Munich Re America HealthCare Newsletter

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Table of Contents

Munich Re America
Munich Re Group

Medicare Part D–2007 Update

Clint Copeland, FSA
Munich Re America HealthCare

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a voluntary outpatient prescription drug benefit for people on Medicare known as Medicare Part D. Effective January 1, 2006, this benefit was available to all 43 million current Medicare beneficiaries exclusively through private plans approved by the federal government. For beneficiaries enrolled in traditional fee for service (FFS) Medicare, drug coverage is obtained through private insurer prescription drug plans called PDP's. For beneficiaries enrolled in Medicare Advantage, coverage is obtained through Medicare Advantage prescription drug plans (MA-PD).

Now in its second plan year, the Medicare Part D program has accomplished its goal of extending outpatient drug coverage to the Medicare population. A large proportion of those eligible have been enrolled, plan choice is considered adequate over much of the nation, and most participating seniors have experienced a reduction in drug costs. Program costs, enrollee premiums, and participation (sponsor and enrollee) have all been better than initial projections.

In addition to offering outpatient prescription drug coverage, the MMA established Medicare as the primary source of drug coverage for low-income and disabled people with both Medicare and Medicaid (commonly referred to as dual eligibles). Assistance with drug benefit premiums and cost sharing is also available for beneficiaries with low incomes and modest assets. Although about 9.5 million beneficiaries are currently receiving assistance, The Department of Health and Human Services (HHS) recently estimated that there were over 3 million beneficiaries eligible for low-income assistance that were not receiving it.

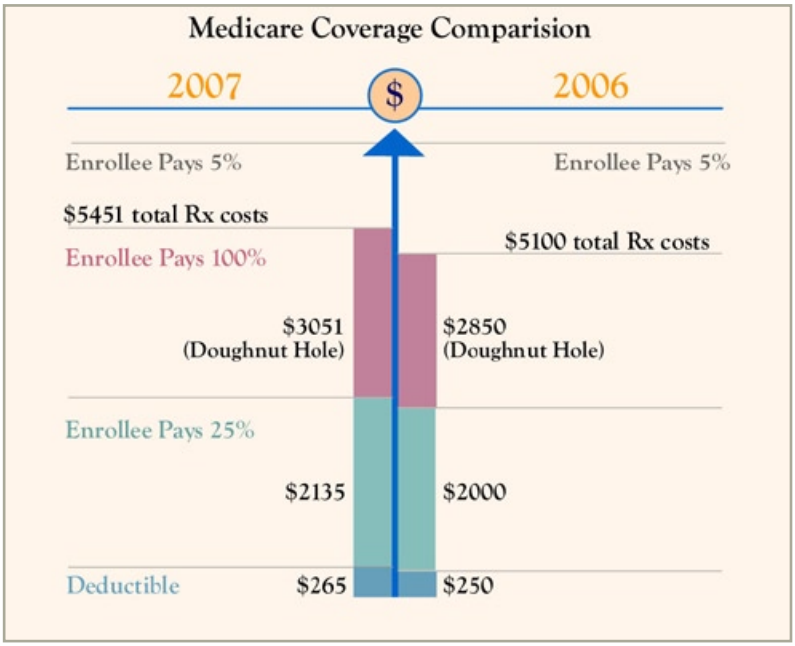
Benefit Structure

Part D plans may offer either a defined standard benefit or an alternative benefit which is actuarially equivalent in value. Plans may also offer enhanced benefits (i.e. benefits greater in value than the standard benefit). Most plans offered are either enhanced or actuarially equivalent to the standard benefit (e.g. 90.8% of PDP plans in 2006).

In 2006, the standard Medicare prescription drug benefit covered 75% of drug costs after a $250 deductible up to $2,250 in total drug costs or $750 in enrollee cost share. After $2,250 in covered costs, the enrollee was responsible for 100% of the next $2,850 in costs (the infamous "doughnut hole") to $5,100 in total drug costs or $3,600 in enrollee cost share. After $5,100 in total drug costs, the plan then paid 95% of all additional costs. Each year, the standard benefit amounts increase by the rate of per capita Part D spending growth.

Table of Contents

In 2007, the standard Medicare prescription drug benefit covers 75% of drug costs after a $265 deductible up to $2,400 in total drug costs or $799 in enrollee cost share. After $2,400 in covered costs, the enrollee is responsible for 100% of the next $3,051 in costs to $5,451 in total drug costs or $3,850 in enrollee cost share. After $5,451 in total drug costs have been covered, the plan then pays 95% of all additional costs.



