



The HMO  
Reinsurance  
Marketplace

NEITHER

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A general commentary on the HMO reinsurance marketplace from the perspective of the reinsurer of HMO clients.

# THE BEST OF TIMES

By Mark Troutman

# NOR THE WORST OF TIMES

**IN THE 1980S AND '90S**, the health maintenance organization (HMO) reinsurance market was dominated by three life and health reinsurers: ING, Allianz, and Lincoln Re. Lincoln Re exited the HMO reinsurance market in 1999, but Allianz and ING are still going strong. Both companies generate business directly through their own staffs and through brokers. ING terminated the managing general underwriter it purchased several years before (aka Lamar & Phillips).

Today, the four major players are ING, Allianz, ERC, and Munich Re. ERC business is underwritten in conjunction with Summit Reinsurance Services, Inc. (Summit Re), and Munich Re business is underwritten in conjunction with Risk Based Solutions (RBS). Both Summit Re and RBS are independent managing underwriter operations.

Last year saw the exit of two second-tier players, CNA and Transamerica. Their departure was from almost all accident and health (A&H) reinsurance lines rather than the result of problems specific to the HMO reinsurance market. The Swiss Re appetite for A&H business is nil; it doesn't appear that its A&H diet will end soon.

The other major global reinsurer, General Cologne Re, is also a second-tier player in managed care reinsurance. Standard Security has finished buying up managing general underwriters (MGUs). East Coast markets Lexington and Chubb write simple cases opportunistically. Specialty players such as Zurich American and Combined focus on carve-out products, which are discussed later.

The HMO excess market enjoys some boost from the decline in the provider excess market (i.e., fewer providers accept risk on a capitation basis). However, what business does flow back to HMOs from

providers is generally offset by loss of reinsurance opportunities due to merger-and-acquisition activity. Certain chains (e.g., United Healthcare, Coventry, etc.) continue to open their pocketbooks and buy small independent plans.

Purchasing excess coverage for all risks combined is still the norm for several reasons. A 100 percent quota share of specific sources of morbidity may cede too large an amount of premium for a standard HMO, or delegate too much medical management. Clients who purchase carve-outs generally have weaknesses in these areas, or want to guarantee some year-to-year predictability of results. These programs do take the frequency and severity risk off the HMO balance itself and provide a budgetable annual expense.

There's also the issue of obtaining the proper reinsurance credit for the remaining excess layer if the client still buys excess coverage for other types of claims. The clients who purchase these covers are typically motivated to focus on more chronic cases and allow vendors and reinsurers to manage the specific types of claim carved out. Another type of candidate would be clients who, for whatever reason, don't have strong contracts with tertiary care facilities in their areas.

## Distribution

RBS and Summit Re are substantially direct distribution markets (they market HMO reinsurance directly to health plans rather than through brokers). Most other markets willingly accept broker business in addition to their own direct marketing efforts. Many of the carriers who have exited the business spawn

additional brokerage activity as displaced professionals with significant experience in the market venture out on their own. There are more opportunities on the broker side than on the underwriting side.

The advantages of direct distribution include:

- Direct contact with the HMO plan enables the reinsurer to do its own risk analysis to best match excess coverage to a plan's needs and objectives. This direct interaction is particularly important due to complex product structures and the evolving needs of HMOs.
- Field underwriting gives the reinsurer a thorough understanding of the HMO's risk it's assuming rather than relying on a broker who will provide a spreadsheet of competing reinsurer options.
- Understanding the individual health plan's strategic direction and having direct contact with management allows the reinsurer to match other products and services to the plan's needs.
- Long-term survival in a competitive managed care market requires low-cost distribution. A typical broker commission adds 10 percent to premium costs.

### Coverage and Underwriting Trends

The market has hardened somewhat since the late 1990s. Goldilocks would say the market is neither too hard nor too soft, but just right. Cases with unlimited drug coverage and no average daily maximums (ADMs) or two-year rate guarantees are few and far between. Reinsurers who want to stay in the market have tightened terms of coverage, both in provider excess and HMO excess reinsurance. This is at a time when clients are actually seeking coverage for more services with increased reimbursement or no internal limits. They've found their reinsurance programs do have meaningful coverage limitations in situations where the care isn't managed within the network. These limitations lead to claim cutbacks.

Consolidating hospital systems also flex their muscles in an attempt to raise reimbursement rates and increase reimbursement arrangements with outlier provisions. Employers and employees have responded to tightened managed care controls by asking for less medical management. Therefore, HMO models have attempted to manage care less and thereby expose themselves to more catastrophic care out of their control.

The trend away from hospital inpatient-only coverage continues. Clients buy comprehensive coverage to match their risk. Coverage looks more and more like insurance carrier treaties with higher deductibles and fewer inside limits.

Terms and conditions for continuation of benefits/insolvency coverage are still case by case. Few, if any, reinsurers provide unlimited insolvency coverage. A typical limitation on such coverage is \$2 million to \$5 million. HMOs also are subject to more rigorous financial review and analysis of risk-based capital ratios and patterns of profitability.

There's some increase in federal and state government promotion of managed care via Medicare+ Choice and Medicaid risks. Will other states keep these programs level, or are they trying to expand them to children and other uninsured populations? As steadily ratcheted down reimbursement rates drive major play-

ers out, small local players attempt to fill the gap. HMO Medicare enrollment has declined from 6 million members to 5 million members, and this constricts the excess reinsurance market.

