

# Summit Perspectives

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Give us the tools and we will finish the job.

Winston Churchill



**Corporate Office**  
 7030 Pointe Inverness Way,  
 Suite 350  
 Fort Wayne, IN 46804  
 260-469-3000  
 Fax 260-469-3014

www.Summit-Re.com

## What's in Your Toolbox?

### A Special Report from Summit Re's 2009 Executive Summit & Networking Retreat

Summit Re hosted its 2009 Executive Summit & Networking Retreat at The Hyatt Regency Hill Country Resort and Spa in early May. The retreat was designed to allow guests to:

- Hear brief presentations on the issues shaping our industry
- Learn strategies for gaining a competitive edge
- Discuss what's working, and what's not working
- Network with colleagues

- Gain new perspectives from other executives

The theme for this year's event was "What's in Your Toolbox?" The speakers focused on how health plans can ensure they have the tools to operate at their professional best. This newsletter summarizes the content of their presentations. If you would like additional information, please contact Anne Cavanaugh at 260-469-3003.

## Healthcare Trends: A Brief History and Prediction of the Future

**Michael Sturm, FSA, MAAA**

**Principal & Consulting Actuary, Milliman**

Mr. Sturm, in our keynote address, presented a macroeconomic view of the healthcare marketplace, including both commercial and governmental programs. In addition to the usual statistics on trends in medical cost frequency and utilization, the presentation provided an analysis of certain current paradigms.

### The 2.5% Rule

One paradigm was the 2.5% rule – the historical pattern of healthcare costs' exceeding overall GDP by 2.5%. The primary cause is that we do not limit or require value standards to be applied to any type of new care or technology.

Eliminating the 2.5% rule may require that we put healthcare spending for the nation on a budget (yes, rationing). This would also limit research and new technology innovations.

Through an analysis of our own economic data as well as that of other countries, it becomes clear that increased wealth results in increased spending on healthcare. Therefore, it's logical that we spend more here than many other countries, given the fact that the U.S. is one of the wealthiest nations in the world.

## Summit Re Contacts

Mark Troutman  
President  
mtroutman@summit-re.com  
260-469-3010

## Health Plan Contacts

Brian Fehlhaber  
Vice President  
bfehlhaber@summit-re.com  
260-469-3004

Larry Stickell  
Vice President  
lstickell@summit-re.com  
260-469-3009

John Broyles  
Regional Vice President  
jbroyles@summit-re.com  
904-269-5618

Faith Johnston  
Regional Vice President  
fjohnston@summit-re.com  
720-746-1366

## Stop Loss Contacts

Jon Anderson  
Vice President  
janderson@summit-re.com  
260-469-3002

Chris Alexander  
Regional Vice President  
calexander@summit-re.com  
704-544-9428

Amy Carlson  
Regional Vice President  
acarlson@summit-re.com  
720-201-2868

# How Health Plans Make Money

## Merit Smith, Vice President

## Robert E. Nolan Company

Mr. Smith provided a presentation on how health plans make money. Economic value can be created in a health plan through any or all of the following operations: investments, health plan administration, benefit funding.

### Investments

A health plan can make money through investments by investing premiums, albeit for the short term, until claims payments are due.

### Administration

Health plan administration can be broken down into claims payment, service and other expenses. If the operation manages expenses better than those included in the premium, there is a gain from health plan administration.

### Benefit Funding

Lastly, benefit funding is essentially the risk-taking capability of the plan. The plan makes or loses money depending on whether or not claims come in better or worse than

expected in the premium development.

Why is it important to know this? Isn't it common knowledge? The point is that the better a plan is at breaking down its profits and those of its competitors into their component parts, the better it can respond in an appropriate manner when problems occur or opportunities arise.

### Improve Earnings

Key principles for improving health plan earnings include the following:

- Short-term spending can be controlled faster than revenue can be generated.
- Short term untargeted spending reductions will have short-term success and long-term adverse consequences.
- If you have a revenue problem, solve it with revenue solutions, such as rating actions (increasing premiums). If you have an administrative expense problem, solve that through reorganization and revising administrative expenses.
- Reinsurance can be used to reduce earnings volatility.

In general, profits are more sensitive to revenue than expenses. In other words, you can increase profitability quicker by increasing revenue than by adjusting expenses.

