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Excess Coverage Reinsurance for Health Care Providers

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Summary: Medical excess coverage is provided to hospitals and/or physician groups to reimburse such groups for benefits in excess of a deductible. This coverage is provided in situations in which provider groups are taking capitation from an insurance company or HMO or contracting directly with an employer to provide for their health benefits. State regulators view this coverage as an insurance product even though it is excess coverage.

Mr. Brian Dale Shively: I'm the director of underwriting for HMO/provider products at Lincoln Reinsurance. I have been with Lincoln for 12 years and in some type of managed care since 1988. I've been concentrating on the pricing and underwriting of excess medical risks for a variety of entities in the managed care environment for the past seven years.

PROVIDER EXCESS LOSS COVERAGE

I want to start with a definition of the topic we have here, which is a little misnamed. It's called excess coverage reinsurance; it is not really reinsurance, but insurance. So I've shortened it a little and made it provider excess loss coverage. I've highlighted certain components of the definition that I have come up with and again; this is just my definition. Provider excess coverage is catastrophic loss coverage sold to providers of health care services that have accepted the financial responsibility for the provision of a predetermined set of services to a certain population.

The definition of catastrophic loss is a predictable financial loss of a significant magnitude, and defining that significant magnitude is somewhat of a challenge in

some circumstances. I know that the Health Care Financing Administration (HCFA) has issued some regulations on the Medicare and Medicaid business in an attempt to define significant loss levels. They have based this on what they call panel size or the number of members who are capitated to a given provider.

The catastrophic losses that I'm talking about here are those caused by premature birth of infants, transplants, accidents of a variety of types, cancer treatment situations, cardiac surgeries, and other things along those lines. As technology develops, this list will probably change. The providers of health care services that I'm talking about—physician groups, hospitals, physician hospital organizations (PHOs) and any category of specialty care—could place a provider in a position to accept the financial risk.

The financial responsibility that I'm talking about here is capitation. Capitation means placing the provider either at risk for providing the service or for funding the provision of those services. One way or another the provider is financially at risk.

The sets of services may vary quite a bit, and usually those are defined most clearly with a responsibility matrix that outlines each party's responsibility in a capitation agreement. Those services are classified by many different breakdowns. There are major breakdowns between physician services and hospital services, and within them there are a variety of breakdowns. This may cause the responsibility to be shifted to one party or another. But that's how it's defined, and there are a variety of different ways that it can be set.

Various populations can be encompassed in this (usually I'm talking about an HMO that's initiating the capitation). They may have commercial lives; in other words, the standard employee lives with Medicare or Medicaid. Categories may be further defined within a certain structure; for example, with Medicaid, there are different categories of Medicaid enrollees and it may be defined in that way. We have also seen populations defined by categories with certain diagnoses or diseases. I think as we continue to go down this road we will see other ways of defining what the population might be.

PRODUCT FORM

I would like to briefly go over the product form so that you have a basic idea of what I'm talking about. This form covers specific excess coverage, which is a per-person per-year deductible type of product. This is the product of choice by those writing the coverage. This type of coverage is specific excess, which will cover a catastrophic insurable risk and help reduce some random fluctuation from large claims. There is also a perceived need in some circumstances for an aggregate excess coverage, which would be a per-year cumulative deductible over all the lives

in that population. However, it's been my experience that aggregate coverage has limited applications. The reason for its limited applicability is because it is a difficult product to price—it encompasses multiple risks within one product. Those risks involve mispricing or missetting the capitation, utilization management, and the random events of large claims under the same coverage. I think it's difficult to align all the incentives and to write that coverage in an appropriate way; however, there are some circumstances where it will work.

SOURCES OF THE PROVIDER EXCESS MARKET

I also want to try to highlight some of the sources of this market as a way of introducing it. One of the biggest sources is increased activity in capitation, which has come along with the increase in managed care. It's also part of the environment in which providers are trying to preserve their market share and preserve their existence. Taking capitation may be one of the alternatives. What we're seeing is an increase in full risk and hospital capitation, especially for Medicare and Medicaid populations, which are moving into managed care. We are seeing direct government contracting in Medicaid in which states have handled this differently. Often they're willing to go directly to provider entities and ask them to assume some level of risk. Medicare, as it moves more into Medicare risk, involves more opportunities for capitation, as would the use of a provider-sponsored network type of approach, which is basically direct capitating to the providers. Another reason for this market development is that when capitation deals existed, there had been the perception that provider excess coverage was beneficial to the managed care organization and not beneficial to the provider organization. This has caused many providers to go to the market and look for options for that coverage.

CAPITATION FORMS

I note that there is increased capitation, and I want to go over some of the forms on those increased capitations. The first one that is most obvious is physician capitation, which may take the form of specialty physician, primary physician, or primary and specialty. It may also include some of the other items that might not directly be services provided by the physician, but it may be things that are under their direction, such as prescription drugs or other items. Sometimes you'll even see the outpatient hospital services under the physician risk as well. On the hospital side there is simply inpatient and outpatient services; however, there may be a need for home health, skilled nursing, or other such things.

Specialty services capitation is basically when a certain, specific category of service is carved out and paid on a per-member basis. The types of things that we've seen are for cardiac care, and one that just recently became an idea is for transplants. The qualifying question becomes, is this a type of service that can be carved out and

capitated? This may encompass some health care services, mental health services, and things along that order.

The third form of capitation identified here is disease and diagnosis-specific capitations. These are situations in which a population that has a certain disease or diagnosis is carved out, and a cost per person, given that diagnosis or disease, is identified. The entity is then responsible for the complete financial end of all care given to the person who falls into that category. Some of the categories we've seen are patients diagnosed with hemophilia, cancer, and a few others. The key is that each of these situations creates a set of unique needs, and that's one of the things that you will discover about this market as you start to get into these different niches. Also, because needs often change, the product has to have some flexibility.

