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Munich Health North America - Reinsurance Division

HEALTH REFORM ROLLS OUT

HEALTHCARE Newsletter Fall 2010

IN THIS EDITION

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MUNICH HEALTH

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HEALTH REFORM MEANS OPPORTUNITY: MANAGING CAPITAL & RISK WILL BE KEY TO SUCCESS

Recent developments, including the new health reform law, an extended economic recovery and continued high unemployment continue to alter the landscape of the health insurance industry. In response, managed care companies have an increased level of urgency to acquire the capabilities needed to develop breakthrough solutions for today's emerging challenges and opportunities. Reform will be disruptive, but it will also bring the potential for growth and diversification to those companies who are creative, flexible and well capitalized.

Risk-Based Capital - current state of the industry

Many companies might be surprised to learn where the industry risk-based capital (RBC) ratio stands now. Our analysis of Highline Data indicates the overall 2008 industry RBC ratio is higher than it needs to be at 577% . In fact, some analysts have suggested that this provides a potential target for regulators looking to deny rate increases.

Although the total industry RBC ratio seems high, almost one-third of all health plans have an RBC ratio below 350%, and over 20% have a ratio below 250%. Going forward, we expect much more regulatory scrutiny for reserving capital and solvency issues, including states now starting to more diligently enforce RBC requirements.

Capital and Risk Solutions

One thing I find common among the many chief executives of health plans I speak with is that they often aren't aware of the full range of options available to make the best use of their capital solutions in improving their RBC ratio. Health plans, carriers and brokers should know that, when it comes to raising capital, there are alternatives to the traditional route of incurring debt or giving up equity. While these capital market tools can help with surplus issues, they typically don't offer additional assistance with strategic planning or risk management. Traditional quota share reinsurance can provide capital relief for health organizations while also providing a true partner in risk.

These quota share agreements are primarily tailored to help clients manage their capital and risk needs, but the right partner can also bring a host of additional services such as underwriting guidance, actuarial analysis, strategic planning, marketing, claims and care management services.

Using a reinsurance quota share can be a creative and flexible option compared to the more constrained terms of traditional debt instruments. One important benefit of this type of arrangement is that the amount of capital and surplus required from the ceding carrier will be proportionally decreased by the amount of premium ceded to the reinsurer. Developing the right quota share structure will, in most cases, improve a company's net loss ratio and ROE, while improving the RBC ratio.

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Opportunities in the Medicare and Medicaid markets

Over the past few years the Medicare market has seen tremendous growth. Some companies have had the opportunity to grow by tens or even hundreds of millions of dollars in a short period of time. But these same market conditions also caused a strain on the balance sheets of some smaller to midsize Medicare organizations. We've helped some companies to finance their growth plans by using quota share reinsurance.

We anticipate that the Medicaid segment will experience significant growth over the next three to five years due to health reform.

Medicare example

A Medicare Advantage company was seeking investors to fund a $10m initiative by giving up equity. They came to Munich Re through an investment banker. After explaining the benefits of a reinsurance alternative, they decided to purchase a 50% quota share instead of diluting their equity. This allowed them to free up approximately 50% of their allocated capital to make operational improvements - their original goal - as well as have an incentivized partner to help manage its risk and profitability. Six months after implementing this quota share the CEO said he was surprised that more companies weren't taking advantage of this tool to help their organizations.

Just as we saw the growth in Medicare coming and were able to help companies succeed in that market, we now anticipate that the Medicaid segment will experience similar growth over the next three to five years due to health reform. Companies currently in this market and those just entering it will need to know how to grow smartly. Quota share reinsurance can be a valuable tool for companies looking to take advantage of this opportunity.

Market conditions may provide growth opportunities but also cause a strain on the balance sheets of some smaller to midsize Medicare organizations.

Commercial example

We recently worked with a large commercial insurer who had a problem – they were expanding too quickly, bumping up against the boundary of having enough capital to support the business. This was actually causing concern among their Board of Directors and the rating agencies.

Their reinsurance intermediary put them in contact with us. We worked out a program where they ceded 50% of their risk to us and, in the process, freed up a proportional amount of required surplus. This allowed the insurer to continue with their marketing campaigns and to continue to grow. Additionally, we put in place an "Excess" coverage to protect them against the volatility of high claims. This solution was developed, presented, and contracts were signed in under 30 days.

