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Session 62PD
Provider Excess: Is it Rosy or Merely Thorny?

Track: Reinsurance

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Summary: This session focuses on provider excess reinsurance, which is an excess of loss coverage for providers assuming risk under various forms of managed care arrangements, such as HMOs, PPOs, and Medicare/Medicaid. An expert panel discusses current issues, including:

- *Trends and experience*
- *Underwriting issues*
- *Follow the risk—where is it going next?*
- *Accident and health versus property and casualty company perspectives and motivations to be in this market*
- *Similarities and differences to HMO excess*
- *Products and service needs*

Mr. Mark Richard Troutman: Jack Reid, our first speaker, is vice president of Hooper, Hayes & Associates, a multi-specialty insurance brokerage firm. Jack is responsible for the management and servicing of health-care clients. He specializes in provider stop loss and HMO reinsurance. Hooper Hayes is one of the largest health-care insurance brokers on the West Coast. Prior to joining Hooper Hayes, Jack was a national practice leader for a provider stop loss and HMO reinsurance and a senior vice president at Marsh McLennan/J&H. Prior to joining Marsh McLennan/J&H, Jack was a senior executive who developed and managed the managed-care reinsurance unit of Northwestern National Life Insurance Company, now named Reliastar. Before Reliastar Jack was president of a United Health Care subsidiary providing insurance and reinsurance products and services to HMOs. At both Reliastar and United it is important to note that Jack was responsible for product development and managing the actuaries.

Mr. Jack Reid: As a broker, I'll try to give you the perspective of the marketplace of the buyer. I'd like to talk to you about how the industry is doing including what

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the buyers actually look like, who they are, how they work, how they make decisions, and where I believe capitation risk is going. I will wrap up with some general thoughts on this product in the accident and health field versus the property and casualty world, and how those two can work together.

I think that many of us who have been in this business for some time are very concerned about the current conditions of the marketplace. There are currently about 18 carriers that include approximately 10 managing general underwriters (MGUs). For those of you that don't understand MGUs, they are not an insurance company, but they have the authority and the so-called "pen" of an insurance company to take risk on their behalf. The specialized nature of the provider excess product really works well with an MGU. Carriers often have difficulty staffing up to write a specialized product like this and it's far easier for them to do the underwriting through a contract basis, which is through an MGU. In many cases, the MGU only services this product, provider excess, and possibly HMO reinsurance. They depend almost entirely on it.

The reinsurers of this industry are very unhappy with the results. I would suggest that they've been unhappy with the results since the beginning. I don't think that the product has produced overwhelmingly positive financial results for many reinsurers. The insurers themselves are having difficulty finding reinsurance, but, at least, they have the ability to take whatever portion of risk they can't place to the reinsurance market. It is different for MGUs. They have no ability to take risk. If they can't fill their slip or fill their reinsurance by placement, they can't be in business.

Reinsurance for the provider excess product is becoming somewhat hard to come by. Most of the carriers and MGUs we deal with will tell us that everything is fine, that they're making money and that last year was a great year, they did very well and their reinsurers are very happy with them. However, many of those same carriers are "pausing" on new business. They call it "pausing" now. "We're going to 'pause' writing new business just to re-group a little bit. We've had some staff changes and we just want to slow down, catch up, and reposition a little bit." What they really mean is they're running out of reinsurance carriers.

The second indication is that the carriers and MGUs are starting to change underwriting rules. We work with the underwriters constantly, virtually every day. We talk to them all the time, and it's a small enough business where we get to know them quite well. The rules might change. They say, "We don't want to do this. We want to do this. Have you seen our new policy? It's a little bit different." We know that "different: means more conservative.

With regard to the rates, the reinsurers have been pushing them up to the insurers and the MGUs. Brokers have noticed substantial increases in pricing especially for the January 1, 2000 renewal season. Another way we find out what's going on with the reinsurance market is by gossip. Underwriters are always good at telling you what is happening with their competitors—how bad their reinsurance is and how much money they are losing. Finally, sometimes we're calling the leadership of the

various markets and find that they're in London. If they're in London in February, then you know they have a significant problem.

It's my belief that the industry has had a loss ratio in excess of 120% since the early 1990s, or even late 1988 and 1989. I don't think it's ever been a good industry from a loss ratio perspective. Now, a number of carriers and MGUs have made money over those years and some have done well for all of the years. In general, I think the rates have been so low that nobody in the industry has been able to make significant profits. The good news is that I think it's improving. I believe that rates are coming up, and the buyers are going along with the rate increases. I think things are stabilizing.

What is catastrophic today to the buyer? We continue to see the traditional catastrophic claims such as premature births, transplants, and traumas. The new claims that we're seeing a great deal of are intravenous therapy treatments (especially for chemo), factor 8 claims for hemophiliacs, and hepatitis claims.

Is the risk stabilizing or changing? The risk can't stabilize because it's health care and health care changes constantly. Therefore, it is changing. From an underwriting perspective, it is important to answer the question, "Who's managing the risk?" Is it delegated to the provider, that is, to the hospital or medical group or is the management of the risk retained by the HMO?

Think about it. If the HMO retains the management but capitates the provider, the HMO is no longer at risk. It's only receiving an a substantial administrative fee off the top of the premium to the employer, and then passing on the remaining amount of money to the provider to manage the delivery of the health care. The HMO will provide all the management of eligibility and enrollment tracking. It will do the claim adjudication, and then finally report that information to the provider. In addition, the provider is supposed to live within the capitation funds.