UNIQUE FEATURES OF THE PROVIDERS EXCESS MARKET

Next I would like to highlight some of the unique features that I see in the provider market that sets it apart from most of the other traditional markets. I guess when I'm talking about the traditional markets I mean other excess markets for medical care that might exist today. One of the clear things is the lack of data, and I think Jerry will talk about this a little more.

Variability of the risk exists because there are many different coverages. Covered services can be divided up in a number of different ways. There are population differences, if you're going to look at Medicaid or Medicare. If you're going to look at a certain segment of the commercial population, you will see that this also causes variability. Anyone who is working in managed care has experienced this. When we go to a different geographical setting, we find variances in the way managed care functions. The impacts on provider risk are very important, and the practice patterns of the local area cause variances as well. All these add together to create a general variability in the product and the pricing of the product.

Also highlighted is the lack of education of the consumer. Again the consumers are provider organizations; often they aren't really educated on their needs and the product. I'll look into this more later. There is also excess capacity in the marketplace, which provides opportunities that attract people from a variety of backgrounds. Group medical carriers that might be looking at a losing business in a traditional group carrier market might be looking here. There might be medical malpractice carriers that have been traditionally working with hospitals and physician groups and now are being made aware of a need here. Many people are looking at this market as an opportunity.

LACK OF DATA

One of the reasons for the lack of data problem is that many of these situations are brand new and their impact is really unknown until you get into them and eventually become more familiar with them. The expectation is that you're moving to a capitation arrangement in which there is greater control, but you really can't predict how changes in utilization management, the changes in the administration of this program, or even just the change in the mindset of the providers in moving to a capitated environment will impact excess claims. It's hard to know how it will work out.

Also, providers are now being put at risk for members. In the past they had been looking at patients, so all the data they collected only involved patients, which didn't really give a basis for how this would coincide with their treatment of a given population. This makes it difficult to use the data that a given provider may have on hand for services it has been providing.

Another area where capitation is growing quickly is Medicare and Medicaid. Compared with the past, these programs are now moving very quickly into managed care. Data on these programs in a managed care environment are simply not available. As new geographical locations start to move toward managed care for Medicaid and Medicare, the data will develop and we'll have something to really look at.

CONSUMER KNOWLEDGE

Next is the topic I mentioned earlier, that is, the lack of consumer knowledge. The providers that are looking for this coverage usually don't really know what their protection needs will be. They don't really know what product might be used to meet those needs. They have a great need for upfront education, and they also have a strong need for a knowledgeable risk partner. They need someone who is there to share knowledge as well as share in the risk. However, in most cases, they aren't sure where to look, because they've been looking at liability coverages in the past and this is a different type of need. A big change in this is that the providers have to switch their mindset from a revenue generation to managing a budget. The questions become: How do they manage a budget? What tools do they need to manage that budget?

PROVIDER EXCESS LOSS POLICY FILING CLASSIFICATION BY STATE

The next thought I have explains the regulatory framework of the product. This product is being sold to non-insuring entities (providers); therefore, it is regulated as an insurance product, which means that it has to be filed and approved. The policy that you're selling also has to be filed and approved, and potentially the rating for it has to be filed and approved. It is fairly clear that it is an insurance product, but the

states differ in their treatment of it. They struggle between whether to consider it as A&H or property and casualty. Many states have switched their positions on this over time. I think the A&H regulators understand the product much more and understand the medical side of the risk. It's easier to work with them in terms of the rating side. When you get on the property and casualty side, they're used to looking at rating agencies, providing data, and filing the structure. So it becomes a more involved learning process for all parties when you start to move into that environment. This list should give you a little bit of a checklist on how states rank it in particular ways. However, some switches may have occurred. Some started out in one category and moved over to another. But a majority of them are now considering it as a property and casualty product.

The following states considered it A&H: Alabama, Arizona, California, Connecticut, Kansas, Mississippi, New Hampshire, New York, Rhode Island, South Dakota, Tennessee, Vermont, and Wyoming. All others considered it property and casualty, with the exception of New Mexico, which is undecided.

That's my overview to get you started on the topic and let you know about the background. Jerry Winkelstein will enlighten us a little more on the underwriting side and discuss some general features of the product. Jerry is a consultant from Towers Perrin (an integrated health care systems consulting practice) in Atlanta. Mr. Winkelstein specializes in actuarial consulting on managed health care issues for payers and providers. His expertise is in the areas of commercial, Medicare and Medicaid managed care, stop-loss and provider excess, point of service (POS), preferred provider organization (PPO) and exclusive provider organization (EPO) products, as well as capitated site and substance abuse programs.

Mr. Jerome Winkelstein: Much of my talk will echo some of what Brian said. I will discuss a little more on the state of the market, the types of cost variabilities, and the types of underwriting issues. I'll finish up with a couple war stories that could be interesting.

OVERVIEW

What is provider excess coverage (specific versus aggregate)? Brian went into what provider excess coverage is. It is basically specific stop-loss coverage sold to provider entities, whether they're institutional entities, professional groups, or a combination of the above. We're seeing a greater demand coming through from clients on the aggregate side. Right now, 95% or more of the product sold is a specific coverage. Brian explained what a specific was and what an aggregate was. We're seeing right now that there's more and more demand for aggregate coverage, particularly from physician groups. Physician groups think that it's hard to get a really big claim on one person. A physician claim may get up to $30,000 or

$40,000 and that's about it. They think they really need claims that greatly exceed the capitation they're getting. Unfortunately at the same time, the market right now has very few companies selling aggregate coverage. Towers Perrin as an entity sells a provider excess manual, but it's a spec-only manual at this time. And with the demands we're getting, we're thinking of doing something on the aggregate side, too. There are companies quoting aggregate, and what they're using is anybody's guess. In fact, some of the rates that you will see as we go through this are questionable; however, this is a rapidly growing marketplace with many new entrants.

