What goes up must come down

Mergers and acquisitions continue to shrink the HMO industry, but new opportunities keep emerging all the time.

To paraphrase Sir Isaac Newton,

what goes up must come down. Even if he wasn't referring to the underwriting cycle, he certainly understood the gravity of the situation.

What market forces have been affecting health maintenance organizations (HMOs)? The managed-care backlash eased up in 2004. As costs increased in 2002 and 2003 at the first-dollar level, consumers felt the pinch of rising health-care costs even more. There's nothing like a reminder in your pocketbook that certain aspects of HMOs aren't necessarily bad. More and more people are willing to consider restrictions on access to health-care services again in exchange for lower deductibles and lower premiums.

But HMO medical care costs continue to increase because of the impact of more open networks and less management of care. Continued expensive advances in medical technology, the aging population, and increased profit margins have also increased first-dollar costs.

The profit margin of the HMO sector improved in 2003. Average profits for the industry were 3.78 percent of premium versus a figure of 2.25 percent for 2002. According to Weiss Ratings Inc., the financial strength of HMOs continues to improve. Using first-quarter 2004 data of roughly 500 HMOs, 119 companies were upgraded by one rating agency, and none was downgraded. The rise of the stock prices of the big chains indicates that their financials are improving for various reasons: increased earnings potential, government expansion of Medicare/Medicaid opportunities, and cyclical profitability.

HMO market penetration, however, has declined somewhat. The number of Americans enrolled in HMOs dropped to 69 million in 2004 from a peak of 80 million in 2000. (See Table 1 page 40.) PPOs have picked up the slack as they provide broader access and greater flexibility but perhaps at a higher cost. According to Managed Care On-Line (MCOL), PPOs now cover 109 million Americans.

Average health-care costs moderated in 2003 and 2004; a Mercer Resource Consulting LLC study indicated that the average cost of U.S. employer-sponsored health coverage rose 7.5 percent in 2004, to $6,700 per employee. This is the lowest rate of increase since 1999. The survey also indicated that employers are raising employee cost-sharing with higher deductibles, co-payments, and co-insurance features.

Consumer-driven health plans are increasingly being offered by HMOs. The most common design is a health account combined with a high-deductible plan. A major chain, United Healthcare, acquired Definity to gain momentum in product innovation in the consumer-driven health care arena. This marries United Healthcare's expertise in managing care with Definity's expertise in administering consumer-directed health plans. The Wellpoint acquisition of Lumenos is a similar play.

Market Consolidation and Expansion

An important trend in the HMO reinsurance market is the continued consolidation of the HMO industry. The merger-and-acquisition activity of the major chains continues to shrink the size of the commercial and Medicaid reinsurance opportunities as these publicly held corporations strive for growth. They do this to achieve economies of scale, expand their market penetration in various geographic areas, and demonstrate revenue/earnings growth to their shareholders. Most chains buy little, if any, reinsurance.

According to Interstudy Publications, there have been more than 100 HMO acquisitions in the past 10 years by major chains such as United Healthcare, Anthem/Wellpoint, Coventry, PacifiCare, Humana, Cigna, and Health Net. There has also been a flurry of M&A activity by major Medicaid chains such as Molina and Centene. These companies alone have engaged in 10 transactions in the past 18 months. Table 2 (page 40) demonstrates the HMO market consolidation.

There is some expansion in Medicare and Medicaid HMO reinsurance opportunities as the government

