

Summit Perspectives

Apples and oranges: Comparing reinsurance proposals

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Nothing astonishes men so much as common sense and plain dealing.

Ralph Waldo Emerson

Any time you purchase one product over another, price is an important consideration. It is just as critical to make sure you are analyzing equivalent products, often referred to as comparing “apples to apples.” The following three case studies detail situations where appropriate comparisons of proposals were important to drawing accurate conclusions.

Case Study #1

One of our prospects was disappointed that our proposed rate was roughly twice as high as a competitor’s quote for the “same” coverage. We asked for a copy of the competitor’s proposal and uncovered the following differences:

1. The competing proposal provided for aggregating specific coverage. This type of arrangement creates a corridor of risk above the deductible, which the health plan would assume. Specific reimbursements are made only after the aggregating specific amount is reached, whether it is due to one or more than one indi-

vidual. This essentially imposed an additional \$300,000 deductible on the health plan. In other words, it reduced the premium substantially through increased retention by the client.

2. The competitor’s proposal only covered hospital charges, while our proposal provided coverage for all services. This change alone could impact the premium rates by 50% or more.

There were other differences, but the net effect of these two considerations alone more than made up for the difference in premium rates when making the “apples to apples” comparison. Usually these comparisons are fruitful and are considered in the final analysis. In some situations, however, they are overlooked.

Case Study #2

Summit Re submitted a proposal to a provider-owned health plan. As it turns out, the purchaser was not aware that the expiring coverage through a competitor had an artificial



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What is needed for a proposal and why?

Occasionally Summit Re is asked to provide a proposal for medical excess reinsurance and is unable to do so due to lack of data. This article provides a brief explanation of the information we need to issue a proposal and why we need it. Request-for-proposal data requirements can be categorized into five areas: census, coverage parameters, claims, provider agreements and financial information.

Census

Membership counts for three consecutive coverage periods (years) are needed to calculate an “experience” rate. Although Summit Re uses “manual rates” in its underwriting and pricing, it blends the manual rate with your experience. Therefore, we need membership totals to divide into claims to determine per-member per-month costs during the experience period.

Reviewing historical census information also allows us to observe changes in membership by lines of business and to determine if deductible or other coverage changes might be warranted for various categories of membership. It is important to provide membership counts for

the appropriate categories to be rated, as the commercial HMO, PPO, Medicare and/or Medicaid coverages are usually rated separately (vs. one composite rate for all lines of business). In addition, there are often sub-categories of membership, especially for Medicaid, e.g., SSI, TANF, etc.

Coverage parameters

It is important to know the expiring coverage parameters. Along with historical claims data and other considerations, we can determine if your coverage is appropriate. This also allows us to recommend coverage changes and explain how they would differ from current coverage. Providing us with a copy of the expiring treaty enables us to do that. It also helps us understand how our quote might differ from competitors’ quotes.

Claims

We request catastrophic claim information generally at a level of 50%-75% of the lowest deductible option requested. We trend those claims forward over the experience periods for assumed inflation. The trended historical claims are used with the census data to obtain an experience rate. It’s also helpful to

know what kind of trend the health plan is experiencing, as this is relevant to the excess coverage assumptions.

As mentioned above, we blend your plan’s trended experience rates with our pricing manual to establish a final rate. Our manual is developed based on a portfolio of industry data as well as proposals and renewals we process

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Transplant risk – Take it or leave it?

Most catastrophic medical excess reinsurance programs cover transplants as part of the program. There may be a few coinsurance incentives to use preferred vendors with fixed fee arrangements, but, otherwise, transplant claims are treated the same as all other claims and are subject to a deductible.

In addition to offering OptumHealth's transplant network contracts to clients at preferred access fees, we also offer access to OptumHealth's Managed Transplant Program (MTP). For clients who need the greatest degree of price predictability, this "carve-out" product transfers the financial risk for transplant services to OptumHealth. The coverage for transplants is available to employer groups and managed care organizations through a separate insurance or reinsurance agreement.

