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Health Provider Excess Stop-Loss Issues

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Summary: This session deals with current issues in the commercially insured health provider stop-loss reinsurance marketplace.

Mr. Steven N. Wander: I was lucky enough to get Michelle Fallahi to speak, which should give the presentation a good balance. I'll be providing background on the pricing and actuarial issues related to provider stop-loss insurance, and Michelle will be talking about the more hands-on underwriting issues.

Michelle is the vice president of underwriting and operations for provider markets at Fortis Benefits Insurance Company. She has been underwriting provider excess coverages since 1993. Much of Michelle's time is spent on the road meeting with providers and brokers, but she also oversees the underwriting department and still gets her hands dirty underwriting during the busy season. Before getting into provider excess, Michelle was an underwriter of employer stop-loss and group medical coverages at Fortis. Michelle also worked for Principal Mutual and Prudential before joining Fortis.

I've been with Towers Perrin for six years. I've been working with provider excess coverages since 1992. The majority of my consulting work is for health care providers and managed care clients such as HMOs. Before joining Towers Perrin I also worked for Fortis.

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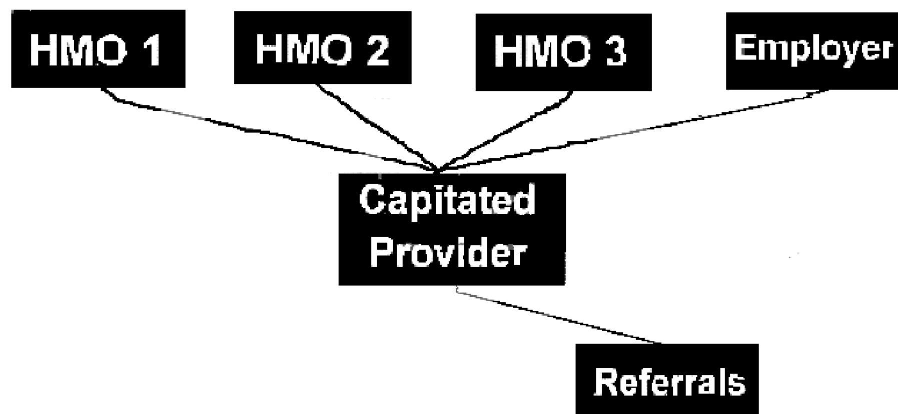
I want to start my presentation with a definition of provider excess insurance in case some of you aren't familiar with this type of coverage. I put together a diagram that does a pretty good job of describing the risks (Chart 1). Generally what we have is a capitated provider such as a hospital, an individual practice association, or a medical group, and they're accepting capitation from several sources. It could be multiple HMOs or large self-funded employer groups that are paying capitation. The providers must provide a predefined set of services to the capitated population for a flat fee per member per month. There may be some capitated services that they cannot provide directly, so the patients have to be referred to an outside provider, and the capitated providers have to pay those claims on a fee-for-service basis.

CHART 1
PROVIDER EXCESS - MARKET DEFINITION

- Generally, specific stop-loss insurance (not reinsurance) purchased by a capitated health care provider from an insurer.



There are two kinds of risk in this situation. There is the fee-for-service referral risk, which is similar to traditional insurance risk, and then there is the capitation risk on the services that are performed within the network. Capitation risk is the risk of a provider providing more service than they're getting paid for, because when a provider is paid a capitation, they're being paid the average of what it costs for the capitated services. If the providers have a population with some expensive cases, they may be providing more service than they're getting paid for.

Generally provider stop loss is a specific stop-loss coverage, and it's insurance, not reinsurance. Many people confuse provider stop loss with reinsurance, but it's really a direct insurance coverage, sold directly to providers. In most states it's considered to be a property and casualty coverage. In some states, however, it's considered to be a life-health coverage. Provider stop loss is more like an income

replacement coverage than it is a true health care claim coverage, because the only "hard dollar" claims are on the fee-for-service referral piece.

I'm now going to provide a brief history of the provider excess market. Before 1990, there really was no provider excess market. Most capitated providers got their capitation insurance as part of their capitation contract. Their capitation contract included a built-in stop-loss provision that was provided by the HMO. The only problem with this was that the HMOs typically charged an excessively high price for the coverage. This was a large source of profit for the HMOs, but the providers weren't getting a very good deal.

According to Towers Perrin research, in 1990, we can only identify three carriers that were writing provider stop-loss coverage, not including the HMOs. We estimate that the three carriers had about $30–50 million of premium at that time. In the early 1990s, when the whole Clinton health care reform debate got going, providers started to educate themselves regarding capitation and stop loss and realized that they weren't getting a very good deal on their stop loss. There was soon an increased demand from capitated providers who wanted to purchase provider stop loss on their own and carve it out of their capitation contract.

Since that time, there has been a rush of carriers entering the provider excess market. We now estimate that there are anywhere from 20 to 30 companies in this market, and we estimate the premium to be somewhere between $150 and $200 million. Actually, it could be more like $250 or $300 million. It's difficult to be accurate because many carriers sell both provider excess and HMO reinsurance, and there's confusion with respect to what the carriers are counting. There is also still extensive provider excess coverage that is provided by HMOs or large insurance companies such as Aetna, who may have an internal provider stop-loss pool equivalent to $25 or $30 million.

My part of the presentation will be how to approach constructing a pricing model for provider excess coverage. I'm going to go through the process that we used at Towers Perrin when we constructed our provider stop-loss rating manual. This may provide some ideas in case anybody wants to create their own rate manual. If anyone has questions on issues not covered in the presentation, we can address them during the question and answer period.

The first step in creating a rating manual is to develop a database. There are several sources for data that can be used to construct a manual. All the sources, however, have some problems. There is a great deal of publicly available data on the Internet or from state databases. One problem with these types of databases is that most of the time the claims for a member cannot be linked. This is due to the fact that the

member identification number is often a social security number, so it is taken off the claim record. For this kind of coverage, where the deductible is on a per member, per year basis, there is no way to determine how many members exceeded their deductible if a member's claims cannot be linked. The other problem with publicly available data is that most of the time this is not managed care data. The utilization rates in nonmanaged care data are a lot higher and, therefore, not appropriate for a capitation product.