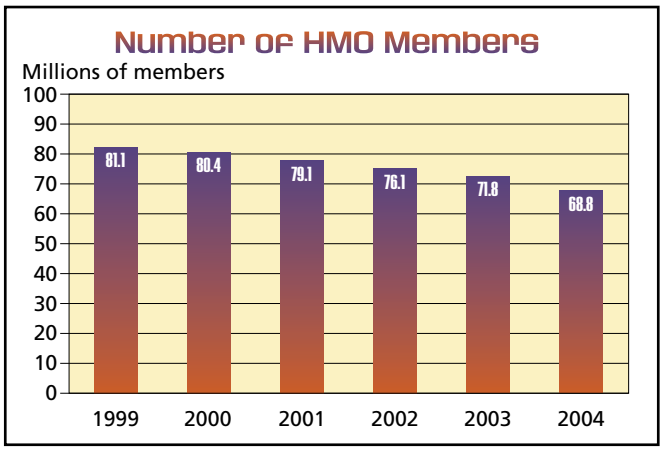

TABLE 1

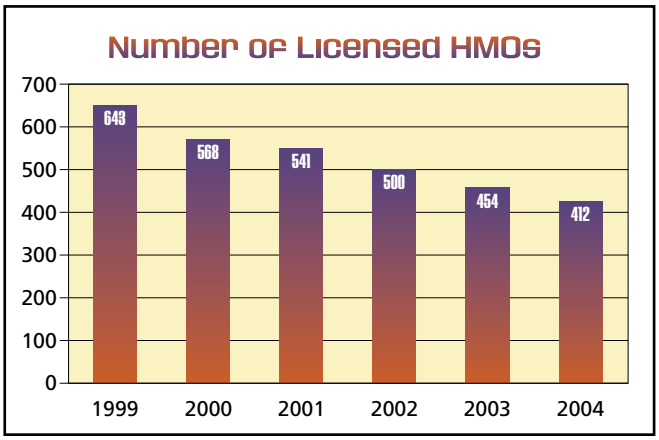

TABLE 2

continues to privatize these programs. Medicaid managed care still faces exposure to potential state and federal budget cuts. The government reimbursement rate paid to managed care organizations increased significantly in 2004 as a result of the 2003 Medicare Modernization Act. This also expanded Medicare to include a new Part D outpatient prescription drug benefit and a regional PPO option. These new or expanded markets partially offset the recent trend of shrinking commercial private-sector involvement as the Balanced Budget Act of 1997 had capped reimbursement at a level below medical costs' rate of growth. Managed care programs enjoy treating government patients but not at a loss.

In addition to the above takeover trends, other plans have exited the market as their provider-owned HMO strategies have changed. For example, the hospital parents of some plans have decided to eliminate the HMO as a distribution channel for their services and focus more on maximizing reimbursement across various payers.

More Medicaid reinsurance opportunities become available as state Medicaid HMO plans expand. There will also be more opportunity to reinsure Medicare HMOs, given the large number of new plans submitting applications in 2005. More than 30 companies have filed new Medicare Advantage applications in 2005.

Reinsurance Underwriting and Coverage Trends

The main coverage trend among HMOs buying reinsurance is movement to higher deductibles and higher average daily maximums (ADM). An ADM is a per diem inside limit on reinsurance claim reimbursement. Increasing the deductible lowers premium rates, while raising the ADM limit increases premium rates. Doing both in combination often results in premium neutrality and higher coverage efficiency because a larger percentage of claims over the deductible are reimbursed instead of being limited by the ADM.

In fact, some HMOs are now looking for coverage that has no inside limits. Different carriers will offer such coverage with various underwriting guidelines, such as minimum deductibles of $400,000 or $500,000. A contract with no ADM limitation is usually between 25 percent and 50 percent more expensive than one with a reasonable ADM limitation. Clients who want to move from an inpatient-hospital-services-only reinsurance coverage to comprehensive coverage including physician services also see sticker shock; coverage for all services usually increases the total reinsurance cost by 100 percent to 200 percent. The selection of which services to cover depends more on individual HMO preference rather than logical decisions about the services with the most volatility. Reinsurers and HMO buyers are both shaping the market in this area.

Inflation cost trend has been roughly between 9 percent and 12 percent for inpatient charges. The primary risk for reinsurance underwriters to assess is reversion of case rates and per diems to outliers as a percentage of billed charges. Outpatient facilities and drugs have trended at higher rates. Interestingly, most of the high-cost pharmaceutical charges are occurring in outpatient or home settings rather than in the hospital.

An analysis of reinsurance contract terms and conditions shows that what might appear to be small differences can have a large impact on cost. Some contracts still have separate definitions for experimental treatments, medical necessity, and treatment in lieu of acute care. Others are more likely to follow the form of the HMO group policy.

Some reinsurers may also apply more exclusions and limitations in an effort to control costs or shift costs back to the HMO. Examples include limiting transplants to two per individual or imposing an ADM limit even for a fixed-fee-based claim. Plans should ensure that they're comparing "apples to apples" reinsurance coverage among carriers.

Regulatory Climate

There is some impact of the ongoing broker/reinsurer scandal that originated with N.Y. Attorney General Eliot Spitzer's inquiries into certain P/C carriers and national brokerage firms such as AON and Marsh. One of the compensation issues was "double dipping"—brokers receiving additional payments from carriers for production or profitability on their portfolio.