## REVENUE LEVERAGE EXAMPLE

	Old	New	Change	% Changes
<b>Premium</b>	100	101	1	1%
<b>Claims and Expenses</b>	97	97	0	0%
<b>Profit</b>	3	4	1	33%

*This illustrates that a 1% increase in premium revenue produces a 33% increase in profit.*

## Competing in Today's Market

### Julie Lampe, MBA, FLMI, Manager, Underwriting Preferred Health Systems

Ms. Lampe provided a presentation on how her health system competes in today's market, both as an HMO and a TPA. Preferred Health Systems is an affiliate of Via Christi Health System.

#### Overly-Aggressive Strategies

Common strategies used by competitors in Preferred Health Systems' marketplace include:

1. Aggressive pricing to gain market share
2. Analyzing only very recent experience, rather than 2-3 years of experience
3. Disregarding claims from terminated members
4. Withholding claim information from employer groups to make it more difficult to switch carriers
5. Pricing aggregate employer stop loss corridors at 115%, rather than 125%

#### Appropriate Response

When competitors take such aggressive moves, your first reaction should not be to match their tactics, but rather to take a deep breath and realize that:

1. Competition is healthy for the economy
2. Patience and willingness are needed to ride out overly aggressive competitor pricing and underwriting strategies
3. Membership growth must come at a profit, rather than at a loss

4. The insurance or reinsurance business is cyclical and sometimes includes years of losses

#### Competitive Advantages

Julie suggests carriers adapting their HMO medical management capabilities and provider arrangements for the employer stop loss market find their own niche. Rather than focusing on price, make sure the employer understands the value of the proprietary networks and medical management capabilities being brought to bear on the overall cost of the benefit program.

Provider-owned entities have an advantage if their parents provide strong contracts that apply to both self-funded and fully-insured groups. Smaller, regional plans are more able to focus on quality management, utilization management and disease management programs, as well as service and flexibility. These plans may be able to emphasize their local operations, including claim payment, as people still prefer to do business with people they know, like and trust.

Plans also need to focus on strong underwriting and rating practices, including appropriate selections of industries, utilization of actuarially sound methods, and combining experience and manual rates, as well as looking for employer groups that focus on forming good, long-term

partnerships, rather than focusing solely on rates.

System automation can provide increased underwriting efficiency. Preferred Health Systems is working toward the launch of an automated sales module that will allow the company to develop quotes quickly and engage the broker community in the underwriting and servicing process.

The presentation ended with a positive reminder that health plans can compete with the major chains of the Blues, United, Cigna and Aetna

**When competitors make aggressive moves, your first reaction should not be to match their tactics.**

if they possess visionary leadership, a willingness to be flexible with change, a desire to live outside the box where appropriate, and a willingness to meet market needs on a profitable basis. A health plan cannot and should not compete on price alone, but rather should sell its organization's strengths, including local operations and parental support, excellent medical management capabilities, provider arrangements and customer service.

# Healthcare Trends: A Brief History and Prediction of the Future

Continued from Page 1

## The 2.5% Rule: Will it Change? Who? When? How?

### Consumers

- Most are not materially affected by the price increases.
- They simply want the best health care.
- They don't know the real reason for cost increases and blame the plans.

### Health Plans

- Are not the problem, but usually get the blame.
- Historically, they've tried to limit cost increases, but get no credit.
- They compete on plan design, care management, and discounts, not on how to reform health care, but many take reform on as a pet project.

### Employers

- Not happy but they lack leverage to drive change at a national level.
- Distracted by other business issues.
- Reaction is to limit cost increases by cost shifting.

### Government

- Only candidate with enough leverage to effect change.
- Do they really understand what's causing the problem?
- Can they attempt to lower health costs and remain in office?

## The "Big Three"

Any healthcare reform is always about the "big three"—cost, access and quality. Although there will be a variety of proposals made, they will all need to address those issues. There are differing opinions about how much health care spending will increase with universal coverage. Mr. Sturm's estimate is \$100 billion per year. What is more interesting are the facts about the uninsured themselves.

## Facts about the Uninsured

26 million of 46 million are:

- Eligible for SCHIP (11 million)
- Earn more than 300% of the Federal Poverty Level, or \$88,000 for a family of four (9 million)
- Not U.S. citizens (6 million)

The vast majority of the remaining 20 million are generally young and healthy. Nonetheless, young,

healthy uninsureds do get sick. What happens?