Currently, our best guess (which was done by a survey of our professionals in Towers Perrin across the country) is that the current marketplace is about $250 million of annual premium inforce. That could probably be plus or minus $50 million. Five billion dollars is the approximate size of the employer stop-loss market. We think that the impetus will get to $3–5 billion at some point. The impetus of that will be whether Medicare reforms or HCFA allows provider-sponsored networks (PSNs). If they allow that within the next one to two years, our crystal ball, cloudy though it may be, says it will zip up to about a billion dollars at that time and then grow to $5 billion within five years. If PSN legislation doesn't happen or is significantly delayed, it could take as much as ten years to get up to the $3–5 billion range. Again, that's our best guess at this point. As an actuary, sometimes you have to put your quarter on the line.

The growth, as Brian said, is definitely mirroring the growth of managed care. As managed care grows, more risk is pushed from the managed care organization. Providers don't want all this risk and try to shift the risk onto somebody else, which is the provider excess reinsurer. It becomes a chain event. The HMO is pushing down the risk, and the providers, not realizing sometimes what they have, are pushing it further down.

Currently, there are no real dominant players in this market. This is very unlike the HMO reinsurance market. HMO reinsurance probably has four to five dominant players and many little players. In this market all the bigger players seem to be in the $5–25 million market; $25 million inforce currently with many people there.

Many people are entering the market, and you would think that everybody is making tons and tons of money. In fact, the opposite is true. Financial results went from good to bad in the 1994 and 1995 fiscal years, which is the way most carriers in this market analyze their results instead of on an incurred-year basis. It's not important when the claim was incurred; it's the question of when the claim was paid. Fiscal year 1994 involves old policies issued in 1994, which becomes a 23-month period of claims. All claims and premiums are set back to 1994. I'll digress

on that a little bit. I believe that the only appropriate way to analyze this product is on a fiscal-year basis. If it were done on an incurred-claim basis, because a substantial deductible could take an individual several months to satisfy, the company would have the incurred claim. If the incurred claim is defined as the first dollar after the deductible satisfied, incurred claims would be pushed to the rear of the year, because it would be very hard to have incurred claims in the early part of the year.

You'll be satisfying the deductible and yet earn your premium rate across the year, which is not a good match. An incurred-claim or an incurred-month basis for claims is not a good way to match revenue and expense. Expense is pushed to the rear of the year, which includes revenues during the whole year. The only way you can really get those two in sync is to talk about the year as a whole.

In any case, 1994 and 1995 went from very bad to disastrous. What else could go wrong? Some companies were running 250–300% loss ratios. I consider that a disaster in any business. The year of 1996 was also disastrous, but of course, there are some exceptions. In 1996 we're seeing mixed results. One of my clients is doing extremely well in the 1996 fiscal year. It had its loss ratio at a very acceptable level in 1996 compared with what it was in 1995. But other companies didn't do all the shadow pricing and are doing OK in 1995, and 1996 actually looks worse than 1995. So 1996, from what I see from my clients and clients of other consultants within the firm, is a mixed result. Some companies are actually going toward the target profitability in this business.

OVERVIEW OF EMERGING LEGISLATIVE ISSUES

This is an overview of legislative issues, which is a little different point of view than what Brian had gone into. The first thing is that HCFA legislation, I believe, is still pending. It seems to have undergone much confusion as to what it means, resulting in various interpretations. But HCFA talks about physician groups that are "substantially at risk." If you are considered to be "substantially at risk" due to your capitation or riskful arrangement, you have to buy coverage, which is usually specific coverage that can vary with panel size. So if you're a large enough physician group, you don't even have to buy it; however, the smaller physician groups have to buy substantial amounts of specific coverage because the deductible they have to use is very low. They do allow aggregate coverage, although many the interpretations of the definition in this regulation are very unclear. We've done quite a bit of work with our clients trying to help them interpret what HFCA is asking for and how best to comply with it or change their arrangements. The clients in this case would be our HMO clients. We try to help them change a riskful arrangement so that they don't put their physician groups in a "substantially-at-risk" category. This could become a real problem. The initial versions were probably

not thought out very well. The key to determining how fast or how big this market can grow is whether PSNs are allowed, in which many more groups will be accepting capitation or requiring protection.

A great deal of legislation on the state level is pending, and those states that do not have legislation pending are being discussed. Some states are talking about the kind of provider group that can accept risks similar to the PSN issue. Georgia, Maryland, and Michigan have either pending or passed legislation about the need for insolvency coverage. If you're a provider group that accepts risk in these locations, you need insolvency coverage. We have heard from our clients that even some states that they're dealing with are contemplating mandating aggregate coverage. Obviously, if that happens, the demand for aggregate coverage will just boom. Whether that happens is anybody's guess at this time. As managed care becomes bigger and bigger, states continue to contemplate a myriad of issues and pending legislation regarding provider excess.

UNDERWRITING/ACTUARIAL ISSUES

The first type of provider excess coverage I will talk about is physician, hospital, and a combination of the two. On the physician side about every quote in this coverage is different. Of 100 quotes only five may be the same as another quote. It seems that everybody is asking for different coverage, different categories, subspecialties, a different deductible, or different coinsurance arrangements, and in turn, this results in a different quote every time. Unless some type of manual has all these relative amounts, it's virtually impossible to cover all the differences, therefore making it hard to get this coverage. This coverage is more diverse than any of the coverages I've ever worked with.

Sometimes physician groups want coverage for every physician specialty, whether or not they have that within their group. They may want to make sure that they cover everything and would like a global cap, because whether it's provided by their group or outside their group, they're responsible. Sometimes they want coverage for everything but cardiology. Sometimes they'll want coverage only for cardiology and everything in between. You almost need a physician specialty matrix to properly handle underwriting for this coverage.