What's most important is transparency to the client HMO when it comes to compensation. One can draw an analogy to life insurance financial consultants. The financial consultant should generally be receiving compensation through fees or commissions but not both. Proper disclosure is key.

In the HMO reinsurance market, some managing underwriters actually load in compensation for transplant networks or other managed care services offered as part of their reinsurance. HMOs are well advised to ask their reinsurance brokers, consultants, or managing underwriters if they receive or have received contingent commission payments for premiums paid in the past. They have the right to know because it's their money.

The National Association of Insurance Commissioners was quick to adopt an American Association of Managing General Agents model act for broker disclosure. In summary, Spitzer's investigation focused on bid rigging and broker compensation. It has now shifted to add P/C finite reinsurance. The focus on health insurance coverage was less significant than that on P/C business, but the fat lady hasn't sung yet.

Licensing issues have also surfaced. Brokers, managing underwriters, and reinsurers are subject to a wide variety of licensing and compliance requirements. These may include insurance and reinsurance policy filings, general agency licenses, reinsurance intermediary broker or manager requirements, general business corporation licenses, and individual salesperson licenses. HMOs are advised to make sure that their brokers, consultants, or reinsurance intermediary managers have the required licenses and approvals to properly conduct business in their state.

Catastrophic Claim Trends

The most common types of catastrophic claims are still the usual suspects: organ transplants, high-risk maternity and neonates, severe trauma (including burns), catastrophic illnesses, high-cost prescription drugs or blood products (such as Factor VIII), complex cardiovascular and neurological conditions, and cancer. The following are new developments in various areas that may have an impact on catastrophic claims:

► *Xenotransplantation.* Transplants are currently limited by the supply of human organs. In 2003, there were more than 86,000 people on the waiting list for organ transplants with just over 26,000 transplants performed that year. According to the Food and Drug Administration (FDA), 10 people in the United States die every day waiting for an organ transplant.

Because the demand for human organs for clinical transplantation far exceeds the supply, xenotransplantation is now being considered. Xenotransplantation basically involves the transplantation, implantation, or infusion into a human recipient of nonhuman organs. (This adds new meaning to the concept of making a pig of yourself.) Xenotransplantation increases the number of organs available for transplantation, but there are risks. Recipients can be infected by both recognized and unrecognized infectious agents, and there's increased potential for cross-species infection by retroviruses.

The FDA initiated the Xenotransplantation Action Plan to provide comprehensive regulation of xenotransplantation, including product safety, clinical trial design, and monitoring. For more information on this topic, please refer to the following FDA website: http://www.fda.gov/cber/xap/comp.htm.

► *eICU.* Neonatal and trauma cases are another major source of reinsurance claims. Intensive care unit (ICU) patients have critical medical conditions and require around-the-clock specialized care. However, many ICUs don't have the specially trained intensivists available to provide this level of care. A facility called eICU now makes this possible.

An intensivist-led eICU-based care team, located apart from the hospital, works in conjunction with on-site ICU clinicians. The eICU facility doesn't house patients or replace the hospital ICU. Instead, it's staffed 24/7 with experienced specialty physicians and critical care nurses who are networked to multiple ICU patients across a health system by voice, video, and data.

The eICU care team uses software alerts to track patient vital trends and intervene earlier—before complications occur. Studies show that this type of care model can reduce ICU mortality by 25 percent and save costs. Several large hospital networks and health care organizations have implemented eICU. For more information on this subject, please refer to the following website: http://www.visicu.com.

► *NICU management.* Preterm birth is defined as birth before 37 weeks, completed gestational age. In 2002, the rate of preterm births was reported as 12.1 percent of all births and is still the leading cause of neonatal mortality and birth-related morbidity. Nearly half of all long-term congenital neurological defects are due to prematurity.

Because of the rising rate of multiple births, the proportion of preterm infants has increased by 14 percent since 1990. In the 1970s, infants born at a gestational age of 28 weeks were considered extremely premature; today, it's 21 or 22 weeks' gestational age. The low birth weight rate (less than 2,500 grams) increase of 7.8 percent in 2002 is the highest level reported in more than three decades. The rate of very low birth weight infants was 1.46 percent in 2002. The twin birth rate climbed to 31.1 per 1,000 births in 2002, an increase of 38 percent since 1990 and a 65 percent increase since 1980. The rate of increase in triplet and higher-order multiple births declined slightly in 2002, but there has been an overall increase is these higher-order multiple births of more than 400 percent between 1980 and 1998. This increase has come from advances in and greater access to fertility therapies and from older women bearing children.

