SUMMIT RE

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Summit Perspectives

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The great virtue of free enterprise is that it forces existing businesses to meet the test of the market continuously.
Milton Friedman

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What are you, Summit Re?

"What is Summit Re, a broker?" ask some individuals in the industry who haven't worked with us before.

Technically, we are regulated as a **Reinsurance Intermediary Broker,** which is very different from the retail broker you may have dealt with before. We place reinsurance for health plans, but only for ERC/Swiss Re. And we do so much more: we're responsible for underwriting each risk, developing and maintaining underwriting and pricing manuals, drafting contracts, processing claims and premium payments, servicing accounts, and maintaining managed care vendor relationships.

The health plan reinsurance marketplace is divided roughly in half between coverages that are delivered directly, which is the way we do business, and those placed through brokers. Which is better? Competition keeps all of us on our toes, but here are reasons we prefer direct distribution.

Deal directly with the decision-makers
Your Summit account team doesn't just sell a coverage, it prepares and delivers the contract language, pays claims under that contract, and works with your medical management team to reduce current and future medical expenses.

Short distribution chain, low expenses
ERC/Swiss Re retains the risks it writes, so there are no back-end pool and intermediary expenses. Summit provides home office services and sales at a cost comparable to broker loads alone.

It's a technical sale—we're a technical company
Summit Re has 3 FSA-level actuaries and 2 CPAs that get involved in your coverage issues. We can tell you we cover LTAC days as standard inpatient days, not restricted step-down days—and be sure we pay the claims that way. Our sales cycle starts with understanding your risk, not just quoting on your current coverage.

Do you work with a retail broker today? You can still get a Summit Re quote. We compete with traditional brokers every day. The broker field is extremely competitive, but the number of reinsurers they have access to is not very large. And that list doesn't include the largest—Swiss Re, only available through Summit Re.

	Summit Re	Retail Broker
Place Reinsurance	✓	✓
ERC/Swiss Re	✓	
Develop Pricing	✓	
Underwrite Risks	✓	
Issue Contracts	✓	
Process Premium	✓	
Process Claims	✓	
Service Accounts	✓	
Managed Care	✓	

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But what if you have no transplant contract.....

Most health plans have contracts with hospitals or medical centers that perform organ and tissue transplants. And, through Summit Re, clients have access to U.R.N.'s Transplant Resource Networks and Transplant Access Program. Most reinsurance agreements provide more favorable coverage for organ and tissue transplants performed in "approved" facilities than for those performed in "unapproved" facilities. The health plan typically submits its contracted rates to the reinsurer during the underwriting process and the reinsurer determines if the contracts will be "approved" or not.

Standard approach

At Summit Re/Swiss Re, that's our standard approach as well. We usually provide 90% coinsurance for approved contracts (we use the term "scheduled") and 50% or 60% for unapproved or unscheduled contracts. We list the scheduled contracts on Exhibit A, part of our reinsurance agreement. We consider U.R.N.'s transplant network facility contracts to be scheduled. Usually those contracts our clients hold directly are also scheduled if they are similar to U.R.N.'s.

A potential problem

But what if a member needs to go to a facility that isn't part of U.R.N.'s network and with which the health plan has no contract for transplants? When the plan tries to negotiate a rate for that member, how will the plan know how the reinsurer will view the arrangement? Usually the plan won't know unless the terms are submitted to the reinsurer for review *in advance* of the transplant, each and every time such a situation arises. This can be frustrating for the health plan and means additional work for the reinsurer.

Summit's solution

At Summit Re, we recognized this issue early on and took steps to make things easier for you. We developed another exhibit, Exhibit B, which helps our clients determine their reinsurance coverage for unscheduled transplants up front. We list specific case rates we consider to be scheduled for each type of transplant. We show rates for inpatient hospital services only and rates that include professional services. We show a separate set of rates for children and a set for adults. We include rates for all three types of bone marrow/stem cell transplants – even those performed on an outpatient basis. If the health plan can negotiate case rates that are equal to or are better than the ones shown on Exhibit B, then the claim is reimbursed at the higher coinsurance level. There's no need to send anything to us for "approval." You already know the level of coinsurance that applies.

Not a cap

There's one more very important point to remember, though. The rates listed on Exhibit B do *not* represent limits on what we consider to be eligible amounts under the reinsurance agreement. They do not represent caps on case rates. Amounts in excess of the listed case rates are not excluded. If a health plan simply can't negotiate a rate that is equal to or lower than the Exhibit B rate, it just means the claim would be reimbursed at the lower coinsurance level.