- *Knee replacement:* They don't get one.
- *Heart attack:* Hospital will take them and assign a physician.
- *Diabetes/cancer:* Sometimes they get free prescriptions. They can't get admitted to hospital and few hospitals will give chemotherapy. They often can't get a doctor to see them, so they get sicker until they are "admittable." They vacillate between home and the hospital until they recover or die.

## Quality of Care

With respect to quality, one can clearly look at infant mortality rates by country and see that the U.S. is not the best despite its higher spending. However, Mr. Sturm challenged whether or not World Health Organization statistics are really comparing apples to apples in case severity mix. The U.S. does have excellent cancer survival rates and the ability to deal with increasingly complex neonatal populations.

Lastly, the impacts of reforms on the "big three" were provided and the chart on page 6 summarizes the impact.

Although he didn't predict the future, Mr. Sturm did set the stage for scenario planning around possible outcomes.

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## Piecing Together the Stop Loss Puzzle

**Jon Anderson, Vice President and Principal, Summit Re**

Mr. Anderson led this workshop designed to focus on best practices for the various players in the employer stop loss food chain. Participants in this open-forum discussion included TPAs, care management companies, insurance carriers, MGUs, employers and brokers/consultants.

The participants discussed how each perceived his or her role in supporting a self-insured client and they shared what they expected the other players to contribute. It was agreed that strong communication was vital to ensure the players provided a seamless alternative to fully-insured products.

In summary, in order to be successful, we all need to work toward the same goal of supporting the employer's self-funded benefit plan. This requires all parties to be focused on maximizing their own capabilities, as well as integrating the value the other players bring to the equation.

## Healthcare Trends

Continued from Page 4

### Impact of Reform on Big Three—Cost, Access and Quality

Reform Element	Cost Per Insured	Cost Per Taxpayer	Coverage	Quality	Feasibility
Individual Mandate		Increase	Increase	N/A	Difficult
Employer Mandate		Increase	Increase		Moderate
Purchasing Pools	Minor savings	Minor savings	Increase?		Difficult
Refundable Tax Credits		Increase	Increase		Easy
Medicaid Expansion		Increase	Increase		Easy
Pay-for-Performance			N/A	Increase	Difficult
Bundling				Decrease?	Difficult
Health IT (cost/efficiency)	Increase	Increase		Possible increase	Difficult
Disease Management (cost/savings)	Breakeven or cost			Increase	Easy
Malpractice Reform	Savings, but unlikely	Savings, but unlikely		Decrease, but unlikely	Easy
Comparative Effectiveness (budget?)	Possible savings	Possible savings		Increase	Uncertain

## Catastrophic Claim Trends

**Brian Shively, FSA, MAAA, Vice President and Principal  
Summit Reinsurance Services, Inc.**

**Gregory Demars, FSA, MAAA, Vice President  
Summit Reinsurance Services, Inc.**

Mr. Shively and Mr. Demars provided insightful commentary regarding trends in catastrophic claims for medical excess programs. Included in the commentary were results from studying Summit Re's own HMO reinsurance experience for business written in 2005-2007. Business was accumulated by various membership categories (e.g. commercial, Medicare, Medicaid). Statistics clearly show the distribution of diagnoses is influenced heavily by member type and deductible.

### Commercial

General observations from the commercial population are as follows:

1. Cancers, circulatory disorders and infectious diseases typically represent a large share of the moderate-sized catastrophic claims, but a decline in frequency is being seen at higher deductibles.
2. The prevalence of infant claims increases at higher retentions because of the potential for such claims to be very complex and intensive as well as continue for long durations.
3. The prevalence of transplant claims increases at higher retentions for similar reasons.
4. Certain rare conditions, such as severe hemophilia or severe

pancreatitis, also make up a material portion of the very high dollar claims.

### Medicare

Medicare claims are dominated by circulatory and respiratory diagnoses, with over 50% of all claims falling into these categories. Due to eligibility requirements, there are no premature infants or congenital anomalies. There are very few injuries as well.

### Medicaid

Medicaid continues to be dominated by women of child-bearing age and premature infants, many with congenital anomalies (over

50%). No other diagnosis has a material concentration.