Sometimes coverage needs to differentiate levels between in network and out of network. In network might want coverage according to a resource-based relative value schedule (RBRVS). Out of network might want it as a percentage of charges. Obviously, this has major risks because most of the big claims will be received when billed charges are allowed, thus resulting in an uncontrolled environment. There is also less managed care control by the physician group when business goes out of network. Even if the physician group is very good at controlling care within

its own group, something that goes out of their network is something that will be out of its control. The higher amount that goes out of network, the risk multiplies by a number larger than two.

Now I would like to discuss the issue of the level of managed care versus total per-member per-month (PMPM) claim costs. When the Towers Perrin group was studying what causes the cost of physician stop-loss to be higher for some HMOs versus other HMOs, we came across an interesting issue. The issue was that the PMPM for the physician is very important and therefore will be a major driver of what is needed to charge for the stop loss. We also saw that two similar HMOs (two HMOs with similar PMPM costs), one in a high-cost area and one a low-cost area, showed that the high-cost area HMO ran lower physician claims. It seems that, even with the same PMPM, if you're in a more managed HMO or dealing with a more managed HMO, your provider excess claims tend to be less. This is something that Towers, in developing the manual, has studied and tried to quantify. It was an interesting thing that came up as part of our analysis.

Physician cost is always an issue because physicians don't even know what their true costs are in many cases. They'll take a capitation, but the cost for themselves is basically the cost of time. Anyway there are fee schedules and the most common are the McGraw-Hill, the RBRVS and in California, a lot of the scales are on the California Relative Value Schedule. We still do a percentage of charges, but we've advised many reinsurance clients that percentage of charges is obviously the most dangerous from their point of view, because the percentage of charges could change tomorrow if the physician group changes its charges. That option doesn't give real good protection to make sure that there is "effective coinsurance" or to avoid reimbursing them less than what "really cost them." We are dealing with the more-art-than-science aspect of underwriting and deductible level. A typical deductible for physician provider excess ranges between $5,000 and $15,000. We see them sometimes more or sometimes less than that, but that's the typical range we see on the specific side.

Another underwriting or pricing issue is the maximum benefit, which is usually a million dollars and not too much of an issue. However, the type of population is critical. There are commercial, Medicare, and then Medicaid classes. Within Medicaid you have Aid to Families with Dependent Children (AFDC), the blind, the disabled, and the elderly. Certain states cut these categories down further and differ dramatically in cost.

Letting our clients quote a Medicaid rate, unless they know the population of that particular Medicaid group, could be disastrous. Disabled Medicaid costs versus

AFDC could be a factor of 4 to 5 to 1. The cost implications of the various Medicaid classes are dramatically different.

Form of coverage is a common term in employer/employee stop-loss. I write down the numbers 12–12, 12–15, and 12–18. The first number is the number of months in the incurred period, and the second number is the number of months in the reporting period. On the employer/employee side usually the incurred period is paid by the third-party administer (TPA). Here, there's nothing really paid by the TPA, but the second number represents the number of months it takes to report the claim. Let's say that you have a 12–18 (which is the most common form of coverage quoted) and a January 1, 1996, effective date. The claim would have to be reported to the insurance company by the end of June 1997. It would then be considered a claim in that policy year. If it's a claim that has been incurred in those 12 months and was reported after June, it would not be covered.

Member growth is the last factor I will talk about involving the underwriting of provider excess for physicians. The two aspects of member growth that I'm dealing with are physician groups that are either growing or shrinking rapidly; usually it's the growing, though. The physician group isn't growing, but the number of members who are capitated in the physician group is growing. A growing physician group has the danger of risks changing or evolving because new members are dealt with throughout the year.

However, a physician group that is growing in number of members has a smaller average deductible accumulation period than one that's stable or shrinking. So if a group is really growing rapidly, the members coming in at the end of the year or toward the end of the year have much less time to accumulate expenses to satisfy the deductible and to run over that deductible. We have developed manuals that include an adjustment for member growth, and it shows that the faster the group grows, the lower the rates are for quoting.

The plan design on the hospital side is similar to that on the physician side. Differences in coinsurance, payment scales, and loss of control for out of network is an issue that underwriters need to resolve when they decide to put a rate on the product. On the hospital side, the most typical way stop-loss programs work is in terms of the schedule, and the simplest is the flat per diem which covers the hospital $1,000 each day. It's very beneficial to have $1,000 a day coverage and a $366,000 attachment point because you don't get a claim in that case. Flat per diems produce the least expensive cost on provider excess. Then there is the more common way, which is a percentage of charges. If you were given a normal hospital charge basis and then covered 60% of charges up to $1,500 a day, you would provide more coverage, but it gives you control.

Straight percentage charges without a per-diem limit is another common thing we see. The diagnosis-related groups (DRGs) are becoming a lot more common. DRGs tend to really control the cost, particularly for Medicare risks, which are substantially higher than commercial risks. With DRGs the risk is reduced significantly because it's hard to really get a major claim with DRGs. However, DRGs with outliers are a different story because outliers will allow claims under DRGs to get substantially above the DRG level for an extended stay. When a provider excess coverage is quoted for a hospital, they want coverage not only for their inpatient facilities, but also potentially for their outpatient facilities, which dramatically increases the cost.

The next item is neonatal, transplant, mental health, and other things such as those. Neonatal and transplants can be carved out of coverage because a hospital will not be capitated for that type of coverage. This is because there may be special neonatal facilities and there may be special transplant facilities, and often mental health will have an inside limit of 30 days. Yes, mental health is covered, but only 30 days is allowed. Certainly all these could affect the cost of claims exceeding a specific deductible. The lowest hospital deductible we typically see is about $50,000, and it could go up to $150,000. I've seen it go up higher than that. But $50,000–$150,000 is common for hospitals, and $5,000–$15,000 is common for physicians.