The formula for success in managed care has never changed. It still is the number of units times the cost per unit. The number of units has changed. The cost per unit generally hasn't changed. They're still relying on per-diem contracts for managing hospital pools. There's a relationship between fee schedules for doctors and resource based relative value schedules (RBRVS). The technologies are changing: new procedures, new drugs, and new devices. That is what's been so challenging for the capitated provider. It is difficult to provide care in a very high cost industry that is becoming increasingly costly.

From an underwriter's perspective, they are responding by changing the terms of the policy. For those things they can't get information about, they put restrictions or limitations within the policy, such as average daily maximum limits, which limit the amount of recovery that will apply towards the deductible or towards the claim for an inpatient stay. Similarly, reimbursement arrangements for doctors may be based on RBRVS or on some factor of RBRVS, and not on the fee schedule according to which the doctors are paid.

The reason for this is valid. We, the brokers and the buyers, don't provide information to the underwriters that can support arguments for not doing that. We can't tell the underwriter what percentage of the claims are referred outside of the provider's network. Maybe the most dangerous risk of this coverage is how much of the business goes outside of the capitated network. If they have to refer to a high-cost facility, that will affect the reinsurance coverage. However, we can't tell the underwriter in advance what percentage of the time this will occur.

Contract rates are proprietary to the HMO, so we can't give that information to the underwriter. In order to improve the provider excess product, we need to find a way to create better measurement tools of the insured. How can we measure the insured in a different format? How can we stand back from what we've done for the last 10 years and find a new way to measure them that makes more sense?

The three lines of business that we deal with are commercial, Medicare, and Medicaid. Commercial is easy while Medicare is more challenging. Underwriters often times will not take Medicare only. Medicaid is difficult because we rely on various state regulations as it affects Medicaid. A number of states have their own rules and regulations on how to deal with the risk of Medicaid. In some states, some high cost claims go back to the state's risk. However, the laws on it are hard to come by. Many times we don't even have a contract; we have to rely on state regulations. State regulations are changed constantly and for the underwriter it is hard to make a determination of what the risk is for the Medicaid population.

Let me try to describe the buyer and the people that we as brokers deal with every day. They're a challenging group. Typically they work for a managed- care department of a hospital. They may be the director of managed care. They may be a medical group administrator. Their entire job is negotiating with HMOs. They spend all day long fighting with HMOs to get more capitation, to get a claim adjudicated correctly, to recover money, or to reconcile capitation accounts and balances. They're constantly in a negotiating mode.

The buyer that we deal with is typically not the actual decision maker. The buyer may report to the CFO of the hospital. Therefore, every message and every discussion we have with that individual has to then be transported to the CFO. The CFO considers it in the simplest manner: How much are we going to have to pay and how much do you think we're going to recover? All the wonderful information we give about the value of protection and coverage doesn't have anything to do with the discussion.

Provider excess suffers from some bad traditions. The CFO knows about these and lives by them. They go back to the beginning of the coverage. One is backdating coverage. Anybody in the insurance industry knows you don't backdate coverage. However, this line of coverage backdates all the time. We will ask to go back six months to bind coverage. We will ask the underwriter if they'll bind two months back. This has gone on forever. We warn our clients that we don't want to do that, that we want to bind in advance of the effective date. Once you have a big claim they say, "Don't worry about it. The underwriters will backdate it for you." It gives them more time to goof around with taking the rates and trying to figure out

whether they are going to make money on this coverage. That's the second point. Provider excess to a CFO is another way to make money. We remind them that this is not a profit center, but, nevertheless they try to find ways to do that.

The third thing, which is really hard for all of us, is that minimal information is OK with some carriers. Not all carriers work that way. A lot of carriers say, "I want everything." However, some carriers are willing to accept less. The worst part about it is that if we do provide three years of claims experience, break it down, and give them the out-of-network utilization, what does that give the underwriter? It gives the underwriter clear information at which to set rates. It's going to be far worse than manual rates. Think of people that are given the option of going to an underwriter and saying, "We have claims experience that's going to deliver a $1.50 rate, or we can provide no information and receive the manual rate of $0.75." I might say, "There is no information because the computer system crashed and all the information was lost." Therefore, the truth hurts by producing this information.

By the way, if you do produce the three years of claims information, it's because the claims information is good, not because it's bad. Now, these are the extremes. Let me remind you that most of the clients and buyers in this business are very good ethical providers. They're just in a very difficult world right now trying to make a living, keep their hospital open and keep their medical group going forward.

Loyalty is hard to find. I think carriers would say the same thing. I wish we could have a client who would stay with us three years and who wouldn't shop us every year. They really want to push down the pricing every year. We have competitors out there that are chasing our clients all the time.

Is there a need for this coverage? Clients ask us that a lot. I still think there is. We still believe that catastrophic claims occur, and that the provider needs to be protected against it, and should buy protection. What buyers are looking for is coverage for the variability of the medical risk. The simple way to cover that would be with an aggregate coverage, which nobody will write, and really, it's understandable why they won't write it. The variability of the medical risk is what is causing the providers to have financial troubles. It's the fluctuation of the medical expense.

One of the problems we have when we're talking about renewal rates is that many of our clients feel that this is just a loan. If you think about it, it sort of sounds like it. You take three years of claims, put them out by member months, and you adjust those three years of claims for medical trend. By the way, providers have never seen a trend in their capitation so that's the first hard argument. The underwriter wants a 7% trend. There hasn't been any trend to their provider, so what's this trend business? Then they put their margins on it and that produces the rate. We put that down in front of the buyer. The buyer asks, "Why would I want to buy this? Three years running now, I've paid more premiums than I've collected back in claims. Why do I want to do that? What's the benefit? What's the purpose of all of this? It seems to me I'm giving money to the carrier and financing my low-end catastrophic claims and I'm paying a high margin to do that. I might as well just go get a line of credit and pay interest on that."