This is just another example of Summit Re's putting into practice its "fairness" Founding Principle to produce balance sheet stability for you.

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Getting your D&O and E&O money's worth

Maybe you are, but then again, maybe you're not. Errors and omissions (E&O) policies cover things a company does, a company does not do, or that don't turn out as a customer expected. Directors and officers (D&O) insurance policies provide protection for a company's directors and officers whose personal financial assets can be put at risk in the event of a lawsuit.

There are no standard D&O/E&O policies. Each insurer drafts its own version, and many fail to provide coverage in key areas. If the unfortunate happens and you become the target of a lawsuit, you don't want to risk losing precious corporate – or personal – financial resources because of inadequate or inappropriate insurance coverage.

As part of our continuing effort to find ways to service you, Summit Re has entered into an arrangement with a national firm that specializes in property and casualty insurance products that are designed for organizations in the health care industry. This alliance was formed to help health plans gain access to better D&O and E&O policies. As part of this arrangement, we are able to offer you a **complimentary analysis** of your current coverage. A recent study showed that over 50% of directors and officers requested changes in their insurance coverage when they learned what was NOT covered under their current programs.

To perform the analysis, we will need copies of your current D&O/ E&O policies. We will determine if we can improve the coverage – and maybe even the pricing. Please contact your Summit Re representative to begin the process.

Cost containment and more

Summit Re recently entered into an agreement with National Care Network (NCN) for its medical cost containment services. NCN's core solutions for out-of-network claims include Fee Negotiations; Supplemental Network Repricing; and Hospital Detail Analysis, a Medicare-based pricing methodology.

Unmet Needs

While NCN had been extremely successful in saving its clients millions of dollars with these products, it realized that neither NCN nor other cost containment companies were doing enough to reduce overall healthcare charges. A new product was needed, a product which would:

- Allow fair reimbursement based on the facility's costs to provide care
- Benchmark similar facilities reflecting the variances within facility costs
- Use flexible pricing methods to meet clients' needs
- Recommend pricing that is transparent to the payer, provider and member

Data *i*Sight

After a year and a half in development with Data Advantage, a company NCN acquired in 2005, NCN recently introduced **Data *i*Sight** to meet all of those needs. **Data *i*Sight** will generate fair reimbursement recommendations that generate legitimate savings. To do this, **Data *i*Sight** leverages nationally recognized data sets to enhance provider understanding and acceptance; reviews both the financial and clinical components of a claim; incorporates cost-based awareness; and provides a transparency component for providers, payers and members.

About NCN

NCN, a privately-held organization based in Irving, Texas, provides its services to large insurance carriers, self-funded organizations, third party administrators, HMOs, employer groups and reinsurance carriers across the country. NCN has achieved many milestones in its fourteen years of operation, including being the first in its industry to receive the URAC Core Accreditation, establishing HIPAA compliant EDI transactions, developing on-line tools for client access of claim tracking and reporting, and reviewing billions of dollars in medical charges.

NCN provides you with a dedicated team to ensure success in helping you meet your savings objectives. Visit NCN at its website, www.nationalcarenetwork.com, or contact Debbie Stubbs, RN, MS, CCM at Summit Re, 260-407-3979.

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Case studies from The Assist Group

The Assist Group specializes in solutions for catastrophic claims management and high-risk premature infants. Current products include CareAssist, a unique, physician-driven neonatal care management program, and ClinAssist, a powerful forensic audit and claims resolution service. The Assist Group has a proven track record for delivering financial value to clients. For more information about these products and services, please visit the company's website www.AssistGroup.com or contact Debbie Stubbs, RN, MS, CCM at Summit Re, 260-407-3979.

CareAssist Success Story
32 % Reduction in Length of Stay and $163,693 Savings

This twin boy was born at 25 weeks, weighing one pound, eight ounces. His mother used multiple illicit drugs throughout her pregnancy and on the day of delivery. He was on mechanical ventilation and in critical condition when referred to CareAssist on day of life (DOL) 17. This infant was not expected to survive due to his prenatal history, the circumstances of his birth, and extreme prematurity. The CareAssist neonatologist recommended an ethics committee consultation to discuss quality of life issues when it became evident on DOL 30 that he would survive. By then, this infant had the severest form of intraventricular hemorrhage, along with hydrocephaly and porencephaly. He also had severe chronic lung disease (CLD) and remained on mechanical ventilation well past his first month of life. His long term prognosis was poor.

