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Session 41PD
Provider Excess Stop Loss

Track: Health/Reinsurance

Moderator: TIMOTHY P. RICE
Panelists: RICHARD BERVE†
CHARLES CRISPIN‡
CATHERINE M. MURPHY-BARRON

Summary: How is the provider excess market changing as providers move away from capitation? What strategies are managing general underwriters (MGUs) and reinsurers using to remain viable in this market? What trends are emerging in recent provider excess experience? Panelists discuss these and other key questions.

MR. TIMOTHY RICE: The focus of our session today is an overview of recent trends in the provider excess market. The session is built for people with moderate experience, so we will cover a broad spectrum of issues. This includes some of the basics of provider excess pricing, as well as recent, current and projected trends in provider excess.

The focus will be on how this market is providing or is responding to changes in the health care environment. Some of the major trends affecting the provider excess market include providers moving away from accepting risk, or accepting risk on a more limited basis. Generally, the higher medical trends that affect first-dollar business are affecting excess coverage as well. In fact, due to the leveraging effect, catastrophic trend is being impacted even more.

New technology, expensive drugs and drug therapies are difficult pricing issues for

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†Richard Berve, not a member of the sponsoring organizations, is director, license management services at Combined Special Risks in Overland Park, KS.

‡Mr. Charles Crispin, not a member of the sponsoring organizations, is president at Evergreen Re in Stuart, FL.

provider excess coverage. Part of the challenge is to keep up with the changes in technology and therapies, if pricing is based on experience. There's always a lag that is difficult to deal with from a pricing perspective.

Finally, I'll cover the overall backlash against managed care and its dynamics from a provider's viewpoint. This includes provider willingness to take on risk and how health plans and providers contract in that environment.

We have three speakers on our panel today who will each provide a different perspective on the issues facing the provider excess market. Our first speaker is Charles Crispin, who is the president of Evergreen Re, based in Stuart, Fla.

Evergreen Re is one of the largest brokers of HMO reinsurance, provider excess and managed transplant insurance in the country. In addition to its involvement in brokerage services, Evergreen Re also provides reinsurance claims advocacy services, health care cost control programs and technical data analysis to its health plan, EPO provider and employer group clients.

Charles has worked for our clients and has developed several proprietary approaches to help them in the process of making reinsurance decisions. Prior to joining Evergreen Re, Charles worked as a consultant in the managed care industry, and has worked with insurers, health plans and provider clients. In addition, Charles is a member of the Provider Excess Loss Association.

Our second speaker, providing an actuarial perspective and a background in pricing provider excess coverage is Cathy Murphy-Barron. Cathy is an FSA and a consultant in the New York office of Milliman, U.S.A. Cathy's been with Milliman for 10 years, has worked with provider HMO and insurer clients and has been involved in health care management issues, pricing issues and provider excess pricing.

Our third speaker is Richard Berve. Richard brings an underwriting perspective and knowledge of financial results within the industry over the last several years. Richard is the director of license management services at Combined Special Risks, an underwriting company working on behalf of Combined Insurance Company of America and is a wholly-owned subsidiary of Aon Corporation. Richard has 13 years of experience in the group health and reinsurance businesses, including employer stop loss, provider excess and HMO insurance.

In fact, Richard has spent the majority of his career in the managed care excess market. His previous assignments include product management responsibility for provider excess and HMO reinsurance for a major carrier and being a lead regional underwriter for provider excess and employer stop loss.

MR. CHARLES CRISPIN: I will go through three basic issues, the first of which is the current capitation environment. Who's in? Who's out? Where is it going, and why? I'll touch upon some statistics from research that we do annually called the

Managed Care Indicator study.

The second issue is the result of risks that providers do or do not have. What are some of their reinsurance issues? What are their needs for coverage, relative to the goals of reinsurance and protecting the organization?

The third issue that I will touch on in a very cursory basis deals with the current reinsurance environment. Richard will be going into much greater detail about that, and Cathy will talk in much more specific terms about coverage.

First, I am not an actuary. I was confused for a while, but finally understood that the future of this coverage depends on a number of issues. As I mentioned, the data from which I'm going to talk comes from an annual study of large provider organizations accepting risk. The study is slightly biased in that we've only studied provider organizations in metropolitan markets around the country with 30 percent or greater HMO penetration.

Our reason for studying those markets is that we feel that's where competition is at its peak. Payers undertake various strategies to further their own competitive position and provider organizations want to do the same. We studied those organizations because that's where the action is.

We didn't spend any time studying small physician organizations with less than 20 physicians. The reason being that we didn't think they should be involved in accepting any risk. That's not to say that there aren't a number of them around the country who have done so; however, from our perspective, they weren't the type of organizations that would be able to flourish. That was a qualifier on the types of groups we studied. This is not to say that these are statistics for the average of all similar organizations in the country.

Table 1 shows the survey results of involvement in capitation at different points in time. One could argue that the numbers are a little misleading.. Physician groups as a whole are still showing a very high involvement in capitation. However, a number of regional regulatory standards pushed a lot of people out of the market. For example, in California, the Department of Corporations requires provider organizations that accept substantial risk to maintain certain high levels of reserves.

Table 1

Percent of Revenue from Capitation Type
Today and Tomorrow

	2006	2003	2001	2000	1999
Overall	26%	29%	33%	41%	42%
Physician	39%	43%	44%	56%	50%
Hospitals	8%	10%	15%	19%	25%

- Direct contracting with employers may positively influence capitation
- Defined contribution may negatively influence
  - Capitation may be difficult to administer/manage
- Urban-setting providers may exhibit higher revenue contribution

For a number of provider organizations, particularly those that are more physician-oriented, the notion of retaining reserves is not really a common business practice. They generally prefer to take reserves out of the organization at the end of each year. For example, the payer solvency standards impacted MedPartners and the Flexible Premium Annuities (FPAs) who once had high-flung stock and were publicly traded companies that ran out of cash when the IBNR (incurred but not reported) caught up with them. Therefore, payers, particularly those in California with PacifiCare, decided they have paid claims twice enough. They didn't want to do that again. If the state does not require certain reserves or solvency standards, we will do so ourselves. Of course, these requirements leave many organizations with the inability to continue accepting that risk.

However, under the PacifiCare model, for example, a very high percentage of physicians still accept risk. The risk they accept today is no longer applicable for all services (global), though. Now, much more commonly, it will be physician services, chemo-therapeutic agents and other high-cost injectables that will be further carved out of that risk. So, while they're still at risk, its nature and severity has changed dramatically.