Enrollment

Enrollment in Medicare Part D is voluntary, with the exception of dual eligibles and some low-income beneficiaries who are automatically placed in a Part D plan if they do not choose one on their own. However, waiting to enroll in a Part D plan once eligible carries a penalty of 1% of the national average monthly premium for each month enrollment is delayed. This penalty is waived if an enrollee has obtained coverage elsewhere that is at least as good as the standard Part D coverage. This is known as "creditable coverage". The Kaiser Foundation reports that as of mid-year 2006, about 22.5 million of the 43 million eligible beneficiaries were enrolled in Medicare Part D plans (about 74% in PDP's, the rest in MA-PD's). There were 10.4 million beneficiaries enrolled in employer- sponsored plans that were deemed creditable coverage. Another 5.4 million beneficiaries have creditable coverage through other sources such as the Veterans Administration. Only about 4 to 5 million beneficiaries or approximately 11% of the eligible Medicare population did not have creditable coverage in 2006.

Most creditable coverage comes through some form of employer sponsored plan and typically comes in one of two major forms. The most popular of these is keeping the existing prescription drug plan and applying for a retiree drug subsidy (RDS), which is worth a tax free 28% on allowable retiree costs (i.e. costs ordinarily covered under the Standard Part D benefit).

The second most popular form is purchasing group coverage directly through an existing PDP or MA-PD sponsor under an employer group waiver plan (EGWP). Employers also offer wraparound supplemental plans which supplement individually purchased Part D plans bought by retirees. Wraparound plans were a bit problematic in 2006 due to the uncertainty of coordinating benefits between the primary and secondary coverage in the start up year of a new program. A clearinghouse has been set up by The Centers for Medicare and Medicaid Services (CMS), which should alleviate some of this uncertainty in 2007.

Financing

Currently, financing for Part D comes from a combination of beneficiary premium payments, state contributions, and general government revenues. The monthly premium paid by enrollees is set to cover 25.5% of the cost of the standard drug benefit. The other 74.5% of costs are paid by CMS. Costs are determined based on bids submitted by plans to CMS in each of 34 regions spanning the 50 states. Bids are based on expected benefit payments and final reimbursements to the plan may be modified by risk-adjusted payments for high-cost enrollees. Reinsurance payments may be received for 80% of costs above the catastrophic threshold (i.e. where the benefit begins to pay 95% of drug costs). The Administration estimates the net federal cost of the Medicare drug benefit to be about $31 billion in 2006 and projects costs of $768 billion between 2007 and 2016. The average premium paid by enrollees in 2006 was around $37 per month for PDP plans and $18 per month for MA-PD plans, though premiums varied significantly depending on type of plan, geography, and individual plan offering.

It has been noted that premiums for PDP plans are increasing in 2007 by about 12%, which is about twice the per capita increase in Part D spending. This could be considered slightly misleading, because it only includes plans in existence in both 2006 and 2007 and assumes no migration in enrollment from high cost to lower cost plans. Premium changes in MA-PD plans are hard to calculate as the MMA allows plans to subsidize drug costs with savings in other areas of medical care (one reason why the average MA-PD premium is lower than the average PDP premium). CMS has stated that taken as a whole, the change in average Part D premium for 2007 is negligible, implying that either average MA-PD premiums decreased in 2007 or that new PDP plans implemented in 2007 negated the increases seen in existing plans, or perhaps some combination of the two.

Plan Type and Design

Reports also indicate that in 2006 there were 1,429 PDP plans nationwide and 1,314 MA-PD plans (divided into 885 HMO's, 273 local PPO's, 114 PFFS plans, and 48 regional PPO's). Although the total number of PDP and MA-PD

plans is similar, the service area of MA-PD plans tends to be much smaller, so the availability of MA-PD plans varies widely depending on what part of the country an enrollee resides. Early indications are that the number of PDP plans will increase in 2007 by over 31% to 1,875. The number of MA-PD plans active in 2007 is still unclear.

Many plans have taken advantage of the freedom to modify the standard Part D benefit structure based on actuarially equivalent values. No-deductible plans and modified cost-sharing are relatively common, especially for MA-PD plans. Many plans have replaced the initial 25% coinsurance benefit with a copay structure. Three- and four-tier plans are common with copays differing by tier. Some plans have a combination of copay and coinsurance for different tiers such as copay for generic/brand drugs and coinsurance for specialty drugs. Copay amounts vary greatly by plan and tier with amounts generally ranging from $0 to $75. Relatively few plans have filled in the coverage gap or doughnut hole between the initial 25% enrollee coinsurance and the 5% coinsurance/catastrophic coverage which kicked in at $5,100 in drug costs in 2006 ($5,451 in 2007). Some plans do provide some coverage in the gap, but such coverage is partial and tends to be with HMO's and local PPO's (32% of HMO's and 30% of local PPO's in 2006). Only about 15% of PDP plans offered any coverage in the doughnut hole in 2006, but this has increased to almost 29% in 2007 with most of the coverage being limited to generic drugs. The increase in gap coverage for 2007 may be driven by CMS guidance, which generally limits plan sponsors from offering a third option unless an option with enhanced benefits is provided.

