

Summit Perspectives

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A prudent question is one-half of wisdom.

Francis Bacon



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Happy Birthday, Summit Re! Happy Anniversary, Swiss Re and Summit Re!

Summit Re celebrates its 10th anniversary in November 2009. The company was established in 1999 with the exit of Lincoln Re from most medical excess lines. Summit Re has partnered with Swiss Re (formerly ERC) for catastrophic medical excess reinsurance since its founding in 1999.

In September, Swiss Re and Summit Re celebrated this 10-year anniversary with a ceremony in the Swiss Re offices in Overland Park, Kansas. The companies exchanged gifts of pewter and crystal.

Jeff Argotsinger, director, Client Markets, and Rudi Flunger, managing director/head, Insurance and Specialty, presented a gift to Mark Troutman, president of Summit Re, and thanked him for an excellent 10-year relationship. Mark Troutman reciprocated and stated that it was an honor to work with them on catastrophic medical excess business.

The 10th anniversary is celebrated and commemorated with tin. The tin anniversary has a theme of preservation, longevity and protection—much like reinsurance! Although tin itself is a soft, malleable metal, it forms alloys with other metals like lead, silver and copper,

creating durable goods of pewter or bronze.

Tin achieved immortality of sorts in 1810, when Peter Durand patented the tin-plated iron can for preserving food. Tin protected the iron from corrosion, enabling the food or liquid within the can to last indefinitely. In 1974, American chemists analyzed canned foods from the *Bertrand*, a steamboat that sank in the Missouri River in 1865 while on its way to provision Montana gold miners. The brandied peaches, oysters, plum tomatoes and honey were still perfectly preserved 109 years later.

Summit Re and Swiss Re believe the key to success in the medical excess reinsurance marketplace is the same as the key to success in a successful marriage. It's more than luck! Both companies emphasize the need for strong communication and a shared vision. The Swiss Re-Summit Re partnership has always been predicated on mutual expertise, transparency and financial strength.

In closing, Mark Troutman described the 10-year relationship like a roller coaster – many ups and downs, twists and turns, but a very enjoyable ride!

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Letter from the President

You've heard the expression, "The more things change, the more they stay the same." There are plenty of changes in the reinsurance market, but reinsurance is still all about value.

Value in buying the right coverage.

Spending your reinsurance dollars wisely. It is about giving you insight to being an educated reinsurance buyer. You know your first dollar problems, but do you know your catastrophic claims problems as well? Value is purchasing the right coverage from one of the leading reinsurers in the world.

Value in receiving help in managing your catastrophic claims.

Are you receiving consultative case management for free? Are you receiving access to the best vendors to manage your reinsurance claims with no additional markup? Are you obtaining access to vendors that charge appropriately? Does your reinsurer offer in-house review and consultation for your internal case management, medical management and disease management functions?

Value in access to products to compete against the national carriers.

Are you working with an employer stop loss partner who understands and uses your plan's claims history in the base employer stop loss pricing? Do you have an employer stop loss partner that would put you in the business to compete? Do you have a partner offering national out-of-area solutions for remote offices and students living out of state? Do you have access to individual health carriers to help you enter that market? Do you (and your brokers) have access to competitive dental, life and disability products to offer one-stop shopping?

Please give Summit Re the opportunity to quote on your reinsurance this renewal period. You'll be glad you did.



Mark Troutman
President
Summit Reinsurance Services, Inc.

Results-Based Wellness Programs: Further Expansion Under Health Reform?

David A. Peppler, FSA, MAAA, Peppler Actuarial & Financial Consulting, LLC

Thanks to final regulations issued in 2007 by the U.S. Department Labor, employers are permitted to include wellness programs in group health plans that apply financial rewards (or penalties) to employees based on their healthy (or unhealthy) lifestyle habits. The effect is added teeth for employers to create plans with consequential incentives for employees to adopt healthy lifestyles and break unhealthy habits. Moreover, health care reform proposals currently under consideration may further sharpen those added teeth.