We are also seeing significant reimbursement pushback from hospitals and specialists. In the case of hospitals, capitation used to be the trump for the health plans, but it is no longer because hospitals now understand this. They've learned how to renegotiate a health plan contract. They've done it very successfully and have decided that, in many instances, capitation is not the best thing for their

revenue.

Direct contracting with employers may positively influence capitation going forward. We asked providers what percentage of their total revenue is derived from risk contracts. They said it was too early to tell whether certain states will enable capitation directly between employer organizations and providers. However, the opportunity for growth in certain geographic situations is certainly there. On the other hand, the anticipated growth in defined-contribution (DC) health plans will be a negative influence, because capitation will be very difficult to administer.

We think that urban setting providers will continue to exhibit higher revenue contribution. This is particularly true in cases where we begin to see some capitations from children's hospitals on a very infrequent basis. It really happens more in the Medicaid area. In particular, as unemployment continues to swell, and as the Comprehensive Health Insurance Program (CHIP) becomes more successful and higher in penetration, we may see more stability there.

Again, we ask providers what the types of memberships are for which they accept risk. The commercial numbers are not as stable as they appear due to the changing nature of the risk. As previously mentioned, Medicare risk withdrawals, and as payers continue to withdraw, which they will in certain instances, provider involvement in capitation will further decrease. Medicaid risk, as I mentioned, is more concentrated around urban providers. While generally stable, it, in many cases, consists of a lot of small contracts. It is more of an "all-or-nothing" type of contracting.

We see that a high percentage of these provider organizations still accept of risk for commercial members, but the number of members under those risk contracts is dropping. In a lot of cases, the largest employers want to get control of the benefit plan. They've been offering a multitude of options, several of which are fully insured. They realize that major direct incentives are potentially a lot more influential to the overall cost as an employer than, for example, an HMO contract with a hospital. When there's a drop in HMO enrollment, the provider revolts against capitation or other reasons.

If payers can't profit, how can providers do so? It took providers, in many cases, a few years longer to realize that. While they thought they had all of the data, many people now realize that, in many cases, they had very little information.

Medicaid, as I mentioned, is all or nothing regarding contracting. With a health plan in an urban setting, such as Detroit, and only one downtown medical center is needed. This is an example of where capitation, at least from the payer perspective, still has a lot of leverage.

The loss of contract to that urban setting hospital is significant in this situation. This is because they will lose all the revenue, or a very high percentage of it.

I've already talked about workforce trends and children's health programs, which potentially swell membership, although not significantly. So the question is, if certain managed care organizations couldn't accurately predict cost several years ago, how are they going to do it now? There's a statistic that roughly 60-70 percent of the increase in national health expenditures since the year 2000 is the result of technologies and treatments that didn't exist in the late '90s.

A lot of providers who had global cap contracts in the late '90s were operating, at best, from data that was then two-to-three years old. It didn't take into account any of these technologies and treatments. Most of them, which are provider organizations, also did not see any reason whatsoever to hire an actuary to do a due diligence on their capitation contract.

The only goal is profit. At the end of the day, the quality of care is vitally important, but if a business is to stay in business, it must make a profit or a surplus. Predictability, this has been extremely hard for managed care organizations over the last several years.

It starts with a provider knowing what you're at risk for, or a reinsurer offering coverage. What services are you at risk for? What services are you not at risk for? Numerous organizations have said that they don't have out-of-network risk. Our response was based on their contract, and they did have it. When an organization is at risk for facility services, I immediately think of the impact of billed charges from children's or academic medical center that may do a tremendous job of marketing.

What is the reimbursement basis? A hospital contract may say they will reimburse the hospital for medical/surgical days at, for example, $950. Intensive care unit (ICU)/Critical care unit (CCU) days will be reimbursed at $1,250 and neonatal intensive care unit (NICU) will be reimbursed at $1,450. To this I ask: What does the outlier say?

Recently, I spoke with the CEO of a small-to-mid-sized health plan with about 100,000 members across two lines of business. He sent me his hospital contracts matrix and I responded, "You have tremendous hospital contracts. Do you not have any outlier provisions?"

Outlier provisions basically mean that, for routine admissions, the health plan pays the hospital per diems. However, if any single admission is greater than $50,000 in billed charges, the plan will pay 70 percent of billed charges instead of paying the hospital these per diems.

The CEO said to me, a reinsurance broker, "What do you mean 'my outliers'? These are per-diem contracts."

I said, "Yes. I was just concerned because there's a children's medical center on the

list, and the designated trauma facility with which you have no common ownership is also on the list."

He said, "Why would I want a outlier provisions, Charles?"

And I said, "If I'm in your shoes, I don't want one a per diem contract, but my job is to protect you."

He said, "I'll go back and ask."

He then sent me an e-mail a week later to say that there were, in fact, some outlier provisions to the contracts. In particular, the children's medical center reversed 85 percent of charges for any admission over $30,000, which has a significant impact on the risk.

Accepting appropriate capitation is based on particular services and costs. I can't drive that point home enough. The objective is to smooth out the effects of catastrophic claims through a properly structured solvency protection program, including reinsurance. This is a lot easier for health plans because states have something called risk-based capital (RBC), which says you will maintain certain levels or the state will help the company run the health plan.

Providers don't necessarily have the same requirements. Also, there is an inherent trade-off between capital and surplus. If you have more, you can afford less reinsurance, a higher deductible, fewer covered services and more limits on coverage. But if a provider has no surplus, or if a health plan has a low RBC ratio and the state is threatening to intervene, you had better make a good case to a reinsurer about why you need more coverage. In this environment, they don't necessarily want to offer you more coverage right now. And now, demand is greater than ever.

In terms of overall environmental outlook, we're seeing much tighter outlier provisions on contracts. Several years ago it was very possible to have straight per-diem contracts for a number of tertiary services, but the leverage has shifted to the hospitals.

These outliers are not going up. They're going down. For example, while a per diem contract may have reverted to a percent of charges at $80,000 in billed charges before, the point at which this reversion occurs will decrease somewhat. Or, if it remains flat and slightly increases, the percent of charges to which it reverts will go up.

The leverage is shifting and needs special attention. It changes during the year as well, which is another reinsurance issue. If there is a contract that goes from decent to horrible mid-year, contact the reinsurer and clearly advise them of a change in cost. Otherwise, they will limit the re-insurance payment to the basis of the original

provider contract, which is reasonable. That's a big issue.

