BY MARK TROUTMAN

# Who Moved My Deductible?

EACH HEALTH PLAN IS UNIQUE, and different factors must be considered in the decision regarding reinsurance coverage parameters. This overview offers considerations for selecting a medical excess reinsurance deductible for commercial, Medicare, and/or Medicaid programs. It is more applicable for large payers, such as HMOs, than for self-funded employers because there usually are not enough expected claims to warrant such analysis on any given employer group. Medicaid risk varies significantly by state program, so generalization regarding frequency and cost is more difficult than for commercial and Medicare plans.

When selecting a reinsurance deductible level, a reinsurance decision-maker can review national excess claim frequency and severity data, one's own health plan data, and, perhaps, data from similar health plans.

A key consideration in selecting a reinsurance deductible level is the number of expected claims. Table 1 can be used to determine expected frequency and severity of claims at various deductibles for Medicare or commercial coverage of comprehensive services (e.g., all hospital, physician, and miscellaneous charges).

These are only estimates, and variations by health plan can be expected because of the unique risk characteristics of each plan as well as random fluctuation. A health plan should usually select a deductible level that is expected to generate no more than five to 15 insurance claims per year. A higher number of claims begins to approach a predictable level, and medical excess reinsurance is designed to cover unpredictable losses. Furthermore, there is an additional cost to reinsurance represented by the expense and profit charge of the reinsurer. If the deductible level is too low, the client pays expense and profit margin on essentially predictable claims.

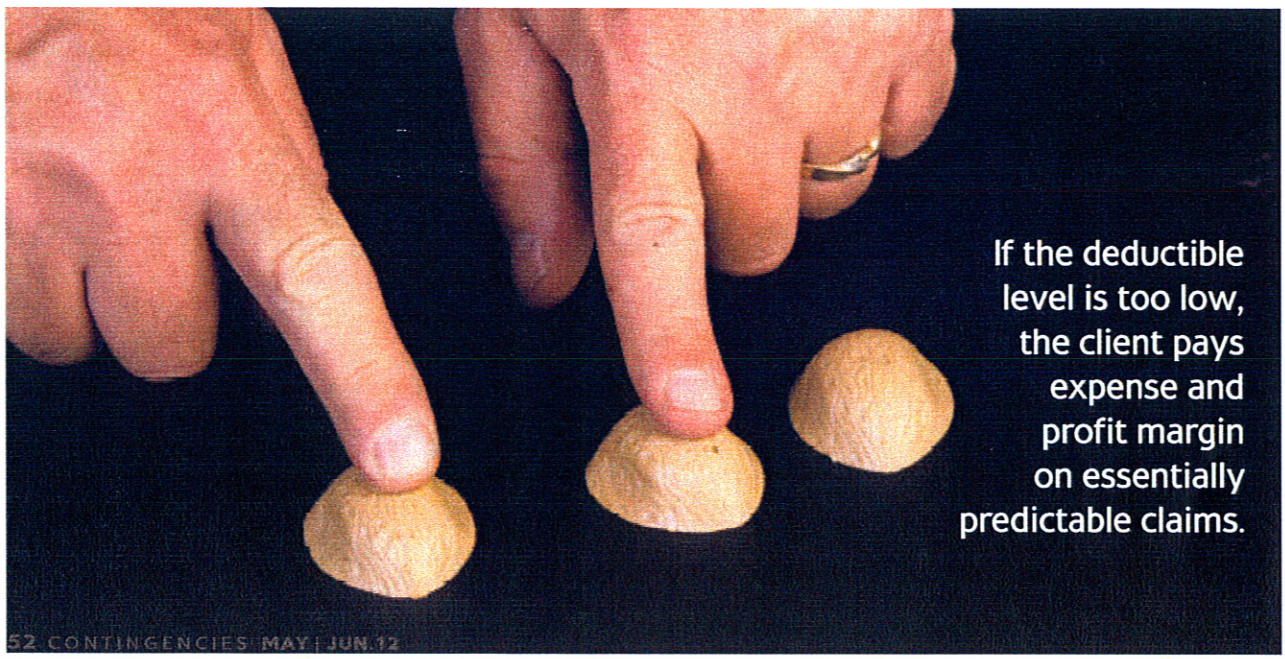
Based on the projections from Table 1 of expected claims and the suggested guideline of targeting five to 15 claims per year, a 100,000-member commercial plan selecting comprehensive coverage might choose a deductible of $400,000, all other considerations being equal, since it will result in approximately 10 expected claims. A health plan selecting coverage for only hospital claims may wish to select a lower deductible to cover a similar number of expected claims.