The next data source is traditional indemnity plan experience. These data have the same problem as public data, because the utilization and cost levels are too high for a managed care product. When a fixed deductible is thrown in, there is a leveraging impact, and the product is really being overpriced.

I believe HMO experience is a better source because it is managed care, and claims can usually be linked by member. One problem with HMO experience is that it is not always easy to get. As a consulting firm that consults with managed care plans, we tend to have substantial HMO data. Our HMO clients typically send us their claim file each year so we can perform an experience analysis. We compiled all of our HMO data together in a database, which was the basis for constructing our manual.

Another problem with HMO data is that this represents an average mix of all the providers within the HMO network. When you are selling a provider excess coverage, you might be selling it to a high-cost or a low-cost hospital, and the HMO data represents a blending of all of the hospitals. With some HMO databases, however, the claims can be separated by provider. With this type of data the differences in the claim curves for high- and low-cost providers can be examined.

HMOs typically do a very good job of managing care, but sometimes when risk is passed from the HMO to the provider through capitation, the provider may not do as good a job of managing care as the HMO. The HMO utilization may, therefore, understate the utilization for a capitated provider. A large HMO database, however, will be made up of HMOs that have utilization across the spectrum, and the claim curves for these plans can be examined independently. In our database, we have utilization rates that vary from 180 days per thousand to 400 days per thousand.

The best data source for pricing provider excess products is actual provider excess experience, but there is not much of it available. This type of coverage is fairly new, and the available data aren't credible to cut it at the level of detail that is needed. We have experience data from our clients that we examined and used as a check of the overall level of our rates, but it was not credible enough to develop detailed pricing assumptions.

Once the database has been developed, the next step is to identify the significant pricing variables. I have a couple of basic formulas that we use in pricing. This is the basic relationship between utilization, unit cost, and cost per member per month that I'm sure most actuaries are familiar with. The utilization rate per member per year, times the unit cost, divided by 12 equals the expense per member per month. On the hospital side, it's fairly easy to get this kind of information. Most hospitals know their days per 1,000 and cost per day, so the formula can be used to develop the per member, per month expense.

BASIC RELATIONSHIP
(Utilization Rate PMPY) x (Unit Cost) ÷ 12 = (Medical Expense PMPM)

INPATIENT HOSPITAL EXPENSE
(Days Per 1,000) x (Cost per Day) ÷ 12 ÷ 1000 = (Inpatient Hospital Expense PMPM)

On the physician side there really is no uniform way to measure utilization and unit cost, so we came up with what I believe is an innovative approach. We matched all of our data to a relative value unit (RVU) schedule, and we calculated the number of RVUs per member per year. We defined the unit cost to equal the fee schedule conversion factor, which is just the cost per relative value unit. The per member per month expense can then be developed with the formula. We went through all our data and classified the different HMOs by utilization level to get an idea of how utilization affects the stop-loss curve, versus how the unit cost affects the stop-loss curve.

PHYSICIAN EXPENSE
(RVUs PMPY) X (Fee Schedule Conversion Factor) ÷ 12 = (Physician Expense PMPM)

When you actually go out in the market and are underwriting a physician coverage, it's nearly impossible to find out a given provider's utilization rate. A physician group will generally know their fee-for-service equivalent per member per month expense or their capitation rate, and then their fee schedule can be analyzed to determine their conversion factor. The implied utilization rate can then be backed into using the formula.

One interesting thing we found when we did this analysis was that on the hospital side, the unit cost had a significantly larger impact on the stop-loss curve than the utilization did. We found that with two hospitals that have the same per member per month cost, but one has a high unit cost and low utilization and the other one has a low unit cost and high utilization, the high unit cost hospital has a higher stop-loss curve. I believe that the reason for this is that when a hospital goes from 300 days per 1,000 to 200 days per 1,000, many unnecessary admissions are cut, and those admissions are usually very short admissions, like one- or two-day stays. If the

small admissions are cut to get the days down, the large claims are not affected that much. If the unit cost is reduced, the cost of the large claims is reduced, and with the leveraging, it has a very large impact on the stop-loss curve.

On the physician side, we found exactly the opposite result. For physicians, the cost per service is relatively low. To get a large claim, a patient must have many services. They have to be visiting their physician over and over again, because usually each visit will cost less than a couple hundred dollars. To get a claim above $10,000, they need to see their physician many times. A high-utilizing physician or a physician with a high-utilizing population tends to have many large claims, whereas the fee side doesn't have as much of an impact. If a physician is charging high fees, but the patients aren't coming in often, there are not as many large claims.

Once we've taken our database and segregated the data samples by utilization level, then we can go back and reprice everything based on different reimbursement mechanisms and reimbursement levels. When a provider stop-loss policy is sold, the provider is capitated, so there really are no claims. A provision needs to be put in the contract that defines how costs will be accumulated toward the deductible, and then once the deductible is exceeded, to determine how much is owed to the provider. We took our database and repriced all the claims using different types of reimbursement methods. For example, we took actual billed charges, applied various discounts, and reran our continuance tables to determine the impact of discounted charge contracts on the claim curve. To test per diem contracts, we used various per diem levels and tiered per diems to see how they would affect the stop-loss curve. We tested diagnostic related groups with and without outliers. We also tested a method based on the lesser of a discounted charge or an average daily maximum; this tends to be the most common way that the hospital coverages are written right now. On the physician side, we used fixed fee schedules such as McGraw-Hill, the Medicare Resource Based Relative Value Scale (RBRVS), and the California Relative Value Scale (CRVS).

The next significant pricing variable we determined was the type of population. The type of population really has a large impact on the rates. For the commercial population there is a lot of data and the coverage is pretty standard to price. On the Medicare side, provider stop-loss policies are generally written on Medicare risk populations. We don't have much data on Medicare risk contracts. Data are available from the Health Care Financing Administration (HCFA) , but this is all fee-for-service Medicare data, and the premium rates developed from these data are too high. We have several clients with Medicare risk data, so we did an analysis in which we compared their Medicare risk claim cost to their commercial claim cost at various stop-loss levels. What we found was that Medicare tends to cost about four

to five times commercial when you are at a lower deductible, but as the deductible increases the ratio decreases. Once we got up to a $200,000–300,000 stop-loss level, the ratio might be a two or three to one instead of a four or five to one. I believe the reason for this is that when people get to that age, doctors are just not going to do as many things on them, or they tend to die before a really large claim can be accumulated. The tail on the Medicare claim distribution starts to cut off earlier. It's still higher than the commercial, just not by as much.