Now I'll talk about movement to utilization management (UM) lite by HMOs. We're already seeing increases there, in point-of-service language in terms of the benefit plan. A client with whom I'm working has had a very severe penalty. The total out-of-pocket risk to the member is $4,000 if you go out-of-network. If I had a life-threatening disease, and there is a $400,000 bill, but I only have to pay $4,000, I will go any place I like.

Is it UM lite with the major inpatient trends? Is it fear of litigation? Is it fear of second opinions? What is causing this? There are utilization increases as well as five –to seven percent unit cost increase. Table 2 shows master inflation, which will make that point a little differently. I've already made the point of the proliferation of technologies and treatments and how that's moving the trend.

Table 2

Tertiary Care Trend is Advancing Rapidly

Average Billed Charges at Select Facilities

	New York		Pennsylvania		California	
	2001	2002	2001	2002	2001	2002
Neonate	$4,954	$5,278	$5,119	$7,218	$6,468	$9,758
Transplant	$9,343	$10,671	$16,526	$23,302	$20,881	$31,504
Other	$4,973	$5,994	$7,312	$10,311	$9,329	$13,940

Source: Reden & Anders, Ltd.

- Aberrant claims or very severe cases could easily be twice the "average"
- Charges inflation exacerbated by tighter outlier provisions
- Providers have little control over in-network tertiary care risk – and less control over out-of-network tertiary care
- If I am a tertiary medical center: "What could possibly be better than charges?"
- Hospitals have the upper hand and capitation is not trump

The traditional HMO coverage in the late '80s and early '90s was by coverage for inpatient services, because that's where expensive things were done to people. There's been a huge migration of risk. In a commercial population in 2002, excluding retail pharmaceuticals, inpatient accounts for less than 30 percent of expected services. Retail pharmaceuticals on a profit-and -loss-(P&L) or line-item is now a greater expense than inpatient costs. There's been a tremendous migration to outpatient services.

It's not just people going in for a $12,000 outpatient surgery. The real concern is

the cost of treatments like growth hormones, blood factor products and the chemo-therapeutic agents. Someone with significant oncology needs also receives significant drugs as part of his or her care. All the costs incurred by that member are catastrophic, not just the inpatient services.

Table 3 shows the shift in services over time. In the other category, which includes home health, it's not the nurse who will cost around $66 per visit. Again, it's the factor products that the hemophiliac having significant bleeds might need every three weeks at $25,000 per bleed. If the plan or provider has inpatient-only re-insurance coverage, the insurance may cover sub-acute, in lieu of acute hospitalization. In reinsurance agreement language, this really means that there is no home health re-insurance coverage.

Table 3

Is the Phantom (Coverage) Ruling the Roost?

Limitations in Reinsurance Policies Can Undermine Predictability and Threaten Solvency

- $2k Per Diem for NICU, Burns, Transplants, etc.
- Inpatient – only, with no provision for outpatient stem cell
- Inpatient – yes; DME in setting – no
- Outpatient and/or Home Health – yes; Synthetic Blood/Factor products and other biologics and pharmaceuticals – no
- Double whammy of per diem limit with DRG as underlying contract cost
- $100k Specific Deductible; $25k for OOA risk (read the fine print)
- Biologics, injectibles and other pharmaceuticals limited to $20k per member per year
- Trap of in lieu of language given technology and treatment advances

Regarding average billed charges at select facilities you have, re-insurance may cover a plan or provider for in-patient hospital service subject to a maximum of $3,000 per day. Consider the impact of the per diem limitation over several years, as in New York, where the average billed charge for NICU cases was $4,954 in 2001, and has increased to $5,278 in 2002. Does the re-insurance provide less coverage in 2002 than in 2001? I think you all can figure that out.

To make it a little worse, in Pennsylvania or California, how do I feel about this coverage? Is this doing a good job of putting a blanket on predictability or in protecting surplus? I show these numbers to make a point about coverage needs.

Now, regarding aberrant claims, we're not really looking to be protected from average claims, but rather from the aberrant or very explosive claims. These are things that you'd like to control, but you can really only manage some of the cost severity. A woman can't prevent her triplets from coming out nine weeks early. She can manage some of the expenses while an inpatient, but she can't get rid of the neonatal costs.

I've already mentioned that, in many cases, the outlier provisions are tightening up, as well as the large master inflation. Taken together, this means the re-insurance per diem limitation is potentially becoming more expensive.

Neonate claims are an example of individuals having little control over in-network tertiary care risk. You can't completely prevent them. Certainly those individuals have less control over tertiary care risk because there is no negotiating leverage there.

Then, for a children's medical center, what's better than billed charges? If a plan wants a contract, that's no problem. They can be given at a seven percent discount. I mean that quite literally. It is potentially a well-negotiated discount. [Editor's note: In many geographic areas, there is only one children's medical center capable of providing NICU and other pediatric tertiary care services. In such cases, the children's medical center will have a very strong position in negotiations with health plans.]

As I mentioned earlier, hospitals have the upper hand and capitation is not trumped. This came from a survey, and is not what we recommend. We recommend far from these figures, but we surveyed providers with risk, who, as the data showed earlier, were fairly good-sized providers. We asked them to tell us the average per-diem limit of their reinsurance, in-network or contracted hospitals and out-of-network or non-contracted hospitals. The resulting data makes no sense, but it is relevant in terms of the statistics involved and number of people surveyed. It says, basically, that they had flat per diems—the same re-insurance per-diem limit for in-network was the same as for out-of-network.

It is likely that significant cardiac or abdominal cases will get referred out, perhaps to California. Those claims are going to average, for severe cases, easily $4,000 to 7,000 a day in terms of plan or provider liability. With the reinsurance per-diem limits, you’re going to end up retaining a lot more risk than originally perceived. So, it is necessary to understand the contracts.

Is the phantom coverage ruling the roost? As I mentioned earlier, in Table 3 with a $2,000 per-diem, how effective is that for NACU, burns, transplants, etc.? The answer is that it's not at all effective.

What about inpatient only, with no provision for outpatient stem-cell treatment? That doesn't happen frequently, but there are reinsurance agreements that read

that way today. One may have thought coverage was purchased for transplants.

Literally, these things do exist. You may have bought inpatient coverage, but there is no durable medical equipment (DME). DME can sound rather benign in terms of what it may cost much to an at-risk entity, but, as DME is typically classified, it includes equipment such as a ventricular assist device (VAD), which is a bridge hooked up to someone with a cardiac condition while waiting for his or her new heart to arrive for a transplant.

