

Summit Perspectives

Contents

Health Care Trends: Accountable Care Organization	1
Welcome News	2
Benefit Design Based on Medical Effectiveness	3
Preconception Care	5
Proven Health Navigator SM	6
Stretching Claim Dollars	7
Medicare Value Chain	8
Rising Drug Spending—PBMs	10
Medicaid Managed Care	11
Acquisition Update	12

Business, more than any other occupation, is a continual dealing with the future; it is a continual calculation, an instinctive exercise in foresight.

Henry R. Luce



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Health Care Reform: Now What?

Summit Re recently hosted its 2010 Executive Summit & Networking Retreat at the Charleston Harbor Resort & Marina in Charleston, South Carolina. This newsletter provides a brief summary of the informational sessions. The retreat was designed to allow guests to hear presentations on the issues shaping our industry, learn strategies for gaining a competitive edge in the new health care reform environment, and gain new perspectives from other executives.

Health Care Trends: The Accountable Care Organization Concept and a Return to Provider Risk

**by John Meerschaert, FSA, MAAA
Principal and Consulting Actuary, Milliman, Inc.**

Mr. Meerschaert began his presentation by discussing notable trends prior to the passage of comprehensive health care reform. These include:

1. Employee cost sharing continues to increase. This is in part due to employers shifting ever-increasing costs to employees through contribution rates and conversion to high deductible plans.
2. Payers are looking for more ways to manage cost trends.
3. There has been limited experimentation with alternative reimbursements, such as pressure to obtain a fixed fee payment instead of a discounted fee-for-service arrangement.
4. There has been some small movement to quality incentives for providers.
5. Limited experimentation with alternate care delivery systems has taken place, such as the medical home, where payments are often bundled for selected episodes of care (most prevalent where virtually all components of care can be delivered by the same legal organization).
6. Residual capitation pockets dating back to the 1990s continue but have not increased due to concerns regarding providers' interest in capitation and their ability to manage risk.

Commercial insurance

The speaker believes health care reform will change health care markets in the following ways.

1. More people will be covered by insurance with fewer restrictions (for example, removing the limitations on pre-existing conditions, coverage parameters and

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Welcome News

Summit Re is pleased to announce the following new employees in our employer stop loss operations.

Shane Kemerly

Shane joined Summit Re on January 26. Shane has over 15 years of employer stop loss sales experience. He will be responsible for a defined territory for employer stop loss sales, primarily in the eastern and southeastern United States. His job will be offering and servicing the value proposition that Summit Re provides its clients. Shane will operate out of Lapel, Indiana.

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Charleen Dugas

Charleen joined Summit Re on March 29 and will be based in Indianapolis. Charleen brings her 14 years of underwriting experience to the benefit of new business and renewals for selected clients.

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Jeana Kidd

Jeana joined Summit Re on May 17. She has over 20 years of experience in the health care and insurance industries. Her primary focus will be on administering our comprehensive managed care programs for our self-funded clients. She will also conduct reviews of

large claim notices and support underwriting staff in the disclosure process. Jeana will be based in Minneapolis.

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Jon Anderson, vice president, Employer Stop Loss said, "The addition of Shane, Charleen and Jeana to Summit Re renews and strengthens our commitment to the employer stop loss marketplace and will allow us to capitalize on new opportunities. I am confident that we will deliver exceptional service to our clients and be a resource to them as the demands on employer stop loss protection change with health care reform."

Scott Terhaar

Summit Re is also pleased to announce the hiring of Scott Terhaar as senior underwriter. Scott will join Summit Re on June 14. Scott will assist Brian Shively and Greg Demars in our HMO-carrier-provider excess underwriting unit. He will be based in our Minneapolis office. Scott holds a bachelor of arts in mathematics degree from the University of Minnesota and brings 15 years of experience to Summit Re.

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Benefit Design Based on Medical Effectiveness Research: Challenges and Feasibility

Michael E. Rieth, FSA, MAAA, Consulting Actuary
CIRDAN Health Systems and Consulting

In the current health care environment, where costs are perennially exceeding general inflation, there is significant time and energy spent on researching ways to slow that cost growth. One area that is enjoying increased focus in recent years is the design of benefit plans for the purpose of increasing the utilization of care that has been proven to be effective.