### SSI Aged, Blind, and Disabled

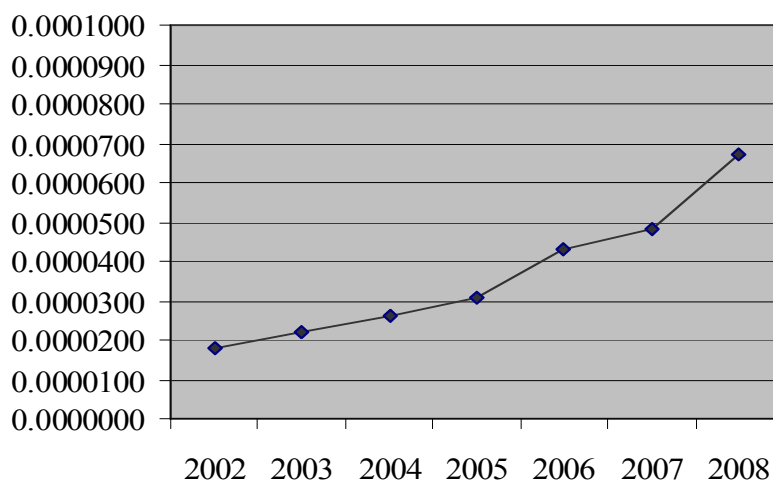
The aged, blind and disabled have a relatively high concentration of transplants, with cancer the secondary diagnosis.

### Medicare/Medicaid

This dually-eligible population demonstrates catastrophic claim characteristics similar to Medicare, with claims dominated by circulatory and respiratory diagnoses. Again, there are no premature infants or congenital anomalies and fewer injuries. There are some

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### Probability of a Claim Above \$1,000,000



## Catastrophic Claim Trends

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claims from cancers, digestive problems and infectious diseases.

### Claims over \$1 million

Claim activity in excess of \$1 million continues to increase at an alarming rate. Large claims are getting larger and more frequent. Both are the product of the higher costs of medical care in extreme situations. Leveraged trend for claims in excess of \$1 million appears to be as high as 50%-60%.

### Diagnostic Trends

After reviewing claims by membership category within Summit Re's own experience, our presenters turned their focus to national trends in several key diagnostic categories.

*Prematurity* – The good news is that nationally the preterm birth rate dropped in 2007 for the first time since 2000. Before 2007, it had increased 36% since 1980. Another

positive note is that the frequency of multiple births is also moderating after climbing 66% since 1980.

Multiples now represent 3.4% of all births and the incidence has been driven by fertility treatments and older childbearing parents. The concern with multiple births is their much higher probability of prematurity and complications, such as low birth weight, pre-eclampsia and gestational diabetes.

*Cancer* – In 2007 alone, there was a 13.3% increase in total sales for cancer-treating drugs, primarily as a result of new therapies. These trends are continuing, albeit slightly reduced due to the increased use of generic drugs. Expectations are that trends for cancer-treating drugs will continue to be in the double digits for the next several years. The good news is that the death rates for the four most common cancers (prostate, breast, lung and colon), as well as for all cancers

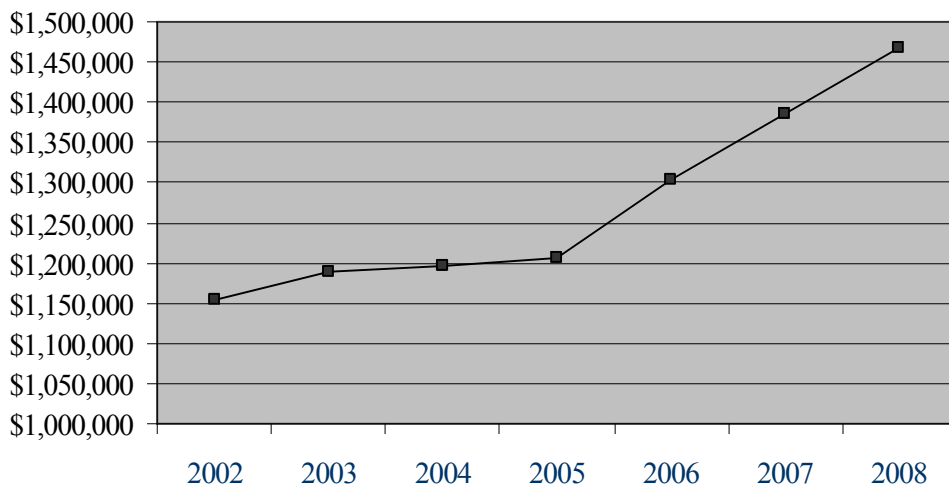
combined, continue to decline. The generally stable rate of cancer incidence since the mid 1990s has been influenced by increased screening, new drug therapies and a decline in smoking.