For Medicaid the problem is that every state has its own definition of Medicaid categories. We don't really have a consistent way to cover all the state Medicaid programs. We developed what we felt are the most common four categories when we looked at the different states. The four categories are Aid to Families with Dependent Children (AFDC), aged, blind, and disabled. The AFDC population is mostly young women with children, and we found that the stop-loss premium rates are pretty close to commercial rates. They tend to have higher utilization, but the fee schedules for Medicaid are so low that they bring the stop-loss cost down. The AFDC population has many of the neonatal claims, but there aren't as many transplant or cardiac claims as there are at the older ages, so the premium rates tend to be fairly close to commercial rates. The aged Medicaid population has claim costs close to the Medicare costs. We found that the disabled costs are about three to four times as high as commercial, and the blind are less than what Medicare would be, maybe 50–60% of what a Medicare rate would be.

From the Floor: How does Medicare compare to commercial?

Mr. Wander: Medicare is about four to five times commercial at a low deductible, and at a higher deductible it might be two to three times. By a low deductible, I mean around $30,000, and a high deductible would be around $300,000.

The next important pricing variable is the scope of services. In provider excess, when you've seen one quote, you've seen one quote. Every quote is different. Every capitation has different services included and different services carved out, so it's really hard to generate a manual that will price all the different combinations that providers are going to ask for. We set it up like a matrix, where we have all the physician specialties and service categories split out, so they can be carved in, carved out, and moved from one place to another. There are some common things that are carved out. Mental health is almost always carved out. Outpatient hospital is sometimes included on a hospital quote, and sometimes it isn't. I have even seen outpatient hospital included on the physician side. Out-of-area emergencies are sometimes the responsibility of the capitated provider and sometimes the responsibility of the HMO. Chemotherapy can be on either the hospital side or the physician side, and the same with radiation oncology and durable medical

equipment; there are really many different ways it can be done, and a sophisticated tool is needed to determine the pricing impact of the different variations.

We identified other pricing variables. Obviously the deductible, co-insurance, and maximum benefit will impact rates. The maximum benefit is typically $1 million per year. The percentage of services provided out of the network also impacts rates. If a capitated provider is at risk for referrals, an estimate of the services that are going to go outside the network needs to be determined, because they're usually reimbursed at billed charge levels. An analysis of the capabilities within the network needs to be performed. Is there coverage of all the specialties? If it is a hospital, does it have a neonatal intensive care unit? Does it have the capabilities to do transplants?

The form of coverage is a contractual provision that affects the pricing. 12/12 means claims incurred in 12 months and reported in 12 months are covered by the policy; 12/15 means incurred in 12 months, reported in 15 months. The 12/18 is the most common form of coverage that we see in this market.

Expected member growth is a variable that we've seen carriers give a discount for. If a capitated population is expected to grow very much during the year, there are members coming on who do not have a full year to accumulate claims toward their deductible; so there are going to be fewer claims on those types of cases. One problem with this is that everyone has projections that they're going to really grow, but it usually doesn't materialize.

A deductible carry-forward is a contractual provision that is usually seen on the hospital side, but not on the physician side. The carry-forward is usually a 30-day or 60-day carry-forward. If somebody accumulated a large amount of claims at the very end of the year, he or she doesn't have to resatisfy their deductible in the following year.

The retention level is a pricing variable that is loaded in with your administration and risk charges, and I believe the total retention, administration, and risk margins tend to run around 30–35%; Michelle will probably have a better answer for this in her part of the presentation.

So, to put the manual together, once all the pricing variables were identified, we started running continuance tables based on all the combinations of the pricing variables. We ran them for different utilization levels, different cost levels, different deductibles—all the different variables. Then we took a look to see where there were patterns and which variables were significant. We actually tested many other

variables. The pricing variables mentioned in this presentation are the ones that were really significant and really had an impact on the claim curve.

Next we repriced everything based on all the reimbursement mechanisms and then the last step was to smooth out some of the continuance tables. At the really high deductibles, such as $500,000, there are not many claims, so some smoothing had to be done. In a database representing 10 or 15 HMOs, there may be some HMOs that stand out or do not fit the general pattern. In those cases we would either look at them in greater detail to determine if there was a problem with the data, or we may throw them out because they just happened to have a bad year.

Once the manual is put together, a carrier can begin to quote rates, but another important thing to consider is the provider's actual claim experience. Experience is very important because often a provider doesn't provide the appropriate information to develop an accurate manual rate, but it may have some history, and if it tends to be very consistent, it is important to evaluate the experience. It has always been my theory that it isn't good to have credibility factors that are lower than everybody else's in the market. A provider with poor experience will be charged a lower rate by a company that assigns low credibility to the experience, and that company will probably end up placing the business. If low credibility is given to a provider with good experience, a higher rate will be charged, and the case will not be placed. In my opinion, the statistics need to be examined to determine the theoretical level of credibility, but it also has to be partially market based, or a selection spiral could result.

The formula that we used is based on the expected number of claims (N), and the credibility is equal to the square root of N over 11, which is a common credibility formula. If there are 121 expected claims, then credibility is 100%. The expected number of claims can be calculated based on the expected claim rate and the number of members. We produced tables with expected claim rates that vary depending on all the pricing variables listed earlier. For example, when underwriting a Medicare case, the expected claim rate is much higher, which means the experience is credible at a lower membership size than for commercial. We give a higher level of credibility to a Medicare case that has the same membership, deductible, and all the other characteristics as a commercial population. When working with a really high deductible, a larger population is needed to be fully credible because the expected claim rate is so low.

The 11 in the denominator of the equation is used to represent the full credibility level of 121 expected claims, which is partially a market-based number. If a company wants to give more or less credibility than the market, the denominator in the equation can be changed.