It would be nice if we could find a way to pool the risk better. In addition, it would be better if there were pooling points to the risk so that the risk wasn't so dependent on experience rating. All the CFO looks at is the capitation revenue minus the administrator expense minus the medical expense minus the premium for this coverage plus the recovery: Do we get a gain at the end? If we're not getting a gain, then there's no reason to buy it. If provider excess doesn't improve the results of capitated business, then our argument as brokers becomes more difficult.

A lot of the problem from some buyers' perspective lies with the fact that they are really not independent. They are totally dependent on the managed-care organization, on the HMO. The HMO does the underwriting, picks the risk, picks the employer group, buys market share as necessary to undercut the rates, and makes decisions about utilization management. It makes decisions about experimental procedures, exceptions to benefits, and where the patient will receive care. Remember, it has a choice between preventing the patient from going to a high-cost referral facility or being on the news for causing a family to lose a loved one. It's an easy decision when it's not its risk. The managed-care organization provides information to the provider and the information is provided 3–6 months too late to do anything about. It's all on a paid basis. A paid basis, as you know, doesn't help you. It just tells you what happened. The information is not good. It's not complete. It's not thorough and it's not totally correct.

Where's this going? It doesn't seem to work well, and underwriters and carriers are unhappy. Nobody seems to be very happy about this business. We don't have underwriters coming into our office scheduling appointments, trying to encourage us brokers to write business for them. . Providers are unhappy because they're losing money on their capitation business from the HMOs. They're losing money by paying too much premium and recovering too little, and they just don't know how this all makes financial sense.

Now the good news is that I think capitation is going to continue. There's lots of articles saying that capitation's going to go away, that the risk is going to revert back to the HMO. It is unlikely that that is going to happen. It may take different shapes, but risk is going to stay with hospitals and with doctors. Some of the hospitals may find that it's necessary to shift the risk back to the HMO and to contract with the HMO on a per-diem basis or some other contract basis. However, that is not going to happen much.

HMOs today are getting more premiums. As you all have read, HMOs have increased their rates in 2000 and they will continue to increase their rates. I think there is now an opportunity for HMOs to start making money. They are sharing that money through capitation back to the provider. In a number of cases providers have a percentage of premium contract. Even in cases where they are on a fixed amount they can re-negotiate with the HMO.

I think provider excess coverage is going to continue. The carriers that are writing this coverage are increasing their rates and finding better ways to underwrite the

business. It will continue and it will become profitable. This is the time for underwriters to get into this business. For those of you that are considering it or those companies that are considering it, I think you should seriously consider it right now.

Having been in both the underwriting and broker sides we've talked a number of times about cross-selling this product. A number of carriers, especially those that have been in professional liability coverages, have felt that it would be helpful to be in this line of coverage. As a broker it's a hard sell because our buyer is different. We often don't work with risk management, which is the department that buys professional liability. We work with managed care, which reports to the CFO. The buyer is different. We've also talked about aggregating the two coverages and making it a special package program. The problem is provider excess coverage is so claim intense. You just chew up 100% of your premium constantly, and it messes up an aggregate program. We have not been able to find a way that would make any sense.

The difference between accident and health (A&H) and property and casualty (P&C) in the state filings creates a little bit of a problem. The P&C carriers that file this on a P&C license in some states file actual rates. They then compete with an A&H company that has found a way to file a rate manual, which gives them a lot more variability. You have a rate in one hand that gives you a plus or minus 10% on that rate, up against somebody who can do an experience rate. The filed rate is always going to lose. It's an unfortunate circumstance, but it's something to think about.

There may have been a lot of gloom and doom in what I have just described. I don't believe it is gloomy. I think that it is a great business to be in. It's constantly changing. It's exciting. It's different. It's hard. It's challenging. It's now going to go forward and potentially provide profits to the carriers.

Mr. Troutman: Tasha Barbour is an assistant secretary and former product manager of the provider excess product for the ERC Health Care Division. Tasha has recently accepted a two-year rotational assignment as a six-sigma quality black belt. In this capacity, she is acting as a project manager to deliver exponential process improvements utilizing six-sigma methodology and tools across many functions at ERC. Prior to joining the ERC in June of 1993, Tasha practiced as a CPA for KPMG Peat Marwick.

Ms. Tasha Barbour: We all have to be pretty honest with ourselves with regards to the current market. I want to give you an overview of what I think the market looks like from an underwriter's perspective. Some of the topics I'll cover are trends and experience, underwriting claims, similarities and differences to the HMO reinsurance market, trying to figure out where the risk is going next, and the products and service needs for the industry. I believe there's quite a bit of actuarial work that needs to be done in this industry.

In regard to trend and experience, the formidable players in the provider excess marketplace five years ago are no longer in the business. Basically what happened was that many players jumped in trying to get market share. When you're trying

to get market share, you're out there with low rates to win as many clients as possible. They won a lot of Medicare and Medicaid business, and they underpriced it to get that business. Those companies that underpriced the rates paid the price with extremely large losses, and because of those losses the players who were the hot players a couple of years ago are no longer in.

The essence of capitation arrangements is still alive and kicking. Right now the term capitation is perceived as a negative term. I think there's a lot of percentage of premium arrangements, which basically is a fixed amount per person per month. There are decision resources group (DRGs) arrangements and per-diem arrangements as well.