Essential Benefit Set

Mr. Rieth shared how he and a work group made up of representatives from providers, health plans, state agencies and employers were given the charge by the Minnesota Commission on Health to define an Essential Benefit Set (EBS). The primary objective of the EBS is to provide more cost-effective and affordable health insurance coverage by encouraging the increased use of evidence-based health care services and, as a result, less use of ineffective or low-value services.

The definition of an EBS for the work group's purposes was a benefit set comprised of a broad range of services, procedures, tests and technologies that have been proven to be clinically and cost effective. This is then overlaid with lower enrollee cost sharing for the EBS, which will increase utilization of the proven benefits.

Conclusions

The conclusions of the group included the following:

- There is significant opportunity to improve outcomes and reduce costs, both through the increased use of effective services and, of equal importance, decreased use of ineffective services. While changes in plan design may have a role, other approaches, such as provider network design and payment reforms, are needed.
- The determination of whether services have been provided in a clinically appropriate and cost-effective manner is, in most cases, too complex to evaluate and administer through standard covered service descriptions as expressed in a plan document or through standard claim adjudication.
- Because of this challenge, the group refrained from creating a static list of covered services, but created an "Essential Benefit Set Certified Product" designation, which is assigned to a health insurance product that provides coverage based on scientific study and evidence of clinical and cost effectiveness, as described in detail in the report.
- EBS Certified Products would cover evidence-based clinical services and exclude categories of service that do not meet requirements. Cost sharing would also vary based on effectiveness review.

Value-Based Insurance Design

This EBS project does closely relate to another term worth mentioning

and growing in popularity, called value-based insurance design (VBID). VBID is insurance design that focuses on the concept of value, which it defines as a measure of both cost and quality. A service must reflect both of these traits, which lead to the goal of maximizing health outcomes at any given level of expenditure. This concept includes many of the following best practices in current designs:

- Use of disease management and wellness programs to target high risk patients
- Incentives to use high-value providers
- Patient monitoring and compliance requirements as conditions for cost sharing reductions
- Rigorous evaluation of the clinical and financial aspects of programs to continuously refine the VBID

Value-based purchasing is a related term used in the market. It focuses on increasing the overall value of a health plan by contracting with high quality providers and providing incentives to providers to adhere to evidence-based practice guidelines. Reduced cost sharing can provide incentives to members for using these providers.

It is an exciting time of change and innovation in the health care arena. Many of the topics discussed in this presentation will certainly play a material role in those changes.

Health Care Trends: The Accountable Care Organization Concept and a Return to Provider Risk

Continued from Page 1

- maximum benefits, and guaranteed renewal).
- 2. Insurers will have more regulatory oversight (minimum loss ratios, premium approval requirements and mandated benefits).
- 3. State-based exchanges for individual and small group markets will emerge.

Medicaid

Changes for Medicaid lines include:

1. There will be significant increases in enrollment due to easing of Medicaid enrollment criteria.
2. State and federal budget issues will be exacerbated.
3. There will be pressure for the development of standardized Medicaid / Medicare reimbursement schedules.

Medicare Advantage

Medicare Advantage plans will be affected by health care reform in the following ways:

1. Government payment rates will decline over time.

2. Plans will be able to earn small bonuses based on quality.
3. Benefits will likely be reduced given decreased payment rates.

Cost Control

Cost control pressures resulting from health care reform include the following:

1. Payers will be looking to reduce provider payments through fixed fee arrangements, global capitation or system-wide payer contracts.
2. More provider integration will take place due to merger and acquisition, pressure for economies of scale, and cost and capital constraints. This will allow more control of the delivery of care.
3. There will be more measurement of quality outcomes and best practices.
4. Technology improvements will focus on supporting care management.
5. Financial incentives will be provided for providing high-quality, cost-effective care.
6. There will be significant changes

in the utilization and mix of provider services, with shifts to lower-cost services.

Short-Term Payer Strategies

Given these trends, short-term payer strategies for managing costs include:

1. Continuing the emphasis on high-cost diseases
2. Increased pay for performance and pay for quality outcomes
3. Increased use of provider “tiering” strategies to neutralize high-cost facilities

In addition, there will be more emphasis on modifying member behaviors through education, incentives, steerage, utilization and case management, and compiling and sharing comparisons of provider quality, costs and outcomes via on-line tools.