We have been seeing new forms of coverage in the provider excess market. The rate manual development process presented here is for a specific stop-loss manual, which is the traditional form of provider excess insurance. I believe there are many risks involved with these new coverages, and the people who are selling them usually don't really know what they're doing. I believe they are just making up rates that will sell. One example is aggregate stop loss. We have had clients ask us to develop an aggregate stop loss manual, and we could run Monte Carlo simulations to create a manual, but when it comes down to it, the hardest part about pricing aggregate stop loss is setting the attachment point. If the attachment point is set inappropriately, chances are that the policy will lose money. We recommend that clients only sell aggregate stop-loss coverages if they can get at least a few years of claim experience, so they can get a good handle on where the attachment point should be set.

A refund feature is another new form of coverage where part of the premium is returned if experience is better than expected. With this kind of feature, there should be a charge, because if premium is being returned on the good cases and no additional premium is being collected on the bad cases, then not enough premium is being collected to achieve the target loss ratio. Many carriers in the market offer this feature, and they don't charge for it.

An aggregating specific deductible is similar to a refund feature. Under an aggregating specific deductible, the provider may only pay about 65% of premium up front, which is called the aggregating specific deductible. This amount is put into a pool, and specific stop-loss claims are paid out of the pool. If the pool is not exceeded, the provider pays no additional premium. If the pool is exceeded, the provider has to pay additional premium until they get to what their normal premium would have been.

Case rate outlier coverage is a new form that cuts the risk down to a very fine level. As an example, for a cardiac case rate outlier coverage, the premium is too small to make it worthwhile unless you have a very large number of members. It is hard to get credible data to price it accurately, so a substantial margin has to be added to the rates because of the risk. It is very hard to make a profit on this type of coverage.

A per diem product is different than a capitation product. This type of coverage is used for a hospital that is paid on a per diem basis, and they have an outlier provision in their per diem contract. If claims go over the outlier threshold, the claim payment method reverts to billed charges. The hospital wants to carve the outlier provision out of their per diem contract in exchange for a higher per diem

rate, and then they can buy the outlier coverage on the open market. Again, the reason for doing this is to get a better deal than they would through the HMO.

A specialty carve-out is another new coverage in which the pie is being cut down to a fairly small level, so a large number of members is needed to make the coverage worthwhile.

We have now started to see carriers give two- or three-year rate guarantees, and they do not charge anything for it. This does not make much sense to me.

Now I will turn it over to Michelle, who will be able to give a more market-based presentation and talk about her experiences in this market.

Ms. Michelle M. Fallahi: As Steve mentioned, we're going to be talking about the issues related to provider stop loss, or provider excess, and there are quite a few.

Steve has done a really good job of explaining the pricing process and how to develop the tools that you will need to sell this product. He has been extremely helpful as we've gone through that process, but there are some other issues. With any product, there's no guarantee that, even if you put together the perfect manual, you'll make money on it. With this particular coverage, it's even more so. I want to cover these issues, because I think that when your company is looking into this coverage, you have to decide how you're going to go at it and what your expectation is.

I want to talk about the availability of underwriting information, underwriting provisions that limit risk, the competitive marketplace, and nonstandard coverages. So let's talk a bit about the availability of underwriting information. I think that it's important to understand where these providers are coming from. If you're like me and you came from an employee benefits background or group background, you were aware that employers were generally pretty good insurance buyers. I didn't think so at the time, but I think that compared to providers, they're really good.

The issue with providers is that they've just recently been acquired, or they're scared they're going to be acquired. Usually they only have billing systems; which is fine if you're going to pay them billed charges, but if you underwrite this coverage appropriately, you should never be paying them billed charges. You should be talking to them early on in the process and saying to them, "Look, the capitation you received from the HMO payer is to pay your fixed cost. You should be reinsuring at your variable cost level." They're going to say, "What?" Because they don't know what that is. They've worked with billed charges for their whole

life, and it was a system they knew and loved, and they don't want to give it up. To underwrite this coverage appropriately, you have to make them believe in it.

There are some severe systems limitations with this coverage. In fact, the underwriters that we work with sometimes have to take billed charge information, because that has the encounter data attached to it, and have to go back and reprice it. If you're going to write physician coverage and you have to go back to every single office visit and recode the billed charge from $20 to $10, so you can figure out what the right amount should be, this is a real issue. It's nasty, but it has to be done. I think in the early years when things were moving fast and furious, some people didn't do it, and now they're sorry.

From the Floor: If you can't get the data up front when you're doing the initial underwriting, how are you going to get it at claim time?

Ms. Fallahi: That's an excellent question. With hospitals you probably are going to be OK, because you're going to probably write the coverage on a per diem basis, a fixed amount per day. So the hospital can tell you how many days this person has been in the hospital, and if they have to refer a case to another hospital, they can show you what the bill is, what they had to pay the other provider of care. But when you're talking about physician coverage it's a different story, and you're going to have to talk about physician coverage if you're going to be out in this marketplace, because Medicare and Medicaid are making it so.

The HCFA has actually decided that stop loss is essential in these situations. So if you're talking about physician coverage, then you're going to have to think long and hard. This is an issue of the flexibility of a carrier. Steve mentioned that there are many different ways, many different fee schedules you can value physician coverage on. You can use the RBRVS. You can also use a CRVS schedule. You can even use a fee schedule that they created themselves. You're going to have to do that because I think that the quality carriers out there are going to want them to report claims systematically. They don't want it to be a horrible pain that they only do once a year. It's usually at the end of the 18-month period, and you have this big surprise. You get a box in the mail, and believe me, there are carriers out there who have gotten boxes in the mail on the last day of the reporting period, and there are thousands and thousands of dollars of claims.

I suggest that you have to talk to the provider up front and say, "Tell us what kind of system you have and let's try and underwrite the coverage around it. Now, are we going to pay you billed charges? No, we're not going to pay you billed charges. Are we going to pay you 40% of your billed charge? Maybe; let's talk about that." I

think you can use their structure, but of course you have to discount it way down to get to the variable cost.

The other thing you have to know is that they're payer dependent. They have just received this capitation from the HMO. The HMO has done everything for them in the past. Not everything, but the things that matter to you as a stop-loss carrier have been done by the HMO. They're going to have trouble getting the HMO on the phone now that they're capitated. The HMO is going to say, "Go with God. We hope you make a ton of money, but don't call us because we've given you the capitation, and we don't care anymore." Now, maybe it's not that extreme, but you have to understand that the HMO is a clearinghouse, a wealth of information, and the provider may or may not be able to get them on the phone. That's going to be a limitation.