Chronic Conditions

Employers continue to face crippling increases in health plan costs, primarily due to rapid growth in preventable chronic health conditions among employees. According to the U.S. Centers for Disease Control and Prevention's Chronic Disease Overview:

- The profile of diseases contributing most heavily to death, illness, and disability among Americans changed dramatically during the last century. Today, chronic diseases—such as cardiovascular disease (primarily heart disease and stroke), cancer, and diabetes—are among the most prevalent, costly, and preventable of all health problems.
- In 2005, 133 million people, almost half of all Americans, lived with at least one chronic condition.
- The medical care costs of people with chronic diseases account for more than 75% of the nation's \$2 trillion medical care costs.
- The direct and indirect costs of diabetes are \$174 billion a year.
- The estimated direct and indirect costs associated with smoking exceed \$193 billion annually.
- In 2008, the cost of heart disease and stroke in the U.S. was projected to be \$448 billion.
- During the past 20 years, there has been a dramatic increase in obesity in the United States. In 2008, only one state (Colorado) had a prevalence of obesity less than 20%. Thirty-two states had prevalence equal to or greater than 25%; six of these states (Alabama, Mississippi, Oklahoma, South Carolina, Tennessee, and West Virginia) had prevalence of obesity equal to or greater than 30%.

HIPAA Nondiscrimination and Wellness Programs

Generally under the nondiscrimination rules included in the Health Insurance Portability and Accountability Act (HIPAA), an individual cannot be denied eligibility for benefits or charged more for coverage because of any health factor. Under the 2007 wellness program rules, however, employers may condition rewards and penalties on an individual's satisfying a standard related to a health factor. For example, a reward or penalty may be

applied depending on whether an employee's blood pressure reading falls within a certain acceptable range. Wellness programs that condition a reward on an individual's satisfying a standard related to a health factor must meet five requirements described in the final rules in order to comply:

1. The total reward is limited – generally, it must not exceed 20 percent of the cost of employee-only coverage under the plan (or 20 percent of the cost of the coverage in which an employee and any dependents are enrolled if dependents may participate in the wellness program).
2. The program must be reasonably designed to promote health and prevent disease.
3. The program must give individuals eligible to participate the opportunity to qualify for the reward at least once per year.
4. The reward must be available to all similarly situated individuals. The program must allow a reasonable alternative standard (or waiver of initial standard) for obtaining the reward to any individual for whom it is unreasonably difficult due to a medical condition, or medically inadvisable, to satisfy the initial standard.
5. The plan must disclose the availability of a reasonable alternative standard (or the possibility of a waiver of the initial standard) in all materials describing the terms of the program.

Results-Based Wellness Programs

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Market Initiatives

To date, relatively few employers have taken advantage of rules allowing results-based wellness incentives. Most corporate wellness programs still reward employees based on effort alone—for example, enrolling in smoking cessation programs—regardless of outcome. Many employers may fear employee backlash against a results-based initiative and compliance with the alphabet soup of related laws (e.g., ADA, ERISA, COBRA, GINA, and state laws).

Probably the highest profile and most vocal company making use of the rules allowing results-based wellness incentives is Safeway Stores, the large supermarket chain. Safeway's "Health Measures" plan has marked differences in employee premium contributions that reflect each covered employee's lifestyle behaviors. The plan emphasizes personal responsibility by focusing on tobacco usage, obesity, blood pressure and cholesterol levels. Employees with screening values within established limits or who achieve year-to-year improvements in the values enjoy reduced premium contributions. The company asserts that its per capita health care costs have remained essentially flat since the introduction of its results-based wellness incentive program.

BeniComp Advantage, Inc. has successfully marketed and administered HIPAA-compliant results-based wellness incentive programs for employers. These programs

favor healthy employees with rewards in various forms, including deductible reimbursements, lower premium contributions, and gift cards. Deductible reimbursement plans work in conjunction with high deductible health plans by giving employees the ability to earn their way to a lower "net" deductible as they lower their personal health risks. The results of voluntary health screenings are used to determine the dollar amounts of deductible reimbursement available to each employee – higher amounts are available to healthier employees. Health screens typically included in BeniComp's programs are tobacco usage, body mass index, blood pressure, LDL cholesterol, and glucose. BeniComp consults with employers to select a suitable incentive design, manages complete administration and communication of the incentive program, assists with links to available wellness activities and programs that facilitate lifestyle behavior change, and oversees program compliance with all nondiscrimination regulations. Benton County, Arkansas introduced a BeniComp Advantage program for its 450+ employees in 2006 and saw sharp decreases in its total health plan costs during the first two years. Additional vendors are emerging who focus on the ins and outs of HIPAA-compliant results-based wellness programs for employers.

