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Munich Health North America - Reinsurance Division

A CHANGING ENVIRONMENT DEMANDS NEW IDEAS

HEALTHCARE Newsletter - Fall 2011

IN THIS EDITION

MUNICH HEALTH

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President

WHAT SHOULD HEALTH INDUSTRY CEOs BE FOCUSED ON FOR 2012 AND BEYOND?

2011 is winding down, and it's been quite a year for those of us in the health-care business: the Supreme Court now has the Individual Mandate under review, states are struggling with the development of their Health Exchanges, M&A activity has picked up noticeably, all while cost and quality continue to be critical issues. As we head toward 2012, a presidential election season looms and much uncertainty remains surrounding the state of our economy.

With all this change taking place, we decided to survey a number of consultants and analysts, asking them what health industry CEOs should be concerned about heading into 2012, and what questions they should be asking themselves and their staffs regarding their readiness to respond to the challenges ahead. With that research in mind and drawing on our own experience with a wide range of carriers, health plans, managing general underwriters, third party administrators, consultants and reinsurance intermediaries, we offer the following observations:

It's a New Healthcare World

The healthcare world is changing in fundamental ways. Like a hand squeezing the middle of a balloon, both ends of the market (the very large and the niche) are expanding, while the middle is disappearing. To succeed in 2012 and beyond, healthcare CEOs will need to have a clear vision of what space they want to occupy and, just as importantly, how to get there.

Nearly every piece of regulation implementing the Accountable Care Act appears to have an incremental negative impact on health industry risk margins.

Margins – Under Pressure

Nearly every piece of regulation implementing the Accountable Care Act (ACA) appears to have an incremental negative impact on health industry risk margins. The impact of individual major regulations such as minimum loss ratio (MLR) requirements, premium pressure from rate reviews and mandated benefits are identifiable, but does your organization have a firm understanding of the cumulative effect of all of these pressures? Have you calculated the impact on margins after the likely shift from group to individual, from insured to self funding, from product commoditization, from provider cost shifting and from anti-selection due to guarantee issue (just to name a few)?

Not all of these issues will surface in 2011—for many, the full impact will not be felt until 2014 and beyond. Still, 2012 will be a critical year for those who hope to succeed (or just survive) in the post-reform world. These plans will have to realistically assess the margin potential of their current products and business models and make the difficult decisions to either transform or exit.

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Exchanges – Hopefully You Have a Plan

Health insurance exchanges have the potential to dramatically impact virtually every sector of the health industry. Everyone seems to have an opinion as to how this centerpiece of the ACA will ultimately affect the way health insurance is purchased. Some advocate that exchanges will lead to a complete "crowd out" of the small employer sponsored market and an explosion in the Individual market. We hear others comment that exchanges will lead to an acceleration of medium and large employers moving toward defined contribution health programs. Exchanges could also become de-facto high risk pools or a virtual expansion of the Medicaid program.

In all likelihood, the impact of the exchanges will vary by state, depending upon how well (or if) the state-based exchange is launched, the number of participating plans, the composition of the off-exchange market and other market-specific factors.

In all likelihood, the impact of the exchanges will vary by state, depending upon how well (or if) the state-based exchange is launched, the number of participating plans, the composition of the off-exchange market and other market-specific factors. CEOs need to have a strategy for how their company can navigate a world with exchanges. Do you have the scale or the necessary cost advantage to compete on the exchange? How will the availability of exchanges and government subsidies change the buying preferences of your existing customers? Do you need to be in the Individual market, and if so, when do you enter? Should you expand into Medicaid or develop an alliance with an existing player? Do you have the products to meet the demands of the off-exchange market buyers? The smart (still employed) CEO will dedicate the resources in 2012 to answer these and other questions and will be prepared for the various scenarios that may unfold.

Capital Management – How Do You Fund the Costs?

Do you have the resources, ability and products to compete effectively on the exchanges? Can you provide electronic medical records (EMRs) and related technologies with which to compete, or enable ACO-like organizations to control costs and improve quality and compliance? Positioning yourself to succeed in a world of MLR mandates, ICD-10 and HIPAA compliance requirements, and all the other preparations necessary to deal with the new government distribution system, will require the wise use of capital. CEOs need to strengthen their balance sheets to be able to take on new products, new risks, and upgrade information systems.