Figure 1 provides a cost curve for the severity and frequency data provided in Table 1.

## Individual Plan Considerations

Important individual health plan considerations in deductible selection are:

- Geographical location and provider contracts—Higher cost geographical areas will have more claims at various deductibles.
- The risk profile of a health plan's membership—Higher risk individuals will have more claims at various deductibles.
- The amount a health plan is willing to pay for reinsurance coverage—A reinsurance premium is an expense item subject to financial constraints.

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- Plan size—Smaller plans require more reinsurance initially since statistical variability is higher. For a health plan participating in multiple lines of business, it is necessary to choose between a deductible based on the total membership and deductibles for each individual segment. This decision should be driven by management expectations for each individual business segment. If each segment is expected to perform within certain financial boundaries on its own, then each will need a lower deductible selected for its particular membership size and type as opposed to basing decisions on the entire health plan risk pool.
- Coverage type—Catastrophic claim frequency will vary among commercial, Medicare, and Medicaid populations. Medicaid plans, for example, are subject to higher neonatal risk than transplant risk.
- The number of years that the product or health plan has been in existence—As a health plan matures, its risk tolerance typically increases, regardless of the size of the population.
- The health plan's targeted and actual underwriting margin—The health plan's capital base and profit prospects are important to protect with an appropriate deductible level.
- The health plan mission, financial strength, and backing by parent, if any—The larger the capital base and/or access to capital, the less reinsurance is usually purchased. Many publicly traded health care "chains" do not buy external reinsurance. Most small provider-owned health plans purchase reinsurance.
- The health plan attitude toward risk and its consequences—Is the health plan management risk averse or not?

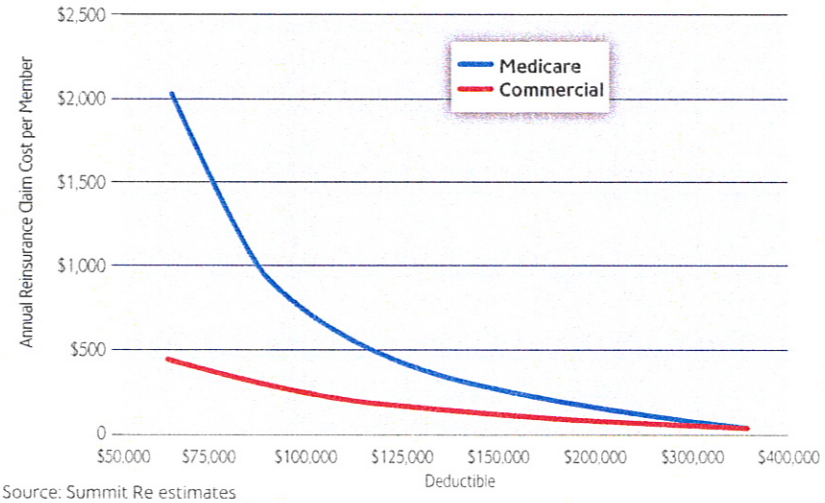
**TABLE 1**

| | Medicare | | Commercial | |
|---|---|---|---|---|
| Deductible | Average reinsurance claim | Annual frequency per 1,000 members | Average reinsurance claim | Annual frequency per 1,000 members |
| $50,000 | $36,850 | 54.8 | $53,605 | 8.1 |
| 75,000 | 43,108 | 23.6 | 69,960 | 4.1 |
| 100,000 | 37,807 | 14.8 | 80,139 | 2.5 |
| 125,000 | 39,221 | 8.4 | 85,254 | 1.7 |
| 150,000 | 54,499 | 4.0 | 89,772 | 1.2 |
| 200,000 | 82,063 | 1.2 | 134,393 | 0.5 |
| 300,000 | 88,302 | 0.3 | 139,691 | 0.2 |
| 400,000 | 104,605 | 0.1 | 140,459 | 0.1 |