*Transplants* – The overall incidence of transplants continues to increase despite the continued limit on the supply of solid organs. Solid organ transplants have stabilized and actually declined slightly in 2008. The increase in bone marrow transplants more than covers this gap, as they have averaged a more than 10% increase annually since 2004. Bone marrows now make up over 40% of all transplants.

Transplants with estimated first-year billed charges over \$1 million are still relatively rare but there are significant increases in frequency. Multiple organ transplants (heart/lung, heart/kidney) and any transplant involving the intestines make up this list of infrequent, yet extremely high-cost, cases.

Other transplant trends include an increase in allogeneic bone marrow transplants, as well as an increase in cord blood and double cord blood transplants. The use of bone marrow transplants for immunological diseases is now driving a portion of this increase. There is a continued growing demand for liver/kidney transplants due to the positive outcomes. Lastly, the use of VADs (ventricular assist devices) as bridges to transplant continues to increase, as the survival rates are over 300% higher when used than when not used.

**Average Size of Claims over \$1,000,000**



# Tackling Three of the Biggest Challenges in Care and Cost Management: Chronic Disease, Cancer, and Complex Newborns

## Managing Dialysis Claims

**Polli Yount, Senior Vice President and Chief Operating Officer  
Golden Triangle Specialty Network**

Ms Yount shared insights into the dialysis industry regarding what drives claim pricing and how to manage dialysis claims. The keys to managing dialysis claims appropriately are to:

1. Understand the disease and the treatment process.
2. Identify patients as early as possible.
3. Direct patients before a facility is chosen.
4. Understand the risk of discount shopping.
5. Consider self-administered Epogen (EPO) but know the issues.
6. Know the date for coordinating benefits with Medicare.

**Dialysis Myths – Fact or Fiction  
True or False?**

1. Rates are determined by taking a life time maximum of \$1,000,000 and dividing by 33 months.
2. Providers do NOT encourage patients to sign up for Medicare.
3. Providers do NOT educate patients or provide a choice for any modality other than in-center hemodialysis.
4. Home hemodialysis charges are much lower than in-center hemodialysis charges.
5. Providers change their rates based on the discounts they give.
6. Medicare rates are usual and customary.
7. I'm taking the deep discount; it's only 1 patient, they won't catch it.

All of the above ...fiction (FALSE!)

Ms. Yount provided commentary on whether to contract directly with providers or not, why not to carve out EPO, whether or not to pay Medicare rates and how to limit end stage renal disease benefits.

To be successful, you must ask what you want from a renal network. This typically includes fair discounts, quick turnaround time, peace of mind and efficiency, as well as a strong technical resource to be there when questions or problems arise with dialysis claims. Early identification and volume drive deep discounts and strong networks can deliver these attributes and discounts to control costs.

## Managing Cancer Exposure

**Eduardo Beruff, President and Chief Executive Officer, ITA Partners  
Susan Spalding, Senior Vice President, ITA Partners**

Mr. Beruff and Ms. Spalding provided an update on cancer trends and managing cancer exposures. ITA delivers value because it's an independent company with an expert staff of oncology and insurance/case management professionals, supported by proprietary, scal-

able decision-support technology. These professionals are supplemented by a medical advisory board of 12 leading U.S. oncologists. ITA mitigates risk in oncology by validating treatment plans according to evidence-based standards and providing patients support and educa-

tion to ensure that proper cancer care is prescribed and followed.

### **Need for Risk Management**

The medical need for expert cancer risk management occurs because 15% of diagnoses are incorrect, 25% of treatment plans deviate

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## Managing Cancer Exposure

Continued from Page 8

from guidelines, 45% of patients do not comply with prescribed treatments, and 50%-75% of cancer treatments include off-label drug use that is at risk of being paid when it shouldn't be or not being paid when it should be.

### Increasing Costs

Cancer claim exposures will increase as the cost of cancer treat-

ment increases, the population ages and oncologist shortages emerge. In addition, personalized oncology care with new, targeted drugs, often used in combination for longer periods of time, are dramatically increasing cancer costs. If used appropriately, these new therapies will provide better outcomes.