High turnover is another issue. I talked about the fact that providers are in a mode of acquiring, letting go, or laying off. There are many new people, and just when you've gotten to know the people in the back office, they're gone. I would suggest that these are the people you're going to really have to worry about. This coverage gets sold to the CFO. They're the ones who are making the bottom-dollar, bottom-line decisions, but the CFO is absolutely never going to let anyone in the rest of the company know that this coverage has been purchased.

If you want to get large claims notices, maybe at 50% of the deductible, so you can set up reserves, you really have to work at it. You have to find out who's in that back office. You have to introduce yourself. You have to send them the same material you send to the CFO, and you're going to have to be on the phone every month to them to ask, "Have you sent in those large claim notices? Either you can do that, or you can sit there and curse the darkness. Many carriers have done that, but it's not a long-term plan. For me, personally, there's not enough antacid around for me to sit there and wait until the end of the 18 months to see what I have for results.

For new players there is another issue that you have to be aware of. It's going to be part of your life in this business that there are some very large, very sophisticated, plans out on the West Coast. They've bought this coverage for three, four, or ten years, maybe. If you think they don't understand exactly what their cost should be, you're wrong. They know exactly what it should be, and they're working with provider excess carriers; and believe me, there's a slew of them out there, who just got into this business, and they're telling the carriers, This is the coverage I want, and this is the price I want to buy it for. And it's working. There have been some huge losses racking up on the West Coast, because their people aren't sophisticated

enough to say, "No, that's not what we're going to write it at. We're going to lose money at that."

But anyway, I digressed. The issue is that you're going to have those kinds of clients, but you're going to have new clients too. For example, you may have a group of providers that have recently formed into a Physician Hospital Organization (PHO), and they say, "We're a PHO; see, we are. Here's the card that says we're in a PHO." They have a hospital and a group of doctors who have never worked together before in their lives, and they don't even like each other. It's true, and if you think that's not supposed to affect you, guess again.

I hope I'm not sounding too negative, but this is real. They only grudgingly got together because they think that if they take risk it's going to make their shelf life a bit longer. I agree with them, and I admire their thoughtfulness and strategic view of things, but when it comes to getting adequate information and to getting the right managed care process, they're living through some very wicked times. When it doesn't work, you're going to be the ones who get the claims.

How can you limit some of this risk? I think there are ways. You have two kinds of risk, basically. As Steve mentioned, you have the really high-dollar risk on the hospital side, and when you have a claim that goes over $100,000, it usually goes way over $100,000. Even if you're paying a fixed amount per diem, even if you have all the right price controls in there, you're going to have big dollar risks on the hospital side, but on the physician side, you're going to have many little risks. You're going to have pages and pages of claims. When we pay claims for a physician group, we have three, four, or five pages of claims. Every line on the page represents an individual, and one person may be over their deductible by $45, and somebody else is over by $1,700 or $500, but if there are three to five pages of claims you may end up with a check amount of $75,000.

So how do you limit risk? Well, on the hospital side, you can limit the big risk through average daily limits on referral services. You're going to say in your contract that if this service is provided in your facility, you get $1,000 a day. If you have to send it out to a referral hospital, you're going to pay the lesser of the actual paid amount or 80% of billed charges up to an average daily limit of $6,000. Why are you going to do that? Because $6,000 per day over the whole length of stay is going to cover some pretty big claims, but it doesn't cover them all.

There's a very notable provider of care in Southern California—and anybody in the business can jump in and say the name—and if somebody gets into an accident, the ambulances have to take them to that hospital. That's a pretty good deal. The ambulance drivers do not have a choice. What happens when they get into that

hospital? They know they're getting paid fee for service. They know this, and they think it's pretty interesting. They hold those patients hostage. They can hold them hostage for as much as $15,000 a day, and it's happening. I wouldn't believe it if we didn't actually see some of these claims. We had a guy who was on a motorcycle trying to outrun the police and ran into a mountain. He totaled his motorcycle, had a closed head injury, and he's in there at $15,000–16,000 a day over a 60-day period. This is a serious claim, no doubt, and he needed medical care, but did it have to cost that much? Well, sure it did if they knew that nobody was going to get him out of there. They have a very bad reputation.

As a carrier you have to protect yourself, and I think that if the client, the provider who bought the coverage, can go to that referral provider and say, "Look, we don't have coverage, we don't have reinsurance protection above this amount. Can you give us a discount? You've got to negotiate with us,"—that has more of an impact on what is going to happen with their billed charges.

The other thing that we're finding is that this particular provider is actually now starting to accept capitation themselves, and everybody else in the area has made a silent vow that if any of their patients get into a hospital, they're never letting them out.

So you're going to require an average daily limit, and is this a tough sell to providers? You bet. Why is it a tough sell? Because not everybody is doing it. Most carriers are, but some aren't. I don't know how they can figure they're not getting selected against, but they're still out there doing it, and I think as a rule, you just have to put that limit on there. Otherwise the cost of reinsurance is going to become prohibitively high. You have to encourage the providers to go out and negotiate contracts with the referral providers who are not capitated, often their friends, their buddies, and their golfing partners. Things they've never done in the past.

Another provision to limit risk is the referral emergency language, which has to be the lesser of the paid amount or 80% of billed charges. You have to give them a target. You cannot say you will pay paid amounts. What incentive is there for them to go out there and negotiate a deal? None. So you're going to have to insist that they go and put some type of negotiation on there because are you going to do that as a reinsurer? I don't think so. I don't think you're going to be as effective at it, and I don't think if you're like other carriers, you're going to have the people that can do that for you. So I think those are important.

I think we talked about the need to reinsure at a variable cost. We tell providers all the time, "I know it would look good to get billed charges, 100% of billed charges

in your contract, and we're going to reimburse you at that level for a large claim. I know it would look good, but do you know what you're going to have to pay for that coverage?" Some of them get it, some of them don't, but you just have to keep at them. You just cannot have something out there that is going to be a profit center for them.

From the Floor: How do you define variable cost?

Ms. Fallahi: If I knew that, I wouldn't be here. I don't know, but the people at the providers have to know, and I tell them all the time when I'm out there, Go get yourself a consultant, a good cost accountant, go out there and try and figure out what that is. You don't even have to be that close. Just have an idea what it is.