In 1999, the average cost for a patient wearing a VAD was $160,000. In that situation, it would be really bad to find out that DME was excluded from one's re-insurance contract.

Medtronics is a wonderful company, and makes some great cardiac implants, catheters and pacemakers. Their new pacemaker lasts two-to-three times longer and has fewer side effects, but it's about three-to-four times the price. It's a darn good device, but to have it excluded from reinsurance when it is implanted might be a painful event for you.

Outpatient and/or home health is covered. Synthetic blood or factor products and other biologics and pharmaceuticals in that setting are not covered. Why, then, would you buy the coverage? I didn't buy re-insurance coverage for a $60 nurse visit or a therapist visit. I bought it for the drugs and biologics in the setting.

The double whammy of per-diem limit with diagnosis-related groups (DRG) is the underlying cost. DRG requires a lot of explanation because there is DRG with DRG outlier, and there's DRG that is "in contract," which, for a certain high-cost admission, could revert to a percent of billed charges. I'm referring to straight DRG reimbursement, either base rate only or base with the Centers for Medicare & Medicaid Services (CMS) guidelines for outliers, which generally revert to fairly controllable per diems.

There is not a lot of severity there. If it's a long, severe stay, you're okay with the per-diem max, but why should it need to be there? It's there because the insurance company provided severity protection to the reinsurer. Be careful with average per-diem limits, particularly low ones, when dealing with the Medicare population, who pays straight DRGs. In those cases, there is a double penalty on coverage.

There's a health plan in Florida with a $100,000 specific deductible. In the reinsurance agreement, they have a $25,000 deductible for out-of-area risk, which is pretty neat. As a managed care organization, I have absolutely no control over the $25,000 deductible, so I thought that it would really protect the customer. Then I read further.

I called up the client and said, "I saw this agreement that you have in place, and I must be reading it wrong. I have read a lot of reinsurance agreements, but it says

that you only have a maximum reimbursement for any out-of-area claim of $24,000."

He said, "Yes, Charles, that's true. We've been lucky."

So, quite literally, this entity was sold zero coverage. Someone told the person that it was a great benefit, but it could have bankrupted the plan. Even with a normal policy with their standard $100,000 deductible with bad average daily maximums (ADMs), they still would have had relief on a 110-day burn stay.

Biologics, injectables and other pharmaceuticals may be limited to, for example, $20,000 per member, per year. Again, that's not catastrophic risk. That's someone receiving fairly mild chemotherapy. That's not providing relief for the significant hemophiliac and other claims.

Regarding the trap of "in lieu of" language, given technology and treatment advances, I'm not sure what in lieu of acute hospitalization means today. I do not like to see that wording in a reinsurance agreement. This is because very little of what's done today in an outpatient or home-health setting was ever dreamed of being done in an inpatient setting 10 years ago.

In the reinsurance environment, particularly in the provider excess category, is familiar with the heroic losses that have been generated over time. Richard has some statistics about this that he'll share with you. A lot of people said the different carriers were buying market share.

I found out about this business while acting as a consultant for an insurance company that was fairly large in this category. I think they were number one in provider excess, and I never, ever once heard anyone at the highest levels of that company have a conversation about market share pricing. They thought they had the right prices out there. They did not. They were far off.

There were some reasons for that. I think there was just a lot of tonnage stuff going on. No one had any reason or incentive to learn the facts. Why bother studying how much biologics and pharmaceuticals are going to cost an organization or the potential reinsurance risk if you don't have to. You can figure that one out as well. It's stated differently.

If I can buy $2 worth of coverage for $.60, why research it any further? That was very much the environment for many years, particularly from 1992 to 1996. There were really amazing things going on with early pricing models. They either ignore or significantly understate claims. For many, reinsurance was as good as Cisco, even into the late '90s. They'd pay a $1 premium and get $2-3 back.

The lemming effect of providers was that if you weren't accepting significant risk, you weren't considered a player. Therefore, you got to accept this new global risk

deal, even though it may have been 73 percent of premium in a declining premium market for four years.

A friend of mine used to be with Kaiser in Northern California. He called me one day and said they could sell individual policies there for $90. And they're paying a provider 70 percent of that as a cap. There's no way providers were going to make money on it.

There's been an awful lot of flight. In fact, the company where I became acquainted with this business has left the market. There's been one exit this year, which was CNA. They made the decision that it wasn't right for their corporation. There are one or two other companies hanging on, and by 2003, I think they'll be gone.

Slowly, there have been some new entrants this year. We're starting to see some Managing General Underwriters (MGUs) come back. It seems odd to me that the reinsurers are allowing that.

The boxes have gotten smaller. Underwriting guidelines used to be incredibly loose. The reinsurers have gotten significant control of their businesses now and they're saying to underwrite and fall into these guidelines, or pay claims.

MGUs in this business traditionally had zero risk. They were paid very high expense loads and there was little-to-no incentive to underwrite profitably. They're all pretty much required to have at least 10 percent risk.

I think that's the right thing and good for business. It's going to force managed care organizations to know their data.

MS. CATHERINE MURPHY-BARRON: I was given the challenge of talking to you about pricing provider excess insurance. I'm going to start with the basics, and build up some of the key issues and pricing, then discuss some of the challenges that we now face.

The two types of provider excess out there are the specific excess and the aggregate excess. The whole idea behind provider excess insurance is to give relief to the provider for catastrophic claims. These are the types of risks that might put them out of business.

Specific excess insures the provider against the risks of claims of any one member that exceed the deductible. This is the most common form of provider excess insurance.

The idea of aggregate excess is to insure the provider against the risk that the total claims will exceed the aggregate deductible. This is not very common because of the difficulties with providing the coverage and pricing it appropriately. Also, when it is sold, it usually requires that the provider purchase specific excess insurance first,

then the aggregate excess will only kick in after the specific excess deductible has been reached.

In this situation, a provider would not necessarily want aggregate excess. There might be a case in which the provider has a lot more individual claims that add up to a total greater than the deductible, but that one time isn't necessarily catastrophic. There isn't really any provision out there right now for that coverage in aggregate excess.

My comments will refer to specific excess insurance in the most common form. However, a lot of the issues apply to aggregate excess if you find you have to price that type of insurance as well.

The key issues in pricing that I would like to talk about are the deductible and the coinsurance level, inside limits when covered expenses are exclusions, the medical-surgical mix and covered populations. All of these are critical when pricing.