His final discharge disposition further complicated his clinical status as his mother continued to struggle with polydrug abuse and was considered unsuitable to care for him after discharge. CareAssist consistently recommended early discharge planning to allow a foster family to be trained to care for this infant upon discharge. This timely intervention allowed this baby boy to be discharged appropriately and safely.

Multiple oxygen weaning recommendations were made by the CareAssist neonatologist. This infant was eventually weaned to nasal cannula oxygen on DOL 59 and was discharged on low flow nasal cannula oxygen.

This infant's nutritional status was complicated by his CLD and tendency to tire during feedings secondary to his compromised pulmonary status. The steroids used to help wean him from supplemental oxygen also compromised his ability to gain weight. The CareAssist neonatologist emphasized to the treating team the importance of using high calorie formula and advised early developmental interventions through the use of non-nutritive sucking and OT/PT involvement in nipple training. As a result of these interventions, the infant was nippling all of his feedings at a corrected age of just 35 weeks.

The weekly care oversight by CareAssist for nearly three months ensured consistency in the implementation of this infant's treatment plan. Due to CareAssist's oversight, this infant was discharged safely to foster care 39 days earlier than originally anticipated. This resulted in a 32% savings of $163,693.

THE ASSIST GROUP

ClinAssist Success Story
$321,757 Savings

A 110 day confinement at a children's hospital resulted in total billed charges of $1,287,027. ClinAssist reviewed approximately 10,600 line items of detailed charges. Utilizing the clinical expertise of ClinAssist's neonatologists and nurses, ClinAssist performed a forensic review of the charges and identified the following exceptions:

- Room and board charges billed at incorrect levels of acuity
- Experimental pharmaceutical therapies
- Supplies and services incorrectly unbundled from the room and board charges

ClinAssist successfully achieved a $321,757 reduction in billed charges after the audit exceptions were presented to the facility. The account balance was adjusted to reflect the facility's written agreement that the exceptions identified by ClinAssist were not payable charges.

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Five essentials for evaluating predictive models

Predictive modeling uses your vast store of information to forecast future needs for medical resources. By becoming a knowledgeable purchaser and user of predictive modeling services, you can enjoy a return on your investment in the areas of care management, underwriting and benefit design.

Key Factors for RFP
There's been an explosion of predictive modeling services, each with different methodologies and technology designs. Ineffective predictive modeling— through either poor models or data—wastes your valuable resources and may have a negative impact on your members. However, by understanding how to assess the offerings and apply the technology once you have purchased it, predictive modeling can realize the promise of using information to significantly improve value in health care. The following factors can be used in a Request for Proposal (RFP) to help you select a vendor:

Accuracy
Always ask for the model's R-squared measurement, the commonly accepted measurement of a predictive modeling solution's accuracy. Reliable vendors will know their R-squared measurement.

Vendors should be able to demonstrate both the sensitivity and specificity of their solutions, especially for case management programs. High sensitivity indicates positive predictive value: an ability to identify most of the people who would benefit from a care management intervention. Specificity or negative predictive value is the ability to limit the number of false positives or people who would not benefit from a care management program. Sensitivity and specificity are important so you can assign resources where they're needed most.

Transparency
Transparency means the ability to differentiate among the data points. For care management programs, transparency means clinicians can look underneath the risk scores to the level of individual claims so they can devise appropriate interventions. A risk score is not particularly helpful for care management nurses; they need a way to understand what's driving the risk. To this end, member profiles should include a listing of all episodes of care and the key services involved in their treatment.

To evaluate transparency in your RFP, ask whether the model is a rules-based or neural net solution. In general, you should look for rules-based models, because they match data patterns to clear clinical rules that identify such things as the disease, type of episode, co-morbid conditions, and drug treatments. In a good rules-based model, you can easily identify these risk markers.

In contrast, neural net or so-called black box algorithms are not clinically based and are technically complicated, so you have to possess real data mining expertise to understand how a specific risk score has been compiled. This robs clinicians of many of the advantages that predictive modeling should deliver for care management. Black box algorithms also make it difficult for you to check the validity of the model.