What's next?

About 60% of employers who provide retiree benefits chose the retiree drug subsidy (RDS) option since it was easy to understand and implement. However these employers will likely consider other options, such as Medicare Advantage or drop drug coverage altogether, as additional cost savings from these alternatives become clearer.

On a broader scale, the challenge for CMS is how to continue offering a Medicare benefit (of which Part D is a small part) that will consume a greater and greater proportion of government revenue as the number of beneficiaries continues to increase. This is certain to be a continued subject of debate.

Editor's Note: The above is a recap of information available on the Kaiser Foundation web site: www.kff.org/medicare/upload/7589.pdf
www.kff.org/medicare/upload/7517.pdf
www.kff.org/medicare/upload/7044-05.pdf
www.kff.org/medicare/7201.cfm

The Impact of Lasers on Specific Stop Loss Trend

By Gary Nidds, FSA
Munich Re America HealthCare

Accurate trend estimates are essential for developing manual rates, experience rating and competitive pricing. Specific stop loss trend is particularly difficult to estimate due to the leveraging impact and prolonged time it takes excess claims to develop. Sources of specific stop loss trend levels include published literature, actuarial consultants, a company's own past claims experience and ground up claims trend adjusted for the specific deductible. Typically, actuaries rely on numerous sources of trend before selecting a best estimate.

Underwriters and actuaries must be very careful when using past claims experience to imply leveraged trend levels for specific employer stop loss pricing. Estimating excess trend is difficult enough with changing deductible levels, high turnover of employer groups from year to year, varying contract types (e.g. paid vs. incurred) and of course changes in underwriting practices. One particular change in underwriting practice that could lead to significant errors in estimating actual trend levels is the practice of "lasering." Lasering is the exclusion or special pricing of known, ongoing claims within a group of insured lives. Since stop loss is an annual renewable, fully underwritten product, it is often necessary to laser known claims to assure a group's premium is commensurate with the risk. Lasering will have the impact of temporarily lowering frequency and severity of large claims when compared to a random population. This could lead to the false impression that specific claims trend is lower than it actually is.

Consider an MGU that only recently began imposing lasers upon renewal. In the past, all known and ongoing claims were accepted into the insured population and year-to-year excess trend closely followed that of a random, non-underwritten group of insured lives. Now, however, many of these large claims are eliminated or reduced through the lasering process. What may appear as a decrease in leveraged trend is actually a temporary change in the risk selection process. More importantly, this one time drop in specific loss trend could span a few years if the full impact of lasering is spread over more than one renewal season.

So what can be done to make use of specific stop loss claims experience even if lasers were recently imposed? One solution is to adjust recent experience by adding lasered claims back in. By adjusting experience for lasered claims, one could imply year to year trend on an "apples to apples" basis. One problem with this approach is that the actual value of a lasered claim may be unknown, so estimates are necessary. Another problem is that accurate and complete laser data must be captured in the underwriting system, which has not been common historically.

Table of Contents

Another approach is to exclude claims from the old experience that would have been lasered under the new underwriting process. Again, this puts recent and older experience on level terms, but it will be difficult to retrospectively replicate the judgmental lasering process. A third approach is to calculate year to year trends without any adjustments and increase the implied trend by a factor that represents the anticipated savings from lasering. Our research indicates that a thorough and consistent lasering approach can save between 5 and 20% on the specific stop loss claims, depending on the extent to which it is applied.

Concluding remarks:

Implying excess medical trend from specific stop loss claims experience can be difficult. One challenge in particular is the impact a new lasering approach can have on claims frequency and severity trend. Therefore, it is important to first recognize the problem and attempt to adjust historical data accordingly. It is also necessary to consider other sources of excess medical trend, such as published databases, consultant manuals and claims experience from other lines of business.

