Munich Re America HealthCare Newsletter

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Hidden Danger for MGUs and Insurers: Aggregating Specific Deductibles

Picture this – you are an MGU or insurer in the middle of renewal negotiations with a key client. Things are not going well. Premiums have been creeping up over the past few years and are now at a breaking point. Reducing this cost is your client's #1 priority, and increasing retention is not an option. What do you do?

For many faced with this type of situation, aggregating specific deductibles has become an increasingly popular alternative. This pricing structure can allow a self-funded employer to lower stop loss premium in exchange for assuming an additional level of liability. But this approach is not without its own set of risks. It should be used sparingly and with care.

Flexibility and Lower Rates

From a stop loss underwriter's perspective, there are several benefits to providing an aggregating specific deductible. First, it offers greater flexibility in dealing with denials or lasers – those individuals with known high claim costs who typically are isolated (lasered) and subject to higher deductibles than the group. With an aggregating specific deductible applied, these lasered individuals no longer have to be priced separately. All specific claims, known and unknown, can now be pooled. This alternative results in a second layer of cost sharing in addition to the initial retention level.

Because this second layer of cost sharing results in the employer holding an increased level of risk, he is eligible for a reduction in insurance premium. This type of structure also reduces the cost components (tax, TPA fees, etc.) that are a percent of premium, creating the potential to charge a higher profit load as a percentage of premium.

Lower Rates – Lower Profits?

On the negative side, an aggregating specific feature can significantly lower stop loss premiums. If overused, this can put tremendous risk on your entire pool of business, resulting in less premium available to fund claim volatility and therefore lower underwriting profits.

A key element in the successful use of this type of deductible is calculating an appropriate level of reduction in stop loss premium. Brokers, TPAs and employers will frequently ask for a premium reduction equal to the full value of the aggregate deductible. While in some specific situations this may be appropriate, in many others this could be a mistake. Consider the following:

Suppose you are underwriting a case with a specific self-insured retention of $50,000 and no aggregating deductible. The TPA approaches you about including a $100,000 aggregating specific deductible and requests a corresponding reduction in premium of $100,000. Is this a reasonable request? In many cases, the answer would be no. You would be assuming full liability for all specific claims above $50,000 that accumulate above the

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aggregate corridor of $100,000 (i.e. a layer that is more volatile) and would have reduced the margin available to fund the increased volatility! Net result - you still hold significant risk but are reducing both your premium volume and profit potential. Caution is necessary.

Calculating the Value of an Aggregate Specific Deductible

The value of an aggregating specific deductible is generally worth something less than the deductible itself. The actual value is based on several factors, including the level of deductible, the size of the employer, the probability of a specific claim, and known claims.

Table 1 illustrates the expected claim costs for a hypothetical 250 life group across three specific retention options.

Table 1 – Group Specifications

Item	Option 1	Option 2	Option 3
Employees	250	250	250
Retention	$50,000	$100,000	$150,000
PEPM Claim Cost	90.00	50.00	30.00
Expected Claims	270,000	150,000	90,000

Next we need to imply a probability distribution around the expected claims in Table 1. The distribution has been simplified to 10 equally likely outcomes for each employer group option. In Table 2, the insurer is paying all claims in excess of the specific deductible.

Table 2 – Distribution of Results

Probability of Result	Option 1	Option 2	Option 3
10%	32,129	–	–
10%	78,171	973	–
10%	116,376	17,277	–
10%	151,107	38,574	–
10%	186,872	65,030	5,884
10%	232,930	99,836	27,565
10%	291,547	145,340	64,290
10%	364,786	215,007	115,926
10%	479,617	311,010	202,955
10%	766,466	606,953	483,379
Expected Claims	270,000	150,000	90,000

Data shown are factious and for illustration only.

Now let's apply an aggregating specific deductible of $100,000 across all options (results are illustrated in Table 3). In Table 3, the employer will pay the first $50,000 per specific claim plus $100,000 of aggregate claims above the specific retention, while the insurer pays claims in excess of the specific and aggregating deductible retentions.