In regards to regulatory oversight, who should be licensed and who should not is the debate in both federal and state legislatures. They're really not sure what to do. They think there should be licensing out there. Why should just any provider be able to take risk on their own, acting like an insurance company, if they're not one?

The HMOs are taking it upon themselves to make sure these providers are solvent or to protect themselves from the provider insolvency. What you will find in HMO contracts is that they're putting in provisions such that the health-care provider has to hold three or more months worth of claims reserves in a line of credit. Basically they're tying up the cash that these providers could have access to on their credit. In response to that, we've received several calls, mainly from people in California and in Texas, saying, "We need help. We can't take our cash and tie it up in these letters of credit (LOC). Develop something for me." From that, a recent product development is provider excess insolvency coverage. What this product is intending to do is to try to take that insolvency risk from the day a provider either declares insolvency or files insolvency, depending on which insurer you're looking at. From that point through the next 30-60 days, to a maximum amount of let's say $2 or $5 million, that reinsurer will pick up the first dollar claims. The HMO does not have to pay twice from the time that it has to shift the members over from this hospital organization or this physician organization to another organization. What we've seen is the HMOs are lessening that LOC requirement, although not doing away with it altogether because of this insolvency coverage.

Better experience in the insurance industry remains to be seen, but we're hoping that this is the trend. I would say as of January 1, 2000, most of the reinsurers got anywhere between 20 to 30% rate increases, even on people who had good experience. As Jack said, the market is hardening. Poor losses in the past have driven reinsurers to where they are today. We need to figure out where these claims are going to come in and price for it properly. I will note to those people who had a shortfall a couple of years ago that there's no way of making that up. You either deal with the losses that you had in the past, wipe your slate clean and go forward, or get out of the business.

The provider excess quote is only as good as the data supplied to the underwriter from the broker. As Jack mentioned, that data is sometimes not very good. There are really four key points to data. The first is MCO contracts. Most typically when

you're an underwriter and you get a request to quote you may get one financial responsibility grid out of 30, a sample grid that a broker filled out, or you may get no grids at all and assume they're responsible for everything. This causes problems. You need to read those contracts and figure out what the provider is responsible for. Sometimes, not seeing those contracts, you don't realize that a provider is not even financially responsible for some items or that the HMO has 80% of the risk and the provider only had 20%. Why give a health-care provider 100% reinsurance for something they're not responsible for? Most underwriters will quote contingent to receiving and reviewing the contracts. This is after the quote is already issued but before you're getting ready to issue the policy. Sometimes, if there are some funny things going on within that MCO agreement, you may have to pull the coverage.

In regards to claims data, given today's tech-savvy world, you would think that we wouldn't have problems getting accurate and complete data. This is far from the truth. The claims systems are extremely varied between hospitals and physician groups. Nobody has data, they can't seem to find the data, or there were numerous systems conversions, etc.

Network information and referral patterns are key to understanding the provider excess risk exposure. How broad is the network? What services do the physician group or the hospital group provide? What do they have to refer out? What risk arrangements are in place? Do they have negotiated rates? If they can't provide a service, are there any risk arrangements in place or is it going to the highest cost facility in town? We actually had a client where we had no idea that their referral pattern was to an academic hospital, with costs ranging $20,000–to 40,000 a day for people staying in the hospital. Needless to say, we were shocked when the claims came in.

Determining the appropriate level of reimbursement for provider excess is really key. The goal is not to make the provider whole on the fee schedule. The CFO may want that to be the goal, but that's not the true goal of the provider excess policy. Like Jack said, if that was the case you're just dollar trading, and that's not the purpose of insurance. Variances in the provider excess loss (PEL) coverage contract are a really big deal. It's frustrating as an underwriter when you receive a call from you broker saying, "Oh, XYZ company is 30 cents below you." You think, "Well, I've analyzed the claims, I've looked at all the data, and it has to be here at $1." One of the things to note is that the insurance contracts out there for provider excess widely vary. ERC has what is called a "following form" policy, which is a page policy that overlays the 10-30 MCO contracts. We don't have definitions of medical necessity. We don't have definitions of home health care, or what an acute home setting is, or what qualifies as a skilled nursing facility. Some of the other insurance contracts do have these definitions, and a good broker will point that out to the client. Then again, the CFO needs to hear that conversation because at the end of the day his or her reimbursement won't look the same under a following form policy, as it will under the other policy.

The next topic is claim issues. Besides general system issues to get accurate and complete claims data, the provider needs a system that is savvy in raising red flags

regarding certain diagnoses. Many times the provider who is at risk for the service does not have the claims management skills. They're not responsible for case management. Often, what you will see is that someone will go in for a transplant or other procedures, and only after the claim is already done will the reinsurer find out about it. I think most of the reinsurers employ case management nurses. We have managed-care networks that providers can access, and what we find many times is that those networks are not accessed because we're not notified of claims on a timely basis. I would say many of the good managed-care programs at the reinsurers go underutilized.

In general, claims notification from the health-care providers to the reinsurers is poor. Often reinsurers will be at the end of the policy period and not have a single claim reported to it. While they know that those claims are looming out there, they just can't estimate their magnitude. It's hard to determine the completion factors. The experience varies so widely from provider to provider. The experience of each health-care provider looks different from the other. As a reinsurer, it's frustrating if you're not getting any claims data. How can you guess at putting a completion factor on zero dollars? You can't.