Accountable Care Organizations

Health care reform introduces accountable care organizations (ACOs) as pilots for Medicare. The emphasis will be on savings due to decreased reimbursements, member assignment, quality, and savings initiatives.

There may also be commercial and Medicaid applications for entities desiring to assume more risk, given their ability to deliver high quality, cost-effective care. Capitating ACOs may provide more stability in a world with minimum loss ratio requirements.

Contracting Matrix

Potential Reductions for Utilization and Service Mix	Recommended Contracting Approach
Low	FFS – monitor risk factors
Moderate	FFS with limited risk corridors
High	FFS with broader risk corridors
Demonstrated reductions and/or health system goal	Full capitation

Continued on Page 5

Improving Birth Outcomes with Preconception Care

Charles Kight, President and CEO, Community First Health Plans

Mr. Kight described Community First Health Plans' (CFHP) innovative approach to addressing maternity claims, a major source of catastrophic claims for Medicaid populations.

Incidence and Costs

In 2006, CFHP noticed an increase in the number of pre-term and low-birth-weight births among Medicaid women. This is a significant issue since low-birth-weight infants who survive their first year are more likely to experience long-term developmental and neurological disabilities than are infants of normal birth weight (2500 grams). Therefore, CFHP decided that the most important thing it could do is to improve birth outcomes.

Mr. Kight shared a few startling statistics regarding this problem. The average hospital charge for newborns without complications is only \$1,500, whereas for premature

infants, average charges approach \$79,000. Approximately 2% of Texas Medicaid births were diagnosed as "extremely immature" – yet these births accounted for 52% of Medicaid birth paid claim expenses. Women on Medicaid are 2.5 times more likely to have had one or more short-interval births (less than 18 months between births) and this leads to higher rates of pre-term and low-birth-weight infants. Although all health care payers, public and private, share the cost of this public health problem, Medicaid plans in particular bear much of the burden.

Spacing Pregnancies

The studies clearly indicated that spacing pregnancies more appropriately can improve outcomes. CHFP's proposed solution to this significant problem is called "preconception care". Preconception care is a set of interventions that aim to identify and modify bio-

medical, behavioral and social risks to a woman's health and related pregnancy outcomes through prevention and management.

Components and Rationale

Preconception care components include a physical assessment of the member, risk screening for physical activity, nutritional status and weight status, a review of substance abuse and other risk factors, as well as providing vaccinations, education and counseling. The rationale for preconception care includes the fact that there has been little improvement in low-birth-weight / pre-term deliveries by improving access to pre-natal care only.

Although a health plan may not always be able to predict pre-term or low birth weight, it may focus on secondary education and prevention. This approach pays dividends for the members and the plan.

Health Care Trends: Accountable Care Organization

Continued from Page 4

Important Conclusion

One important conclusion for integrated health care delivery organizations analyzing payment structure risk and dynamics is that they may be better off financially if they assume more risk (e.g. capitation) and capture the reward for improved outcomes and cost-effective health care.

The integration of the organization should be positively correlated with the contracting methods. The more fully integrated the organization is,

the more it should consider comprehensive payment bundling, such as capitation and global case rates.

Relative Risk of Potential Decline in Aggregate Provider Payments (Assumes Stable Patient Base)

Payment Method	Unmanaged Utilization	Declining Utilization
Discounted charges	Very low	Very high
Fee schedules	Low	High
Bundled payments	Low / moderate	Moderate
Incentives or risk corridors	High	Moderate / low
Capitation	Very high	Low

Proven Health NavigatorSM and Proven Care – Geisinger Health Systems' Medical Home Model

Janet Tomcavage, RN, MSN, Vice President of Health Services
Geisinger Health Plan

Geisinger Health Plan chose its approach to managing health care because it felt that the health care system produces marginal quality due to uncoordinated patient care, escalating costs and inattention to the burden of growing chronic diseases.

Based on Partnership

It decided to create a partnership between the health plan, hospitals and primary care physicians, with each party doing what it does best.