Interoperability
Your RFP should ask whether the vendor supports your relevant database technologies, so they can load the data quickly and reliably into their model's data mart. You should also ask if supporting databases will be exported to your care management, underwriting, and actuarial applications.

Another key question is how the model defines and groups care— by procedure, diagnosis, or episodes of care. Using fully fleshed-out episodes of care results in better predictions since the groups are clinically homogeneous. This approach takes into account all of an individual's underlying clinical factors, not simply a diagnosis or severity indicator.

Supports operational needs
The solution selected must adapt to your operational issues and must generate predictions as often as your business needs dictate. Also, the data used in the solution must be fresh, reliable, and accessible. In particular, it should be refreshed at least monthly to be available for client renewals.

Finally, the solution must be flexible enough to use the data that is available, e.g., medical only, pharmacy only, medical and pharmacy combined. It should also be able to incorporate emerging data sources, such as lab resu[illegible]

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Disclosure and insurability

Disclosure is the process of revealing information. To bind reinsurance coverage, you must reveal claimant data that may not have been available at the time of underwriting. This disclosure is important for identifying chronic situations that represent known risks and is necessary because of the inherent delay between underwriting the risks and binding the coverage. Disclosure is intended to be a quick review of the latest claim activity at the time that a binder for coverage is signed.

Why is disclosure important?
When preparing a quote, the reinsurer performs a careful analysis of claim costs and trends, including an analysis of the current year's activity. A critical assumption is the degree to which this data can be considered complete. Disclosure helps the reinsurer solidify the accuracy of this assumption.

The disclosure also identifies claimants that may be categorized as chronic and, therefore, highly predictable in both the usage and the cost of services. Depending upon the level of predictable costs, certain members may become uninsurable.

Further, the reinsurer may be able to immediately employ a managed care program to assist in the management of these new claims. This, of course, would potentially benefit both you and the reinsurer.

An accurate disclosure is important to you to protect against possible denial of a claim. The disclosure statement is part of the signed binder. Therefore, without full disclosure, the reinsurer has the right to exclude serious losses that were known by the plan, but not disclosed. This may be rare, but the reinsurer does this to protect against the situation where a party knowingly withholds serious losses.

What to disclose?
The disclosure statement (sample below) identifies the claimants that need to be disclosed: any member that is expected to have covered losses that will exceed 50% of the selected specific retention. Limiting this list to those representing a potential serious loss will expedite the process; however, you need to be careful to list all members that are known to you.

No matter how long or short your list, it is critical to provide the following data for each claimant:

- *Diagnosis or diagnoses*—allows the reinsurer to identify chronic or ongoing care which is highly predictable in nature.
- *Prognosis*—helps identify a near term resolution versus an ongoing situation and helps identify future costs. An estimate of future costs should accompany a prognosis.
- *Charges/claim amount*—identifies the magnitude of the claim.
- *Current status and future treatments*—supports the information provided in the prognosis.

When these items are provided in a concise but thorough manner for each disclosed claimant, the process can usually be completed very quickly with little, if any, additional discussions of clinical details.

Continued on Page 7 ⟶

Disclosure Statement by Reinsured
(Used by Summit Re and ERC/Swiss Re)

You agree that any serious losses known by you as of the date you sign this Offer will be excluded from coverage unless previously disclosed to and accepted by ERC. Please enclose with this Offer any serious claim information that has come to your attention so that we may re-evaluate our underwriting. A "serious claim" is defined as any loss known by you for which:

1. charges incurred have exceeded 50% of the Specific Retention selected; or
2. charges are expected to exceed the Specific Retention selected due to the nature of the illness or injury; or
3. any Member remains hospitalized or disabled and is expected to exceed 50% of the Specific Retention.

Information submitted for each serious claim should include the diagnosis or diagnoses, prognosis, charges/claim amount, current status, and future treatments.

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Premium check-up

The last thing any of us want to hear is, “We’re going to be audited!” We all face scrutiny in one fashion or another—whether it’s CPAs examining our financial statements, the NCQA reviewing the quality of care provided to covered members, or maybe even the IRS checking our tax returns. On a different scale, Summit Re began a review process in 2006 to test the premium paid on its reinsurance and stop loss contracts.

Typically, our clients submit premiums on a monthly basis using remittance statements we provide at the start of the agreement year. You simply fill in the number of members at the beginning of the month, multiply that by the applicable premium rates, and send payment for the result. And when it’s received by our accounting department, we review the statement for accuracy—to verify that the correct rates were used and to determine if the census fluctuated significantly from prior month—before forwarding it to the reinsurer. The same process is followed for both HMO reinsurance and stop loss premium.