Here's an anecdote about something Jack mentioned earlier, the A&H versus P&C company perspective. In the state of Texas, ERC files a provider excess policy. The state said, "Oh, because ERC is a P&C company we also need you to file a rate filing, and by the way, we're going to consider provider excess P&C for the state of Texas." We have this rate filing we have to abide by. At the same time John Alden, an A&H carrier, filed its policy in the state of Texas, and it didn't have to file a rate filing. It filed a rate manual. We always had to stay within that dollar plus or minus 25% or whatever the rate may be, even if the claims experience dictated more, and we always had to decline on the risk. There is a real problem in equity when you're looking at P&C versus A&H filings. It's unusual that the same state would classify the same product as two different things for two different companies.

Another thing is that you need to make sure that you have appropriate claims staff to handle the provider excess claim. This can be an extremely labor-intensive product to adjudicate the claims. A health-care provider that is used to generating billed charge type data will submit that to you because it thinks it looks like it has a claim. By the time the reinsurer adjudicates the claim under a resource-based relative value schedule (RBRVS) it may look like something totally different. You can understand when you're talking about retentions as low as $5,000 on the physician policy how extremely busy claims people can be.

I also want to examine similarities and differences to HMO reinsurance. Basically, it's the exact same service risk, but is the health-care provider or the HMO holding it at the end of the day? Premium payments are generally on a per member per month basis. We see insolvency risk for both provider excess and HMOs. That used to be a difference when only HMOs had a solvency risk, but now providers can have that as well.

As far as the differences, the provider excess product is considered an insurance product, since the provider is basically an unsophisticated client in the eyes of the

Department of Insurance. It is a regulated product. There is a filed policy form in all the states, a rate filing in some states, therefore, a broker intermediary needs to be between the insurance company and that health-care provider. As far as HMO excess is concerned, there may or may not be a broker presence. HMO excess in Virginia, Tennessee, and Kansas is considered to be insurance. In the other 47 states, HMOs are considered like an insurance company, so the reinsurers can go to them directly just like it's a regular treaty that they would have with any insurance company.

As far as the risk variations, providers do not generally take on pharmacy risk, whereas the HMO may hold pharmacy risk itself, or may actually fund that out to a pharmacy benefit management company. I would say there are probably fewer loss limitations in regards to the provider excess contract than what you would possibly see in HMO excess contracts. The HMO is more sophisticated and can probably handle more internal limitations, exclusions, restrictive per diems, etc., than a provider would. Providers would prefer the more straightforward stop loss.

As previously mentioned the health plans most often retain the case management duties even though they pass on the financial responsibility to the health-care providers. The health plans keep control of the networks, which is a difference between HMOs and the health-care providers.

Where is the risk going next? The first point is trends in decreasing capitation. Jack mentioned that there were recent articles regarding where capitation is going. The cover story in the September 6, 1999 issue of *Modern Healthcare* was on decapitating managed care contracts. The article stated, "In the mid-1990s globally capitated contracts seemed like the wave of the future, making per diems and DRGs look like yesterday's news but things have dramatically changed as managed care has evolved into a much more dominant but troubled industry. The momentum towards capitation has stopped or even reversed itself. Many providers didn't have a technological infrastructure and expertise to track and quantify their risk." That is very true. But like Jack said, what we are seeing are more percentage of premium arrangements, per diems, per diems without outliers, and other types of discounts going on.

According to a 1999 capitation survey conducted by National Health Information, a limited liability company in Atlanta, Georgia, the percentage of providers reporting profits under capitation was 34% in 1999, 42% in 1998, and 52% in 1997. You can see there is a steady decline in those able to produce profits under capitation arrangements.

There is a slight emergence in the direct contracting model whereby employers are trying to directly contract with bidding health-care systems in their geographic area. Many of the HMOs are acting like a third-party administrator or administrative type arm. Additionally, there are rumblings that through the Internet that there will be defined-benefit plans set up where the employees of an employer can go in and select as if they are at a grocery store. "I'll take one of these and one of those, this gynecologist or that primary care specialist." The employees will be getting a fixed-dollar amount per month to spend for their

insurance. They would spend their own money out of pocket for any additional services that they select. That is possibly a wave of the future. Something to note though is that there are some states that consider direct contracting to be illegal.

The next topic is in regard to lawsuits and patient rights. Managed care emphasizes cost cutting and cost shifting. Some lawyers have seized on these economic incentives that are inherent in the system, and they are trying to turn those back on the MCOs and back on the providers. For some lawyers the malpractice frenzy of the 1980s has turned into the managed-care feast of the 1990s imperiling the whole managed-care system.

Last, is managed care here to stay? I would say that it depends. Can we meet the needs of health-care providers? Health-care providers need several things. They need good claims and data tracking systems both from a clinical perspective and a general claims perspective. They need good efficiency measuring tools from which to benchmark, identify best practices, and share those with the physicians. Physicians are very sophisticated people that appreciate data. I think once you give data to them then they can see the variations and they can start making changes in the way they practice. The providers need consulting services. The health-care industry itself needs to be trained how to behave like a business with fiscal accountability, and it hasn't had to do that in the past.

With the ever-increasing pressure from the states, HMOs are now seeing a need for risk-based capital (RBC) consulting. RBC just used to be something insurers had to worry about. Now it's passed along to the HMOs and if providers are regulated, that could stretch on to the provider industry as well.

Errors and omissions coverage and other ancillary insurance products are needed as the litigious nature of today's environment evolves. While some managed care organizations may not practice medicine itself, they make business decisions that influence medical practice. Is the employer health plan something that can now be sued? The employer created the plan design, so it's kind of crazy with all the lawsuits out there.