MLR requirements alone will put significant pressure on overhead costs (SG&A). Deploying capital in ways that help lower SG&A will be critical.

The MLR requirements alone will put significant pressure on overhead costs (SG&A). Deploying capital in ways that help lower SG&A will be critical. Examples include achieving an increase in scale through a merger or acquisition, investing in new technology, or developing service area expansions. Anything that helps ratchet down expenses will help margin management and, to the extent possible, margin expansion.

While the large national players are flush with cash and RBC ratios are high, mid-size and smaller organizations, like provider-sponsored health plans, may find it necessary but difficult to raise money for opportunities they see in the new market. Capital and capitalization will be more important than ever, both as offensive and defensive tools.

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Scale – Should You Grow or Specialize?

It is apparent that economies of scale will be paramount in the new healthcare market. Without sufficient scale, it will be difficult to compete in some market segments and/or geographic regions. We expect the current consolidation trend among health plans to continue as the new government distribution model rolls out and state exchanges begin to come online. A few of the biggest players, like Cigna and United, will be in a class of their own, dominating much of the market. Faced with that reality, we anticipate that small to mid-sized organizations will need to merge, acquire, sell or alternatively concentrate on specialty businesses.

Without sufficient scale, it will be difficult to compete in some market segments and/or geographic regions.

Mid-size companies who don't increase scale will need to sharply focus their product offerings and geographic presence. For example, they might concentrate in supplementary medical, a narrow network offering, smaller size self-funded programs, or specialize in specific segments of Medicaid. Success will depend on being very good at several narrow segments, in whatever regions they target.

Ultimately, the choice is to either step up and become a bigger player, or evolve into a more sophisticated niche operation. There is no middle option left.

Risk Sharing – Will New Incentives Drive New Models?

Providers have traditionally been risk adverse, but that situation is changing. The trend now appears to be more risk shifting to providers through the ACO model, along with new incentives to encourage the move. It may be called pay for performance, pay for measurement, pay for efficiency, or pay for effectiveness. Whatever the label, the trend is clear—more groups are trying to identify the sweet spot where incentives and risks are aligned so that it is mutually beneficial for both the insurer and the provider.

The trend now appears to be more risk shifting to providers through the ACO model, along with new incentives to encourage the move.

This shift is one reason why companies like Aetna and United are spending large sums to provide EMR systems to the medical groups they purchase. In an ACO context, the insurer is empowering and incentivizing the medical group to accept more risk by giving them access to data, which should help track and improve medical outcomes and drive greater process efficiency.

However, as providers take on more risk, it creates a capital issue. Providers typically wouldn't have enough capital to support the risk they take on, and they are not experienced in the risk business. This creates an opportunity for health plan CEOs to work with providers, helping them with both capital and insurance issues.

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Provider Capacity – Will It Be There?

Are you building a path to affordable provider capacity in 2014? One of the structural flaws of health reform is that it creates significant new demand for coverage in the exchanges and Medicaid, but nothing has been done to ensure capacity in terms of provider supply. There will be a pressure on demand for provider services, particularly primary care, that could create a cost challenge for MCOs. Some large organizations are attempting to address this issue by acquiring their own integrated care delivery capabilities. Regardless of the size of the company, CEOs need to be revising network strategies to address this likely provider shortage and the associated cost pressure.

The current unprecedented level of uncertainty should not lead to paralysis or a reliance on the status quo.

Now is the Time to Act

What the health insurance industry will look like on January 1, 2014 is still uncertain. Regulations will evolve, compromises will be made and we may even see changes in the law itself. However, this unprecedented level of uncertainty should not lead to paralysis or a reliance on the status quo. The successful health industry CEOs are right now challenging their staffs with these difficult questions, taking actions to minimize enterprise risk and positioning their entities to be viable players in the years to come.

We hope that we have given you some additional things to think about as you contemplate how to deploy your resources over the course of 2012.