Regarding deductible levels, the idea with this insurance is that it is catastrophic coverage, so for a physician group, usually a deductible is in the $7,500 to10,000 range, and for hospitals, it is in the $50,000 to100,000 range. The probability of a claim being above the $100,000 deductible is less than half a percent.
The coinsurance level, which can be anywhere from 50 to 100 percent, is critical for the management of ongoing claims. Usually, it's at the 80 to 90 percent level. Once a claim hits the deductible level, you don’t want a situation in which the provider no longer has interest in the ultimate claim level, because he is the one providing and managing the coverage. This is critical to limiting the amount of loss that you’re going to have. The coinsurance level is very important to limiting losses.

There are inside limits, which is how you limit the size of loss also. This is the basis on which the insurance will pay the provider for any of the claims it has to cover. It outlines the basis on which the provider is paid. It is used because you want the provider to have an interest in managing the claim and in the care. It's usually on inpatient claims, and on a per-diem basis, but it does not necessarily have to be.

If issuing a provider-excess insurance policy giving coverage to a provider with multiple HMO contracts that will have a number of different capitation contracts, you have to be careful in what you use for your inside limit. The average daily maximums are not necessarily the best inside limits to use. It is necessary to examine all the capitation contracts and try to figure out what the actual daily rate will turn out to be. If you used ADMs, a person might find that the actual experience is a lot different than what you expected.

Again, inside limits are primarily used for inpatient claims, but there's a trend to also use inside limits for other claims, such as those for outpatient, DME or home health. The impact of the inside limits on these claims is actually small, but as more claims move into the outpatient setting, it's becoming more of interest to limit the amount

of the claims.

Usually, the limits for outpatient claims are in the 60 to 75 percent range of billed charges. There isn't a uniform rating method for outpatient claims, so that adds to the difficulty. However, Medicare is now moving over to the ambulatory payment categories (APCs) method, so as health plans become more familiar with their Medicare population using APCs, they will move more into the commercial field. This will be one way of putting together inside limits on outpatient claims also.

Covered expenses are exclusions. This is what Charles was talking about in outlier provisions. This is a big-dollar ticket item and this would be what the provider is buying this coverage for. It is necessary to understand what the contract provisions are on the outlier per diems. One could have a situation that looks like a per- diem contract, then once the outlier provision is triggered, it switches to a percent of billed charges.

Does the percent of billed charges apply only to the claims above the trigger, or does it revert back to it on the entire claim? That alone will make a huge difference on what payments will be on this particular claim. Understand the contract and price according to what is actually happening. Also, make sure to get the contract, as Charles mentioned.

I had a conversation earlier today, in which I was told what the contract provisions were, and the results that I came up with didn't match what was actually happening. They couldn't understand why it was so different. It turns out there was some fine print in the contract that I wasn't aware of. Their outlier trigger hit, and the whole entire claim switched to quite a large percentage of billed charges, which changed everything. They hadn't really noticed that and I didn't know about it until it made a huge difference in what the answer was.

The other big-ticket-item is "out-of-network/out-of-area." The provider has no contract with the caregiver, and has no control over the utilization, so it's going to be huge. The provider needs to understand what you are paying for in creating this provider excess policy so that you can price appropriately.

Other items in the covered expenses or exclusions are high-ticket items, such as transplants or infertility. These are high-cost items. Are they part of the capitation contract? Is the provider excess policy providing coverage for them? Also, you need to make sure to understand what exactly the company is covering and price it based on what actually might happen.

The mix of services between medical and surgical is a lot different for this type of coverage than it is for first-dollar coverage. These are high deductibles, so these are high cost items. That, of course, rules out a lot of the medical claim costs in the low-dollar level, which are a huge part of first-dollar coverage. The mix between medical services and surgical services is going to be quite different for this kind of

coverage.

Also, if you're looking at experience and using that to help in pricing, try looking at the experience in layers. An attachment point is $50,000, so you're looking at all the claims greater than that. Also, look at the claims under $50,000, and what kind of patterns are there, because when pricing this again at renewal, those claims will be part of what the customer is covering, due to leveraging. Look at the first $50,000 worth of claims, then the first $100,000, and see how the patterns are different. Try and take this into account as well.

The covered population will also have an impact on the pricing. Is this a commercial population? Is this the Medicare population? These factors affect the levels of utilization and risk involved. Generally, with the Medicare population, there will be a much higher deductible because of the chances of having more utilization and of something more catastrophic happening, thus incurring higher costs.

Some other factors to consider when pricing that are not quite so important, but definitely need to be considered, are the market that you're in and the type of product that you're pricing. The amount of experience the underwriting department has in this type of coverage is important because it is very different from first dollar coverage.

The age and sex on this type of coverage are not as sensitive as for first-dollar coverage. When looking at first-dollar coverage, I tend to use smaller brackets. For this type of coverage, when using wider brackets such as "under 40," "40–65" and "over 65," it's not as sensitive as first-dollar coverage.

Next, there is geographic area. Claim costs vary widely depending on the part of the country. This is something that needs to be taken into account. Charles's slide of the different areas pointed that out.

Regarding the competition in the marketplace, you may have a level at which it seems appropriate to price a certain product, but market conditions may be such that they can't exactly be priced. That would be a business decision that may be out of your hands.

The provider's specialty type also has an effect on the level of claims. Trends have a huge impact also.

There's also utilization management. What do you know about how care is managed? If you know certain things are being done, and you know the effect that these items have on utilization, then this can be taken into account in your pricing. There's also your load for administration and profit to consider.

I will now talk about experience rating—when to do it, and whether or not to do it. It all depends on what information is available. In order to price this product using

experience, a large amount of data is needed.

This is a much larger amount than what you would need for first-dollar coverage because these are catastrophic claims. Hopefully there aren't many of them, so there won't be enough data to experience rate a lot of the time.
If you want to do experience rating, some of the ways to get around it would be to retain the opportunity to write rate and use an experienced refund or swing rate. That way you have some control over the cost if the experience turns out to be a lot different than estimate based on past experience. Then, as you gain more and more experience, these items can be phased out.

Here is a quick word about reserving. Because of the difficulties, the traditional lag patterns don't work well for this type of product. No single provider group is going to have enough data to discern any kind of pattern, hopefully. The only way to use the experience is if enough providers pool together. Then it might be possible to ascertain the pattern. Look at the experience in total and use that to come up with some kind of indicator of the reserving level, as opposed to trying to complete the claims per se, as you would under a traditional reserving method. It's a little difficult, but that's the best that you can do.

Some of the pricing challenges now and in the future include the ability to charge the price that reflects actual expected cost. Or, you have some idea of what the price level should be based on the available information. Will the market allow a company to charge people at that level?

