was in the system. Well, it had these really complicated risk pools for dealing with referrals that went in its system, and it was trying to hit us with full charges because we'd given it a contract that really kind of looked at hard dollar cost separately from soft dollar cost. If anything was a referral or out of its facility it had to write a check for it. We didn't mind covering it if it had to write a check, but here it was writing a check that was going to a risk pool, and then some of that money was coming back into its pocket. So you need to be aware of these things because if you're not aware of them, you're going to get hammered. On the hospital side, again, the subcapitation and the risk

pools are the big things. We did not have nearly as much trouble with the hospitals as far as what they were responsible for and what they weren't responsible for.

COVERAGE DESIGNS

If you're not very careful about developing your coverage then people will find the cracks, and you will get claims that you weren't anticipating. I think it's probably a general rule that you want to reimburse at something that's less than cost. A bit later on I'll talk more about some ways that you can go about determining what the cost ought to be. Cost is not as difficult to determine for the physicians as it is for the hospitals. Almost everybody uses schedules to determine cost. There are practical difficulties being able to support too many schedules. However, if you can support a lot of different schedules, you will have a market edge. For instance, we had three or four IPAs that had developed their own schedules. We found in all of these situations that once we had the tools to be able to evaluate the schedules, they were really very good schedules. Not only that, but we found that the experience we had from these groups was really excellent. It appears that organizations that have made enough of a commitment to go in and develop their own schedules, to really look at what it costs them and how things work, are going to manage care better. That is what we found out. The last item is critical. Whatever schedule you have, it really does need to be comprehensive. It needs to cover all current procedural terminology (CPT)-4.

The conversion factor schedules is a type that you see often. They aren't quite as accurate at reflecting cost, but they're a lot easier to use. Many of the brokers on the West Coast will request the 1974 California Relative Value Schedule (CRVS). It covers very few of the expensive CPT-4 codes that have been created for newer procedures. The 1994 CRVS is a little bit better, but it still has severe limitations. The McGraw-Hill schedule is relatively comprehensive.

RBRVS is a good schedule, but is not complete because it was designed for the aged population. The Medi-Risk Managed Care Schedule is the most comprehensive schedule. It tracks closely with RBRVS. HIAA and MDR are good schedules but do not reflect managed care discounts. The 70% percentile of MDR has been used for CPT-4 codes that aren't addressed by the 1974 or the 1994 CRVS. There you do need to check for completeness and appropriateness.

COVERAGE DESIGN FOR HOSPITALS

Again, reimbursement needs to be at cost. The cost on the hospital side varies a great deal—from as low as 40–42%, up to 70–80% of billed charges. It is very sensitive to the geographic area. Cost on the West Coast is in the neighborhood of 40–45% of billed charges. The most successful methodology is the use of a combination of percentage of the bill charges that is close to the estimated cost

basis and then add a per diem cap. The per diem needs to be appropriate to the area and the facility. Finally, add the deductibles and the coinsurance.

Regarding the hospital per diems, be a little bit more liberal for the referrals than for the in-facility services. Encourage the hospitals to try to develop discounts or other arrangements with facilities that they refer to. That will take some of the pressure off their financial position. I do recommend strongly that you use separate per diems for the different services, like intensive care unit, cardiac care unit and acute care unit. Finally, make certain that the outpatient cost is capped.

Exclude subcapitation. Again, what's the risk pooling situation, and how are you going to deal with that? We ran across suicides. This is interesting. We found out that a lot of the HMOs in California were prevented from excluding suicides, and we had a suicide exclusion in our contract because we never priced for it, but it turned out that—as a practical matter we couldn't very well leave the provider out there hanging. So, I would recommend that you think about how you'd price suicides.

The last thing is if you want to avoid litigation, all kinds of bad feelings, and trouble with your clients, make certain your coverage and your contract are clear. I recommend strongly that you provide examples to people. Use real live stuff and explain the way it's going to work because, if you don't, you're going to get into arguments later down the line about how something should be adjudicated.