Table 3 – Distribution of Results after Agg Spec of $100,000

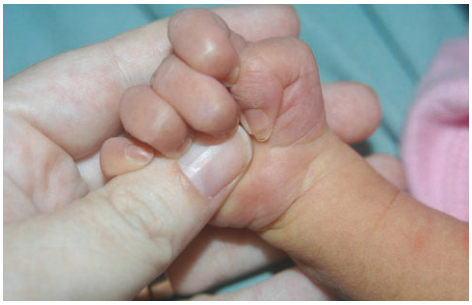
Probability of Result	Option 1	Option 2	Option 3
10%	–	–	–
10%	–	–	–
10%	16,376	–	–
10%	51,107	–	–
10%	86,872	–	–
10%	132,930	–	–
10%	191,547	45,340	–
10%	264,786	115,007	15,926
10%	379,617	211,010	102,955
10%	666,466	506,953	383,379
Expected Claims	178,970	87,831	50,226
Reduction in E [Claims]	91,030	62,169	39,774
Value of Agg Spec	91.0%	62.2%	39.8%

Data shown are factious and for illustration only.

As can be seen in Table 3, the greater the retention the lower the value of the aggregating specific deductible premium credit.

The value of the aggregating specific deductible is correlated with the likelihood of incurring specific claims. As in our example, there is an 80% chance of incurring specific stop claims in excess of $100,000 in Option 1, while there is a 30% chance of incurring stop loss claims in excess of $100,000 in Option 3.

Aggregating specific deductibles are a valuable and effective tool in managing cost to the employer in the stop loss market, but their value varies based on a number of factors. Understanding fully the mechanics and subsequent risks in the use of these structures can greatly enhance your underwriting accuracy and improve financial results.



RSV Treatment May Widen Payer's Approach

By Len Dino, Jr. and Vickie Bohn

MedImmune's injectable drug Synagis has cornered the market when it comes to preventing respiratory syncytial virus (RSV) in high-risk infants. However, a new drug in development is on the horizon that will impact the market within the next five years. The drug, which is currently in Phase II clinical trials, is A-60444. As companies look for a share of the market – approximately $1 billion in 2004 worldwide sales, payers will continue to struggle to provide benefit coverage while still maintaining a viable plan.

Health plans typically review their claims for preemies at risk for developing RSV during the critical first 24-months of life. However, research shows that risk in the elderly and immunocompromised is equally threatening. An article in the New England Journal of Medicine cites a four-year study by a research group from the University of Rochester Medical Center on the incidence of RSV in elderly and high-risk adults. The research estimates that 14,000 adults die annually, with more than 177,500 annual hospitalizations as a result of RSV. The cost of the hospitalizations? More than $1 billion.

In healthy elderly patients and high-risk adults, the study revealed that RSV infection accounted for:

- 10.6% of hospitalizations for pneumonia.
- 11.4% of hospitalizations for chronic obstructive pulmonary disease.
- 5.4% of hospitalizations for congestive heart failure.
- 7.2% of hospitalizations for asthma.

Currently, A-60444 is in two clinical trials. The major one is in stem-cell transplant patients who have severe RSV infections. This is across the adult/elderly groups. The second trial is treating otherwise healthy adults who actually have RSV. The trials will begin with adult studies before moving on to treat infants. With respect to treating those with the disease, the aim is to produce a significant change in the morbidity and mortality caused by RSV.

With Synagis costing approximately $3,500 to $6,500 per treatment, will any potential cost savings exist from treating those infected versus those at risk? It could be a cost-effective measure if people with RSV received treatment; however, it is not known at this time what the cost of the new drug will be. With the cost of specialty drugs on the rise, it's a safe bet that the cost will be at least equal to or more than Synagis.

It's important to give the medicine to only the people who need it, but Synagis is targeted toward a high-risk population of infants already. Most physicians will go for prophylaxis rather than treatment. That is, to provide the medication instead of waiting until someone is affected and then treat them. While the majority of health plans may have limited benefits when it comes to prophylactic treatment, the wait-and-see-what-happens method could prove to be the more costly approach. In the near future, health plans will need to be diligent when it comes to reviewing their cases for potential RSV patients. Not only will they need to review for preemies but also high-risk adults and the immunocompromised. An opportunity for case management intervention could result in helping to lower the risk of costly hospitalizations.

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Stop loss: Navigating through a soft market

Supply and Demand

Since January 2004, the estimated $4.0 billion stop loss market has shown signs of progressive softening. Stop loss outlets grapple with the balance between growth and profitability in a very competitive market. As this is a cyclical event, it's nothing new to the stop loss industry. Why do we find ourselves in this predicament every few years, and are the cycles becoming more frequent and severe?