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What is a typical quota share structure?

Quota share reinsurance is a risk transfer vehicle that moves risk away from the primary insuring entity to a reinsurer in a "proportional" manner. This means all facets of an insurance program (premium, claims, expenses) transfer from the company that originated the business (the ceding carrier) to the entity willing to share the risk (the reinsurer).

Traditional quota share reinsurance can provide capital relief for health organizations while also providing a true partner in risk.

A simple example would be a straightforward 50-50 quota share, with 50% of the premium ceded to the reinsurer, who would then also pay 50% of the claims. Typically, every quota share agreement is specifically tailored to the individual opportunity. They can be structured so the percentage you keep can slide up or down based on some agreed upon trigger. A company might start with a 50-50 quota share but if they grow faster than anticipated, or have some new opportunity to acquire a block of business, they might need a 60 or 70% QS, and only keep 30 or 40% of the risk. In this manner, the tool offers more flexibility than using a traditional financial instrument, and the margin for this type of program is moderate.

I believe companies that have a financially strong reinsurance partner at their planning table, helping with capital and risk management needs, will have a significant advantage during the next few years as health reform is implemented

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LIMITED MEDICAL PLANS - REFORM MEANS SOME WINNERS AND SOME LOSERS

Even prior to the passage of the Patient Protection and Affordable Care Act (PPACA), the market for limited medical benefit plans (sometimes known as "mini-meds") was one of the fastest growing components of the health insurance industry. Kaiser Health News notes there are over two million workers nationwide now participating in such plans.

Reinsurance brokers and third-party administrators who have not given much attention to limited medical may be under the impression that the recent health reform legislation marks the end of the road for this market. That is not necessarily so. Only limited medical plans that are considered "group health insurance plans" will be subject to the new regulations. The Society For Human Resource Management notes this would be approximately 60 percent of the limited medical plans now in place. Those not impacted by PPACA will be well positioned for continued growth.

From a carrier's perspective, the limited medical market can be an attractive risk segment because it offers greater margins, more predictable price and utilization trends and an absence of catastrophic claim exposure that challenges comprehensive health plans.

The limited medical market can be an attractive risk segment because it offers greater margins and more predictable price and utilization trends.

Two types of limited medical plans

There are two types of limited medical plans: those filed as **expense/incurred** (sometimes referred to as co-insurance) and those filed as **fixed indemnity** plans. Expense/incurred plans resemble traditional major medical insurance with co-pays and deductibles, but they also have "caps" on benefits and annual maximums. These plans can offer more affordable health insurance premiums because they restrict annual and lifetime benefit limits.

On the other hand, fixed indemnity plans control premium by identifying a fixed dollar amount reimbursable for hospital care, doctor visits, lab tests, medications, etc. There are typically no co-pays or deductibles.

Which plans will survive?

The real winners here are the many fixed indemnity limited medical plans that were not filed as HIPAA creditable coverage.

The determination of whether a limited medial plan is subject to PPACA regulation or not is driven by how carriers choose to file their policy form. Plans filed as expense/incurred, including many of the largest players in the market, are subject to PPACA and will likely not survive because they meet the definition of a "group health plan." As such, their policies are subject to the many changes that took effect in September 2010. These include:

- Elimination of lifetime limits and overly restrictive annual limits
- Dependent child maximum age increased to 26 years
- Coverage cannot be denied due to pre-existing conditions
- Enhanced preventive services and immunization benefits are required
- Insurers cannot rescind coverage, except in cases of fraud
- Minimum loss ratio requirements

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Even some fixed indemnity limited medical plans that are filed as HIPAA creditable coverage may also fall under this same regulation. These carriers may exit the market, petition for an exception, or simply refile new limited medical plans that would comply with the new law.

The real winners here are the many fixed indemnity limited medical plans that were not filed as HIPAA creditable coverage. Because they are considered supplemental in nature and are "excepted benefits" under PPACA, these plans are not subject to the new regulations. In fact, they will have significant potential for growth. Here's why:

Disruptions in the existing market

Dominant players in the limited medical market will have to file waivers seeking permission to retain their plans. As a result, large segments of this market may be in play.