CLAIMS

It's really difficult to obtain good claims data on the front-end when you're trying to evaluate an organization. The experience is usually always incomplete. Much of that's because of the claim lags. There are a lot of different reasons for the claim lags. First, the organizations of providers are not as sophisticated, not as used to dealing with claims as insurance organizations are. Second, there are referrals. Even if they're doing a good job with claims that are in their own facility, the HMOs send capitated individuals to other facilities for treatment. They do not find out about it until two or three months later. Third, the experience is just not applicable because the basis of the claim—billed charges, contracted charges, actual amount that was paid, actual amount negotiated—has not been identified.

In order to evaluate experience and to determine completeness, check actual service dates versus reported dates. We do this on an individual case basis to set our reserves.

The other thing is, after you settle the case, somewhere along down the line you need to get your claims personnel out there, and you need to get them to sit down

with the people and the providers' organizations that are going to be responsible for making sure that the data are transmitted. You need to get these people talking, and they need to talk frequently. We found that in situations where we have done that we've been much more successful at getting quick reporting, quick claims, and the relationships have been a lot smoother. Another thing that we found out is that many times the providers are not nearly as good as most insurers are at checking eligibility to make sure that these charges that are coming downstream are charges that they're responsible for. Finally, if you do a lot of IPAs, physician groups, and everything like that, you're going to need to develop a system to adjudicate these things or you are going to be inundated because you're going to get a lot of claims, and you're going to be talking about having to reprice these things on a CPT-4 code by CPT-4 code. If you don't have some kind of system, you'll just be swamped.

If you develop a RFP, I think you ought to start asking for claims data (and these are my recommendations) reported current for two preceding years, summarized by claim. You need to know the type of claim, whether it's a hospital or physician; the type of member, whether it's commercial, Medicare, or Medicaid; and the basis of charges. Again, are they talking about bill charges, negotiated charges, or paid charges? Where is the service delivered? Is it in or out of your network? You run into situations where many claims that are in the facility will have pieces that have been referred out. Finally, you need the member months corresponding to the number of claims or the claims you have.

A few underwriting points. Design a good RFP and adhere to it. Too many times we've had too many brokers send us really sketchy information, and we have marketing people pushing us to use that sketchy information to do something. My recommendation is if you can't get me the information, then, sorry. HCIA, a health information data firm located in Washington, D.C., has some publications that will help you benchmark some of the hospital statistics that I talked about earlier. It will give you some idea of what its actual cost is, how well it manages care, and actual days per thousand. It will also give you some idea of what its mix looks like as far as Medicare, commercial, and Medicaid, and give you some idea of what its average per diems look like. This can help you or guide you to try to develop the correct kind of coverage and get the rates that you need out there. Also, the American Hospital Association has some publications that can help you determine what services the hospital is able to deliver within its own facility that will help you decide what it has to contract out for which will also help you in your rating.

And that leads you into the second point, which is you must factor in the services that are going to be referred out and get some idea of what the associated cost is going to be for those. One of the things that we ran into was a lot of folks wanted to give a large amount of credibility to the claims that are out there. I would not

recommend that. We've seen some huge swings from one year to the next on both the physician and the hospital side. Everybody's looking to say, well, these folks really manage care. We found that generally to be true for the physicians. They seem to have a better handle on managing care, and I'm not sure why. On the hospital side, I would be very reluctant to give too much of a discount for an organization that ostensibly manages care because we just have not found that to be true.

When you get into a renewal situation, get your claims folks involved. They're really down there where the rubber meets the road. They really know what's going on with the case. They know whether they're getting good, clean information. They know what the claims are looking like that are coming in. Involve them in it. We had a lot of contracts that were minimum premium or split-funded contracts. I really do not recommend those. We've tried to weed them out and get out of that. A lot of the contracts that we had for the larger clients were experience refund. Also, we got into the situation of having contingent renewals because we did not know what we were looking at at the end of the first year.