Risk Factors Impacting Neonatal Costs

By Patrick Burcher, CPA
Executive Vice President, The Assist Group

Premature or low-birth-weight infants account for $18.1 billion in U.S hospital charges based on the statistics reported by the March of Dimes. Although 13% of U.S. births are comprised of premature infants, almost 50% of the total charges for infant hospital stays were for these babies. Claims for neonatal intensive care unit (NICU) confinements can be very expensive and challenging for health plans. The following factors are unique for the NICU risk:

- Length Of Stay – babies may remain in the NICU for periods ranging from several weeks up to a year or longer, depending on gestational age at birth and comorbidities.
- Clinical Outcomes - are widely variable for babies born at the same birth weights due to the unpredictability of conditions such as chronic lung disease, interventricular hemorrhage, necrotizing entercolitis and retinopathy of prematurity.
- Experimental or Research- Oriented Therapies – are considered in the interest of rescuing fragile infants who may have limited chances for survival. Bowel and lung transplants are being considered for babies with significant comorbidites.
- Average Daily NICU Room and Board Charges – may range from $1,500 to $22,000 per day, based on the facility.
- High Frequency of Ancillary Service Charges - including respiratory therapy, laboratory, pharmaceuticals, and blood products may add additional daily costs ranging from $1,800 to $17,000 per day.

NICU claims are complex and not easily validated through conventional claims payment processes. The itemized detail of a hospital's billed charges can consist of many thousands of line items for all the services. The process of validating that the charges submitted are not only clinically appropriate but within industry billing standards requires a multidisciplinary skill set including Neonatologists, nurses and coding professionals.

A "Forensic Review" service can help payers analyze and adjudicate claims based on the care that was actually received. This process differs from a conventional medical record audit which focuses on matching services billed to physician orders. The savings outcomes from medical record audits generally range from 2% - 5% since facilities have strong internal controls and automated billing systems to ensure services billed are ordered. Forensic reviews, on the other hand, can result in aggregate savings of approximately 20% or more of charges, after application of any contractual discounts. An effective Forensic Review should focus on the following core areas:

1) Validating the NICU room and board charges to reflect the actual clinical acuity of the patients. Although babies are confined in the NICU, the amount of daily nursing resources required varies significantly for each patient. During a Forensic Review Neonatologists review the constellation of billed charges to determine each daily acuity level and corresponding room and board charge within the four revenue codes defined by the UB-92 guide and the American Academy Of Pediatrics. Since room and board rates should decrease approximately 20% - 25% for each reduction in clinical acuity, the Forensic Review process can have a significant impact on the clinically-adjusted amount of NICU room and board charges paid.

2) Identifying experimental or research-oriented therapies which may not be a covered plan benefit. Periodic patient clinical updates transmitted by facilities to the health plan's utilization review or case management staff may not detail these therapies. As a result, the prior authorization and precertification process may not identify services which the plan does not cover. The Forensic Review Neonatologists and nurses refer to plan document language and accepted clinical practice guidelines to determine coverage for experimental or research-oriented therapies.

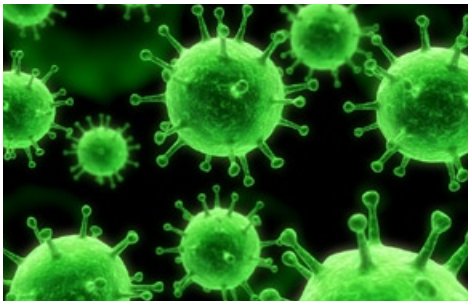
3) Isolating supplies and services which are billed separately, but which should be included with the room and board charge. Floor stock supplies and physio/cardio pulmonary monitoring activities are often billed by facilities, even though these items are more appropriately included in the NICU room and board charge. The Forensic Review process acts as a virtual NICU to use clinical experience and understanding to determine if charges are appropriate.

Below are two examples of significant billing adjustments achieved by ClinAssist. Forensic Review reports were presented and discussed with the facilities, resulting in facility signoffs for these adjustments to billed charges:

Total Billed Charges	$590,164
Less Forensic Review Adjustments	
Respiratory Therapy Billing Errors	9,757
Experimental Therapies	66,254
Unbundled Supplies And Monitoring	44,111
Total Forensic Review Adjustments	$ 120,122
% Of Billed Charges	20.4%
Total Billed Charges	$288,049
Less Forensic Review Adjustments	
Lab and Respiratory Therapy Billing Errors	15,712
Room And Board - Incorrect Acuity	20,766
Unbundled Supplies And Monitoring	42,764
Total Forensic Review Adjustments	$ 79,242
% Of Billed Charges	27.5%

ClinAssist performs a prescreen of claims for Munich Re America HealthCare clients. Average daily billed charges in excess of $4,500 may indicate opportunities for a Forensic Review. The prescreen and forensic review process is completed in a timely manner prior to payment to ensure no loss of PPO or contractual discounts.