Managed Transplant Program

With 12 years of experience underwriting transplant risk and \$25 million dollars in current transplant risk premium, OptumHealth is unmatched in its ability to manage transplant risk. MTP clients benefit from full case management, including pharmacy and outpatient services, as

well as post-transplant protocol compliance monitoring, case reporting and claim processing.

As a carve-out product, MTP mitigates volatility and frees valuable resources for other areas of your business. Transplants can be extremely unpredictable – and costly. The average billed charge for a transplant episode is \$427,000 (source: Milliman 2008 estimate), but depending on the circumstances, it can rise to \$1 million or more.

Managed Care Plan Benefits

OptumHealth allows you to outsource all of the risk for transplants. You simply pay a standard monthly premium, and OptumHealth will then pay virtually all claims that result from transplant cases. There are numerous benefits to this approach:

- Eliminates volatility through first-dollar transplant coverage so that transplant costs become a stable budget item.
- Allows you to focus attention on high return-on-investment areas of your business.
- Frees up dollar reserves, allowing you to reinvest in your business.
- Eliminates needless costs by using OptumHealth's Cen-

ters of Excellence network and clinical management team to avoid inappropriate transplants, identify eligible patients for Medicare and reduce the re-transplant rate.

- Reduces the cost of health reinsurance premiums via a credit for transplant claims which are no longer covered under the traditional reinsurance program.
- Covers virtually all transplant-related costs, including immunosuppressant (anti-rejection) drugs.
- Covers all transplant types: solid organ, blood and marrow (cord blood, stem cells, bone marrow transplants).
- Covers transplant-related expenses from the day prior to the transplant through a maximum of 365 days following the transplant.
- Includes coverage of evaluation, search and registry, organ procurement, home health, outpatient treatment, and travel and lodging benefits.
- Risk-sharing options available from full risk to specific or aggregate deductibles.

Employer Group Benefits

When offered as part of an em-

What is needed for a proposal and why?

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for each plan. However, it's also important to look at regional differences in provider contracts and the medical management capabilities of each health plan. Where else does this best show up but in the actual experience of the plan?

In addition to billed and paid charges, we request additional information on claims, such as admission and discharge dates (length of stay) and diagnosis. The lengths of stay or dates of admission and discharge are needed to determine the impact

for reimbursement under the reinsurance agreement.) If the plan has no ADM limitation, length-of-stay information is not necessary. Its submission is encouraged as another source of information, however, and it still is important to provide the diagnosis and to identify the actual hospital provider to indicate where care is usually delivered.

Provider agreements

It's important for us to receive copies of provider agreements for the key tertiary-care facilities utilized by the health plan to determine what financial arrangements and costs can be expected for catastrophic claims. Tertiary-care facilities are those that provide care for high-cost, complex conditions, including severe trauma, complicated newborns, severe burns, organ transplants and the like. It's important to know if

the agreements allow for case rates, such as DRGs, per diems or discounts from billed charges, as these significantly impact medical excess costs and hence, risk. "The devil is in the details," so it's critical that we understand

if the rates vary by level of care, if there are outlier or "stop loss" provisions that become effective at some point during the course of treatment, if discounts vary by type of service, and any other provisions that impact costs. Although all provider agreements are important, the tertiary ones are critical, and the more information that is provided to us, the more accurate we can make our rate proposal. Key terms of the arrangements also are included in the reinsurance treaty as the basis for reimbursement.

Financial information

If coverage is required for the continuation of benefit in the event of the plan's insolvency, Summit Re needs statutory and GAAP financials (last year-end and most recent quarterly), as well as annual reserve certification, to assess the risk of insolvency prior to providing the coverage.

These are the typical data requirements that any reinsurer would ask for to develop a catastrophic medical excess proposal. All of this information is kept in strict confidence. Comments and questions are welcome.