Cost Savings Experience

Much of the initial employer cost savings under a results-based wellness incentive program spring from

targeted shifts of more premiums or health care costs to employees who persist in unhealthy lifestyle habits. These are tangible savings harvested by the employer from day one. Savings have also arisen when some employees – those with poor screening results or refusing to participate in screening – drop coverage and presumably move to their spouses' plans. Additionally, "bending down" of the future cost trend curve is anticipated as employees faced with higher out-of-pocket expenditures because of failed screens work to break unhealthy lifestyle habits in anticipation of next year's screening, concurrently lowering their risks of chronic health conditions.

Actual results of consecutive years' screenings for a sample of BeniComp's groups give insights into the impact of result-based wellness incentives. The sample included 43 employer groups with 7,640 employees covered under BeniComp Advantage who participated in screenings in each of the two most recent years' screening events. Statistics were gathered as regards improvement in the number of employees with screening values falling in "critical" ranges where lifestyle modification is vitally important.

Encouraging results are seen in year-to-year movement of employees from critical to non-critical ranges. Modern prescription drug treatments allow relatively easy reduction of blood pressure and cholesterol values to non-critical

Results-Based Wellness Programs

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ranges. Body mass index and tobacco use are more “sticky” and require a higher degree of personal discipline to move out of critical.

Positive Change: Critical in Year One to Non-Critical in Year Two

Measure	“Critical” Value	# of Critical Employees in Year One	# of Those Moving to Non-Critical in Year 2	Percent Moving to Non-Critical
Body Mass Index	≥ 30 kg/m ²	2,469	256	10.4%
Blood Pressure	> 140/90 mm Hg	1,010	656	65.0%
LDL Cholesterol	> 160 mg/dL	497	220	44.3%
Tobacco Use	Positive	1,697	168	9.9%

On the other hand, some “backsliding,” characteristic of the average U.S. population trend toward unhealthy lifestyle behaviors, is seen among non-critical employees.

Negative Change: Non-Critical in Year One to Critical in Year Two

Measure	“Non-Critical” Value	# of Non-Critical Employees in Year One	# of Those Moving to Critical in Year Two	Percent Moving to Critical
Body Mass Index	< 30 kg/m ²	5,171	334	6.5%
Blood Pressure	$\leq 140/90$ mm Hg	6,630	473	7.1%
LDL Cholesterol	≤ 160 mg/dL	7,143	314	4.4%
Tobacco Use	Negative	5,943	167	2.8%

Overall, the profile of the entire cohort of 7,640 employees showed fewer critical blood pressure readings, but slightly more critical values of body mass index and LDL cholesterol, and little change in tobacco use. The overall effect of the results-based incentive programs on the cohort appears to be *deceleration* in an unhealthy trend.

Entire Cohort: Change in Number of Criticals

Measure	“Critical” Value	# of Critical Employees in Year One	Percent Critical in Year One	# of Critical Employees in Year Two	Percent Critical in Year Two
Body Mass Index	≥ 30 kg/m ²	2,469	32.3%	2,547	33.3%
Blood Pressure	> 140/90 mm Hg	1,010	13.2%	827	10.8%
LDL Cholesterol	> 160 mg/dL	497	6.5%	591	7.7%
Tobacco Use	Positive	1,697	22.2%	1,696	22.2%

These results have implications for the proper design of results-based incentives that keep all employees on course toward healthier lifestyle habits.

Health Care Reform

The health care bill approved by the Senate Finance Committee contained the “Safeway amendment” which would increase wellness program rewards from 20% to 30% of the cost of employee-only coverage under the plan, and would allow the Secretaries of Health and Human Services, Department of Labor, and Department of the Treasury the discretion to increase the reward up to 50% of employee cost. The amendment was passed by a vote of 18 to 4 in committee. This contrasts with repeatedly stated goals of health care reform of creating a system in which no one can be denied coverage or charged higher premiums based on their health status. However, President Obama has publicly singled out for praise companies including Safeway who “...are able to take initiatives to make their employees healthier, to give them incentives and mechanisms to improve their wellness and to prevent disease...” Look for continuing growth in results-based wellness programs.

For more information, contact Dave Pepler at 260-402-2744, dave@pepleractuarial.com.