From the Floor: So you do not really have to figure that out.

Ms. Fallahi: I'm not saying that I have to figure that out. I'm just saying that, look, I know that your billed charges are $2,000 a day, but don't think I'm going to be paying that in the contract. Let's start talking about what $1,000 or $1,200 a day gets you, and let's talk about those prices. I would suggest for those of you who are thinking about getting into this business, you should have some underwriters who can talk directly to providers. Believe me, that's the only way you survive in this business, if you're actually out there trying to convince them, because one of the things that you're dealing with is a distribution system. You're talking about this product being distributed by maybe 30 brokers over the whole country. It's not very wide. There are not very many people who do this. So they may be the best thing since sliced bread, but you're going to have to be on the phone for them. You're going to have to be on the phone to providers, or you're not going to be successful in this.

Renewal guarantees are another subject. Steve talked about some carriers giving two- and three-year rate guarantees, and they're not charging anything for them. I'd say, Why would you want to do that? You don't have to be the sharpest knife in the drawer to figure out that you're the only one that's going to lose on that deal. These providers are virtually unknowns when it comes to managing care, and you're going to let them go for three years at one rate. The one small advantage is that maybe by the time you get the first renewal, you would actually know what the first two years looked like—maybe, but I just wouldn't do it. The trouble is that renewals are going to be a problem because you're doing them in the ninth or the tenth month, and you still maybe haven't seen any claims yet. But the second renewal, you're going to know what they look like.

I talked about this a bit before, but it's very important: you have to get those claim notices in, and believe me, there is just not a very sophisticated system to make that easy. You have to be very persistent, and some of the investment that you have to make as a carrier is to go out there and help them retrieve it out of their own system. You may ask, How smart is that? You're out there helping them send claims to you so you can write them a check. Well, it is smart in the sense that, the other things that the HMO used to do for them, such as large case management, really make a difference. These are good programs. Even if you've got the best provider of care in the area, do they know what's happening on a nationwide basis? Do they know who the best closed head injury specialist is six counties away, or even six states away? That's the kind of thing that you can help them with as a carrier.

The other thing that you can do to help, and you have to think about whether your company is going to make a commitment to do this or not, is to help them do the third-party recovery and those kinds of cost-saving measures. This is another thing that they used to depend on the HMO to do for them, and now the HMO is saying, "Hope everything works out. Just let me know." Are they going to spend any time doing it? No. Should you be spending time doing it? Yes, because frankly, the best thing would be to teach them how to do it, and then they're going to be out there recovering their dollars and your dollars. But they may not have a clue. This has not been anything they've ever done before.

From the Floor: Are these arrangements that you're talking about where the ultimate risk taker for the employer is the HMO, or is the provider direct contracting?

Ms. Fallahi: There's not too much provider direct contracting with the employer. Most of what we see is that the employer buys a policy from the HMO. The HMO says, We're capping the whole thing out to the provider.

From the Floor: I think that is a great issue when you say that, because the HMO, if they're going to provide incentive programs and be Health Employer Data Information Set (HEDIS) certified, they have to track quality of care, and the only way you get that is to have the data. Many of the HMO contracts that I have either worked with or consulted with are really incentive pools in which the only way the providers get the incentive pay out is if they do indeed send all the claims in, so that the HMO can process the fee-for-service encounters or stop short of making payment.

Ms. Fallahi: Oh, yes. You're absolutely right.

From the Floor: I find it very rare that any HMO that's on the ball is not going to want to be able to get that quality data and prevent the provider from coming back and saying the capitation was not adequate, because the HMO can say, Well you should have done better. Without data, neither one of them could do that.

Ms. Fallahi: Well, my comments are based on the fact that, yes, the capitated provider is sending the HMO information, but what is the HMO going to do with it? They're going to do all of the things that HEDIS requires them to do. But are they going to go back and say, "Look, I saw in your data that you had a motorcycle accident, and you really ought to be going after that and trying to get third-party money out of that?" No. Are they going to say, "We used to do that for you, but here are the nine things you ought to do," and send it back to them and say, "Go for it kids, we want you to succeed?" It's not happening. So who are they going to find to do that? I think a reinsurer is an interested third party that could help.

From the Floor: Have you ever seen an HMO contract with a capitated provider that says that the HMO gets any coordination of benefits recoveries?

Ms. Fallahi: Yes. Isn't that something? That's like asking your ex-wife to iron your shirts. Yes. That's out there. Can you believe it? In a company that I'm intimately familiar with, we go out and say, look you're buying this reinsurance coverage, and maybe we're a dime higher than what you could get it from somebody else, but this is the kind of stuff we can help you with.

I wouldn't have believed that could happen, but these are providers, and their daily work has been providing care. Do they know how insurance companies operate and do all these things? They're just starting to get that blip on their radar screen, and believe me, there's other stuff out there as well.

I want to talk about those nonstandard coverages that Steve talked about. Aggregate stop loss is a coverage that you get a lot of questions about. When I go out and talk to providers, many ask about aggregate. Theoretically, they should be asking for it, because, hey, they've just accepted all the risk from the HMO, and now they want you to take it. They think that they should be able to do that at a reasonable cost. Well, what's wrong with that? They can control utilization, so if they have legitimate claims at 105% of expected and if the attachment point is at 115%, why not go after the extra 5%? Keep people in and go above that deductible range. They're the ones who have the control. This is just like fee-for-service days, except they get the money.

Now, maybe I'm skeptical, and maybe there's a way to do this, and maybe specialty carve-outs is the way to do it. Maybe they have a capitation on the specialty carve-

out. Maybe there's something that can be done there, but my experience has been that with specialty carve-outs, either you don't have enough information or you have too small a capitation or too low a membership to make it worthwhile. You have no potential to make any money, but maybe that will change in the future.

Then why not do aggregate? Well, I don't know. Some carriers have done it, and I'm not sure how successful they've been. There's been abundant anecdotal information that would suggest that it hasn't been all that they had hoped. Basically what they're saying is, Look, if you can't get enough with your cap, then we'll guarantee you 95% of your fee-for-service income on those same clients. Maybe I'm wrong, but I think as a carrier, global aggregate coverage is something you should stay away from. I think there's just no way you can't get selected against. Anybody disagree with me?