We need data about your experience because the final rate is a blend of manual rates with your plan's trended experience rates.

of the average daily maximum (ADM) limitations, if the reinsurance treaty includes such limitations. (An ADM limitation is a limit on the amount of charges per day that are eligible

New staff expands Summit Re's expertise

Summit Re announces the hiring of two new managed healthcare reinsurance professionals to enhance an already strong Summit Re team. We are committed to hiring the personnel needed to provide you with unmatched service and expand our presence in the managed healthcare reinsurance market. We remain dedicated to this market and the customers we serve.

Greg Demars

Greg joined Summit Re on September 15 as Vice President, Actuarial and Underwriting. Greg is a senior executive with 16 years

of experience in healthcare actuarial, underwriting and operations. His previous position was executive vice president, HCC Life Insurance Company, where he was responsible for the Healthcare Risk Management and LifeTrac divisions. Greg will join Brian Shively of Summit Re in directing the underwriting and pricing of all managed care business at Summit Re. Greg will work in our new Minneapolis office.

Linda Beckman

Linda joined Summit Re on October 20 as managed care coordi-

nator, self-funded markets. She is responsible for providing consultative case management services to our clients and assisting our underwriters in the assessment of potentially catastrophic claims. She also will assess the effectiveness of Summit Re's managed care programs and assist with the vendor selection process. Linda is a registered nurse with over 16 years of experience in the health insurance and reinsurance industry. She was most recently excess risk medical case manager, stop loss insurance, at ING. Linda will work in our new Minneapolis office.

Transplant risk – Take it or leave it?

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employer stop loss program, the following additional benefits are obtained:

- Reduces cost of specific stop-loss insurance premium.
- Eliminates lasers at stop-loss insurance renewal for potential transplants.
- Protects against the possibility of multiple specific deductibles over a two-year period.
- Protects against potential costs of multiple transplants in one year.

- Assists in reducing financial liabilities for the specific stop-loss insurer.

Additional Patient Benefits

- Includes centers with the highest survival rates and transplant volumes.
- Provides first-dollar coverage, meaning no deductible, coinsurance or copays.
- Allows \$1,000,000 lifetime benefit.
- Preserves the lifetime maximum benefit of underlying

major medical coverage based on plan design.

For managed care organizations, including HMOs, a reinsurance treaty is available in all states. When offered via an insurance policy to self-funded employer groups, certain policy forms and amendments vary by state.

To learn more about Optum-Health's Managed Programs or to request a proposal, please contact your Summit Re sales representative.

Apples and oranges: Comparing proposals

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per diem limit on the services received from the owner hospital. The reimbursement was limited to \$3,000 per day, irrespective of the charges that were actually incurred. This artificial limitation translated into a 25% difference in the premium rates given the type and frequency of care delivered at the owner hospital. There's nothing wrong with offering such a limitation. However, it is important to understand its value and cost relative to competing proposals with no such limits.

Case Study #3

Our current client received our renewal and a competitor's pro-

The analysis allowed our client to conclude that the coverage was *definitely not* "basically the same."

posal, which produced a significantly lower cost option to the plan. The competing reinsurer told the plan that the proposed

coverage was "basically the same." However, further analysis by Summit Re indicated these four material differences:

1. Long-term acute care facility charges

Long-term acute care (LTAC) is a recognized designation by the Centers for Medicare and Medicaid Services for acute care hospitals whose average length of stay is at least 25 days. Because patients require and are receiving acute care, we consider these the same as any other inpatient hospitalization.

In this case, our competitor treated the LTAC as a "step-down" facility and applied a significantly lower per-day limit of \$750, as opposed to our inpatient hospital limitation, which was more in line with the actual cost of care.

In our review of this client's claims, we found that there were several claims that this limit would affect. One claim in particular stood out because our competitor would have disal-

lowed over \$23,500 in LTAC charges.

2. Drug coverage

In this case, our competitor covered outpatient facility charges up to \$2,500 per day, including drugs. Our preferred way of dealing with the risk of high-cost drugs supplied to members who are not hospital confined is to offer a separate coverage limitation for those services. With separate coverage, clients have more options for those high-cost drugs that our competitor would have greatly limited.