Hone Your Sales Skills at Swiss Re Academy

Swiss Re's commitment to professional development is evidenced by the Swiss Re Academy's consultative selling and negotiation techniques course. For nearly two years, the client management development program at Swiss Re has helped individuals hone their soft skills, such as consultative selling and negotiation.

Available to Clients

Many Swiss Re and Summit Re personnel and their clients, primarily those that work with employer stop loss and HMO or carrier medical excess, have participated in this course at the Swiss Re Academy in Kansas City. Although some clients hesitated initially due to travel restrictions and time constraints, they ultimately determined the opportunity and the return were worth the investment.

One Client's Experience

Summit Re's client Dave Fox, director of sales, Health Alliance Medical Plans, said, "The role play situations (where responses from the other party were pre-programmed) were extremely helpful in understanding various buyer dispositions and reactions toward the sales effort. I personally came away with a strongly worded note to myself to better prepare and rehearse for each sales call, anticipating various buyer responses and dispositions."

Course Content

This particular course stresses the importance of setting an agenda, probing for business and personal

needs and providing ideas for solutions before entering into negotiations. A simple process of prepare, ask and listen reaps great benefits.

During the course, participants engage in a needs development exercise that illustrates how making assumptions about a client's needs can result in missing the mark. The exercise helps participants develop the ability to uncover customer circumstances, concerns and the consequences of those concerns on a professional and personal level. This helps them to more effectively identify client needs and solutions.

The excellent instruction is enhanced by solid textbook information and significant interaction and role playing among the participants.

Benefits

Although most sales personnel are very experienced, everyone can improve. Further, individuals that are not typically in sales but support the sales effort can benefit greatly from such a course. The primary benefits of the course include:

- Develops a consistent approach to consultative selling.
- Builds a shared lexicon and culture in sales for better results.
- Equips participants with the skills to enhance sales performance.
- Enhances competitive positions.

By the end of the workshop, participants are better able to:

- Appreciate and advocate the requirement to sell in a consultative manner.
- Differentiate themselves through

a compelling message.

- Identify their preferred selling style, strengths and areas for development.
- Plan and prepare effectively prior to customer engagement.
- Demonstrate the use of multi-level questioning techniques during needs development to identify and prioritize the key needs of a customer.
- Use the needs development phase to raise their relative value.
- Present the benefits of their product/service in a manner that is relevant to the customer's needs.
- Demonstrate the use of the APAC (acknowledge, probe, answer, confirm) tool to manage objections.
- Employ and follow a structured and phased sequence for conducting sales interactions.

Faith Johnston, regional vice president of Summit Re, said, "Having been through the consultative selling and negotiating course, I would absolutely recommend it to our clients. What Swiss Re provides is the textbook definition of value-added."

Summit Re is Swiss Re's exclusive distribution partner for HMO and carrier medical excess reinsurance and provider excess insurance. For more information about consultative selling and negotiating courses at the Swiss Re Academy, contact your Summit Re sales representative, or Anne Cavanaugh, acavanaugh@summit-re.com, 260-469-3003.

Expanded Transplant Network Access

Summit Re's clients have always been free to use the national transplant networks of their choice, and those networks' contracts have been considered to be "approved" for reinsurance coverage purposes. That continues to be the case. However, Summit Re historically has not had formal relationships with multiple networks.

In response to customer requests and changes in the transplant network market, we are pleased to announce

that effective January 1, 2010, we will have formal agreements in place with the following networks:

- CIGNA *LifeSOURCE* Transplant Network
- Cofinity's Institutes of Excellence Transplant Network
- INTERLINK Health Services
- LifeTrac Network
- OptumHealth Care Solutions

All of the networks have gone through Summit Re's rigorous due

diligence process, including on-site visits by Summit Re staff.

We are completing an analysis of the contract terms for each facility for each network by transplant type. While contractual terms are confidential until you execute a written agreement to access the network(s), we will help you determine which network(s) best fit your referral patterns. This service is provided at no charge to our clients. Contact your regional vice president for more information.

New Cost Management Services

Even more cost-savings opportunities are now available through our relationships with companies that specialize in high-cost claims.

Golden Triangle Specialty Network, LLC.