Source: Summit Re estimates

**FIGURE 1**

Commercial and Medicare Cost Curves




Source: Summit Re estimates

## Modeling Individual Plan Experience

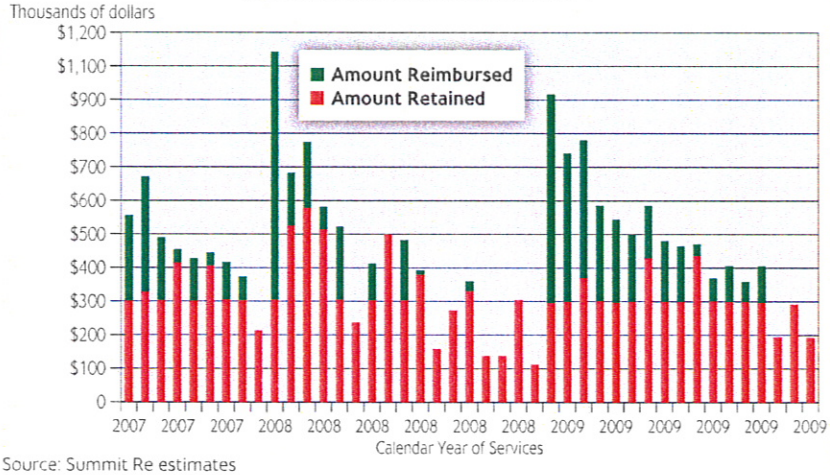
Another useful tool is to model the reinsurance coverage being considered relative to the health plan's own claim experience over recent years. In reviewing one's own plan experience, it is helpful to examine it graphically. Figure 2 illustrates one health plan's claim experience. An average daily maximum (ADM) is a per diem limit on claims to be reimbursed by the reinsurer to provide incentive for the health plan to control costs and manage care within the contracted provider network as much as possible.

This bar chart illustrates the amount reimbursed by the reinsurer versus the amount retained by the cedant. Any portion retained by the cedant above the $300,000 deductible represents an amount cutback and retained because of the ADM limit.

A review of three years of health plan experience indicates that a $300,000 deductible and $10,000 ADM may be appropriate for this plan. It is helpful to see the frequency and severity of claims to determine what deductible level and ADM will cover a reasonable amount of the "peaks and valleys," neither too high to provide too little coverage nor too low to trade dollars with the reinsurer.

**FIGURE 2**

Trended Individual Plan Experience
$300,000 Deductible and $10,000 ADM




Source: Summit Re estimates

**TABLE 2**

Percentage of Claim Above Deductible Covered by the Reinsurer

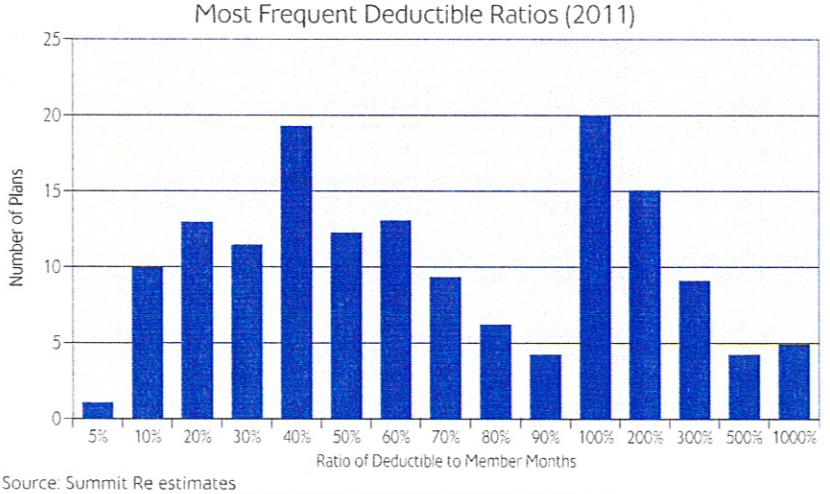
| | $300,000 Deductible | | $400,000 Deductible | |
|---|---|---|---|---|
| Year | $8,000 ADM | $10,000 ADM | $8,000 ADM | $10,000 ADM |
| 2007 | 82% | 97% | 79% | 92% |
| 2008 | 63% | 81% | 58% | 74% |
| 2009 | 90% | 98% | 87% | 96% |
| All Years | 88% | 97% | 82% | 95% |

Source: Summit Re estimates

Although the deductible is a significant out-of-pocket cost, reinsurance coverage should also be selected with other important criteria in mind. A properly structured reinsurance program will result in a high "coverage efficiency ratio" of actual reimbursed claims relative to total claims in excess of the deductible (i.e., few reimbursement "surprises"). This creates the most cost-effective reinsurance program by providing the best value for the premium. Key considerations in this decision include hospital inpatient versus comprehensive cover, ADM limit, outpatient, and step-down facilities coverage, which may have day and/or dollar limits.

**FIGURE 3**

Most Frequent Deductible Ratios (2011)




Source: Summit Re estimates

Table 2 provides an example of coverage efficiency ratios. Reimbursements above 80 percent represent an "efficient" level of coverage as the amount provides predictability instead of not knowing how a claim will be adjudicated.