► *Disease management.* Employers, insurers, and federal lawmakers increasingly are focusing on early intervention for potential chronic diseases to avoid hospital admissions and complications later in the disease process. Disease management has become one of the fastest-growing areas in health care.

Programs may include information technology such as specialized tracking and documentation software, data registries, automated decision support tools, and call-back systems. The majority of disease management vendors offer programs for asthma, diabetes, cardiovascular disease (congestive heart failure, hypertension), chronic obstructive pulmonary disease, maternity management (including high-risk pregnancy), and end-stage renal disease (ESRD). Disease management programs for obesity, back pain, and depression are now being added to disease management portfolios.

Many disease management vendors now offer predictive modeling as a part of their total programs. The predictive modeling system can analyze data from a variety of health-plan sources to identify the patients who are consuming the greatest portion of health-care dollars and have the greatest potential for future complications and admissions. Plans use this information to focus their disease management efforts on patients who have the greatest need, resulting in lower claim cost and a return on investment.

The diagnostic group that often hits the reinsurance layer is ESRD with resulting dialysis (assuming Medicare is not primary). The average monthly cost for an ESRD patient is between $15,000 and $40,000. The average time on the kidney transplant waiting list is five years. In addition, the majority of these patients have co-morbid conditions such as hypertension, diabetes, and cardiovascular disease, which can result in costly hospital admissions.

Stop-Loss and Insured Medical Programs

Many employers turn to HMOs and other strongly managed care programs to help control health care costs. Others look to the cost-control aspects of self-funding. HMOs that offer their administrative services, managed care capabilities, and provider contracts to self-funded employers can bring the best of both worlds. However, the number of HMOs that are expert, strong players in the employer stop-loss market is still limited. Although they are often at a fixed cost disadvantage, they should be able to compete on total cost (including expected claims) given their provider network and medical management capabilities. Most are experimenting with the idea but still are not effectively competing with the standard third-party administrator model.

In addition, there are still a small number of HMOs that look for assistance from their reinsurers to provide insurance carrier arrangements to handle PPO, point-of-service, and out-of-area indemnity lives for employers with members outside the HMO service area. This limits their attractiveness to many self-funded employers.

Carve-Outs

The transplant carve-out market is estimated at $50 million. The neonatal carve-out market is still very small. Neonatal and transplant carve-out products transfer the entire risk for a specific health care condition to the reinsurer (i.e., 100 percent quota share). This is in contrast to excess reinsurance where the transplants are included with other reinsurance claims. Plans that purchase such a carve-out cover are looking for predictability on a specific risk because they may have inadequate medical management capabilities or provider contracts of their own.

Also, buyers are typically smaller, less-capitalized HMOs. A traditional excess-of-loss reinsurance cover is usually the most appropriate because it allows for the pooling of all catastrophic risk. Carve-outs have not been a big seller in the market to date. Most clients who do look at them are window shopping.

If a plan buys a transplant carve-out and also seeks traditional excess coverage, the traditional excess-of-loss carrier will provide a credit for that specific carved-out condition relative to the remaining excess-of-loss reinsurance program.

Provider Excess

There is still a modest market for excess-of-loss programs reinsuring health care providers that have entered into risk capitation arrangements. Over the past several years, rates have increased and liberalization of terms and conditions has moderated. Also, provider groups substantially raised capitation rates or returned the bad risks to the managed care entities that originated them.

The market size has stabilized after a considerable contraction of both supply and demand for several years. Most providers moved to higher deductibles with higher ADM combinations. Therefore, the rates may be less significant to their balance sheet, and there is less negotiation over rates. Carriers that stayed in this market deserve their current profitability, given a historical pattern of losses in this segment. Perhaps the carriers and providers that remain are the ones that truly understand and manage the risk.

The consolidation among commercial and Medicaid plans is offset somewhat by new opportunities in Medicare and Medicaid, as managed care demonstrates that it's still effective at controlling costs. Therefore, state and federal governments are providing incentives for new players to enter these markets and for current players to expand their coverage areas. The more things change, the more they stay the same. ●

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