GTSN's focus is on the high costs associated with end stage renal disease. GTSN has created and maintains a network of renal facilities by entering into contracts with outpatient dialysis facilities, vascular ac-

cess facilities, and renal specific laboratories to deliver services at reduced rates for GTSN clients.

London Medical Management, Inc.

London Medical Management specializes in providing assistance with health claim cost containment strategies. The company reaches out to hospitals and other providers when the pre-negotiated discounts are less than desirable or members

have received care from out-of-network providers where no discount applies. Years of experience and the company's internal health claims data provide the confidence their knowledge-based negotiators need to achieve a history of increased savings. The company's philosophy speaks for itself: "Everything is negotiable."

Contact Debbie Stubbs (260-407-3979 or dstubbs@summit-re.com) to access the companies' services.

Key Addition to Employer Stop Loss Team

Summit Re is pleased to announce the newest member of its employer stop loss team, Amy Carlson. Amy brings to Summit Re more than 20 years of knowledge and experience in employer stop loss and health care risk management. She most recently was a senior regional group manager for Symetra Financial.

As regional vice president, Employer Stop Loss, Amy will work closely with HMOs, TPAs and brokers, providing experienced underwriting and service for employer stop loss groups in the western United States. Amy will be based in Chicago and can be reached at 720-201-2868, acarlson@Summit-Re.com.

"It's rare that a company gets the opportunity to bring an employee on board with the skills and level of experience that Amy possesses," said Jon Anderson, vice president and principal of Summit Re. "Her vast knowledge of the employer stop loss market allows her to provide a high level of service to clients and prospects."

Covering Managed Care Vendor Fees

Sometimes, you have to spend money to save money. The following clarifies the handling of fees for the Summit ReSources programs and other vendors.

HMO & Carrier Medical Excess

Our handling of vendor fees is based on the definition of loss in the HMO and carrier medical excess agreements, as follows:

“‘Loss’ means (1) the amount of eligible benefit expenses incurred by the Reinsured for Covered Services under the Reinsured Contracts, and (2) network access, case management, and other related fees and expenses which are *agreed upon in writing by the Corporation.*” (Emphasis added.)

Our preferred Summit ReSources vendors and programs that we approve and promote are always allowable expenses per the reinsurance agreement. Other vendors’ fees may be allowable if they can show savings net of their fees.

Employer Stop Loss

For employer stop loss business, the following treatment applies if the specific deductible is penetrated.

Summit ReSources Vendors: When utilizing this select group of vendors, the entire fee will be considered a claim cost once the specific deductible is penetrated.

Other Vendors:

- PPO/repricing fees—Summit Re will cover up to 25% of savings

when an outside vendor, not related to the TPA, is used.

- Case management fees—Summit Re will cover up to \$100/hour when an extra-contractual case management firm is needed. This will be reviewed and approved on a case-by-case basis.
- Hospital bill audit—if an outside hospital audit vendor, not related to the TPA, is needed to help control the cost of a large claim, Summit Re will allow up to 25% of the savings, if the provider agrees to reduce the claim by the indicated amount.

Please contact Kristin Lahey, klahey@summit-re.com, 260-469-3017, if you have any questions.

It Pays to Check Your Claims!

When Summit Re is working to develop a new relationship with a health plan, our approach is to ask questions and listen carefully to understand the challenges that our future client is facing. Our goal is to be a strategic partner with each health plan. With that valuable input from the client, we structure a solution that best fits the client’s needs, whether it is reinsurance coverage options, medical management consultation or assistance in managing some other facet or risk of the organization.

Part of our initial review includes a thorough analysis of the plan’s

claims data to see if there are any significant deviations from the norms we see based on our national presence in the market. One example was a plan we were reviewing this past summer. The plan included in its submission a summary of reinsurance recoveries and explanations of benefits on all recent claims. In cross-checking that information with the raw claim data, it was noted that the prior reinsurer was reducing claims in excess of the reinsurance agreement limitations. In total, *there were over \$500,000 in reinsurance recoveries that had gone unpaid by the prior reinsurer* and unnoticed by the

health plan. Needless to say, all parties were quickly made aware of the error and the appropriate adjustments were made.

The “take-aways” from this situation are two-fold. First, be certain you are reviewing your reinsurance claim payments for timeliness and accuracy. Everyone is capable of making mistakes periodically, so a careful review of claim payments is essential. As you can see from this example, the findings can be significant. Second, Summit Re pays careful attention to detail, in addition to a strategic, solution-oriented approach that adds value.