I will now try to answer the question, "Is managed care here to stay?" Everything changes, nothing is stagnant, and we all know that. I don't believe the fee-for-service world will come back the way it was. It just can't happen. I think that care management is here to stay. Whether it's the risk stays with the HMOs or the risk is going to be held by the provider, care management is here to stay. I think the excess coverage will continue to be available for whoever is holding the risk at the end of the day.

Mr. Troutman: Carol Adams is a managing consultant at the Apex Management Group, which is a subsidiary of NiiS/APEX Group Holdings Company. Before joining APEX, Carol held actuarial positions at Anthem Health and Life Insurance Company and at UNUM America. She's also a member of the Provider Excess Loss Association (PELA).

Ms. Carol B. Adams: As Mark mentioned I'm a managing consultant with the APEX Management Group and the practice leader for our reinsurance consulting area. That enables me to work with many of the reinsurers and MGUs who write provider excess in the industry. I'm going to first talk about an overview of the provider excess marketplace. Then I'll continue with a discussion of excess claim issues and finally wrap up with a discussion of manual rates and modeling provider reimbursement rates into the rating models.

Throughout the presentation I'm going to make references between provider excess loss and employer stop loss. Provider excess really spawned from employer stop loss, at least from an underwriting and marketing perspective. I think that's part of the reasons behind some of the current problems in the industry. I will compare provider excess and employer stop loss, especially from an underwriting and rating point of view, which really just leads to disaster.

Let's take a look at the marketplace. We really can't have a discussion of the marketplace without talking about the loss ratios. As you've heard from the other panelists the loss ratios have been less than stellar over the years. In 1998 I would estimate that the loss ratios were probably between 120–145%. In 1999 there probably was a 5% improvement. In the year 2000 hopefully we'll see a little bit more improvement, but we have a long way to go to return to profitability.

In general, capacity is drying up. I'm sure that's not a surprise to many of you. Reinsurers are placing stricter guidelines on their MGUs: requiring them to use certain rating manuals, putting certain constraints around the underwriting process, and not allowing the underwriters to deviate from that. Whether it's underwriting discretion, experience rating or underwriting guidelines, they are formulating requirements for them.

There have been some recent exits of the market. I'm sure you've heard about Fortis and Lincoln, two well-known players who exited the market. As some exit the market, new entrants always come in. Some P&C companies view this marketplace as potential opportunity. Therefore, you do have the new players coming into the market.

The market rates are hardening slightly, especially in 2000. We've seen probably 20-40% rate increases on average across the board. However, we still have a ways to go to return to profitability.

Is anyone making money in this marketplace? I guess that's a question we all ask ourselves. Should we be here? The answer is yes; there are some people who are making money. It's those that have not aggressively pursued the top line growth but have been very careful and prudent about the risks that they select.

What are the reasons for some of the losses? In general, I think there's a misunderstanding of the risk here. Again, I think it spawns from the employer stop-loss marketplace. People try to draw the analogies between the two products and they really are different in nature and risk. Getting reliable and predictable claims data from which to project future incurred claim costs is very difficult. I

believe the misinterpretation of data is another plague of the industry and accounts for some of the losses.

There are rating inconsistencies. Jack talked about this a little bit. As a broker in the marketplace, I'm sure he's seen a variety of rates for the same case. Again, it just goes back to the misunderstanding of rating and pricing.

Another problematic view of this marketplace is that it's a commodity product. Some brokers, are spreadsheeting this product. They're basically shopping for price, and it is the underwriter who misses something and, therefore, has the lowest rate that gets the case. It's really not off-the-shelf underwriting or off-the-shelf pricing. PEL can be very complex and it is more of a specialized product.

Also, I think there's a misunderstanding of the coverage. The buyer sophistication is lacking in some respects. I was reading a survey that polled providers who have PEL coverage, and asked them "What type of coverage do you have?" Twenty percent said they had aggregate coverage. Now isn't in interesting that 20% say they have aggregate coverage yet no one here writes it? Again, it just goes to show a misunderstanding of the risks and the buyer sophistication that they really don't understand what they have.

Here's a little comparison to employer stop loss. The PEL marketplace is probably $200 or $300 million of premium. Compare that to the employer stop loss marketplace, which is probably like $3.5 billion of premium. You can see that there's a large magnitude of difference there. PEL is still relatively small and a relatively immature market.

The policyholder in provider excess obviously has some control over treatment and the resulting loss. This is cause for concern for some entrants in this market and the reason why some people are staying away. On the other hand, the providers may not have as much surplus behind them as most insuring entities, so they're very sensitive to fluctuations in their results.

Provider excess claims really present a unique set of challenges, and it sounds like a reasonable requirement to have the following items necessary to submit to the reinsurer to get reimbursed for your provider claim : proof of eligibility, copies of the provider bills, the explanation of benefits and the proof of payment doesn't sound like it's too hard, right? If you think about it, the capitated provider is usually a level removed from the process. The HMO usually maintains the enrollment records. The provider might have some on-line access to confirm patient eligibility, but they're really not allowed access to the actual enrollment forms. This becomes problematic in some cases.

A provider may also be in the dark about claims referral services, yet they're still financially responsible for them. Most capitated providers do not pay their claims directly so it's difficult for them to obtain copies of the bills. They may not even participate in the authorization of the medical care to the HMO members. This is usually the function of medical director of the HMO. Only at reconciliation does this information come to light. This makes it difficult for the capitated provider to

identify the claims, let alone report them in a timely and accurate manner. These are some of the claim problems inherent in this line and some of the reasons for the long lags in the claims.