Patrick Burcher is Executive Vice Presidnet of Business Development with The Assist Group, which specializes in solutions for catastrophic claims management and high-risk premature infants. Current products include CareAssist, a unique, physician-driven neonatal care management program and ClinAssist, a powerful forensic audit and claims resolution service. For more information about their products and services, visit www.AssistGroup.com or call 877.631.9080.



Technology Pipeline

1st Quarter 2007

The following technologies have been identified this quarter by Munich Re America HealthCare as those that may have significant cost impact in the current and subsequent years:

1) HIV Antibody Testing Recommendations - In September 2006, the Centers for Disease Control and Prevention (CDC) announced a revision of its recommendations for HIV testing in an effort to make it a routine, although not mandatory, part of standard medical care for individuals from ages 13 to 64. The revised guidelines are intended to increase HIV screening, foster earlier detection, identify people with unrecognized HIV infections, and further reduce perinatal transmission. Testing environments likely affected by the CDC's revised recommendations, if adopted, include public and private sectors, such as hospital emergency departments, urgent care clinics, inpatient services, substance abuse treatment clinics, public health clinics, community clinics, and primary care settings. However, there are currently a number of states that have at least one law or regulation that will impede or prevent these recommendations from implementation. Users of this information should be aware of whether these barriers are in effect for a given population or covered group. Assuming a peak utilization of 50.62/1000 in late 2007, and a cost of $55 per test, the following are the expected costs:
Projected PMPM impact: $0.16 (2007), $0.23 (2008), $0.23 (2009)

2) Tysabri® (natalizumab) - is a monoclonal antibody therapy that halts progression of multiple sclerosis (MS). MS is an autoimmune disease that affects the central nervous system (CNS), which consists of the brain, the spinal cord, and optic nerves. Symptoms of MS are unpredictable and vary from person to person and from time to time in the same person. Examples include abnormal fatigue, vision problems, loss of balance and impaired muscle coordination. It is estimated that 211,000 people in the United States have some form of MS and that approximately 3 times more females are diagnosed with MS than males. Tysabri, a monoclonal antibody, is a selective adhesion molecule inhibitor. It is designed to hamper the movement of potentially damaging immune cells from the bloodstream, across the blood-brain barrier, and into the brain and spinal cord. It delays disability and reduces relapses in patients with relapsing multiple sclerosis. Furthermore, it is viewed as superior to other MS drugs in terms of its ability to reduce the rate of MS relapses. Tysabri costs approximately $2,400 per patient annually, which includes all direct and offsetting costs. Peak utilization is expected by early 2016 with a $0.24 pmpm.
Projected PMPM impact: $0.04 (2007), $0.09 (2008), $0.17 (2009)

3) PreGen-Plus™ – is a multitarget fecal DNA screening that detects the presence of cancerous and precancerous DNA in a home-collected stool sample for people > 50 years of age. In 2002, more than 56,000 people in the United States died of colorectal cancer (half of which were men), and it was estimated to be the second leading cause of cancer-related deaths. Despite the evidence that risk increases with age, an estimated 42 million Americans ≥ 50 years of age have not been screened for colorectal cancer. Colorectal cancer cells and precursor polyps contain mutated DNA shed into the colon and may be detected in fecal matter. The PreGen-Plus test identifies 23 microsatellite mutations known to be associated with colorectal cancer cells, including BAT-26, APC, K-ras, and p53. Additionally, PreGen-Plus can detect abnormally long DNA fragments produced by cells commonly associated with colorectal cancer. Patients are supplied with a home specimen collection kit; a minimum of 30 grams of sample is required for testing. Though PreGen-Plus is not approved by the FDA, it is unclear whether FDA approval is required. PreGen-Plus costs approximately $773 per patient annually. Peak utilization of 3.28/1000 is expected by mid-2007 with a $0.21 pmpm.
Projected PMPM impact: $0.21 (2007), $0.21 (2008), $0.21 (2009)

Staff Contacts

Steve Abood
Stop Loss and Managed Care
(609) 243-4206

Umesh Kurpad
Chief Financial Officer
(609) 951-8270

Gary Nidds
Chief Actuarial Officer
(609) 243-5566

Rich Phillips
1st Dollar Medical and Portfolio Excess
(609) 951-8177

Mike Shevlin
Business Development
(609) 243-4893

Bob Trainer
President
(609) 243-4229

Questions/Comments

We welcome questions and comments on the Newsletter and the topics covered.

To make comments, please contact Claudia Scott, VP Marketing.