The general consensus or feeling was that the people in this business were pricing to buy business, like Charles said. Whether that's the case or not, it was a business decision they made. If the people chose not to price it at the level they thought it needed to be, a lot of times this would be out of your hands when going forward.

Getting good data has always been a challenge and is not going to get any easier going forward. I don't have any magical answers about where to get good data. The providers involved, though, have finally begun to recognize that they need to collect data in every part of their business. If they're in the risk-sharing field, they really need to have relevant data and understand what's going on. So, with recognition of that need, there is some hope that in the future you will have better data with which to go forward.

The other challenge is capitation and risk sharing backing off. I don't think it's been as great as what the press has made it out to be. Charles might contradict me here, but I work primarily in the New York area and on the East Coast in general. I think the providers out there may have been a lot slower to get into risk sharing and capitation fields, so they might feel they have a better handle on it. However, I haven't seen many of them backing off just yet.

Then again, I talked to the chief actuary for our health plan on the West Coast this

morning, and was told that they only have two capitation contracts left and, hopefully by the end of the year, they won't have any. So I think things are a little different there than they are on the East Coast.

If there is a significant backing off from risk sharing and capitation, you can see a significant shrinkage in this market. That, of course, will affect the players in the market and the pricing. It will be a good challenge or a bad challenge depending on how you feel about the whole thing.

Finally, one of the big challenges is the area of new technologies and treatments. They are developed every day, and the problem with trying to price these for coverage is the lack of data and, therefore, the increased risk as a result.

There are a few things to account for this. When creating the policy, you can exclude the treatment altogether, but it seems that's what the provider wants this type of coverage for, so that may not be the best idea. Based on the data available, you can include them and price them conservatively. You're not going to have a lot of data on the actual cost for one has utilization levels for these new technologies. Use what you have, price it conservatively and adjust it as necessary. Then, when going forward, gain more information. And thirdly, you can cover it under the policy, but use a different risk-sharing level. Use, for example, 50 percent coinsurance as opposed to 80 or 90 percent coinsurance that you use for the other services.

MR. RICHARD BERVE: I'm with Combined Special Risk, which is an underwriting company headquartered here in San Francisco. I appreciate the opportunity to speak to you today. I am charged with providing an underwriter's perspective on the past and current provider excess market.

At the conclusion of our session, hopefully you'll have a broader understanding of the past and current status of the market. I also hope you will be aware of some of the issues and challenges that face us today, and have a bit of appreciation for some of the opportunities that we see on the horizon.

I will focus our discussion on recent trends and experience in excess coverage structure, the underlying risk contracting between the health plan and the providers. Then ultimately, the impact on the excess market.

As Charles mentioned, the commercial market for provider excess really kicked off back in the early '90s. There were very few players at that time. Prior to that, provider excess existed but it was provided by the HMOs—it was capitating the provider. There was mass entrance in the early-to-mid-'90s, and those reported underwriting profits quickly became a thing of the past.

I stress underwriting profits here, because one of the challenges for the market, out of the box, was that many of these new entrants who came in were stop-loss,

managing general underwriters (MGUs) and carriers who were in a very soft market and looking to diversify to grow their premium base. These were jumbo accounts in comparison to an employee stop-loss appeal.

The MGUs were getting pretty rich on underwriting fees. The brokers who were new to the coverage were getting some nice commissions. And in the end, the capitated provider was getting a real nice return on his or her provider excess purchase, so the carrier held the risk in the end. It was the odd man out.

Today, most markets report that they're profitable. You have to raise an eyebrow at that. There are still a lot of markets that appear to be on the cusp of that, as well as several of them that exited last year. If you survey the reinsurers that participate in this business, most of them will say that there is not a truly profitable program out there. This means that from inception-to-date, the program is operating in the black.

It probably got the ugliest because the market was at its peak as far as size, premium-based and loss ratio in '98. These are estimates gathered from industry sources. It was potentially pushing about 150 percent on a net basis.

In 1999, it did improve a little bit. It improved again in 2000 because with some of the changes in coverage structure that Charles has mentioned, specifically underlying capitation, we expect there to be significant improvement, but is it going to be enough? Is it really going to develop to the point necessary in order to support the industry in going forward?

Reasons for the losses are very basic. In the earlier years, the capitated providers and, ultimately, the underwriters just didn't get a good understanding for the risk. They didn't look at those contracts or the details. They didn't look at the network that the provider had, where the tertiary care went. A lot of that was driven simply by the inability to get data. The HMOs were very tight with the data and wouldn't release it. So, the markets were willing to gamble and underwrite based on what they had.

With a strong manual, maybe you could get away with that, but the early rating manuals were based on small data sets, were inadequate in many areas and listed under-priced coverage in certain areas. On top of that, since it grew out of the soft, employer stop-loss market, when this product started it was driven by a total commodity mentality. Often, these capitated providers would assign two broker-of-record letters to new market assignments, and tell them, "Go get them boys." Then they'd go to every carrier that was offering a quote.

It was quite difficult to truly find a win-win situation. Ultimately, as most actuaries who are involved in this product may have heard underwriters explain, "If it wasn't for that one account, my loss ratio would be 20 points better."

This speaks to the volatility of this product. You can have a medium-sized account on a premium basis and grossly distort the book overall. We've seen accounts with 500, 600 and 700 percent loss ratios.

Because of these dismal results, the underwriters and the reinsurers reacted in the '99 era. Finally, after three years of people saying it was getting ready to do so, there was true market-hardening with the January 2000 renewals. Some of the changes included mandatory rate manuals, which you would think would be a given, but it wasn't. It was very much an experience-rated product on very small accounts. Minimum deductibles were there. Things like mandatory maximums and limitations, average daily maximums were there too.

Then finally, some approved underwriting guidelines from a risk selection standpoint were tightened up a little bit. It was a good news/bad news scenario with the market hardening.

There was significant rate improvement, and the bad news is that it's tapered off recently. In my view, the market is still not where it needs to be. The market has consolidated the number of carriers that offer coverage, which is always positive.

The contract terms have been substantially limited to the point where the value of the coverage is becoming questionable in the purchaser's eyes. While it's good from a loss-ratio standpoint, it's a quick fix that can't be a long-term solution.

We have a lot of books that are upside down for all years and potentially slightly upside down in recent years. They try to fix themselves in an era where excess market is much smaller than in the recent years due to capitation being down. And since prices are up, the providers that are remaining in capitation are buying much less coverage than they used to.