A partnership between the health plan, hospitals and primary care physicians to transform primary care from transaction-based to value-based and outcome-based

For the health plan, this includes population analysis; aligning the reimbursement and financing of care to emphasize successful outcomes; engaging the member, employer and provider in delivering successful outcomes; and then reporting on the results. For the hospitals and their primary care physicians, this includes identifying best practices, designing systems of care to support those best practices, educating patients and families on the appropriateness of care for these settings, and then continual monitoring and reporting.

Targets

The targets of this Geisinger partnership and transformation of care delivery were unjustified variations in health care outcomes, the fragmentation and delivery of the care, the perverse payment incentives (focusing on piecemeal work rather than outcomes) and the patient as a passive recipient of care rather than an active participant.

Proven Health NavigatorSM

The main program discussed was the Proven Health NavigatorSM, a patient-centered “medical home” model. The objective of the program was to transform primary care from a transaction to a value-based and outcome-based focus. The Proven Health

Navigator steers the parties in the health care delivery system to improve quality and efficiency across the spectrum of care.

Functional Components

The five functional components of an effective integrated medical home model are:

1. *Patient-centered primary care*
This requires patient and family engagement and activation through education and informed decision making. A physician-led team must set the stage for the expectation of care and the

effective utilization of chronic disease and preventive care programs.

2. *Innovative population management*

This involves effective population profiling and segmentation, health promotion and primary care on site, case and disease management and remote monitoring, and pharmaceutical management.

3. *Value care systems*

These require the effective use of the resources provided by high volume specialties, radiology, lab and care received in the hospital, home health or skilled nurse facility settings, as well as emergency room coverage and community outreach services.

4. *Quality outcomes program*

This requires a positive patient experience and the effective monitoring of satisfaction. In addition, this requires proper monitoring of disease metrics for diabetes, congestive heart failure, coronary artery disease and hypertension. Lastly, preventive service metrics focus on HEDIS scores. It requires active involvement of providers through pay for performance for quality outcomes and value-based incentive payments based on the efficiency of results and achievement of quality metrics.

Stretching Claim Dollars: How Far Can You Go?

Donn Duhon, Vice President, TPA Sales, SIHO Insurance Services

Linda Burk, Director of Self-Funded Services, Health Alliance Medical Plans

Julie Lampe, Manager, Underwriting, Preferred Health Systems

A Continuous CARE Model

Mr. Duhon began the presentation by describing how SIHO adapts its operations to meet each employer's specific needs through a continuous "CARE" model, a process for customizing health care solutions for each group member.

The key components of the CARE system include:

- **C**ategorize by determining the health status of each member.
- **A**ssess the medical and/or wellness needs of the member.
- **R**ecommend the proper level of care or treatment needed.
- **E**valuate with continuous follow up of member status.

The comprehensive program includes case and disease manage-

ment, worksite wellness programs such as health fairs, nurse practitioners, predictive modeling and wellness tools. Nurses become valuable information resources, advocates and coaches for employees.

Partnering with Employer Groups

Ms. Lampe focused on stewardship in managing employers' dollars. She also believes the key to success is via establishing a partnership with employer groups. The partnership focuses on value-based benefit design and service to promote wellness and prevention, and steerage to high quality, cost-effective network providers (often tiered networks). The partnership continues by identifying cost drivers, providing price transparency and delivering valuable management information re-

porting of utilization and claim experience to provide the employer groups with the tools they need for proper analysis and prospective decision making. As with SIHO, the value proposition also focuses on delivering a continuous spectrum of care management through effective pre-certification, large case management and utilization review programs. The partnership concludes with claim audits to make sure the plan is getting what it paid for.

Combining for Strength

Ms. Burk concluded the presentation by describing how Health Alliance Medical Plans combines the provider contracting and medical management strengths of an HMO/insurance company with the cost-effectiveness and excellent service of a TPA.

Proven Health NavigatorSM and Proven Care – Geisinger Health Systems' Medical Home Model

Continued from Page 6

5. *Value reimbursement programs*
These require pay-for-performance measures linked to provider efficiency and quality metrics.

Geisinger believes that creating a successful delivery model requires

the daily presence of an advanced practitioner, called an embedded case manager, a focus on redesigning care through reconciliation of medications, early identification of acute conditions, focus on prevention, and enhanced connectivity to the case management and primary care teams for discharge planning.