The maximum benefit is normally $1 million. It could be more, but normally it's $1 million. Here again, the type of population, whether it's commercial, Medicaid, or Medicare, is very, very important. A 12–18 form of coverage is the most common form of coverage. Member growth is also very important. A growing member base for hospitals that accept capitation will reduce the cost for the hospital, probably even more than for the physician group. Because the deductibles are higher, you will need more months or longer lengths of stay in a hospital to exceed your procedure deductible. I'm not really sure whether it's more than the physician, but it's the same issue. Combined hospital and physician groups will have all the underwriting issues contained in the individual hospital and physician issues. Higher deductibles and physician claims will help a hospital claim get over the deductible, which will result in a little claim becoming a much bigger claim. So there is really leveraged inflation on any claim over the deductible when you add another whole set of benefits. Typically, physician hospital organizations (PHOs) will have the same deductible as hospitals, but will cost more because of more claims coming through.

EFFECT ON EXPECTED CLAIM COST

I would like to give you a sense of the effect that expected claim costs can have. On the physician side it is very, very important, from an underwriting standpoint, to

refer to past experience. Seemingly identical physician groups may run a gambit of costs that are different, and to many this will be credible experience. In other words, two physician groups that seem to accept the same level of coverage, and the same percentage of RBRVs and that have similar geographic areas may run twice the amount of claims as another one, year after year. It may be 1.5 one year, 2.5 the other year, but one will be always more. So any kind of past experience, of course considering statistical credibility, is certainly very, very important to the underwriter in determining how good the risk is. Seemingly similar risks can differ dramatically in this coverage more than in any other coverage I've been associated with. There are really managed care issues involved. There are many reasons why one physician group is being run more efficiently than another physician group, whether it's a better risk pool, better physician education, a better group of physicians, etc. So any past experience you have will be useful.

On the physician side, I talked about a situation in which you have a similar PMPM in two physician groups, yet one is in a higher cost area and has basically twice the managed care as the other one. That type of effect can be worth more than 100% because that's actually a very significant underwriting criterion. If you're the better managed group, it could be a factor of more than 2 to 1 in terms of your excess claims.

Now I would like to give you a sense of what the deductible is like and the effect the deductible has in this highly leveraged coverage. If you talk about a $7,500 deductible and a $10,000 deductible, the $7,500 deductible will have approximately 75% more claims than the $10,000 deductible. Again, that will vary with many of the other aspects of the underwriting. For example, Medicaid disabled, which is the worst population, versus commercial is worth more than 300%. That's more than four times the cost.

On the hospital side, echoing what I said on the physician side, past experience is critically important. So if a hospital is taking a capitation from a very well managed HMO, it could have a substantially lower claim. As underwriters, you always have a situation in which a hospital has existing experience and now is signing a contract with a new HMO. This could create a problem within underwriting because, to some extent, the past experiences may not be indicative of what they may run into with the new HMO.

The underwriting of experienced underwriters is absolutely critical. A client of mine had very poor experience in 1995 and good experience in 1996. The underwriters got smarter from the learning process they went through in previous years. This is a very difficult and a very unusual coverage to underwrite. Somebody with experience in other types of coverage will still have to walk through

the fire before they know what to look for to get a sense of what good and bad risks are.

Let's talk about a flat per diem versus a percentage of charges equal to the same per diem. Let's say the average charge in an area is $2,000 per day, and we're going to cover 50% of charges on the coverage for provider excess. Now compare the costs for 50% of the charges in which the average charge is $2,000 versus a $1,000 per diem at the same per-diem level. The cost according to our study varies by the percentage of charges. Seventy-five percent is three times as high. So percentage of charges is significantly more expensive, because you get the big claim without a long length of stay. When you have a per diem, the only way to get the big claim is when there is a long length of stay.

Let's say you have two hospital situations, the average of one of the hospital's charges is $2,000 a day, and you cover that hospital at 50% of charges. Alternatively, if you were to cover that hospital at a $1,000 per diem, the 50% it charges excess claims will be 75% to three times as much as the $1,000 per diem. The reason is because there are percentages of charges. If somebody gets very sick in the hospital and needs a great deal of intensive care, even though the "average" charge for the hospital is $2,000, they may be running $20,000— $40,000 a day. It would become out of control and you'd be stuck for 50%. If you're giving the hospital a $1,000 per diem, the patient would really have to be in the hospital a long time before he or she would have a claim. So it's much more risky to use a percentage of charges than per diems. The type of population is also very essential to underwriting. For example, a commercial population would not be as expensive as a Medicare population. A Medicare population is typically 75%–400% more.

WAR STORIES

Information is so hard to get here. We're dealing with a relatively uneducated provider community. Provider groups are accepting inadequate capitation, and we are trying to help them decide what is adequate capitation.

They don't understand the issues, the coverage, or how to request provider excess coverage. Sometimes a group will send out nebulous requests and get 20 quotes back, with each on a different coverage. They all want provider excess coverage, but they don't say what kind of deductible or what fee schedule they want.

Along with an uneducated provider group, broker interference complicates matters. Most provider excess carriers sell through brokers, who like to be in control of the situation because it is their client with whom we are dealing. So the brokers put themselves between the provider group and the reinsurer. If the reinsurer wants more information, he has to pass through the broker. It's like the old child's game

of playing telephone. You tell the broker something that you want, and the broker then asks the provider group something entirely different. It gets filtered both ways, so that you end up not getting what you want. Then the broker tells you that this quote is needed in a week. So getting adequate information is extremely hard when you have to go through many different avenues. Brokers tend to send a message that the information is not available when what they are really trying to say is that they don't have the time or the inclination to work further to get that information. This becomes a real problem because of the lack of knowledge and education on both the provider and broker sides.