I want to talk a little about claim completion. I'll explain a comparison between provider excess and employer stop-loss in just a moment. Some of the variables affecting the completion patterns obviously are the deductibles. A $200,000 deductible versus a $25,000 deductible will have different completion patterns. The contract basis, i.e., whether it's incurred in 12, reported in 15, 18, or 24, again will affect the claim lag. The population (commercial, Medicare, Medicaid) also impacts the claim lag. Coverage types such as inpatient hospital only, hospital total, physician, and global will affect the lag. Finally there is the issue of claims processing. Is it electronic or paper? You may laugh at the thought of the type of paper processing but believe me, it's still out there.

The employer stop-loss completion pattern is a lot quicker than the provider excess loss. After 12 months, the employer stop-loss is 60% complete, but the provider side is maybe 15-20% complete. Now go back to my prior statement that people are using the employers stop-loss information to price provider excess loss. Imagine if you used a completion factor that was based on something that was 60% complete and applied it to something that in reality is only 15-20% complete. This really led to a lot of underestimating of the actual incurred claims, which goes back to the historic loss ratio and the problems there.

I'm going to turn away from the claim lags for a moment and discuss some of the developments of the manual rates. When underwriting a case, part of the analysis is experience-based. The other piece of it becomes based on your manual rates or rating system. Given all those problems with experience, more emphasis is placed now on manual rates. When we're modeling the provider arrangements, what is the true cost of the provider services? For instance, if they have a $1,500 per diem, that's where they get reimbursed at. However, what is the true cost to them actually keeping a hospital bed open? It may be $600. You really want to model down to the true cost.

We'll talk about the frequency of large claims in just a moment. When you're looking at the stack of contracts in your underwriting file, you have this array of facilities and you really want to look at which ones are going to handle the catastrophic events, especially neonatal and pediatric intensive care. Do you weight them by bed days? Do you focus on where the care is actually going? It's probably something that people often overlook.

Another concern is outliers. Roughly 50% of contracts have outliers. An outlier is really just an exception to the rule. Typically, at some charge level something different happens. Charges may revert back to percentage of billed charges at the first dollar level or perhaps they revert back to a percentage of billed charges in excess of some specified level. If you are looking at an arrangement and you don't see the outliers, you really should ask about them. You should be seeing them fairly frequently.

Let's take a look at what happens when the outlier provision is modeled properly and when it's missed in the manual rate. We'll just go through a brief scenario. We have hospital inpatient services only. The coverage is for a $50,000 specific deductible, contract basis 12/18, hospital reimbursement $1,500 medical/surgical per diem, and the outlier provision is, if charges exceed $30,000 all charges are paid at 85% of billed. The impact on the provider excess rate of that scenario, if the underwriter had not modeled the outlier provision, for a commercial population would be a rate of $2.81. Had they properly modeled the outlier provision the manual rate would have been $4.72. On the Medicare side the rate would have been $11.39 per diem with the manual rate at $19.17. This would have been about 40% underpriced just by missing the outlier provision.

Typically large claims increase by the trend that was heavily dependent on the changes in inpatient hospital costs. We did a study for a client that plotted the distribution of cost by service category for the different claim sizes. In other words, on a $25,000 claim maybe 55% of the cost was due to hospital inpatient, and the other 45% was due to hospital outpatient, physician, and other. If you move to a $150,000 claim more like 75% was based on hospital inpatient cost. This is very dependent on what's going on with the hospital inpatient side. What's interesting is that the frequency of large claims is rising faster than trend alone would predict. I don't think people were predicting the increase in frequency of large claims to this level even two years ago. It really comes back to the point that the underlying rating manual really needs to be updated very frequently and catching these types of trends.

Where is the increased frequency of claims coming from? Well, we know about the catastrophic conditions, typically neonatal, burns, organ transplants, bone marrow, and trauma. With the increased use of fertility drugs we see many more multiple births, and not only multiple births but also multiple births with lower birth-weight infants leading to higher neonate claims. Bone marrow transplants really have taken off. You've seen that they are the treatment now for many conditions even though there's not clinical proof that they improve the prognosis of the condition.

Let's consider some of the new concerns. I'm sure all of you have heard about the rising increase in prescription drug costs. Part of this is due to the new innovative drugs that are designed to improve the quality of life and treat the condition. The emergence of drug-resistant bacteria is also a cause of great concern. Hospital-born bacteria have led to record claims for admissions to the hospital, which really should have been routine. The patient becomes infected with these hospital-born bacteria, which are not treatable.

There are new and expanding transplant techniques. Split liver research, where you actually split a liver and it can be used, more or less, for two people because a liver has the ability to partially regenerate itself. There is also the cloning of organs. If you have more availability of these organs, you can imagine the transplants are really going to increase. Also, Hepatitis C is labeled the "new plague." It's similar to HIV in that it's blood born, but it's actually more dangerous since it can survive outside of the body. It's estimated that an infection rate of about 2% of the population has Hepatitis C. About 60% of those people with

Hepatitis C antibodies will develop chronic Hepatitis, and therefore they'll have liver failure, cirrhosis, which ultimately leads to liver transplants. This is another concern for the future.

We know this market is defined by consolidation. The future marketplace encompasses the spectrum of entities taking health-care risk, whether it's the insurer, the reinsurer, or the provider. Tasha talked about provider insolvency coverage. State capital requirements could really open the door to provider excess loss. It would open it into a new wave of products. HMOs are gaining significant rate increases on their commercial business. Part of this will restore their own profitability, but it's also an opportunity for the providers to take a look at their contracts, re-negotiate their bad ones, and perhaps take a stricter look as to which ones they enter into in the future.