This model has been applied by Geisinger Health Plan to a number of procedures and conditions, including coronary artery bypass grafts, stent placement, cataracts, hip and knee replacements, obstetrics and gastric bypass surgery. In each case, the approach is the same: outcomes-based, patient-centered medicine.

The Medicare Value Chain – A Survival Guide

Lindsay Resnick, Chief Marketing Officer, Gorman Health Group

Mr. Resnick began by describing the changing Medicare landscape. Health care reform will reduce government reimbursement for Medicare Advantage plans. He then offered a path to success for those who wish to remain involved with Medicare programs.

The current Medicare marketplace is broken down as follows:

Program	Covered Lives
Original Medicare	34.2 million
Medicare Advantage	11.4 million
Prescription Drug Part D	17.7 million
MediGap	9.6 million

We all know the aging population will increase the number of seniors and, hence, Medicare enrollees.

The primary impact of health care reform on Medicare Advantage programs is changing the reimbursement level to be more consistent with the funding provided for traditional Medicare enrollees. In addition, health care reform initiates the closing of the “donut hole” for prescription drug programs (PDPs).

Successful companies will need to find a way to demonstrate value in a market which is growing due to increased enrollees, but may also become slightly reduced due to government reimbursements and a potential return of many enrollees to “original” Medicare given reduced benefit incentives.

Major changes to Medicare due to health care reform are shown on the chart on page 9.

The new standard reimbursements and bonus payments will be phased in over time based upon Medicare Advantage benchmarks versus fee-for-service programs. High performance plan bonuses can be achieved by offering programs that manage chronic conditions, having efficient operations and promoting wellness through screenings, tests and vaccines.

Medicare Value Chain

A core component of the presentation included an analysis of the Medicare value chain. A value chain describes areas where significant value is created in a product or operation. The objective is to maximize the value chain since it improves one’s competitive position and profitability.

Product portfolio –

A variety of Medicare Advantage PPO, HMO and special needs programs can be designed to meet the diverse needs of various income groups. Products designed should take into consideration reimbursement changes, market demographics, the competitive landscape and Medicaid program direction.

Regulatory compliance –

A plan must know Medicare Advantage rules to limit exposure to legal and financial penalties. Regulatory scrutiny over Medicare Advantage marketing and sales will intensify to increase protection for seniors from abu-

sive or misleading practices. This compliance will require additional reporting of costs and utilization statistics.

Revenue management –

The plan must maximize the value of its revenue through appropriate service area selection, enrollment reconciliation, eligibility management and risk adjustment factors. It’s this “blocking and tackling” in particular that separates winners from losers going forward.

Reform will change reimbursement of Medicare Advantage programs to be more consistent with traditional Medicare

Customer service –

Given the increased financial impact of adding or losing members, excellent customer service is even more important during these times of transition, as beneficiaries are seeing changes in their benefits and cost sharing. The more successful is the interaction with the customer throughout year, the greater is the retention rate. Plans with retention issues should analyze who is disenrolling and why, and develop programs to increase customer satisfaction and loyalty.

The Medicare Value Chain – A Survival Guide

Continued from Page 8

Medical management –

Medicare Advantage has always been about successful medical management. Seventy-five percent (75%) of Medicare costs are tied to chronic conditions, so programs need to be continued, developed and enhanced to manage these conditions. Many new pilots focus on a patient-centered “medical home”, wherein health plans are more actively involved by interacting through nurses and other mechanisms with patients to effectively coordinate care.

Accountable care organizations are seen as leading to quality and cost improvements for Medicare fee-for-service programs. ACOs

are the new buzz word for opportunities under health care reform. They are based around integrated delivery systems, such as physician-hospital associations and academic-medical associations. They share responsibility for the cost and quality of care for the assigned beneficiaries. Financial incentives and disincentives are provided when care targets are met or not.

Marketing –

Smart marketers are using customer profiles to more effectively leverage their brands, manage the tactical product mix and deploy scarce resources. Find out what’s important to customers, what concerns them and how to make their

experiences with the plan optimal. Medicare Advantage sales involve agent selling, web-based leads, telemarketing and other retail brand builders.

Future Success

In summary, Gorman Health Group feels that future Medicare winners in the new health care reform environment will be plans that seize opportunity while managing risk. They can do this by implementing value-added programs, integrating medical management, aligning with key providers, managing revenue, developing successful marketing and product strategies for today’s senior consumers, and meeting regulatory requirements.