But up until now, we’ve not tested the underlying data, the membership numbers used to calculate premium. Our reinsurers, in audits of our own operations, thought that such reviews make good business practice, and we agreed. While we trust our clients to submit the appropriate premium agreed upon in the contract, it still makes sense to verify it once in a while.

Now, we won’t visit every client, nor will we come calling every year. Rather, we’ll select a few each year for review and travel to your offices to examine the source documentation. While it’s tempting to schedule clients located in the south for review during February (after all, we are in Indiana), we’ll likely perform the reviews in the summer after the busy winter and spring activity has subsided. And we’ll promise that we’ll be as efficient as possible. Generally, all we need is a couple of days to complete our work.

So, there’s no reason to panic if you get a call saying that we’d like to come and verify your premium numbers…you can save that for when the IRS letter arrives!

Predictive Modeling—Continued from page 4

Industry credibility

One of the most obvious markers of industry credibility is market penetration. The RFP should probe whether others use the solution and if they will speak to its value.

Because predictive modeling is changing and improving at a rapid rate, credibility is not just rooted in the solution itself, but in the on-going support the vendor offers. Upgrades and support require a team that fully understands not just the technology, but also how health care works. The RFP should check whether the support offered includes an integrated team that brings together IT, clinical, actuarial, and underwriting experts.

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Disclosure—Continued from page 6

What are the possible outcomes?

Most likely the disclosure will reveal a normal level of catastrophic claim activity of an acute nature, which allows the reinsurer to confirm the terms as originally priced.

Another scenario is that a chronic claim is identified to have a high probability of continuing into the coverage period in question, and a separate deductible may be assigned to that claim if it is likely to exceed the retention. This has now become a known claim to both you and the reinsurer and, therefore, uninsurable. A basic premise of insurance is that known events with predictable costs are not insurable.

A third scenario is that the disclosed claim information is dramatically different from the claim information presented during the quotation process, and the reinsurer is forced either to materially modify its quoted rates or terms or to completely withdraw their quotation. This rarely occurs.

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Employer Stop Loss expansion

Summit Re has expanded its self-funded marketing and underwriting staff and opened regional offices to provide even better service to you.

Meet Allen Engen
Allen Engen joined us as Regional Vice President in July 2006. Allen has more than 14 years of experience in employer stop loss and health care risk management, specifically in underwriting and sales. He brings a tremendous amount of energy to Summit Re and has hit the ground running. Allen's clients appreciate his focus on meeting their needs and his ability to seek solutions that may fall "outside the box." When not at work, he is very active in Boy Scouts and enjoys golfing and fishing.

New Regional Offices
As part of our commitment to you and to the self-funded market, we opened two regional marketing and underwriting offices. Chris Alexander, located in Charlotte, NC, runs the Eastern Employer Stop Loss Office and Allen Engen, located in Minneapolis, MN, heads up our Western Office.

Employer Stop Loss

Eastern Regional Office

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"No Floors" Transplant Network

The most important consideration when choosing a transplant network should always be the quality of care delivered. A secondary but important consideration is the cost effectiveness of the network.

Contracts for the U.R.N. Transplant Centers of Excellence network and Transplant Access Program (TAP) are structured in a variety of ways, allowing Summit Re customers referral options based on their desire for cost predictability. In order to assist in the contract selection process, U.R.N. has identified a subset of network contracts without floors and aggregated them into a "No Floors" network.

The U.R.N. "No Floors" network consists of programs with transplant contracts that eliminate the possibility of a transplant being paid at a percent of billed charges. This network consists of 51 centers and 237 transplant programs and increases the transparency of network providers without minimum payment provisions. This provides you with greater transplant cost predictability when using a "No Floors" network facility.

Information regarding the "No Floors" network, including a listing of the facilities, can be found on the U.R.N. website (http:www.urnweb.com) or you can contact Debbie Stubbs, RN, MS, CCM at 260-407-3979 or at dstubbs@summit-re.com.

Summit Perspectives is a periodic newsletter published by Summit Reinsurance Services, Inc., a full-service managing underwriter and reinsurance intermediary that focuses exclusively on managed care. *Summit Perspectives* highlights various items from both Summit Re and the managed care 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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