Dominant players in the limited medical market like SRC, an Aetna company, and Star HRG, owned by Cigna, predominately offer the negatively impacted co-insurance type of plan. These companies will have to file waivers seeking permission to retain their plans. As a result, large segments of this market may be in play.

Employers searching for ways to control costs

As health reform takes effect and insurance costs continue to rise, more employers could move away from making contributions to employee health plans and instead shift toward offering an array of core products with group health like dental, vision, life, disability, etc. as "voluntary" benefits. Employees typically pay one hundred percent of the cost of coverage for these so-called "gap plans." These plans (another form of limited medical) will likely grow in popularity as more employees combine them with high deductible health plans as a way to improve coverage while lowering their premiums.

Demand will build in the individual insurance market too

Limited medical plans will likely grow in popularity as more people combine them with high deductible health plans as a way to improve coverage while lowering their premiums.

The individual health insurance market will feel the same cost pressure that is impacting employers. As insurance rates continue to increase each year, those looking for coverage through the individual market will either drop their health insurance because it is too expensive, turn to limited medical plans or purchase higher deductible and higher out-of-pocket expense plans. Many may purchase a limited medical plan for routine medical costs and elect to pay a relatively modest fine proposed by PPACA for not purchasing medical insurance. In 2014, the fine for an individual not purchasing health insurance is $95. It becomes $325, in 2015 and $695 in 2016. After 2016, it increases by a cost of living adjustment.

Also, as PPACA's policy for "young invincibles" is implemented it will provide those under thirty years old with catastrophic coverage only. It is possible many of these individuals will purchase a limited medical plan to cover the gaps in their benefits. This movement will likely continue to grow during the next few years and see significant acceleration starting in 2014.

Taken together, these trends should fuel significant growth in limited medical plans.

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Who buys limited medical plans?

Limited medical plans were originally designed for low wage hourly workers who typically were not eligible for major medical group/employer plans. This type of insurance product offered "limited" medical coverage to those who otherwise would have no employer sponsored health coverage at all. Over the past decade, many large national employers shifted their workforce to employ larger numbers of part-time, temporary workers and independent contractors. In the process, many began looking at limited medical plans. The Wall Street Journal cites Wal-Mart and HR Magazine lists Lowe's and Hair Cuttery as examples of the increasing number of large employers offering limited medical plans today.

Limited medical plans are attractive to members because they offer affordable first-dollar coverage for everyday medical expenses.

Limited medical plans are attractive to members because they offer affordable first-dollar coverage for everyday medical expenses. They also provide a basic level of coverage for the increasing number of individuals and employees who may not otherwise have access to affordable health insurance.

Is it adequate coverage?

According to the actuarial and consulting firm Milliman, 50% of all Americans accrue less than $2,000 of healthcare costs annually; 90% accrue less than $5,000 and 99% accrue less than $50,000. Limited medical plans are directly aimed at providing a benefit to cover what most Americans experience when they become consumers of healthcare: doctor visits, prescription drugs and trips to the emergency room. Will this cover organ transplants or dialysis? No, but a limited medical benefit plan is, by definition, not intended to be all things to all customers.

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MEDICARE ADVANTAGE - FLOURISHING IN A DYNAMIC NEW MARKETPLACE

With the many conflicting opinions that have been voiced about the way in which healthcare reform will play out in the market, it has been difficult to determine this legislation's true impact. But now as we are gradually starting to see more specifics concerning a number of the actual rules, some clarity is finally starting to materialize. While implementation of some reform provisions is still years away, other near-at-hand measures could open up new opportunities, particularly for Medicare Advantage plans.

Some politicians have made Medicare Advantage the proverbial "whipping boy" of the healthcare industry, while others have touted its value to their constituents. These polarized views ignore one constant about the market: demographic trends show the undisputable emergence of a rapidly aging population that seeks, even demands, ever-increasing levels of benefits and services. This trend, coupled with an increasing recognition among the general population that the current cost curve is unsustainable, presents a pressing dynamic that is sometimes lost in the political rhetoric.

While health plans have generally done a good job of controlling costs and improving benefits over the years, flattening and declining rates pose a difficult challenge to health plans.

While health plans in general have done a decent job over the years of controlling costs, the flattening and reducing of rates presents a new challenge.