Major Changes to Medicare

Medicare Advantage

Medicare Advantage payments	Reduces payments to fee-for-service levels over 3-7 years
Coding intensity	Health and Human Services determines appropriate adjustments to risk scores
Quality bonus	Increases payments to plans that achieve at least a 4-star quality rating
Minimum loss ratio	Plans refund revenues that do not meet minimum 85% loss ratio requirements
Beneficiary rebates	Phases in a new beneficiary rebate tied to the quality rating of the plan

Part D

Discount on brand name drugs	50% discount
Closing the coverage gap	\$250 rebate for beneficiaries reaching the coverage gap and phases down beneficiary costs in the gap from 100% to 25%
Elimination of tax deduction for retiree drug subsidies by employers	TBD

Rising Drug Spending – How To Get the Most From Your Pharmacy Benefit Manager

Roy Armstrong, Principal, The Target Group

Douglas Pick, President and CEO, Pharmaceutical Technologies, Inc.

In the 1980s, drugs represented 5% of a typical employer's benefit plan costs. Now, they approach 13%. Given this inexorable rise in drug spending in employee benefit plans, a health plan striving to be successful at controlling costs must maximize the value of its PBM relationships.

Brand-name drug pricing is comparable among many PBMs, while generic drugs have the most significant variation

Benchmark PBMs assist employer groups in controlling costs, creating good plan designs and providing drug cost and utilization transparency. Mr. Armstrong's presentation provided a candid review of issues associated with PBM contracting and administration. These include how they price for their services, including administration fees, rebates and mail order.

Brand Name Versus Generics

Although many clients focus on brand-name drug pricing, brand-name drug pricing is comparable among many PBMs. It's actually the generic drugs that have the most significant variation in pricing.

This is evidenced in particular in the great difference between average wholesale price / sticker price and maximum allowable cost (the maximum a PBM will pay a pharmacy for a particular generic drug, regardless of who manufactures it). The maximum allowable cost is often only 5% of the average wholesale price for generics.

Generic utilization is one of the best and quickest ways to decrease drug costs. Therefore, to obtain a complete and accurate picture of PBMs, one must evaluate both brand and generic pricing. Look beyond the surface! What appears to be a better deal due to rebates, no administration fees and discounts for brand drugs may *not* be the best deal. It depends on the costs of the drugs being provided and both the generic and brand utilization.

Spread Pricing

Look for differences between what the PBM pays the pharmacy for prescriptions filled versus what the PBM bills the plan sponsor. A PBM often makes most of its profit on this brand and generic drug pricing spread. In addition, a mail order pharmacy controlled by a PBM also needs to provide maximum transparency to make sure there is no unusual spread pricing in the mail order pharmacy arrangements. One also cannot consider administration fees alone as a metric in the

PBM selection process. One must look at the PBM administration in conjunction with all other aspects of the program pricing.

Rebates

Pharmacy rebate practices are often difficult to understand. The golden rule of rebates is, "The sponsor cannot possibly obtain enough rebate to make a brand drug a better value proposition than an appropriate generic drug." Rebate practices are an important component of PBM analysis. However, promoting generic drug usage is still the major issue to address to maximize cost control. The more generics a plan utilizes, the lower the rebates, but the better the plan's claim experience will be.

Reporting

Another important safeguard is to obtain the PBM's maximum allowable cost list and updates as part of the reporting requirements for each billing cycle. This provides a plan sponsor with the raw material to purchase or renew with knowledge. Transparency is essential to derive maximum value from the PBM program.

As a general rule of thumb, generic drugs should be nearly 58% of the total prescriptions provided. Also, for each 1% shift in generic drug usage, the sponsor may experience

Medicaid Managed Care: A Successful Public-Private Collaboration

Thomas Johnson, President and CEO, Medicaid Health Plans of America

Health care reform will present significant opportunities and challenges for Medicaid managed care plans. Most expect more enrolled Medicaid managed care lives due to health care reform as the state and federal governments promote this public / private partnership to deal with the significant amount of the uninsured below the poverty level. Mr. Johnson estimated there will be 16 million new enrollees through expansion of Medicaid SCHIP eligibility and extension of special needs plans and dual eligibles. Many of these will end up in Medicaid managed care plans.