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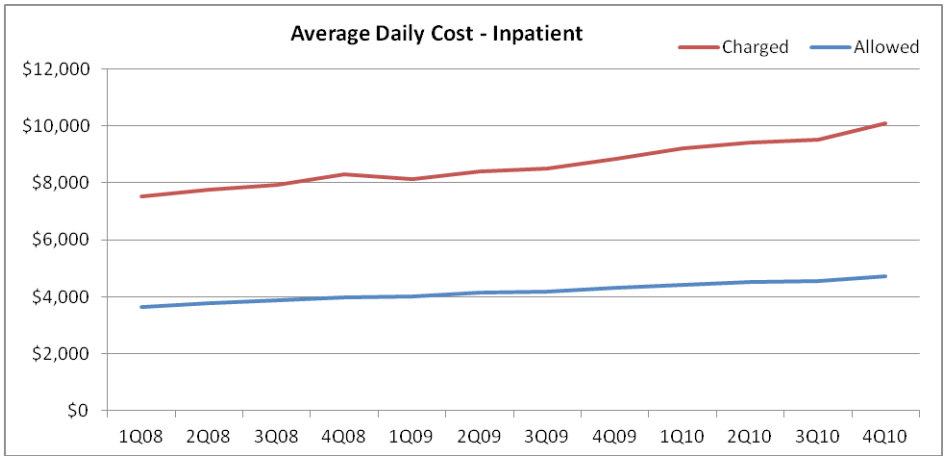
MEDICAL COST TREND REVIEW

Munich Health North America (MHNA) has observed a fairly steady increase in overall commercial medical costs of 9% annually over the last three years. We expect that the forces behind this trend, such as increases in utilization due to an aging population, increases in cost from inflation and technological advancements, and cost shifting from sources such as Medicare and Medicaid, will continue. It is also possible that provisions of PPACA, such as the gradual elimination of annual maximums on coverage, may put additional upward pressure on trend for 2012.

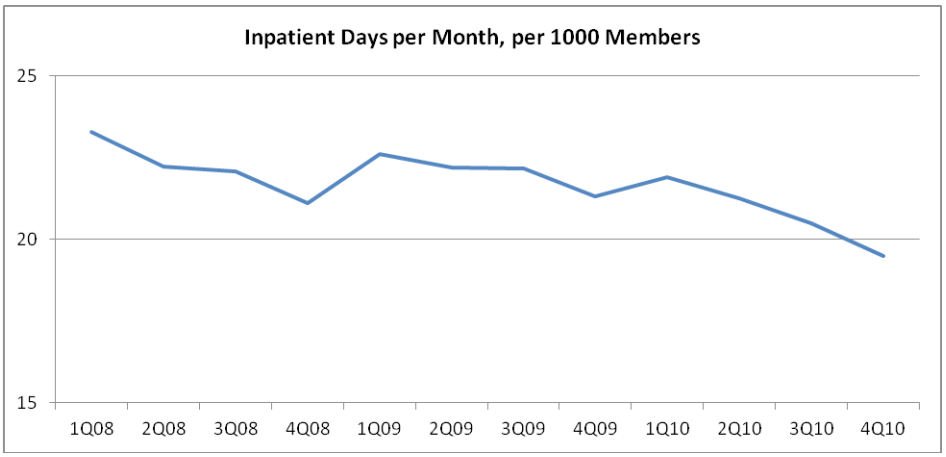
We examined ground-up claims for a large fully-insured commercial population for calendar years 2008 through 2010, looking for patterns in both cost and utilization. The results show that overall cost increases for outpatient services continue to outpace those for inpatient services. Much of this is due to improvements in medicine, which allow for more services to be performed in an outpatient setting.

An examination of inpatient trends reveals that average inpatient hospital charges continue to rise year after year. The discounts shown here are quite large, since the contributors to this commercial dataset include several large insurance plans with extensive networks.



Average charge per day, along with negotiated (discounted) amounts.

While the average daily cost of a hospital visit is increasing, the frequency of hospital visits is declining.



Inpatient utilization in 2009 was similar to that in 2008, with only a slight decrease. The decrease in utilization for 2010 was more significant.