The second issue is to know what the coverage is. One of my clients wrote coverage as a DRG because the hospital group wanted DRG coverage. About 12 months later, the claim came through and the hospital group wanted to know if this DRG was with or without outlier. The client didn't know, and it actually paid the claim as if it did include outlier. Reinsurers have this word-of-mouth type of agreement, and it actually went and paid the higher amount. Sometimes the reinsurers issuing the provider excess are new to the coverage and don't even know what they're selling.

Now I will talk about sizing up the prospective insured. When we talk about the size of a network, we really mean how expansive the network is. This is a critical criterion for underwriting. If two physician groups take a global cap for all physician services, one physician group may be large enough to have adequate numbers of the specialties, such as orthopedic surgeons, cardiovascular surgeons, oncologists, etc. They are the ones who will be able to control the cost better than another group either that doesn't have these specialties, but tries to take on the responsibility for these specialties, or that doesn't have enough specialties. Some provider groups have a large population to insure, and they may have an oncologist but need three to four to adequately serve that population. Being able to evaluate what's likely to be handled with the resulting managed care controls versus out of network is very important in predicting what the provider excess experience is likely to be. Most of these claims involving transplants, neonatal, and extreme cancer cases are very expensive procedures.

Do we "shadow price" the crazies? In 1994 and 1995, one particular carrier had several other carriers following it. It was pricing, particularly Medicare, very low. My client was constantly telling me that a certain carrier had a Medicare rate 35% over the commercial rate. "How does it do that? It should be two to three times the commercial rate." I advise my clients to raise the commercial rate and to mirror what it is doing 35% higher. You raise the other rate up and you get the same amount in total if you just want the image of your Medicare rate being 35% higher. Eighty percent of the experience on this particular case was from the Medicare

eligible. So, obviously, the Medicare eligibles were causing the bulk of the cost and yet they were being charged 10% of the premium. It turned out that this particular company and all the ones that were following it were losing a ton of money. And by being such major competitors in the market, many other companies were following it. Either you mirrored it or you didn't get the case.

It's very likely that ten or more carriers will be quoting on one particular quote. The hit rate in this business, for most of my clients, seems to be in the 2%–4% range. You're going to write 2%–4% of the cases you quote on. During this crazy period I've heard of some companies that were even having 1% hit rates. They were convinced that their rates were right, and they did not want to follow the companies that were charging ridiculously. The range of quotes on this product, even now, is dramatic. It is not unusual to have 10–15 quotes, and the lowest from the highest may still be a factor of 2.5 or 3 to 1. Still many companies out there don't have a clue, and there's an awful lot of underwriting judgment going on about this product, much more than with any other coverage I've been associated with.

One of my clients came to me last week with a quote it got on prescription drug coverage. We get requests in which companies want to cover physician claims and prescription drugs. Others may just want prescription drugs. They want coverage just for prescription drugs with an aggregate cap or a specific cap. I think in this case it was an aggregate cap.

Another unusual request was for a proposal from an acquired immune deficiency syndrome (AIDS) organization in Florida. All it did was manage AIDS cases, and it wanted to get provider excess coverage just for AIDS claims. I could list ten requests for assistance I received from clients. Each one is very unusual. So even when a solid manual gives you the basic rates, you will get very diverse quotes in which you have to extrapolate from your knowledge base. There are many requests for many different types of coverage out there.

Mr. Thomas D. Snook: I have a short question for Jerry, and then a longer question for both of you. Jerry, regarding your clients that have seen better results in 1996 versus 1995 and 1994 financial results on their reinsurance coverage, did they take corrective-rate action to achieve that, or did they just turn bad luck into good luck?

Mr. Winkelstein: No, there was substantial corrective-rate action. Basically, it was substantially rating up business that was running very badly. I guess like most health businesses, when you have a "bad block of business" (maybe 20% of your cases are really bad instead of the normal 10%), you can usually figure out, if you work at it, which cases are really causing you trouble. I think more importantly we were able to get rid of the bad business, but they always seem to be more selective

in writing the better business. Plus, the general rates in the market, in my opinion, have gone up dramatically. I think many the people who were, as I euphemistically said, "shadow pricing the crazies" have learned that perhaps we shouldn't because it costs us too much money to do that.

From the Floor: I came here hoping to get a magic answer. When I look at this market, it looks just crazy to me. There are not much data and what data there are may be bad. Even if you had perfect data, the actuarial analysis and underwriting analysis would be so complicated it would create room for error. Even then if you could price it right, you wouldn't even know if the market would bear that rate, which led me to the question, is this even, in the long term, a viable market? Is this something that will make sense? Or are we splitting the risk up into too tiny a piece to really make this work right?

Mr. Winkelstein: Well, I think it's a viable market just because there's an economic demand for it. It's going to keep growing. I think when there's that much money around, as I was saying, $3–5 billion in the ultimate market, the companies that can crack it can really crack a treasure chest. Some case histories do have clients that have done OK in it. I think any market tends to go through cycles. I saw this in the employer/employee stop-loss market when a lot of profits were being made there in the early 1990s. Many companies flocked to it when many people were losing money. Some people have dropped out of the market and it really raised their rates. I think it is viable, but you have to be very careful and you really have to be smarter than the next guy.

Mr. Shively: As long as the risk continues to get pushed to providers, which seems to be the trend in both government programs and in the other programs as well, the risk pool will continue to broaden. I think it will increase its viability as the risk pool broadens in that manner. A smaller risk pool is difficult to manage and work with when there are just isolated situations. I think it should improve in that way.