From the Floor: Why would you take a capitation if you're just going to take all that risk out the back door anyway?

Ms. Fallahi: I'm right there with you. You're supposed to be motivated to do cost-effective care because, in fact, you have the risk.

Mr. Wander: Michelle, one other comment I was going to make is that I've heard people refer to aggregate stop loss on a capitation as being like contracting stupidity insurance and basically that's what it is. If you give a provider aggregate stop loss, they can go out and negotiate capitation contracts, and they don't have to worry about what the rate is because they have aggregate stop loss. If you put in a 125% attachment point, then it's a little different, but we've seen providers requesting a 100% attachment point and carriers writing policies.

From the Floor: Do you rate stop loss before you see what the capitation arrangements are?

Ms. Fallahi: Yes, we don't know what the capitation amounts are. When we write specific stop loss, we know the list of services that they're at risk for, and we base our underwriting on that; whether or not they got a good capitation rate, God only knows.

Mr. Wander: Well, even if you know what the capitation rate is, you don't know if it's right. They could be capitated for $50, and it should be, maybe, $70, so even if you put in a 120% attachment point, they're going to blow right through it.

Ms. Fallahi: It's just something that you're putting yourself at risk for, and the premiums are very low. There is a very high potential to lose, and you're not even

at the negotiating table when half of it gets done. That's what I don't like about it: it's a control thing. If you were sitting at the table negotiating a capitation rate, that may be different, but God only knows what that looks like.

One thing we haven't talked about is the competitive marketplace. It is very competitive out there. New payers are coming in every day. You have a limited number of brokers, inexperienced carriers, and some big clients that understand this coverage better than some of the underwriters do. You're getting some nasty rates out there, some unbelievably low rates. You have some contracts that have no average daily limits in them. They have paid amounts on the referral piece. Some scary things are going to happen out there.

My suggestion to you would be, if you're helping your company decide whether or not to get into this market or stay in it, you need to help them decide if they are going to be involved or committed. If you want to know what the difference is, somebody told me once that in a bacon and egg breakfast, the chicken is involved and the pig is committed. So, you have to decide if you're going to be involved or committed, and if you're only involved, I'd say get out of it. If you're not going to be committed to this for the long term, it's a very expensive lesson to learn. You could lose a lot of money in learning some very basic principles.

From the Floor: How do you set reserves and incurred but not reported for this coverage?

Ms. Fallahi: Well, we actually go out, and we beg, plead, grovel—anything we can do. We're out in that provider's face almost every month, and we say, what system do you have? Now, if it's this system, we worked with that before, and we can help you get this report out, and this is standard. And then we can work with that, or you can send it to us over the Internet. Do you have a report that you can put into Lotus or Excel? Send it to us, and we'll work through it, and we'll get those claims. Or, if there are some people who just have handwritten forms and we go over their large case notices, or they're 50% of the deductible, we track them, and we set up reserves for them. It's a combination of many different tools, and it's not very refined at this moment. But it's the best you can do, and it's better than nothing.

You absolutely don't have a claim lag, like you're expecting from group business. If anybody has learned anything, it's that if you have no claims in six months, don't break out the champagne yet. It's coming.

Mr. Wander: We've done some claim lag analysis for clients for this product, and when we do that we typically use a policy year basis, instead of an incurred year basis. You want to look at the duration from policy issue. That's really like what is

done in the employer stop-loss market, and I think it's the only way that makes sense. It is really hard, because, especially on the physician coverage, you'll get people who bring you a box of paper claims on the last day. If you write a 12/18, they wait 18 months, and then they bring this big cardboard box full of paper, and those are your claims. So it is really hard to estimate a lag.

From the Floor: What if the box of claims comes in the first week of the nineteenth month?

Ms. Fallahi: You have to work at it. It's not an easy declination, particularly because you can't show prejudice.

From the Floor: My company was in this market, and we had a very bad experience and very poor loss ratios. The contracts that were originally worked out were very, very weak. Many times we didn't have as much contractual protection in there as we'd like to have in terms of their making deadlines for reporting claims in a proper time period. So it's a very tough situation. You have to be extremely careful.

Mr. Wander: Would you mind telling what your loss ratios were during those years?

From the Floor: Well, the loss ratio for the '95 underwriting year, on the basis of a theoretical manual that actually wasn't used, was right on target. So we now have a manual that we know was correct. The actual premiums charged were in the neighborhood of about $25 million, and the incurred got to be, like, $32 million. Against $25 million, the expenses were maybe $7 million. So you really have $18 million available for claims, and the claims have to be around $32 million. It was because the people setting the rates didn't completely understand many of the factors that you went into, about how you have to manage the rates and the contracts, and all the rest. They weren't being done by an actuarial group. They were being done by marketing, underwriting people. So it's a significant problem.

The other part of it is, if you do get a manual that seems to be adequate, we've had the situation where, one, the rates are probably higher than you can sell to many customers. Two, we had two very large contracts coming at the end of 1995, and in one of them, there was a significant deviation on the hospital Medicare component—a deviation of about 2.5 times the expected claims, and I'm talking about $4 million in claims. So it was very credible. The other bad experience was just the opposite. It was on a very large group where the negative experience was on commercial hospital, regular employers with people under the age of 65. To reconcile that, I don't know whether there was a manual error. I don't think that

was it. I think it really related to some severe anti-selection on the part of the policyholders. Something where—it might have bordered on fraud—but it was at a point in time when we were getting out of the business, and I don't think we were in a position to go deeply into it, to see exactly what happened. But it's very disturbing when you get a manual that seems to be quite accurate, but then you get certain cases, very large credible cases, with an enormous deviation, which is unexplained.

Mr. Wander: I believe that shows the importance of looking at the experience on those cases. We've seen that too, where you'll have certain cases that really deviate from what the manual would say, but it's consistent over time. They deviate consistently year after year. A good experience-rating methodology helps to catch some of those cases.

From the Floor: You said early in your presentation that the HMOs that were providing stop loss under this contract between the HMO and provider groups were overcharging for the stop-loss coverage. So tell me, what data did you look at to conclude that it was an overcharge?