Simple economic theory can provide some explanation. The forces of supply and demand are always at work. During "profitable" periods, the supply of stop loss capacity increases while the demand for stop loss coverage remains relatively stagnant. The opposite occurs during unprofitable periods. For example, it is estimated that the number of stop loss MGUs dropped from a few hundred a decade ago to under 50 today. While this serves to mitigate the current supply of capacity, managed care companies have entered the stop loss market more rapidly than in the past. There is also some flow of business between the fully-insured and self-funded markets. Some large health plans have been pricing more aggressively on their fully- insured products, potentially driving previously self-insured employers out of the stop loss market.

Suppliers continually try to maintain and gain market share within a fixed-size market. This results in an extremely competitive marketplace where great pressure is placed on pricing levels and overall contract terms. This activity, alongside the increase in healthcare costs, results in slim margins. Add to this the difficulty of predicting leveraged trend and even slim margins can be at risk. Eventually, for some suppliers, the profits that once existed turn into losses, and those entities are forced to exit the marketplace.

Risk Selection and Technical Underwriting

Due to the longer tail of stop loss underwriting results, it can take a while to determine how a block of business is actually running. Proper up front risk selection is an important part of building and maintaining a profitable block. In a soft market, it is a good idea to stick to the business that is familiar and has produced favorable results. Chances are, the group size, industry, and demographic that has performed well in the past will continue to perform well. Unfortunately, even with a large block of stop loss business, it's difficult to extract credible historical experience at the underwriting segment level. Consider complementing your own experience with industry data from consultants, reinsurers and nationally published claims databases.

Verify that the requested quote specifications make sense for the group. Ensure that the deductible is accurate for the group size, as a percentage of total claims dollars and for the large claim frequency the group has experienced. Also, it is critical to verify that the data submitted for quotation is accurate and reasonable based on the group's characteristics.

Accurate manual targets are critical. First, be very careful comparing historical rate to manual (RTM) levels to actual loss ratio experience by deductible, as many of the available pricing manuals have adjusted base rates by deductible over time. One widely used manual provides rates that are fairly accurate across the entire deductible range, so discretion should

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be consistent across all levels. Also, a target close to manual on small- group experience helps to keep targeted a certain amount of premium on each case due to erratic experience on small groups. This target manual also helps with the pooling effect on small groups where the collection of adequate premium offsets the volatility of claims over a small group block. Generally, cases with larger deductibles have more credible experience and therefore possibly a lower RTM target.

Historic experience should be examined in association with the target manual levels as part of the risk selection process. Although more credible with large groups, consistently unfavorable experience on any group is telling. When established as part of the underwriting review of any group, an experience evaluation can help determine the amount of premium an account requires to run profitably. The experience evaluation takes the claims, trending, and expenses into consideration when making its premium projection. Often the allure of a large premium account is strong, but the bid for such an account may overlook the fact that the projected premium dollars do not cover the risk and expense structure.

PPO network-evaluated discounts should be used when available. In other cases, it is important to use the default discount amount rather than estimated discounts, as network discounts can vary drastically within the same area. Also, in the interest of accuracy, evaluated discounts less than the default should be utilized rather than reverting to the default. And lastly, it is important to re-evaluate the average discount on a book of business to recalibrate default discount factors on a regular basis.

Aggregating Specifics are used as a marketing tool to shift additional liability to the employer group, typically on better risks. While this is an effective tool to attract business, it should be used judiciously, particularly in a competitive market. Overuse on a block will erode premium and compromise the pooling effect on the overall block.

The Aggregating Specific deductible can be effectively used as an alternative to a laser. Employer groups often prefer this option to the additional cost of premium associated with a known risk or the focus of liability on one person.

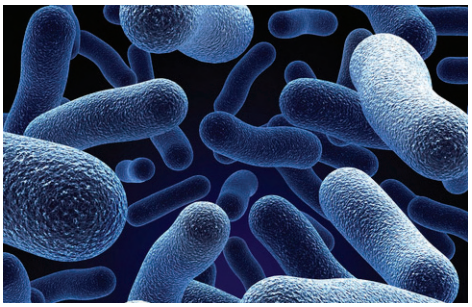
Large Claim/Disclosure Underwriting and Claim Management