As far as take-aways from trends and experience overall, most of the current markets today are challenged and suffer from past losses and they're trying to fix. The decline and the capitation, the risk of moving back to the HMO, and the reinsurance capacity having dried up make true, healthy recovery that much more challenging. It is fully expected that there will be one or two more exits in the short term.

I don't think the other players in the market are going to be provider excess specialist shops anymore. They'll diversify, reposition themselves and have providers as one of the products that they bring to the market.

We talked a little about some of the rate increases out there. They were pretty hefty numbers, and it wasn't really what the market needed overall. What ended up happening is that underwriters went through the excess claims data that they've been collecting, actuaries evaluated it and came out with a bunch of quick fixes.

They tried to patch the holes in the policy and in some big loss drivers in the experience, and they just put maximums or caps or carve-outs on those loss drivers. So, a lot of the hardening in the market was driven by term changes. I just listed several of the fixes that were put in place to stop the bleeding, many of which Charles covered.

Some of these are very significant. The average daily maximum for in-network services is a huge hammer. It was a bitter pill for the providers to swallow, but it's the norm in the market today and is not healthy overall.

Lasering, which is very popular in the stop-loss market, has finally surfaced in the provider excess market. There again, you're carving out the risk for which the provider is desperately seeking coverage.

Underwriting changes were also impacted with the market hardening. Minimum deductibles went up, as did variable coinsurance. For example, if a transplant went to a non-reinsurer-approved transplant facility, it would pay a lower coinsurance on the excess coverage.

Multi-year rate guarantees finally went away, fortunately. Minimum membership and premium requirements were put in place. So many of these accounts with new contracts came in with 700 cap members, but they were going to be 1,000 by the end of the year. What ended up happening was the physician group had a $5,000 deductible, which generated $15,000 of excess premium with one claim that just blew it. Then finally, more experience was required and it was much more closely examined.

Cathy hit on IBNR factors. Traditional lag patterns don't cut it here. And finally, starting in 2000, the underwriters were using much more conservative completion factors in their experience rating.

As far as other underwriting changes, risk loads were increased in this coverage. In the early years, they were mirrored based on employer stop-loss risk loads. Provider excess has proven to be more volatile, so those risk loads have been increased overall. This meant hard requirements on blending, experience and manual rates, and the underwriter had to justify deviation from the norm. It also meant moving away from cost plus.

It would be interesting to see statistics for the top three or four markets in 1998 and 1999. I bet that approaching 50 percent of their premium base was on some sort of a cost plus approach, be it an experience refund or profit share. They very rarely had an upswing in the rate and it has a detrimental effect on the health of the book overall once those profits are pulled out.

Carriers, at the pushing of reinsurers, started enforcing some of the claim filing restrictions guidelines and deadlines that were built into the policy. As far as take-

aways from the changes in coverage, the provider excess policy was changed to be structured as more of a risk-sharing device on catastrophic risk and an entry-risk transferring device, which was the original reason for having the coverage there.

The providers are now participating in the risk—all the way to the top—in a very significant way. We expect the terms to start liberalizing and have seen some of that in 2002. Common sense will prevail as long as you can get an adequate rate and are able to rate that additional exposure. What's driving it is that the value of coverage is very debatable now because it's not transferring the risk that providers need to transfer over. Alternatives will emerge out of that.

I won't spend much time on capitation. I think that Charles and the study he helps put together each year speak to it loud and clear. Capitation is down. We listed various reasons here. We don't need to go into the detail on it, but it pushes underwriters. The question we end up asking is if capitation is down, the market is small and we all recognize that as fact, is the capitation out there today better than that of years past, or is it just as different?

We're optimists, so we say it's better than before, and here's why: In past years, the providers were after the gravy-train revenue stream, and were very willing to assume risk. From our perspective, it looked like they did so almost blindly. If you would try to find someone in a provider organization who knew his or her cap contracts and what risks he or she assumed, that person didn't exist. The person assigned to them wasn't there and it seemed like no one else had read the contracts, and there was very little analysis done around the capabilities of this provider, be it a physician provider group or hospital provider group.

The capabilities that they were able to offer around the risk they assumed were negotiated for. They can't do it themselves, so they find somebody who can do it for them and they have a contract in place. That effort just wasn't there.

In fact, there was very little effort around managing the care. They relied on HMOs to do utilization management. The HMOs no longer had the incentive to do it, since they had transferred that exposure to the provider, so the care was literally unmanaged. The early cap contracts significantly favored the HMOs.

Also, at that time, physician groups would openly sign global risk contracts and try to build a network around them through an affiliation with a hospital system. Regarding cap rates versus cost, very little analysis was done. I don't know if a lot of these provider groups, such as physicians, hired actuarial help to analyze these contracts from a cost standpoint to see if it was an adequate cap rate or not.

Hospitals were accepting very aggressive per-diem contracts with no outliers. They were straight per-diems, just to fill the beds, and they were guilty of this responsibility for services they couldn't provide. They would assume transplant risk when no facilities in their network could do transplants. Then they would go down

the street and try to negotiate with their arch-enemy on a good transplant rate. It just didn't happen.

We look at the National Insurance Information Capitation Survey each year. It features the overall providers that report profits under their capitation contracts. It's not a very positive trend until 2001. That up-tick is expected, hence a lot of the providers that were really losing money on their cap contracts exited in 1999 and 2000.

UNIDENTIFIED SPEAKER: I suppose the 1997 and 1998 numbers probably included a lot of publicly traded companies.

MR. BERVE: Yes.

UNIDENTIFIED SPEAKER: They later realized there were no profits.

MR. BERVE: The reason we think it's better today is that providers aggressively push high catastrophic risk back to the HMO. They no longer accept transplants if they don't have the ability to provide them or if they haven't negotiated for provisions to provide transplants.

Almost all of the hospital per-diem contracts contain outliers, as Cathy and Charles have both mentioned, and revert to some percentage of billed charges at much lower levels than they have in years past. The hospitals that are still on per diems are no longer on the old medical/surgical/ICU.

Instead, they may have four different NICU per diems and three different ones for CCU. It just goes on and on and you have a per diem menu to choose from. If providers aggressively increase the cap rate overall, they'll walk away and it's not that important to them anymore. Most of them are much less willing to assume responsibility for services they just can't provide.

As far as take-aways, there's definitely a risk shift back to the HMO. Capitation out to providers is significantly down. Though with the capitation that's still there, the risk transferred under those contracts is down because so much of the high catastrophic risk stays with the health plan. This has a significant impact on our provider market, as I mentioned before, from the ability to recover in a market that's in decline.