I believe there's still a demand for capitation, although I think it may take different forms for different risk transfer mechanisms. There's a lot of media attention in California especially with the dropping of capitation contracts by providers, but I still think capitation is going to be a trend that continues in the future. There still will be demand for the provider excess product.

In summary, capitation and the risk transfer to providers are here to stay. There is money to be made in this market for those who are wise and prudent, but you have to be very careful and pick up on the nuances and the challenges of this product. Otherwise, it can be very thorny.

Mr. Jeffrey D. Miller: One of the things that was mentioned was the idea of defining the basis for indemnity as the true cost of the services for the provider. My understanding is that is almost impossible to get to the true cost with respect to the cost accounting systems in the hospitals and the physician groups. How do you get a true cost in setting your benefit arrangements for these provider excess contracts?

Ms. Adams: I agree with you. In theory, that's the level you're trying to go to, but in practice, you're really setting it at the contracted cost. It's more theoretical that you're trying to model down to the true operational costs, but in fact, you're exactly right in that it's very challenging.

Mr. Reid: We advise buyers that a way to reduce their premium is by reducing the valuation of their claim. In theory, if a significant part of their claims occurs within their own facility and a smaller portion occurs outside we would recommend that they put all their money on the outside claims. Logically they should want to only insure the inside claims at their true cost, but there is low-quality cost accounting within hospital systems and certainly within medical groups.

Ms. Barbour: As an underwriter, what we look for are those claims that are within the health-care network or within the system. I would say you generally look at about 65–75% of billed charges. Considering the other 25% could be like the margin, and 65–75% could be their cost for out-of-network and referral services that a provider cannot control, you would consider those at the 100% of billed.

Mr. John Michael Crooks: I have many clients who are providers and I think what Mr. Reid has said is fairly accurate. The CFO looks at this not necessarily as a profit center, but they are extremely concerned at the idea that they're getting a $.60 on the $1 return on their investment in these things. Now some of these physician hospital organizations have gotten very large. Even though they're not officially insurers, they've got a lot of capital. One of the questions they're trying to answer and that they're asking us to give them some feedback on is, "Why should I do this?" I've got providers that are insisting on going naked, which I don't think is the right answer. But how do you answer that question when they're saying, "Look, I'm four or five years running, I've paid out $1 million and got back $600,000." I think these guys understand that it is insurance, but how you do approach that question with them?

Mr. Reid: It's an interesting question because the answer to it is the wrong thing to keep me in business. But I think that you first have to ask them if they treat capitation as a separate business line. I think many systems or hospitals treat it as a separate business line or at least view it that way. If that's the case, and capitation represents 30% of their top-revenue line, then I pose to them that it becomes a budgetary function where you can set your rate. An underwriter will give us a premium rate that will lob off the spikes of claims and make projecting your medical expenses more accurate. It makes it more predictable for the business line. They should not view it from the perspective of, does this increase my profitability of this line.

Mr. Troutman: One of the ways I would look at it would be that it's really the reinsurers' responsibility to make sure that this is not an easy opportunity for them to dollar trade. It's your responsibility to set the terms of coverage and make sure that what deductible is offered is actually far enough up so that it is difficult for them to say, "Well, I know I can do better than that particular price and this is going to be a profit center to me". If that situation is occurring, I think you are selling too low a deductible for that particular provider.

Ms. Adams: I will add to that on a slight tangent. A lot of providers aren't really happy with the coverage they have in the provider excess. On the risk taker's side, they have the maximum per diem limit, but what the providers really are seeking is true protection. They don't want all these limitations that we're putting on them. You have this dichotomy of what's out there as a product versus what they perceive as their needs.

Ms. Sujata Siddharth Sanghvi: I had a couple of questions. One was with experience rating. What types of credibility are you using as you're moving more towards manual? The second question I had is about case management and using your own networks. What's the relationship with the HMO and their resistance or cooperation from that perspective?

Ms. Barbour: I'll answer your second question. ERC has probably 16 different managed care offerings. What we try to do when working with an HMO is to determine with them which programs are better. Then we try to customize our programs around what the HMO offers. We do a site visit with the HMO and

cooperatively try to figure out what the HMO's needs are and go from there. It's customizing the needs for each HMO.

Ms. Sanghvi: You're able to do that even when you're providing provider excess insurance as opposed to HMO excess reinsurance?

Ms. Barbour: What we find is there are some providers that we provide our services to. As far as the claims experience, from an underwriting perspective we usually look at three years being credible. I think it's kind of an evolution. The manual rates of a few years ago weren't very good. The manual rates of today are getting better because they have more experience incorporated. I think right now it's just kind of a balancing act as far as what credibility you give as your manual rates improve.

Mr. Troutman: It's one of my beliefs that the industry losses are, to some extent, because too much credence was given to the experience of the plans. Now, as we've said several times, there's a dichotomy because every good plan wants fully credible experience, every bad one doesn't. That's a cautionary note to try to make sure you have a very good manual and then try to figure out some scientific basis for credibility. If your manual says one thing and the experience is much different, then the broker and the client are going to find somebody who takes a different mix than what you have. You'll lose that case or win it depending on the situation.

Ms. Barbour: By the way, just as an editorial comment, we as brokers argue against providers buying coverage through their HMO. It seems to me to be logical that if the HMO were capitating out the middle risk, why would it want to retain the most volatile risk without marking it up?