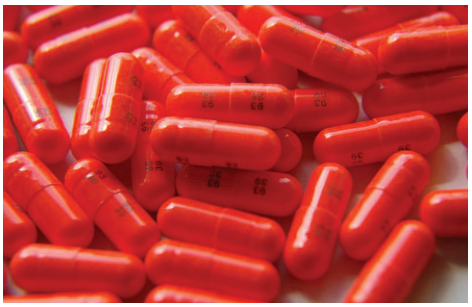
Clinical review of large claim reports and disclosure statements is crucial to assessing known and potential risk and in projecting cost associated with treatment plans. Stop loss is an annual renewable, fully underwritten line of business. If renewal business is not underwritten with the same level of scrutiny as new business, competitors will select against you. As in the initial quote stage, it is important to ensure that data is accurate and that report dates are current. Reported data should encompass all requirements imposed by the wording of the disclosure statement. As part of the contract and schedule pages, it is helpful to address terms on individuals with qualifications, exclusions, or separate deductible amounts. As you've probably experienced, hindsight review often shows that stop loss claims could have been better managed at the time of disclosure.

In quoting run-in contracts, the review of pending, denied, and paid claims reports is helpful in determining outstanding claim risk. Going forward, a reliable UR/Case Management professional is valuable in managing ongoing claims. Specialty care management companies are also effective in the management of catastrophic claims such as organ transplants and premature babies.

Relationships Are Key

Rely on trusted partnerships. Chances are, the strong relationship that has grown over time will continue to hold. The efficiency achieved in working through the bidding, post-sale, and renewal process reduces time and cost. An established rapport will increase the likelihood that clients will listen to and understand the rationale of trend, leveraged trend, and overall renewal increases. Results and relationship leveraging on overall blocks will aid in attaining proper increases and appropriate pricing levels. After all, this is a business of people, and people will engage in business with people they like. That said, keep a close eye on historical loss ratios by producer to make pricing adjustments when needed.





Technology Pipeline

3rd Quarter 2006

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.) Lucentis™ (ranibizumab) - is indicated for the treatment of wet age-related macular degeneration (AMD). The Food and Drug Administration (FDA) approved Lucentis for this indication on June 30, 2006. Wet AMD is the leading cause of blindness and vision loss in the over age 65 population and affects 1.5 to 2 million patients. Lucentis is not seen as a cure for this disease but rather a treatment to slow or reduce vision loss. Lucentis costs $1,950 per 0.5 mg injection plus professional fees of approximately $1,600 per injection. Most patients will require 5 to 7 injections annually. Peak utilization of 8.52/1000 is expected by 2009 with a $2.37 pmpm.

Projected PMPM impact: $0.02 (2006), $0.33 (2007), $0.90 (2008)

2.) New Target Cholesterol Guidelines for Acute Coronary Artery Disease - In July 2004, the NCEP issued updated guidelines for cholesterol management in adults. These guidelines are expected to influence increased utilization of statin drugs. The NCEP's panel of experts now recommends that serum concentrations of low-density lipoprotein cholesterol (LDL-C) in high-risk adults be kept below 70 milligrams/deciliter (mg/dL), rather than the previously set therapeutic target of less than 100 mg/dL. This is expected to increase the demand for intensive dosing of 3-hydroxy-3-methylglutaryl-coenzyme A (HMG-CoA) reductase inhibitors, commonly known as statins. Overall, approximately 36 to 40 million Americans have an indication for statin therapy. These statins cost approximately $120 per dose and will have a peak utilization of 365/1000 by late 2007. The peak pmpm is expected to be $3.69.

Projected PMPM impact: $2.38 (2006), $3.51 (2007), $3.69 (2008)

3.) Symlin® (pramlintide) – is an additional therapy to insulin that aims to improve glycemic and metabolic control in people with type 1 or type 2 diabetes mellitus (DM) who may or may not take oral hypoglycemic agents. It is the first in a new class of drugs called amylin receptor agonists or amylinomimetic agents. Symlin® is administered via subcutaneous injection using a syringe or pen delivery device as an adjunct to insulin, but it cannot be mixed with insulin in the same syringe and must be administered as a separate injection. These injections are expected to cost approximately $211 per treatment and have a peak utilization of approximately 31.4/1000 producing a peak cost of $0.55 pmpm sometime in 2008.

Projected PMPM impact: $0.28 (2006), $0.49 (2007), $0.55 (2008)

This information is made available through license with the Ingenix Health Technology Pipeline and is provided for informational purposes only. For additional information about the Ingenix Health Technology Pipeline call 1-866-278-4602 or email HealthTechnolgyPipelineSupport@Ingenix.com

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Questions/Comments

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

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