Mr. John F. Fritz: I had a similar question for you, Jerry, but first just a comment to kind of reinforce something that Jerry said about the percentage-of-charges approach and what leverage the cost might be. Many providers may look at their reinsurance coverage as a profit center and as a way to help the bottom line. One particular case, involving a hospital client, proved that looking at past experience wouldn't have been very indicative of what the future experience would have been. As the hospital learned how to work with the reinsurance, it decided that its way of defining its charges wasn't in its best interest and it didn't do a good job of itemizing all of its costs and expenses. So when going from one year to the next, it kept "improving" its way of costing out expenses, which obviously dramatically

increased the cost on the reinsurance side. So this is another good reason to try to cap it with per diems as opposed to percentage of charges.

Mr. Winkelstein: An article in *The Wall Street Journal* about a month ago talked about how hospitals would legally upcode things.

From the Floor: I didn't see that article. I think what they were doing wasn't necessarily upcoding as opposed to just going through and re-itemizing everything and making sure they had everything covered. From their perspective, they thought they were doing everything legitimately; they were just missing charges before and not pricing everything out. So it's a different perspective.

A question was asked in which you mentioned one of your clients that halved its loss ratio from one year to the next. Even though I say that the pricing is fluctuating and prices are going up, doubling or more than doubling a rate would seem as if you'd lose much business along the way. Are other things being done because of the many variations and how coverages are offered? Redefining coverages and changing the contracts to use a different benefit design or learning something in the prior year on how to offer this coverage will add a big contributing factor to reducing loss ratios like that.

Mr. Winkelstein: I think it's all of the above. Contractual changes weren't dramatic. They redefined their DRGs and gave specific definitions of outlier, rather than just saying DRG and whatever Medicare covers. Another thing with DRGs is that many Medicare and Medicaid DRGs are different. Some are homegrown, some are Blues, and some states use the term DRG to refer to their schedules, which is not identical with either Medicare or Medicaid. Today they redefine DRG to refer specifically to Medicare, and they redefine their outlier to define a per diem, an actual per diem that doesn't go through the Medicare definition with the cost and length of stay. An outlier can become complicated. I would honestly say that the biggest thing it did was use its underwriters, who just learned from the cases they had bad experience with. I'm not sure whether there is an answer except to learn the hard way on this coverage. Many cases out there will really put you in a bad situation, but as an underwriter you get smarter the more you do it.

Mr. Shively: That's a good point. You can usually correct the situation and bring the block of business in line just by fixing a couple cases, even though the block of business may be considerably above pricing targets.

The other point I noted when you were speaking earlier was when you were talking about limiting the coverage in terms of making the rating more predictable and accurate. From a risk standpoint, you need to be careful when doing that because

you still need to meet the clients' needs. The providers still have a need for protection. The coverage can become so limited that it's not protecting them from the real risk. There needs to be a blending of that somewhere. It is managed care, and there needs to be some limit on things, but at the same time if a provider is really at risk for some percentage of charges, then the coverage needs to somehow take that into account and not just leave it hanging when it needs it. That was a good point, though.

Mr. Rodney Laverne Brunk: Given the wide range of rates that you say exist, I was just curious whether you had seen many instances in which HMOs and the physician groups were getting together and making it a win/win situation for both of them by seeing the potential and running different scenarios.

Mr. Winkelstein: Well, one thing that I have noticed in the marketplace is that, typically in the past, HMOs used to provide some coverage for their physician groups. They would have a global cap for a particular physician group of perhaps $25, but instead they'd give you $22 and you would not be responsible for any claim above $15,000 or something such as that. It actually included the provider excess. One of the things that has helped the growth of provider excess coverage is that HMOs have stopped doing that. The trend has been for them not to do that and to just give the money to the physicians and let them operate on their own.

Mr. Shively: I think the perception was, when that type of environment existed, the HMOs were taking advantage of the providers. There's generally a controversial situation there anyway between HMOs and providers. They try to get the better of one another. The excess coverage was just another area in which providers perceived they were getting taken advantage of. I think it was only natural for them to move away from those types of arrangements to the extent there's a market to do that.

From the Floor: It just seems to me that you could take the adversarial relationship of the HMOs, providers, and brokers and make it a win/win situation for all parties involved.

Mr. Shively: I think we're seeing situations such as those where the HMO values the stop-loss protection in one way and offers that as part of its capitation package. If that option is chosen, then you're free to go to the market to see what's available there as well. An option is left open, and if the provider can get the coverage appropriately somewhere else for a lower rate, let it do that now. I think we will see more of that happening.

Mr. Winkelstein: I agree. In fact, I am seeing more of that type of coverage among the pharmacy firms, the pharmacy benefit managers (PBMs). What I've seen them more commonly offer is an administrative services only (ASO) agreement. The pharmaceutical card system (PCS) and MEDCO will offer an ASO agreement and also provide an aggregate stop-loss with that. So it's not identical to what you talked about, but it's the same type of thing in that you're dealing with one entity rather than going out to a reinsurer to try to protect yourself.

From the Floor: I was curious about the rationale used in making it a property and casualty coverage in many states. It seems as if this would minimize opportunities for HMOs and various organizations that are providing the initial coverage to offer the secondary coverage to the providers.

Mr. Shively: The HMO can still offer that as part of a capitation agreement. It's just part of the agreement. But if that coverage has to be purchased outside the agreement, it then becomes an insurance product. It then becomes regulated as property and casualty or A&H, depending on the state.

Mr. Fritz: When you were answering or commenting on my question before, I completely agree. You need to meet your customers' requirements. I wonder if anybody has seen the kind of coverage in which you play off of the fixed and variable costs of a hospital entity, as opposed to defining per diems or percentage of charges or defining the coverage in terms of what the institutional variable costs are.