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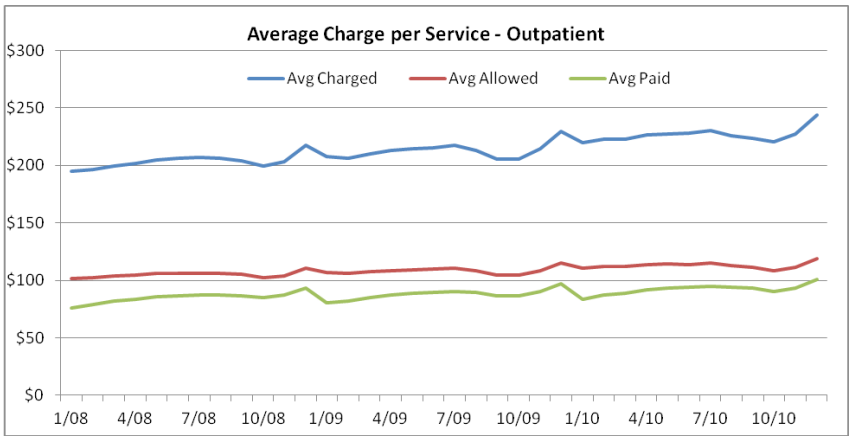
The combined effect of cost increases and utilization reductions yields an overall inpatient cost trend increase of 6-7% annually. The shift toward outpatient services affects the overall profile of inpatient claims. While the total number of hospital visits may be declining, a larger percentage of inpatient visits are for complicated and expensive surgeries that require an overnight stay, which drives a portion of the increase in inpatient claim costs.

Average charge per service for outpatient services increased by 5.5% per year from 2008-2010.



There is a noticeable seasonal pattern in the results; a drop occurs each autumn, followed by an end-of-year "rush" on benefits. Types of procedures which experience this end-of-year spike include carpal tunnel decompression, colonoscopy, and caesarean section. Utilization review programs may help to determine whether such procedures are necessary, or whether a lower-cost alternative may be available.

Between 2008 and 2010, we found annual utilization increased 5-15% for the majority of outpatient procedures, though a few were higher. Some of the biggest drivers of cost increases include dialysis, specialty drugs, and lab tests, which are fairly high-cost services that have seen marked increases in utilization.

The overall outpatient cost increase was 9-10% annually over the three-year period.

As cost trends continue to rise and the mix of inpatient and outpatient services continues to evolve, employers and insurers must be aware of the types of coverage that best suit policyholders' needs while keeping costs down. It is also important to keep in mind that although inpatient services are becoming less prevalent, they are also becoming more costly. As a result, the risk of very large claims becomes greater. This is especially true with the removal of annual and lifetime limits, as we have seen hospital claims in recent years growing to previously unheard of levels. As an example, in the 2008 dataset the highest cost individual incurred $5M in claims, in 2009 one individual incurred $10M, and in 2010 one individual incurred $20M in claims!

MHNA will continue to monitor medical trend closely, especially in light of the anticipated legislative changes over the next few years.

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IS THERE LIFE OUTSIDE THE EXCHANGES?

Much has been written recently about the Affordable Care Act (ACA) requirement mandating creation of government-funded public health insurance exchanges in each state by 2014. These exchanges are intended to play a central role in organizing information and facilitating consumers' decisions about purchasing insurance and qualifying for financial assistance.

The Congressional Budget Office (CBO) estimates that 22 million individuals will be buying health insurance through the exchanges by 2016, and that 18 million of them will be receiving federal tax credits to help pay their premiums. These are certainly significant numbers, but even so, they represent less than half of the current uninsured population. With the rollout of the exchanges and the inducements to buy through them, health plans now face a central question: "Do I need to be in the exchange if I want to stay in the health insurance business?"

For some, particularly the larger players, the answer will be "yes" if for no other reason than their size alone, which would make them a political target if they did not participate. But mid-size and smaller plans are more likely candidates to operate successfully outside the exchanges if they can identify niche markets the exchanges fail to serve adequately.

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"Off-Exchange" Insurance Will Still Exist

While states' exchanges will be the only place to get qualified benefit plans and subsidies, there will be many who are not eligible for a subsidy, or who are eligible for a level of subsidy they deem insufficient to cover the cost of a qualified benefit plan. How large will this market be and what types of off-exchange products might best appeal to this group? These are important questions carriers, health plan sponsors and even employers should be asking themselves.

A blog post by Larry Levitt and Gary Claxton for Kaiser Family Foundation noted: "Looking at the non-group and small-group markets combined and extrapolating the CBO projections, more people will likely be getting coverage outside of the exchanges (about 31 million) than inside (about 25 million)."