Figure 2 and Table 2 provide the health plan with important insights regarding its own historical claim data, both severity and frequency, and assist in the selection of the appropriate deductible and ADM limitation.

## Keeping Up With the Joneses

When selecting a deductible level, it may be helpful to see other health plan purchasing behaviors. Figure 3 illustrates the ratio of the deductible selected to the number of annual member months for the health plan. For example, a 50,000-member plan would have 600,000 annual member months and might be selecting a deductible of around $120,000, or 20 percent of the number of member months (D÷MM=20%). These observations represent a mix of hospital-only and comprehensive coverage and a mixture of commercial, Medicaid, and Medicare business.

Many different types of members, geographical locations, and coverage parameters are selected, so there will be some natural variation in this relationship, not to mention the differing risk tolerance of each health plan. Although this is a simplistic view of risk tolerance and deductible selection, it is valuable for providing a general idea of the deductible levels selected by a large number of health plans.

It should be noted that most of the right tail activity on Figure 3 with a ratio at 100 percent or greater is composed of

startups, small plans, or small segments of larger plans. Deductible levels were set higher than normal, either because of current size and anticipated growth or because of other, larger blocks of business within the same entity.

Figure 4 shows the prior results from 2004.

Comparison of Figures 3 and 4 demonstrates the increase in health plan deductibles to adjust reinsurance costs for leveraged trend (assuming a stable membership base). Notice a flattening of the curve at the left and some movement to the right. What used to be a steep bell curve with many health plan ratios of 10 to 30 percent is now a smoother curve with more health plan ratios at 20 to 50 percent.

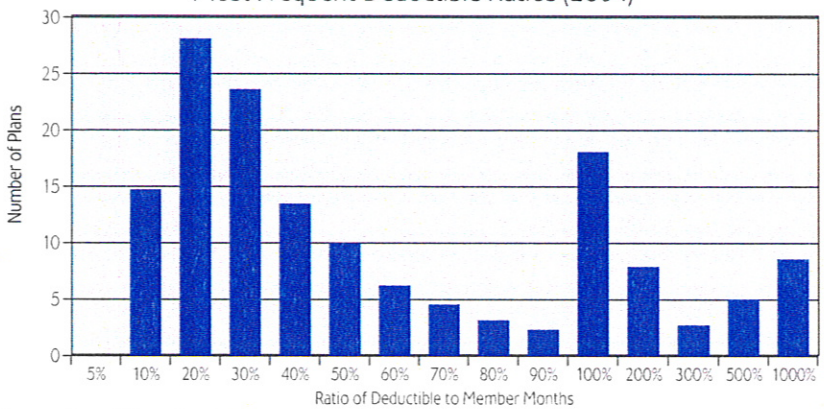
Carriers, because of their scope, presumably more capital, and more spread of risk, often purchase higher deductibles ($0.5M-$1.0M) with comprehensive 100 percent coinsurance and no inside limits such as ADMs. This leads to a large numerator and, hence, a higher ratio.

Because of health care reform, there is a significant trend among self-insured plans to review the reinsurance market cost for high-deductible coverage, often in requests for rates at various layers (1M x 1M, 3M x 2M, 5M x 5M, 10M x 10M, unlimited x 20M). Most are window shopping for now. Only 5 percent of Summit Re's current portfolio of clients have purchased an unlimited annual maximum benefit. However, many clients that currently purchase reinsurance of $1 million to $2 million have raised their annual reinsurance maximum benefit to $2 million to $5 million.

Reinsurance premium is also a reflection of risk tolerance. Risk-averse health plans have medical excess reinsurance premiums of $4 million to $5 million or even higher. Health plans with more risk tolerance often have premiums of approximately $250,000 to $750,000. An "average" reinsurance premium is approximately $1 million.

**FIGURE 4**

Most Frequent Deductible Ratios (2004)




Source: Summit Re estimates

In conclusion, purchasing the appropriate reinsurance coverage requires a thoughtful analysis and the consideration of multiple factors. Finding the proper balance between the premiums paid and the benefits provided can lend stability to a health plan balance sheet. □

MARK TROUTMAN is president of Summit Reinsurance Services Inc. (Summit Re), a managing underwriter providing managed care insurance and reinsurance to HMOs, providers, self-funded employers, and insurance carriers. Portions of this article are used with permission of America's Health Insurance Plans (AHIP) from an earlier article written by Troutman.