Mr. Wander: The reason I said that they were overcharging is because in the late 1980s there were only one or two companies writing this coverage, and I know one of them was making a lot of money, because there was no competition. They were selling at lower rates than the HMOs, and they were still making huge profits in this market. Then in the early 1990s, it started to get competitive, and the rates came down significantly. Then it became harder to write business. I'm not sure if HMOs are still overcharging now. This may have been a phenomenon of the late 1980s.

Ms. Fallahi: I would say that now HMOs are all over the board on this. When I've done other presentations, there were representatives from HMOs who came up to me and said, "Look, can I have some of your cards, because I want to give them to my capitated providers because we don't want to mess with this. This is not in our daily work, and we don't care about it, and we're probably not charging enough, but it's something we don't have time to goof around with." So there are some HMOs like that. Also, some clearly see this as a profit center, and they have only one contract with the providers, the capitation contract, and it usually doesn't specify how much the stop-loss coverage costs. It's included in the capitation rate, and it's an unknown. It's not a wholesale thing that is overcharged every time and every situation, but I would say we've seen that in many situations.

Mr. Wander: When you look at a capitation contract with stop loss, you're mixing two things together. It's like when you buy a car. You can buy a car and get a great

deal on the price of the car, but then you get a bad deal on your trade-in or something else.

Ms. Fallahi: Like your financing.

Mr. Wander: Or rustproofing or whatever. With a capitation contract, the HMO could give the provider a great deal on the stop loss and give them a bad deal on the capitation rate, or else give them a bad deal on the capitation rate and a great deal on the stop-loss. Much of what the providers are trying to do through carve-out is to make it two separate negotiations. There's one negotiation for the stop loss, and another one for the capitation rate, and then they don't get blended together.

Ms. Fallahi: Another issue that happens from a provider's perspective, another reason that they want to look outside for coverage, is because when they capitate, they capitate with two, six, or eight HMOs, and they want to wrap one contract around all those HMOs. Administratively it makes sense, and then if they have a member who moves in the middle of the year from one HMO to another, they have coverage. If they bought that coverage through the intended HMOs, they don't have any protection. If they buy it through an independent carrier, they have protection because essentially our risk hasn't changed.

From the Floor: We recently published a study of large claims, claims of $25,000 or more, and I wanted to get your reaction to how useful these data are for pricing provider excess insurance, if you're familiar with the study.

Mr. Wander: Actually we have a copy of the study, and I think that fell under the fee-for-service indemnity category. I believe most of the large claim study was from fee-for-service indemnity carriers. I don't know if there was much managed care.

From the Floor: Actually the largest group was PPO, and then there was a very large indemnity group. There was a significant number of HMO, exclusive provider organization type of carriers as well. That was broken out separately.

Mr. Wander: My impression was that much of the data was indemnity, so the utilization levels would be much higher than for managed care. Also, when you're looking at a capitated population, you need a good denominator. You need to know the membership, your exposure. You need to know the people who were members and didn't have claims. I'm not sure, with the study, if there was a really good denominator involved with some of the data. On the fee-for-service side, many times things are done on a contract basis, so you know the number of employees, but you don't know the number of members associated with the employees.

From the Floor: For some of the data the denominator was missing. We did have an actual denominator on a combined basis. In the tables we showed the actual rates of claim per member. That was combined indemnity, PPO, and HMO data, and the reason for that was that we could never publish something that has only one provider in it. It may only have one managed care provider that had the denominators for us. So, it is included in that blended rate in the tables.

Mr. Wander: There are three things that we were really looking for in our data. One is that we wanted it to be managed care data. Two is that we needed to be able to link the claims for each member; and, three, we had to have the denominator, because that's a really important part of it. That was probably the reason we didn't use the SOA large claim study. I think next year as we redo things, we'll probably take a look at it again and see if there is anything we can use out of it.

From the Floor: I have a totally unrelated question as well. Looking at your full credibility standard of 121 expected claims, that's quite different than what the classical, Longley-Cook formula would have generated. I was wondering, what kind of justification is there for that formula or how you view that in terms of if it yields large fluctuations?

Mr. Wander: I believe it's more of a market-based number. When you're looking at large claims, let's say you're looking at something with a $100,000 stop-loss level, you need quite a few members to get 121 claims. It's pretty much a market-based number, comparable to what we have seen in the market. It's not necessarily something that we recommend. As I mentioned earlier, there is a selection issue that if you are giving higher credibility than everybody else, if you get a good case, you're going to give it higher credibility, and you're going to get that case. If you get a bad case, you're also going to give it higher credibility, and you're not going to get it, because it's a higher than average case, so you're going to rate it higher than everyone else. So it's sort of a selection issue that if your full credibility standard is not market based, you're going to be selected against.

From the Floor: Are there substantial risk loads in the overall rate that you can afford to give that kind of credibility without giving away your margin?

Mr. Wander: Well, there are some pretty big loads. I believe the retention level is about 35–40% on this kind of coverage, and the actual administrative costs are probably more like 15–20%. So there are some pretty good margins. I don't know if you're really giving anything away either, because if you're giving the higher credibility, you might be getting a better selection than your competitors. So you might actually do better with it.

Ms. Fallahi: I think another point is, how much are your underwriters going to stick to that performance, because if there's something in the experience that would make them get twitchy, even though it's a sound formula, there's no way the underwriters are going to believe it. There are underwriters who are going to throw that credibility out the window and see how they can develop a higher rate because some providers are just bad news. They just walk around with a black cloud over them and the sooner you figure that out, the better off you're going to be.

Mr. Wander: With statistical analysis, when you try to develop a full credibility level, you're going to come up with many more claims. From what we've seen with experience, there are many cases that consistently have numerous large claims, and they don't have that much membership, but it looks pretty credible when you look at it over a few years. It just seems that with providers, they can really control things, or they cannot control things at all. Many times you get a hospital, and even though they only have 3,000 capitated members and they have zero expected claims over $100,000, they get three or four every year.

We had one provider that had several physician claims over $100,000, which you never see, and they had three or four of them over $100,000. We dug into it, and the reason was that they had a doctor who was prescribing growth hormones, and he had three or four claims above $100,000 on the physician side. We notified the stop-loss carrier, and they caught it. I don't know how it got through in the first place, but that's something that statistics aren't going to say. This was not statistically credible, but it was something that happened for several years because of that one provider.