3. Average daily maximum (ADM) application

Our competitor's coverage included an ADM that was applied to all hospital confinements, regardless of the structure of the health plan's contract with the facility. This meant that even if the health plan had case rates for various services, the ADM limitation was applied. Since case rates or other fixed fees remain the same regardless of the length of stay, we feel it would be penalizing the client for a short stay if we applied the ADM limitation

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under those circumstances.

We reviewed five claims that would have been affected by this difference and found our competitor would have disallowed \$15,700 in charges we would have considered eligible for reimbursement.

4. **Deductible carry-forward and run-in provisions**

Our coverage provided an option to allow charges that did not exceed the deductible and were incurred by a member during the last 31 days of the agreement period to count toward the satisfaction of the deductible for the new agreement period. We offered the same option for charges incurred during the 31 days prior to the effective date of the proposed coverage. Our competitor did not offer these carry-forward and run-in provisions. We discovered nine claims where \$41,824 in charges would have been disallowed by our competitor as a result of not including the provisions.

The net result of this analysis allowed our client to conclude that the coverage being proposed

by the competitor was definitely not “basically the same” as the coverage being proposed by Summit Re, and the differences could have an impact on potential claim recoveries.

Other considerations

There are many other areas where it’s important to compare one proposal versus another. These include:

1. **Covered services** – Does the quote cover all the services that can create high claims for the health plan and was a careful analysis performed to determine the appropriate covered services for that plan?
2. **Average daily maximum limitation** – If an ADM is included, is it calculated for each continuous confinement or per calendar year?
3. **Maximum benefit** – Is the maximum benefit an amount above the deductible or is the deductible subtracted from the maximum benefit amount? Is the annual maximum the same as the lifetime maximum?
4. **Network access fees** – Are

organ transplant network access fees considered to be eligible claim expenses and therefore recoverable under the reinsurance agreement?

5. **Definitions** – Does the reinsurance treaty impose its own definitions for medical necessity, experimental/investigational and acute care? If so, the plan may make coverage decisions that will later be challenged by the reinsurer based on its own definitions, rather than the health plan’s definitions.
6. **Lasered members** – Does the proposed coverage require higher deductibles for certain members or exclude them entirely?

When it’s all about the bottom line, it pays to read the fine print and make sure you’re comparing “apples to apples.” Summit Re stands ready, willing and able to assist your plan in comparing proposals. We will provide you with objective advice and highlight the benefit differentials between competing proposals, regardless of whether or not they favor Summit Re. Our interest is in making sure you have the details to make an informed decision.

Why we market directly to our customers

We believe in marketing directly to our health plan customers rather than through a middle man, such as a broker. The advantages of direct marketing include:

- Direct contact with you gives us a thorough understanding of the risk that we are both assuming and allows us to work with you to best match your excess loss coverage to your plan's needs and objectives. This direct interaction is particularly important due to complex product structures and the fact that needs continuously evolve.
- Understanding your unique

business strategies and having direct contact with your management staff allows us to match other products and services to your needs. Summit Re provides a wide variety of managed care programs and services to allow you to provide a full array of employee benefits.

- Expense management is needed for long-term survival in a competitive managed care marketplace. Typical broker commissions add 10% to premium costs.

Summit Re is one of the four major providers of HMO reinsurance, defined as carriers with

over 10% market share. Two of the top four reinsurers only market directly to clients. This means that if you use a broker and don't access the direct markets independently of your broker, you will miss quotes from half of the major reinsurers in this marketplace.

If you have historically used a broker, nothing stops you from accessing the expertise of Summit Re as well. We can act as a check and balance on your broker and vice versa. If you give us a chance to help you and demonstrate what we can do, you won't be disappointed.

Summit Perspectives is a periodic newsletter published by Summit Reinsurance Services, Inc., a full-service managing underwriter. *Summit Perspectives* highlights various items from both Summit Re and the medical reinsurance marketplace. We will publish it only when we have important information to share.

If an item in this edition generates questions or comments, please give us a call at 260-469-3000 or write to us at www.Summit-Re.com.



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