The CBO estimated that about 9 million individuals would continue to buy coverage independently, outside of the exchanges. They also expect that few small businesses will buy insurance through the exchanges (only about 2.9 million workers out of a total small group market of about 25 million people). Why? The premium tax credits for small businesses available through exchanges are temporary and targeted towards the smallest businesses with low average wages. The maximum credit allowed is only 35%. This would apply to an employer with 10 or fewer workers with average annual wages of less than $50,000. The credit is quickly scaled down as the number of employees increases, or as the average annual wages grow, which creates the perverse incentive for an employer not to hire more employees or increase their wages for fear of losing their tax credit.

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Will the Exchanges be Affordable?

Kathleen Sebelius, Health and Human Services Secretary, has been quoted as saying that, in theory, the exchanges will pool risks and premiums, allowing individuals and small businesses to purchase health insurance with "the same purchasing power as big business." But as more regulatory details are released, it is becoming clear that the exchanges do not seem to be the panacea some had envisioned. Pricing appears to be one concern. Bob Laszewski, in his blog Health Care Policy and Market Review, provided this example:

Under ACA, paltry fines offer little incentive to drive participation in the individual mandate requirement.

In the exchange, a family of four making $55,000 per year (250% of the federal poverty level) would pay approximately $4,400 after federal subsidy, annually. But under the health law's individual mandate, the maximum fine for not purchasing health insurance would be only $550 the first year, $1,100 the second year and $1,375 the third and subsequent years.

Similarly, a family making $85,000 a year (400% of the poverty level) would have to pay $8,075 for their share of the cost of health insurance or pay a fine the first year of $850 that would likely cap out at $2,125 in later years.

Laszewski's point was that the paltry fines offer little incentive to drive participation in the individual mandate requirement. Our observation is that the cost of insurance on the exchange, even after subsidies, is simply too high. This suggests there could be a significant need for off-exchange health insurance products that are more economical. Off-exchange products would not be subject to ACA's many costly regulations (limited age-banding and gender-neutral rates, mandated minimum benefits, MLR guidelines, etc.) and could provide more affordable options for many consumers.

The cost of insurance on the exchange, even after subsidies, is simply too high.

Some products which might be successful include:

- Limited Benefit plans on an indemnity basis as opposed to expense incurred.
- Short Term Medical plans – full coverage subject to pre-ex.
- Hospital Indemnity plans – pays a fixed amount for each day that you are hospitalized.
- Cancer or other disease-specific plans – pays a fixed amount for treatments related to the diagnosis.

It is true that anyone purchasing one of these "non-qualified" policies outside the exchange would still have to pay a fine. However, the net out-of-pocket cost (premium + fine) would still be less than the cost of the minimum qualified plan inside the exchange.

What About Choice? Private Exchanges Offer an Alternative

To those who remember, the industry's past experience with Health Insurance Purchasing Coalitions (HIPCs) might serve as a useful example. Back in the 1990s, HIPCs were set up by a number of States to create an insurance pool for individuals and small employers to buy insurance at more competitive prices. What was initially lauded as a step toward controlling the cost of health insurance ultimately did not accomplish any significant cost reduction, and eventually failed. However, a few private purchasing co-ops that were also established at the same time did survive longer than their State-run counterparts, in part because they were more innovative in their attempts to control costs. Some would say that those who don't learn from history are doomed to repeat it.

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Today, private health exchanges could provide an important alternative for those who do not qualify for government subsidies, or who choose not to participate in public exchanges. According to HealthExchange.com, there are over 100 private exchanges now in existence, representing a significant part of insurance carriers' distribution efforts. A key element in consumer success for these non-government private exchanges has been the availability of a wide range of products with respect to cost, product design, benefits and network participation.

POLITICO reported that two insurance companies (Minneapolis-based Medica & BCBS of Michigan) would jointly open a private health exchange. Under this setup, the companies pay a defined contribution – a set amount each employee can use to buy health coverage. Employees also have the option to contribute some of their own money to get a richer benefit package.

In the long term, it is our belief that state health exchanges will have difficulty delivering what they were intended to - affordable insurance.

The report speculated that if employers are moving to a defined contribution model now, it may mean they are less likely to drop coverage after 2014. This is in contrast to a McKinsey & Co report earlier this year which suggested that, under ACA, as many as a third of companies would stop offering insurance.