On the surface, this evolving landscape may seem threatening for Medicare Advantage plans, but like any evolving environment, it is not without its opportunities.

With this evolving landscape in mind, Munich Health North America's Reinsurance Division has been working with its Medicare Advantage clients to find ways to flourish in this dynamic new marketplace. Our efforts to date have yielded the following important points to keep in mind as jockeying for position - and opportunity - now starts to occur:

- The Department of Health and Human Services will write rules with an emphasis on protecting consumer choice, pay-for-performance, coordination of care and caps on various things. Accordingly, health plans that can consistently deliver increased real value while operating in an increasingly efficient manner (despite the complications and challenges of doing so) will have a significant competitive advantage. Achieving and leveraging economies of scale wherever possible will become even more important.

Health plans that can consistently deliver increased real value while operating in an increasingly efficient manner will have a significant competitive advantage.

- Some health plans may exit markets, segments, and/or products as they did many years ago. As a result, some type of land grab in addition to some industry consolidation may occur as less efficient players aren't able to compete in the new landscape. Moreover, others may smell opportunity and be ready to acquire, while sellers may be more willing to sell than in years past. At its core, some competitive rebalancing is quite likely to occur.

- Revenue driving and cost saving activities will go from being important to being critical. Revenue drivers will include HCC and complex case reporting/management, Star ratings, altering the product and geographic mix and potential acquisitions (despite the increased M&A scrutiny that is likely to result), to name a few. Cost saving drivers will include superior customer

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service that must translate into higher rates of member retention, medical management, more sophisticated network contracting, altering marketing and distribution mixes, and investments in technology.

Companies in the senior health management market must make compliance an integral part of running a "lean and mean" operation.

- Compliance will demand even more attention. Individuals in senior management must make compliance an integral part of running a "lean and mean" operation. This means that compliance (and all is related activities) must become an integral part of the fabric of an organization.

- All of these demands will lead to a squeeze on capital, particularly so as investment values - though improved – remain relatively depressed for most people. Organizations that do not have, or cannot acquire, the financial capital and resources to operate in this post-reform world will not survive.

As indicated above, the changing landscape is not without opportunity, but just how large is the opportunity?

Total Medicare Advantage enrollment was slightly less than 8 million members at the end of 2006. Today, Medicare Advantage plans cover nearly 12 million members – a roughly 50 percent increase, and we are just now at the beginning of the expected increases stemming from rapidly aging Baby-Boomers.

All of these demands will lead to a squeeze on capital, particularly so as investment values remain relatively depressed.

As Vice President Biden so aptly put it, this is indeed a "big deal." In our view, big deals bring big opportunities. The long-term negative impact to Medicare Advantage may not be as severe as some have suggested during the rhetoric of the legislative process. Moreover, the now-forming "rules of the road" have started to remove uncertainty and may ultimately lay a path to opportunity. This couldn't come at a better time, considering the explosion of membership in Medicare members that is soon to occur.

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MEDICAL MANAGEMENT - NOW MORE THAN EVER A KEY TO BENDING THE COST CURVE

As the nation watched on March 23, 2010, the approximately 2,000-page healthcare reform (HCR) bill was signed into law by President Obama. Although the healthcare landscape will undoubtedly change as a result of this new legislation, some things will remain the same – among them, positive opportunities will continue to exist for medical management to make a meaningful impact in the marketplace.

While HCR will implement relatively few changes this year to how healthcare is delivered and paid for, 2011 and beyond will see significant transformation. The sheer number of people who will now have access to healthcare will force change. However, comprehensive services, program excellence and cost containment must be maintained as the foundation of reform if we are to provide quality treatment when serving millions of Americans.

The long national debate over healthcare reform that preceded the new bill should have given health plans, large and small, an opportunity to recognize the growing importance of well designed medical management programs as a cost control tool. The prospect of 25 to 30 million individuals seeking health coverage for the first time and the tight new medical loss ratio standards proposed must be a wake-up call; going forward, successful plans will have to become masters at delivering effective, integrated medical management.

Here are some important points to consider:

- Improved access to data will also improve the integration of case management, disease management and utilization review. These are important to keep costs in check.

- Comprehensive precertification serves as a pillar of strength when used not only to validate medical necessity, but as a door to case management and disease management for catastrophic illness or injury.