The prevalence of current Medicaid managed care lives is dramatic evidence of the success of these programs. Medicaid managed care is in use in 47 states and the District of Columbia. As of 2008, 71% of Medicaid enrollees were in managed care plans. They must be doing something right!

Benefits to States

States continue to look to Medicaid managed care plans to provide innovative, cost-effective new programs, such as long term care and behavioral health disease management to manage the significant health care needs of these large populations. Medicaid managed care plans control costs while providing high quality care to a disparate and unique population through collaborative approaches with providers, including pay for performance, patient-centered medical homes and disease management programs. Medicaid managed care plans are more adept at providing reports on quality and producing higher quality outcomes than fee-for-service Medicaid programs. Medicaid managed care plans help states control costs through risk-based capitation arrangements, pharmacy and disease management programs, and efforts to minimize fraud, abuse and costly medical errors.

Challenges

There will be challenges, such as the establishment of proper funding levels, the need to deal with duplicative government oversight and the current lack of understanding by some regarding the industry and its value proposition. The fiscal crisis has created a heavy burden for financing existing health care costs, let alone new reform initiatives for this large state and federal obligation. Medicaid managed care plans will need to continue to explain and expand their value proposition to the government payers to remain successful.

In summary, Mr. Johnson feels the future is very bright, as the Medicaid managed care industry is expected to grow as long as it continues to demonstrate value through cost savings, quality improvement and innovation, redefining Medicaid managed care as a modern delivery system, not just a contracting arrangement.

Rising Drug Spending – How To Get the Most From Your Pharmacy Benefit Manager

Continued from Page 10

a 1% decrease in total cost. Lastly, the sponsor should expect a generic drug discount equivalent to average wholesale price less 60%.

Take Control

It's also important to remember that the health plan or employer as plan

sponsor is in the driver's seat. The customer should take control and set the direction. Do not accept excuses that the utilization and cost data are not available. The PBM must have this data to bill the health plan and it's your data! However, another little known fact is that

PBMs often sell non-PHI data on providers' prescribing patterns to drug companies so they can target their marketing efforts to the physicians not prescribing their drugs.

How does your PBM compare?

Acquisition Update

Summit Re was acquired by Companion Life Insurance Company on December 31, 2009. What's the same? What's changed? How's it going?

In the employer stop loss business, Summit Re is now an insurer-owned managing underwriter. Although we're no longer "independent", Summit Re continues to operate in this marketplace with no change in our approach.

The Executive Summit & Networking Retreat reaffirmed our commitment to supporting your risk management, reinsurance, and product development needs. Summit Re's management team and staff remain in place and this change in ownership will have no impact on Summit Re's exclusive relationship with Swiss Re.

Companion Life is an A+ rated insurer based in South Carolina. Summit Re is a leading underwriter of reinsurance solutions for health

plans and insurers. The combination of our companies provides a strong foundation for further growth. Summit Re's philosophy and business model of working with reinsurance buyers, providing professional risk analysis, and assisting independent plans in raising their competitive posture remain at the core of how we do business.

As part of the acquisition, Companion Life and Summit Re management requested and received the requisite Swiss Re approval for Summit Re to continue in its role as a managing underwriter for Swiss Re for various medical excess-of-loss reinsurance lines, including HMO, provider, carrier medical excess reinsurance and employer stop loss insurance.

Jeff Argotsinger, Senior Vice President of Swiss Re, said, "We are pleased to continue our now 10-year relationship with Summit Re. Swiss Re values its exclusive relationship with Summit Re and our

joint approach to the medical excess-of-loss business, focusing on consultative expertise, transparency, benchmark service and value-added managed care services. We look forward to working with Summit Re in meeting the risk needs of our commercial, Medicare and Medicaid clients as the market faces a new health care reform environment."

Summit Re continues to operate in these markets on the same basis and with the same objectives as before. Summit Re still underwrites medical excess reinsurance exclusively on behalf of Swiss Re and acts as a managing underwriter for employer stop loss insurance for both Swiss Re and Companion Life.

Our value proposition has not changed from the time we started the company in 1999. Summit Re's business model is to work with insurance and reinsurance buyers, provide professional risk analysis and assist independent plans in improving their competitive positions.

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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