Our risk that's left is definitely changing, but don't confuse that with stabilizing. It's much different. Ways that it's changing, and from a pricing standpoint, what's been difficult with provider excess, is it's carved up to price. Employee stop loss is a comprehensive medical plan. There are a lot of data out there to price, and with provider excess, there is a listing of services for which the providers assumed risk.

You have to price each one of them, hope there are no gaps and that it has all been

billed and that nothing has been missed. Unfortunately, we feel the risk is becoming more splintered as we move forward. A good example is one Charles mentioned. Capitation with children's hospitals for healthy kids programs and with Medicaid is up significantly. This introduces a new demographic challenge to pricing and the services that a children's hospital assumes. Now the demographics of a healthy kids' population are built into pricing as well.

Carve-out programs are especially gaining momentum. This is for some of the areas that I've listed here. On a capitated basis, they're actually transferring medical risk based on these conditions. And, of course, self-directed health plans are also growing in popularity. There are risk-sharing devices behind these programs. There will be some capitation, some of which is self-funded with the employers. Then there is often a pool left over.

There again, risk is splintered up and split into many different buckets. Then, direct contracting is still around to some degree, but it's not really gaining the momentum of some of these other areas.

As far as the impact of all these changes on our provider excess market, this is anecdotal evidence that I've been gathering over the years, whenever I have the chance, from speaking with reinsurers, MGUs and brokers. This illustrates estimates, but I think they're in the ballpark of what we see.

Thirty or more players are sitting out there. Often, you compete with 15 of them on any given quote, for $300-400 million, which is a relatively small piece of the pie. With the changes in capitation declining, deductibles increasing substantially and many providers just selecting to go bare because they don't think the coverage has value, the market is much smaller today than it has been. Luckily the number of carriers in the market is much less, too.

What's our market challenge? What do we need to do to get over the hump? Based on history, our buyers expect to have a measurable return on their investment each year they purchase this coverage. The carriers and reinsurers demand a return on their equity because they can no longer fund this business.

The underwriters are battling for more data and we don't know if the market is going to support this or if they'll just elect to go bare. Loyalty has always been an issue in this market, starting with the buyer of the coverage. The buyer won't make a commitment to one broker or consultant for help, and instead shops every year against multiple carriers and brokers. The loyalty issue has always been out there.

This leads us to ask this question: Are underwriters ever going to have the ability to truly develop a healthy pool of risk? Or, are we going to have to live in an opportunistic pricing environment, where you're trying to win on every given account, manuscripting coverage for each account that comes in the door, where all the limitations come from?

If we are able to bring a product to the market that does have true value and does offer the risk transfer that the providers seek, will they buy it? Is it going to be too expensive for any of them to say it is a good investment? Will they be willing to stabilize earnings the way they need to? Are they willing to spend a certain amount of money to buy coverage with the value and transfer the risk the way they need it to? We don't know whether or not they will do these things.

These things are all critical to increasing the overall health of our market, and the ability to do that is twice as tough in a market that's in decline. Ask the following question: Will the capacity decline at the same rate the market declines, or is it going to be the same eight-to-ten carriers fighting for a $100 million pie two years from now, thereby still leading to a soft market and opportunistic pricing? Hopefully this will not happen.

Regarding re-insurance, we don't really expect any new capacity. The reinsurers have their own challenges related to the property & casualty (P&C) losses of last year. The hardening will continue and that will be focused more on price, especially on risk selection and analysis, because the terms are going to start to liberalize a little bit. Justifiably, they should do this, but it's going to be based much more on risk analysis than it has been in the past.

As I mentioned, the reinsurers are very challenged. They have capital fights inside and many of them are shifting more of their efforts to P&C because they can get better long-term returns on that market right now. We think that's going to push our underwriting capacity to dry up even more. With the 2002 renewals for the MGUs, as well as the carrier programs, the smaller profit challenge programs will have real difficult renewals this year. As I mentioned, we expect to see a couple more companies exit this year.

As far as our outlook for the future, we firmly believe that capitation will survive in some form, in some region or in some way. It will be different than it is today and it's not going to be as widespread as in years past, but we hope the providers that stay in it will be the larger, more sophisticated providers that are committed to capitation as part of their core business strategy.

We do expect some new entrants out there, both in the forms of new providers entering capitation in a very traditional sense as well as some nontraditional new entrants that I'll mention. I feel that as HMOs start having a more difficult time selling the increases that they've been able to sell for the last couple of years, they will become more motivated to subcontract the risk again.

The thing to note is that when looking back at the late '80s, in the health care environment where utilization, medical costs and Rx inflation were up, and employer dissatisfaction was going through the roof, it fueled the managed care revolution the first time around. All the indicators show that we're right back at the starting point.

I think it's going to fuel a new revolution of managed care and some interesting alternatives will come out of that. We're starting to see a bit of that now. As a side note, I was in the market at the time of the managed care revolution. We spent a lot of time worrying about national health care, which really detracted from what needed to be done to fix some of the problems that were in the market.

As far as what we see coming down the tracks, we think that since the HMOs are holding all this risk, especially the publicly traded ones, they need to protect their balance sheet. They're going to start carving out some of their catastrophic exposures—the neonates, transplants, oncology or whatever the case may be.

These DM companies are growing in size as well as in number. There are a lot of new ones out there and we feel it's possible that some of these DMs could become the next major wave of capitation. Regarding Medicare, CMS has a demonstration project out there now where they are willing to capitate to DM companies in the areas of congestive heart failure, diabetes and asthma as a demonstration project. Many of the providers or the DMs are bidding on these. It will be interesting to see how that goes.

Compare the data that's available to our fingertips today to what was available in the early '90s. Now, it's better data, both in terms of quality and quantity. We're seeing the emergence of new pricing tools and some predictive modeling tools out there to complement traditional pricing models that we've had in the past. A lot more managed care data has been collected today than in the past, so we hope that there will be a better data element around the pricing of this new risk going forward.

The bottom line is that the old managed care formula still applies, which is the number of units times the cost per unit. It is necessary to make sure that whatever the risk arrangement is, it adequately manages both sides of that equation. Capitation managed the cost element, but I don't think it was meaningful as far as the number of units.

So, with whatever new models come out, as long as both sides of that equation are managed, hopefully they stand a good chance of succeeding. In the end, we're being optimistic. We think our future could be bright. We have to learn from the sins of the past, embrace these new models and just do it differently the next time around.