Comprehensive Medical Management Evaluations Through Summit ReSources

Summit ReSources provides access to medical management resources that are designed to offer cost savings, primarily through appropriate care management that is focused on clinical outcomes. At the core of Summit ReSources is our medical management consultation. Our professional staff meets with our clients' key medical management staff for information gathering, to identify key issues and to collaborate on resolution. We interact with our clients on a daily basis to provide consultation on a wide range of care management and clinical issues. But some may not be aware of our comprehensive medical management evaluation capabilities.

Evaluation

Our comprehensive medical management evaluation is designed to assess a health plan's current utilization, disease and case management departments and make recommendations on how to move toward the most efficient, cost-effective model while meeting National Committee for Quality Assurance guidelines. The objectives are individualized for each plan but typically include the following:

- Evaluate current utilization management processes, procedures and benchmarks
- Evaluate current case management processes, procedures and benchmarks
- Evaluate current disease management processes, procedures and benchmarks

- Evaluate the communications between utilization/disease/case management and the claims department
- Provide a summary report of findings for:
 - ◊ Utilization management
 - ◊ Disease management
 - ◊ Case management

Process

Both medical and behavioral health services can be included in the evaluation. Data collection is in the form of direct interviews and reviews of policies, procedures and data, including staffing ratios. The results of the data collection are compared to national benchmarks. The comparisons, along with recommendations regarding any changes in medical management structure, are summarized in a final report.

Results

A number of clients and non-clients have taken advantage of this service and have implemented changes to enhance the effectiveness of their programs based on the results of the analysis. Recommendations that have been implemented include:

- Separating utilization and case management functions/staff and improving staffing ratios
- Delegating non-clinical functions to non-clinical staff, thus allowing clinically-trained staff to focus on clinical issues

- Revising pre-authorization and case management referral requirements
- Focusing more on case management than utilization management in an attempt to prevent the need for acute services
- Forming an integrated medical management model
- Revising policies and procedures to improve adherence and staffs' understanding of expectations
- Developing a cost savings methodology for medical management

The objectives are individualized for each plan

- Developing an audit process for medical management staff
- Developing a case management acuity system to better quantify caseloads

This service is provided at customer request. An hourly fee is charged, in addition to travel expenses. Please contact Debbie Stubbs (dstubbs@summit-re.com or 260-407-3979) or your Summit Re regional vice president for additional information.

Is \$9 Million of Savings Value-Added?

One of the principles on which Summit Re was established is to offer value-added managed care programs to complement those of our clients, particularly in high cost areas such as organ transplants, traumas and low birth-weight babies. One of the programs we offer is through GlobalCare Inc.

GlobalCare offers a national PPO network and re-pricing service with average discounts of 25% of billed charges. Summit Re insurance and reinsurance coverages will typically consider GlobalCare's fees as an eligible claim expense if the catastrophic claim exceeds the reinsurance deductible.

With access to over 100 national, regional and local networks, GlobalCare delivers direct savings for out-of-network medical claims. It does this through a single agreement that provides access to multiple PPO networks via one connection. There are re-pricing programs for directed savings, pre-negotiated savings and fee negotiation savings.

GlobalCare Savings Analysis for a Summit Re Client	
Description	Calendar Year 2008 Results
Claims Sent to GlobalCare	43,141
Total Dollar Volume of Claims sent to GlobalCare	\$32,742,231
Total Number of Re-Priced Claims	35,949
Total Dollar Volume of Re-Priced Claims	\$29,066,123
Average Re-priceable Claim Size	\$809
Hit Rate on Dollar Volume	88.8%
Hit Rate on Number of Claims	83.3%
Average % Discount	32.4%
Average Turnaround Time (Business Days)	4.6
Total Savings	\$9,420,049

One client saved over \$9 million on \$33 million of claims sent to GlobalCare, an average savings of 32.4%. "To our client, \$9 million is more than a drop in the bucket. This program is a meaningful contribution to its operating results and a protector of its capital and surplus

position," said Brian Fehlhaber, vice president, Sales and Marketing for Summit Re.

For more information about GlobalCare, contact Anne Cavanaugh at Summit Re, acavanaugh@summit-re.com, 260-469-3003.

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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