Mr. Shively: Partially the intent of moving to a percentage of charges is to try to define the fixed-versus-the-variable-cost part of it. However, we don't go to the level of actually looking at the charges for a provider or a facility and breaking them down internally. I don't think I've ever seen that. The percentage-of-charges method is trying to make that distinction by drawing the line at some percentage basis.

Mr. Winkelstein: I have not seen that. I think that with such a complicated arrangement as this product usually is and with all the misinformation passed around in the proposal process, they try to keep it as simple as possible. That may be the reason they haven't gone to a more complicated formula or defining what coverage is. Right now, with DRGs and certain other things, it's sometimes very hard to figure out what a claim is, and making it more complicated would just exacerbate the problem. But it can make sense. I've seen so many unusual things happen in the past year that nothing would surprise me at this point.

From the Floor: It seems to me that reinsurance companies were supporting the shadow pricing in 1994 and 1995 by providing an outlet for the carriers that were

charging low rates. I was wondering if you've noticed reinsurance companies changing their approach in 1996 to provide better results for underwriting purposes.

Mr. Shively: I'm not sure I understand the question when you refer to reinsurance companies as an outlet.

From the Floor: To provide and take part of the risk for the carrier that's providing the provider excess.

Mr. Winkelstein: Do you mean a company such as Lloyd's?

From the Floor: Yes, or perhaps Lincoln—any reinsuring company that's writing this on a direct basis by taking off some of the risk for that carrier and charging a co-insurance basis of 80% or some percentage of the rate. For example, if you're charging $2 PMPM and take $1.60, and another carrier is charging $4, you're, in essence, penalizing it for being perhaps more accurate in its pricing.

Mr. Shively: Many of the entities that are in that market of offering this as an insurance product are reinsurance companies. So it's not that they're just on the back end covering carriers, they're the ones actually out there in the market as well. It's the responsibility of everybody to do their evaluation and to do what they think is appropriate and follow the market. I think it's at all levels. I don't think you can make a distinction in this particular market between reinsurance carriers and direct insurers.

From the Floor: A part of it is that the carriers wanted to increase the market share in those years when the experience was poor. Unfortunately, it was so poor that the management didn't give them a chance to rectify the situation.

From the Floor: I want to comment on the comment about fixing variable costs. One of the impracticalities of doing that is working with hospitals. First, they don't know what their costs are. Their cost accounting systems are either hybrids of what they do for Medicare, or they're nonexistent. Second, what they call fixed and variable costs are not necessarily what we would call fixed and variable costs in a traditional accounting sense (not that I'm a cost accounting expert). But the way they look at things is not a true indication of what is fixed and what is variable. They tend to be so overhead-laden that basically, the true variable cost of an extra patient day is almost immaterial when you look at it from a true cost accounting standpoint. The laboratories are always going to be staffed. I've talked to financial officers in hospitals who tend to agree with me. It's like throwing the food away that's wasted everyday anyway, so it's not going to cost you anything there. Potentially, there is housekeeping. The true cost lost to them of an extra patient day

is any opportunity to fill the bed that currently is occupied. They're not having problems like that now.

Another complicating factor is that they're so overhead-laden right now, they're operating at a very inefficient level. So with everything in their industry being contracted and the commodity being the way it is, I think it's a good theoretical approach, but it's virtually impossible because of all the consolidation changes that will occur in the hospital industry within the next five years.

Mr. Winkelstein: I agree with most of your comments.

Mr. David B. Berg: First, who are the major players providing the coverage? Second, part of the reason for capitation is controlling cost. As this market stabilizes, it introduces additional costs to hospitals and physicians. Will they be able to absorb these costs, or will they try to raise the capitation rates and pass the cost back on to consumers? What's your opinion?

Mr. Shively: I'll let Jerry comment on who the carriers are.

Mr. Winkelstein: I hesitate to give you a list of carriers off the top of my head because some of them are clients. I would hate to leave one of them out.

Mr. Shively: The additional cost you spoke about is a cost that's existed all along. To the extent there are catastrophic claims that providers need to be protected for, they have been protected at some level before. It may have been the HMO before capitation, and their needs were at a higher level because they have a broader membership to spread it over. Now it's down to smaller membership segments. Because they've lowered the threshold at which they need protection, the cost has apparently increased. But the catastrophic exposure does not change unless other underlying factors are changing, such as technology people's perspectives on what treatments they need, and things such as those.

From the Floor: I meant the additional cost was in, because now brokers are passing those out. These carriers want a profit on these costs. So now additional players are just adding a lot more to the system.

Mr. Shively: The perception was that HMOs wanted a profit as well. If that was accurate, this really doesn't create additional costs, except to the extent that a distribution cost is added in. That's a cost for someone who thinks he or she needs to go to the market and see what the options are and is willing to pay the cost for going to the market.

Ms. Jane-Anne Tateishi: Jerry, when you talk about the 1996 results, how have they improved on some of your clients? I assume there's still a large amount of IBNR in there. Even if the majority of the underlying policies are January 1, they're still written for the most part on 12–18.

Mr. Winkelstein: Correct.

From the Floor: What reserve methodology do you recommend that the client use? Are the claim lags, if it is a completion factor or a run-off approach in general, longer than they are in the typical employer stop-loss self-funded market?

Mr. Winkelstein: To answer your last question first, yes. They are a lot longer and often, unfortunately, they seem to come in right at the end of a 12–18. It comes in like the last month. I'm not sure it's the last day, but that's the feedback I'm getting from clients. I would reserve for them in an approach very similar to the one I suggest for employer/employee stop-loss, which is analyzing the month-by-month completion from the effective date of the policy. So if a case is written January 12, 1995, you would have any claims paid or reported—because often there is reporting early—each month and track the historical experience that way. That's what I suggested and it takes a while. One of the problems with many of my clients is that they are relatively new to provider excess. They've been in the product only since 1994, and a lot of history has not built up yet.