As an alternative to offering no insurance at all, a growing number of businesses are considering a defined contribution model linked to a private exchange as a way to control cost while continuing to offer coverage. This concept, developing private exchanges where a business purchases coverage for all employees together and no one is turned away for a preexisting condition, is just being tested. Premiums range from $200-$400.

Will Exchanges Work Long-Term?

As has been widely reported, creating state exchanges is a complex process that has gotten off to a relatively slow start. With a 2014 deadline looming, a recent Kaiser report noted only 15 states had enacted laws to fully establish exchanges, and there remains considerable skepticism and resistance among many Governors. In some states, too few insurers have expressed interest in participating, and many among those who have are new to the health market.

Adding to the uncertainty, the initial threat that HHS would step in directly if states failed to create exchanges now seems more hollow. Fred Hunt, SPBA's former President, reported in a September e-mail alert that no pre-funding was ever allocated as part of ACA to allow for such federal intervention.

In the long term, it is our belief that state health exchanges will have difficulty delivering what they were intended to - affordable insurance. This may take five years and another election to become evident. With that in mind, mid-size and smaller health plans may want to think twice before abandoning the market, even if they don't want to participate in the exchanges.

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UNDERSTANDING THE CANCER COST CONUNDRUM

Cancer Statistics

It's anticipated that more than 1.5 million Americans will be diagnosed with cancer in 2011. More than 1/3 of those patients are expected to be terminal, making cancer our nation's number 2 killer (behind heart disease), according to the American Cancer Society's Cancer Facts & Figures 2011 Report.

The Society's research indicates that the 5-year survival rate for all cancers from 1999 to 2006 is 68%, which is up from 50% during the period of 1975 - 1977. Survival statistics vary by the cancer type, stage, and other co-morbidities at diagnosis; however, earlier detection and improved treatments account for the improved survival rates. It is important to note that the 5-year survival point includes patients cured, relapsed or currently in treatment.

While one cancer case is one too many, the number of cases reported annually is actually declining due to better preventive measures and advanced screening. Still, cancer is expensive. In 2010, the overall costs of cancer were $263.8 billion, of which $102.8 billion were direct medical costs. This represents a significant increase from 2005, when direct medical costs were $74.0 billion.

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Increasing Cost of Care

Even as the number of cancer cases is declining, the cost of treatment is increasing due to the growing number of new and novel effective medications, and the necessary maintenance therapies that have prolonged life for an increasing number of survivors.

As oncology drugs have become more targeted and easier to administer, they have also become more expensive. Medco reports that chemotherapy administered in the office setting can constitute up to 33% of annual revenue for the average oncologist in private practive. Some estimate 50% - 75% of oncology practice profits come from the drugs alone. An even more important statistic for benefit plans is that 50% - 75% of oncology medications are used outside of Federal Drug Administration (FDA) approved prescription labeling or "off-label." (Medco 2011 Vol. 13 Drug Trend Report, Page 97)

New and novel oncology agents such as Avastin®, Herceptin®, Tarceva®, as well as those receiving generic status such as Gemzar®, are exciting and may have many more uses than the initial indications received for FDA approval, either in single-agent form or in a combination chemotherapy regimen. But this excitement can lead to over-use in areas outside of clinical trials in an effort to learn more about their efficacy and safety. These medications are often combined with other agents in attempts to improve outcomes with the hopes that they provide a synergistic effect. While the additional cost to the plan for what can essentially be considered a non-approved drug trial is high, even more critical is the increased risk a patient faces with exposure to extremely potent medications that have not been thoroughly tested in these new combinations, as well as the potential loss in efficacy.

Editor's note: EthiCare Advisors, Inc. is one of the MedNet Munich Health North America℠ family of service providers. EthiCare is a leading medical cost containment organization that helps claim payers control costs on high-dollar claims.

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FDA Approval/Standard of Care/ Experimental Investigational

In the therapeutic area of oncology, single agents (such as Gemzar® and Erbitux®) undergo the standard FDA approval process that rigorously reviews drugs over a lengthy period of time for efficacy and safety through registered clinical trials. A medication can be approved either for use alone, when administered in combination with another agent, or it can be restricted for use only when appropriate (e.g., secondary to a failed single-agent or combination treatment regimen).

Oncology is the most prominent of all therapeutic areas to utilize drugs or a combination of drugs as a standard of care.

