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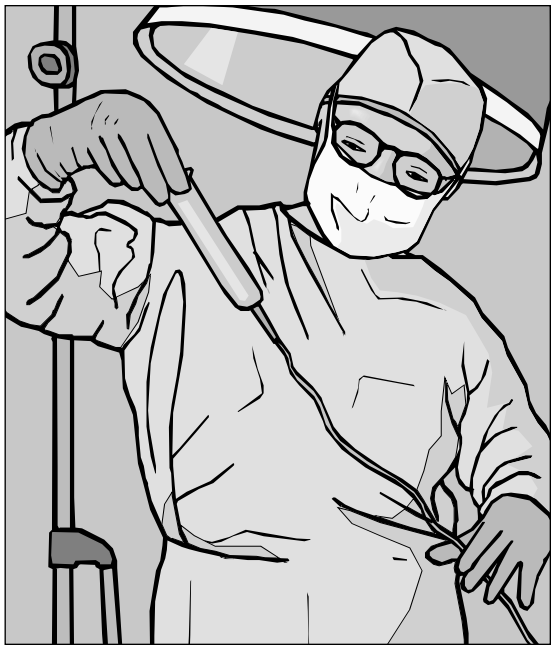
Hospital Charges Become A Significant Issue Again

by John P. Cookson



Over the past few years hospitals, through consolidation and affiliations, have gained back much of the negotiation strength they had lost to HMOs and PPOs during the late 1980s through the mid- to late 1990s. As a result of this strengthening, hospital charge levels have become a more significant issue than they were five years ago. Many out-of-area and out-of-network payments are a function of charges, many in-network contracts (especially outpatient) are still based on discount from charges, and in-network contracts based on fixed payments have increasingly added stop loss provisions that convert the payment to a percentage of charges once the case reaches a charge threshold such as $25,000 or $50,000. In addition to the high cost impact on hospital claims, these stop loss provisions have caused particularly high cost escalations at some reinsurers that provide catastrophic claim stop loss protection for employers and insurers.

There are substantial differences in charge levels by hospital, and these differences are not readily available to most employers and claims payers. In order to understand and measure these

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Chairperson's Corner: Looking Back...

by Daniel L. Wolak

Dan Wolak

Twenty-five years! Wow, it's been twenty-five years since I started in the group life and health field. I remember that summer day, walking into the CNA offices in Chicago and having my desk in a pod shared with five other young, aspiring actuaries. There was Bruce Iverson (now on the SOA Staff overseeing research), Mitch Serota, Eric Smithback, Bill Sonnleiter and Kathy Manning. I remember after working that day, I attended a ball game on the "south side" to see my team back then, the White Sox, take on Reggie Jackson and the team which I now enjoy seeing with my son, the Yankees.

Twenty-five years. So what have I seen in the health insurance market from the risk taker side, that is, insurance and reinsurance side? I've seen changes in health plans (going from Base + Supp to MSAs and cafeteria plans), new ways to control claim costs (hospital utilization review in the '80s to negotiated fees for PPO's in the '90s), small group medical pricing (select and ultimate pricing to small group rating laws) and healthcare trend (rising in the '70s to… well, rising currently…some things don't change).

Experience is always the best teacher, but at times a comment or tidbit from someone else can be very helpful. Okay, as a health actuary "enjoying" my silver anniversary, the following are several of my thoughts on "lessons

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3.4.5 also consider the use of Premiums. This standard leaves room for use of premiums in these certain situations where there is a historical and apparently permanent ongoing subsidy by a population external to the plan sponsor. Furthermore, it does not limit this use of the community premium rate to the situation where the community rate is based on retiree, only experience as Mr. Hogue suggests is should. Appendix 2, clearly states "if the insurer appears to be committed to continuing such subsidy for the retirees, there is some justification for valuing future retiree costs for the post-retirement plan sponsor with the community rate" (p. 30).

From a theoretical standpoint, the essence of retiree medical valuations is the valuing of a sponsor's expected liability. What is meant by expected? One clue is FAS 106 says the actuary should not "expect" or anticipate changes in the federal Medicare program. In the same vane, community rated plans may change their rating methods or stop writing new coverage. Is this a reasonable expectation? I don't think it is reasonable. In fact, some community rated plans have been around longer than Medicare. Not just a few old HMOs, but a number of small and large regional HMO and insurance companies frequently show little ability or interest in differentiating between pre-Medicare retirees and active employees. In these cases the liability is borne by the entire insured community. There is no reason to expect this to change. Thus there is every reason to expect that the retiree medical plan sponsor's cost will be a function of the plan's community rate.

Given this is the case, I think it is appropriate that the answer to question 11 in the Implementation Guide was written as it was, regardless of intent.

Sincerely,

Wes Edwards

Chairperson's Corner

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learned" on the health insurance side of the practice.

1. "It's Good Business"

Those are words that I have learned to be cautious of. Generally when this statement is made, there is little information to support it. If all the people who said that they were "cherry-picking" the good risks were actually able to do this, health insurers would never have lost any money!

2. The Price of an Education

Being involved with a new product is always interesting, and generally significantly more challenging than pricing an inforce product. There are three challenges. First, there is a lack of data when pricing a new product…naturally since it is new. Second, underwriting guidelines and marketing techniques to write the better risk are untested. Lastly, to push a conservative organization like an insurer to venture into a new product generally involves an energetic product champion who is convinced, and convinces many others, of the success of the new product. Naturally, an education is involved and the price is a tuition which many times is accompanied by initial experience losses.

3. The Twilight Zone

The most uncomfortable aspect is being in situations where the common belief suggests sound reserves or pricing, but there is little information available to the actuary to support it. This might be related to the actuary's own lack of expertise with the product, or the quality or source of data is not defined, and/or time is limited to really focus and develop a knowledge of the product. In such situations, you as an actuary are now entering "The Twilight Zone". What should you do when asked to analyze and validate a product where you and possibly your company/client lack a core competence?

The lead article "Déjà vu all over again" published in the February edition of *The Actuary* was excellent. Towards the end of that article, one of the participants in the panel discussion states the following:

"I think the question for the actuary comes back to this: since it's the life (A&H) companies that were getting burned so badly by reinsuring this workers' comp carve-out, were their pricing actuaries equipped to handle this? Did they realize they weren't equipped to handle it, and were they trying to bring in people who did know what they were doing, or should have known what they were doing?"

Unfortunately most people agree the answer is no. Recently, workers comp written by A&H reinsurers has surfaced as a problem, but in the past there have been losses from MEWAs and failed METs that strained the surplus of life and health insurers. Five or 10 years from now, it may be déjà vu if we are unwilling to question the questionable when we are in the "Twilight Zone".

4. Is it Priced Right?

From my experiences on the risk side, insurance company and reinsurer, I believe the fundamental responsibility of the health actuary is to be able to answer the previous "simple" question. This is naturally the challenge. Our friends on the individual life side, I suggest whimsically, have seen their costs decline at the rate of 0.5% or 1.0% a year, based on mortality improvement. We on the health side have seen health costs change from year to year in a range of 2% to 20% over the past 25 years! And the change in cost for stop loss and other high deductible programs has been a multiple of that! What a business!

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