- Specialty case management must assure that care provided is medically necessary, evidence-based, high quality and efficient, or claims dollars will be wasted. This is especially true in high-cost areas such as high-risk obstetrics, cancer and the needs of premature babies.

While health reform will implement relatively few changes this year to how healthcare is delivered and paid for, 2011 and beyond will see significant transformation.

In a post-reform world, more patients with more complex conditions will make medical management even more of a necessity.

In a post-reform world, more patients with more complex conditions will make medical management even more of a necessity. Statistics indicate the need for expanded prevention programs and effective management of lifelong conditions to avoid catastrophic and costly illnesses.

According to Centers for Disease Control and Prevention, about 785,000 Americans have a first heart attack each year. In 2010, heart disease will cost the United States about $316.4 billion. Cancer will claim the lives of more than half a million Americans annually. Diabetes-related kidney failure accounts for much of the dialysis and kidney transplant related expenses, including amputations and surgical heart disease procedures.

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It is important to continue identifying diabetes prior to complications through disease management, care coordination, teaching self-management, and promoting long-term behavioral changes in diet, exercise and smoking. Additionally, Health Risk Assessments (HRAs) will continue to serve as a valuable tool in identifying people who are overweight, sedentary, lack nutritional intake or who need coping mechanisms for stress management.

Historically, health plans' efforts to manage their members have been hampered by a fragmented delivery system and lack of true care coordination.

Management of these chronic conditions will be critical to any health plan's success. The Gorman group notes that chronic medical conditions account for $3 out of every $4 spent on healthcare in the US. By 2030, over 20% of the population will be 65 or older and those with chronic medical conditions will consume a majority of healthcare spending in the US. For Medicare Advantage, Gorman cites the "5/60 rule" where 5% of membership typically accounts for 60% or more of medical expense.

Historically, health plans' efforts to manage their members have been hampered by a fragmented delivery system and lack of true care coordination. Going forward, medical management, grounded in evidence-based clinical practices, predictive outcomes modeling, member engagement and multidisciplinary professional collaboration will be required.

The new increasingly competitive environment will require health plans to be better care coordinators. Medical management programs will need to work together with other entities, focusing not only on health management but cost containment. This will require alternatives for the patient and new targeted venues. Medical tourism and global medical care are expanding, and such options are a two-way street for patients seeking answers to health issues both here and abroad. At Hines and Associates, we anticipate increased utilization of Centers of Excellence to enhance health outcomes and control costs.

An increase in the need for stop loss protection may also be necessary, particularly if annual or lifetime limits were previously the health plan's primary cost control tool for high-dollar claims. Real time data sharing will be more important than ever to make this additional risk protection affordable to employers entering the self-funded arena, or those who previously did not elect stop loss coverage. Medical management's collaboration with stop-loss providers to project future needs contributes not only to controlling costs but also to efficient use of resources.

Effective medical management has always been at the core of our healthcare system and this continues to be true even in a post-reform world.

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How governments and the pharmaceutical industry respond to this growing concern may have far-reaching implications for the healthcare industry. This article, reprinted with permission from the September 2010 edition of *Health Affairs*, describes a growing fear among health agencies.

FIGHTING ANTIBIOTIC RESISTANCE: MARRYING NEW FINANCIAL INCENTIVES TO MEETING PUBLIC HEALTH GOALS

Click the title above to access the article. This is a web only feature and by license agreement is available to our readers until 12/23/2010.

WHY THIS ARTICLE IS IMPORTANT

Even before the new health reform law was passed in the United States, many analysts were speculating that one of the outcomes would be an increase in the demand for medical services abroad, also known as medical tourism. But this may not be the panacea that some believe. In fact, it might come with a completely different set of problems.

News stories continue to pop up about the growing number of cases of antibiotic resistant bacteria showing up in patients returning home after medical treatment abroad. One recent article reported on three Americans and two Canadians who returned from India with a drug resistant "superbug" after undergoing medical treatment.

How governments and the pharmaceutical industry respond to this growing concern may have far-reaching implications for the healthcare industry. This article (reprinted with permission from the September 2010 edition of *Health Affairs)* describes a growing fear of health agencies.

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QUESTIONS/COMMENTS

We welcome questions and comments on the newsletter and the topics covered. Please direct questions to raristarco@munichhealth.com.

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