Although there's no discernible trend, some HMOs do at least consider first-dollar carve-outs for organ transplant and neonatal risk. Clients who purchase this coverage generate a more significant amount of reinsurance premium than that found on a typical excess deductible program.

The impact of Sept. 11 has provided a hard market across all reinsurance lines as capital levels and return on capital requirements have increased for many reinsurers. Hence, problem areas of medical malpractice, asbestos, and normal property and casualty problems with weather or terrorists do have an impact on the A&H medical reinsurance marketplace.

And don't forget declining asset portfolios in the stock and bond markets and guaranteed minimum death benefit (GMDDB) concerns with some large professional reinsurers. These are asset and liability risks that may not be adequately reserved on their balance sheets.

HMOs themselves have responded to employer demands and inflationary increases with new programs such as tiered hospital co-pays and "defined contribution" programs that attempt to put the patient at the center of the medical management model. Such plans provide patients with information they need to select among providers' quality and cost differentials.

These programs have little impact on the HMO reinsurer as most of the claim impacts are on attritional claims rather than catastrophic claims. However, as noted above, to the extent that medical management and network constraints are lessened, this increases the possibility that the severity of claims (if not the frequency) trends upward.

Witness the reappearance of significant trend increases. In the mid-1990s, medical inflation was in check for various reasons and trend was 10 percent or less. Leveraged trend is back at high deductibles—a function of tougher hospital contracting with HMOs.

Negotiating strength increases as consolidation occurs in the hospital industry. It's also a function of standard leverage as medical inflation is now significantly higher than the standard consumer price index (CPI). A Mercer Resource Consulting costs survey shows a 14.7 percent medical trend increase, versus 2 percent for the CPI. Hence, medical costs are increasing at a rate seven times higher than the overall increase in the CPI!

Plan sponsors and payers enjoyed several years of medical cost stability in the mid-1990s, as managed care plans had significant leverage over medical providers. Plans also competed fiercely for market share, and this helped keep rate increases low.

The tight labor market and some dissatisfaction with HMOs now make the situation much different. Health care costs have increased for five consecutive years, and the increases are growing! The only potential savior in sight is a soft economy, which may give employers some ability to request tighter managed care again.

This increase in the medical CPI or trend factor is driven by the well-known factors of the increased utilization of health care services (especially expensive new medical technologies); the aging of the population; and inflation in the prices of medical

services far in excess of the general price inflation rate. Drug costs continue to escalate dramatically. Now that we're saturated with direct-to-consumer drug commercials, maybe salespeople coming to the door will be next.

HMOs would do well to see if the reinsurer will follow the HMO's benefits, if approved, or if it has its own definitions for experimental procedures or medical necessity. There have been numerous situations where the HMO and the reinsurer have had a claim dispute because the HMO paid it and the reinsurer denied it on these grounds.

Notwithstanding all of this, it's time to get back to the future with the concept of insurance—purchase the coverage for the unpredictable, unbudgetable items. "Defined contribution" models typically employ this concept. Does anyone really think a \$5 or a \$15 co-pay affects our utilization? All it affects is whether we have lunch or gas money that day!

More and more clients are buying higher ADMs as another response to these cutbacks from reinsurers. Remember, reinsurers imposed these ADMs because HMOs have indicated they can manage care better within a network and have contracted with certain providers on a per diem or similar basis. HMOs also look to reduce or eliminate any other internal limits.

There's also a continued heavy focus on price, price, price in the HMO reinsurance market.

#### Products and Services

Many HMOs continue to look for reinsurers to assist them in expanding their product portfolio. This would include HMOs interested in adapting their networks and medical management capabilities to the self-funded market (i.e., employer stop loss) in conjunction with their own third-party administrators (TPAs) or contracted TPAs.

A critical element for the stop-loss carrier is proper analysis of the managed care network, and the HMO excess reinsurer is in an ideal position to assist in this regard. HMOs without their own insurance company subsidiaries also look for arrangements with captive/front company combinations to allow them to write point of service (POS), preferred provider organization (PPO), and out-of-area benefits for groups that have these needs. Otherwise HMOs lose fully insured HMO business if they're not able to meet the needs of a small subset of an employer population.

Some states are providing more flexibility to allow HMOs to write these programs on their HMO licenses. Specialty insurance carriers continue to meet HMO plan needs to provide group life insurance.

#### Managed Care Programs

New procedures that lower antibody resistance to donor organs have the possibility of increasing the frequency and the cost of transplants. Though they apply to kidneys currently, if proved successful in the long term, they could also have significant repercussions on heart and liver transplant frequency and cost as well.

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We've seen an increase in the development of disease management programs by HMOs, so there's less need for HMOs to access them through their reinsurers.

There's also been some consolidation among independent vendors of these services. The overall impact of such programs from a reinsurance perspective is generally not significant.

Most of the targeted conditions (e.g., diabetes, asthma) are chronic rather than catastrophic. There has been some increase in the incidence of preterm births, and greater attention is being given to managing those cases.

The HMO reinsurance market is still a niche market governed by its own cycles as well as by those of the reinsurance market in general. The reinsurers and the terms and conditions they offer for HMO excess reinsurance coverage respond to the usual supply-and-demand economics that follow new developments, as well as the profits and losses on accident and health business and the reinsurance market. ●

**MARK TROUTMAN** IS PRESIDENT OF SUMMIT REINSURANCE SERVICES, INC. IN FT. WAYNE, IND. SUMMIT PROVIDES HMO EXCESS-OF-LOSS REINSURANCE IN CONJUNCTION WITH EMPLOYERS REINSURANCE CORP.



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