Standard of Care

There are times when the medical community accepts a drug or combination of drugs for use outside of the FDA-approved labeling. In this instance, it is only acceptable when there is peer-reviewed literature of efficacy and safety data available to support this off-label usage. The drug or combination use of drugs is then considered by the medical community as a "standard of care." Oncology is the most prominent of all therapeutic areas to utilize drugs or a combination of drugs as a standard of care. One common example is Avastin®, which is FDA-approved for first-line treatment of unresectable, locally advanced, recurrent or metastatic non-squamous non-small cell lung cancer in combination with Taxol® and Carboplatin. Avastin® is also used alone following this combination therapy as a standard of care as maintenance therapy until disease progression or unacceptable toxicity occur.

Experimental /Investigational Treatment

A drug or combination of drugs may be considered experimental/investigational if the peer-reviewed literature or data are not available to support use for certain types of cancer than otherwise indicated by FDA-approved package labeling.

The critical task for a plan administrator is to determine whether the drug or drug combination is supported by the definition as supplied in each group's benefit plan document.

The application of this term is important for a benefit plan. Each plan with exclusions for experimental/investigational medications will include a corresponding definition. The critical task for a plan administrator is to determine whether the drug or drug combination is supported by the definition as supplied in each group's benefit plan document.

The Case for Case Management: Ensuring Safety and Controlling Cost

It is imperative for benefit plans to review a patient's treatment plan prior to administration. During the prior authorization review process, good case management will identify many critical factors in the care of the patient, including but not limited to drug treatment, laboratory testing, and required imaging scans. Many view this as purely a cost-containment measure, but when done correctly, the process of having a skilled nurse review a proposed treatment regimen can ensure the quality of care a patient receives.
For example, a case manager reviewing a cancer treatment plan which proposes a three-drug combination might discover each drug is approved as a single-agent, but not as a combination treatment regimen for that specific type of cancer. Further research of the peer-reviewed literature would determine whether this combination regimen is either a standard of care or experimental/investigational. The case manager would then check to see if this

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combination is supported by the benefit plan document for reimbursement. This is critical, as some benefit plan document definitions might consider a drug undergoing any clinical trial to be experimental/investigational, or the plan definitions might recognize the drug as a standard of care for use if merely FDA-approved for any indication.

Patient Safety Comes First

It is important to remember that patient safety is of primary concern. This goal can sometimes be difficult to communicate should a case manager be unable to find the peer-reviewed literature to support a treatment plan and be required to deny authorization. This is not a denial of treatment for the patient, but rather of reimbursement. The intention is to ensure treatment is both safe and efficacious.

Chemotherapy agents are toxic compounds and considered hazardous waste. Drug combinations that have not been tested are likened to bleach and ammonia—both kill some of the same bacteria, but when put together they become toxic.

This "patient first" approach leads to the quality care the patient deserves and a managing of cost to the benefit plan. It is a win-win. By having the information prior to treatment, the plan is able to estimate costs and help the patient receive the most optimal care at a highly-qualified facility.

Not surprisingly, this information is of incredible benefit to claims management. The treatment plan costs can be estimated from billed charges directly requested from the provider. In appropriate situations, a referral to an ambulatory infusion center with nurses skilled in the administration of chemotherapy might help control costs and reduce unnecessary patient exposure to various illnesses present within a hospital's clinic setting.

Claims Review

Once the first claim arrives and is reviewed, the treatment plan can be compared to the claim to ensure that services have been administered in the manner indicated. Proper coding can be compared to the treatment plan outlined in case management reports. A review might show that a drug was not administered in a manner that is approved or standard, or that a drug was given in a different manner than treatment protocol provided, or even that a drug from the same therapeutic class was substituted in the combination regimen. The latter is problematic in that drugs of the same therapeutic class, while similar in molecular structure and mechanism of action, can have differences in both efficacy, safety and toxicity. The objective of these reviews is as much about patient safety as it is about cost control.

Communication is Key

In order to manage the high cost of treatment associated with chemotherapy, it is critical that a strong line of communication be established between provider and case manager, then followed up by communication between case manager and claims manager. When these "best practices" are instituted, the benefit plan can become a patient's best advocate, sensitive to the care they need and deserve, taking into account the efficacy and safety of the treatment plan, while at the same time managing medical costs.

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Munich Health North America - Reinsurance Division

HEALTHCARE Newsletter - Fall 2011

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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