### Risk Management Outcomes

Cancer risk management (or the

appropriate risk management of any targeted high-cost condition for that matter) can improve both medical and financial outcomes. This is largely accomplished through the prescribing of appropriate treatment plans according to evidence-based standards, ensuring treatment compliance, and providing guidance and coordination among all parties – patients, providers and payers.

## Managing NICU Exposure Using Clinical Oversight and Forensic Claim Review

**Beverly Skram, CNP, Vice President, The Assist Group**

There has been a significant rise in the severity and frequency of catastrophic claims due to specialty drugs, transplants, and neonatal care. In 2000, the incidence of million-dollar claims was one per million members. In 2010, there are projected to be roughly 30 million-dollar claims per one million members. Neonatal intensive care unit claims are a significant contributing factor to the increasing prevalence of catastrophic claims. With NICU costs as high as \$14,000 per day, the heroic rescue of fragile newborns can easily produce a significant number of claims that exceed \$1 million.

### NICU Care Management

The Assist Group helps payers identify cases that may benefit from neonatal care management. This is accomplished through:

1. Peer-to-peer interaction and oversight by a national, multi-disciplinary team of leading neonatologists, helping to ensure continuity of care
2. Predictive modeling software for early intervention
3. Industry best practices and medical interventions that improve outcomes while decreasing lengths of stay
4. Focus on prevention of costly NICU complications rather than treatment after the fact (200 grams of prevention are worth 1,500 grams of cure)
5. Family education
6. Early discharge planning

### Forensic Bill Review

Forensic bill review is another approach to managing NICU exposure. Pre-screening of hospital bills is complimentary and may include

written reports that identify potential savings. Full forensic review utilizes an algorithmic approach combined with a hands-on clinical approach to identify gaps between the care provided and billed charges. Certain things should not be charged for separately and these algorithms will assist clients in identifying numerous types of provider bundling and unbundling claim errors. In addition, the algorithms check for the appropriate level of care. For example, a Level III NICU claim should become a Level II NICU claim after a predictable period of time, assuming no complications. Forensic claim review also can identify items as simple as a daily oxygen fee of \$500 per day being charged as \$500 per hour. There's a big difference between \$12,000 per day and \$500 per day!

## Scenario Planning – How to Prepare for an Unknown Future

**Don Hall, MPH, Principal, Delta Sigma**  
**Sherri Rohlfing, Principal, Delta Sigma**

Mr. Hall and Ms. Rohlfing reminded the audience that you can't predict the future, but you certainly can prepare for it. They used the case study of how Southwest Airlines capitalized on the difficult market presented by the September 11, 2001 attacks and differentiated itself from its competitors.

Southwest Airlines handled the economic impact successfully because it had planned for a variety of scenarios and was prepared to execute accordingly. It's no different than a typical disaster plan. How many companies have disaster plans they can pull out when necessary in the event of fire, computer shutdowns, etc.? You simply need to prepare and plan for a range of possible and probable futures and develop a roadmap of how you would navigate through them. You'd be surprised how much easier it is to navigate through difficult times when

you've got a roadmap that was prepared in a quieter time.

Good scenario planning shakes up status-quo thinking, develops early warning systems, prepares the company for potential opportunities and allows it to survive and thrive in more challenging times. Start by defining your company's goals, such as to make a profit, achieve job security for employees, or to make flying affordable for more people (Southwest Airlines).

The second step is to assess your company's core competencies. For Southwest Airlines, it was high-frequency, short-haul flights with low fares and no frills.

Third, identify your company's current strategies. (One type of jet, quick turnaround, avoiding congested airports and focusing on employee retention and commitment.)

Then create the best, the expected and the worst-case scenarios for various types of contingencies and plan accordingly. Determine resource requirements and developmental timelines.

For Southwest Airlines, one scenario was the possibility of decreased passenger loads and increased fuel prices. It hedged the latter through long-term fuel contracts, which provided significant value to the company.

Any strong strategic plan needs to take into consideration a variety of potential future environments. For us, this is not just the health care marketplace, but also events taking place in the political arena and in society itself. It's also important to keep your plan as current as possible. Don't just consider it done and file it away.

*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](http://www.Summit-Re.com).



**SummitRe**

Summit Reinsurance Services, Inc.

**7030 Pointe Inverness Way, Suite 350  
Fort Wayne, IN 46804**

**260-469-3000**

**Fax 260-469-3014**

**[www.Summit-Re.com](http://www.Summit-Re.com)**