VBCExhibitHall.com

Educational Webinar Series

Don’t Let Downside Risk Get You Down

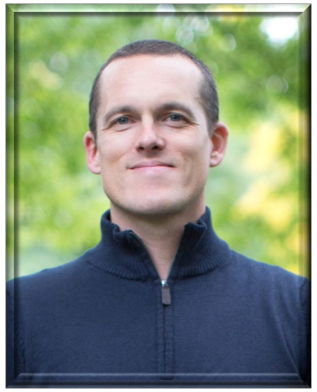
Effectively right-sizing your risk exposure, Part 2

SummitRe

Today's Presenters

Scott Machut, CPA, FLMI

Vice President, Sales for Reinsurance and Provider Excess



Rick Lassow, FSA, MAAA

Vice President, Underwriting and Actuarial

SummitRe

Key Takeaways from Part 1

- CMS has been the catalyst behind value-based care risk sharing.
  - Extends to all product lines (Commercial, Medicare, Medicaid).
  - Has led to many types of risk-taking provider organizations.
  - Downside risk is real.
- Cell and gene therapy costs introduce a new level of potential volatility.
- Downside risk for provider organizations is insurable!
  - Specific: protection from single member's catastrophic loss
  - Aggregate: protection across entire membership
  - Both

SummitRe

Downside Risk: Third-Party Specific PXS

SummitRe

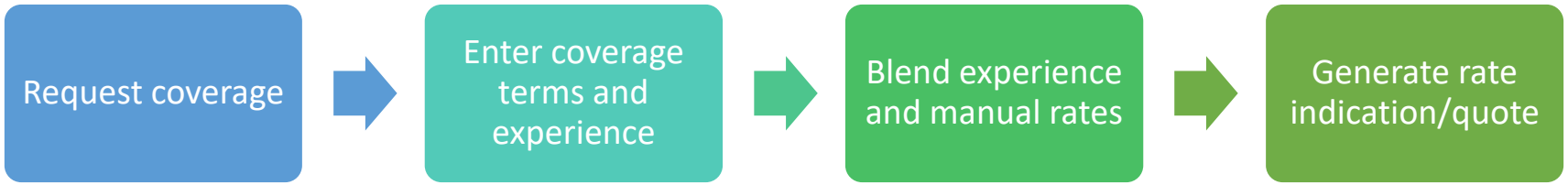
Poll: What level of risk are you currently taking?

1. Upside only
2. Upside now but transitioning to downside in next 6-12 months
3. I'll only take downside risk when they make me.
4. I'm all in—bring on ALL the risk!
5. None / Not applicable

SummitRe

Provider Excess Loss (PXS) Underwriting Process

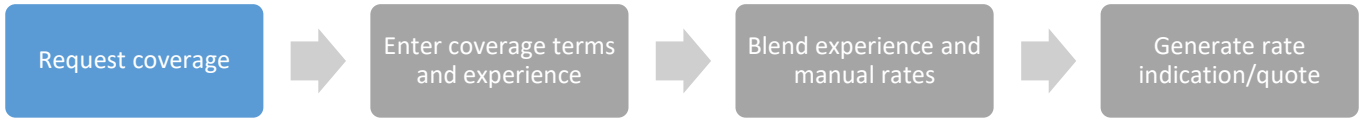
1. Licensed insurance agents submit proposals requesting coverage.
2. The underwriter enters the experience into the experience rating, and the coverage terms into the manual rating.
3. Experience and manual rating are blended to determine quoted rate for each requested option .
4. Proposal is generated to the agent for delivery to the client



SummitRe

RFP Components and Why They Matter

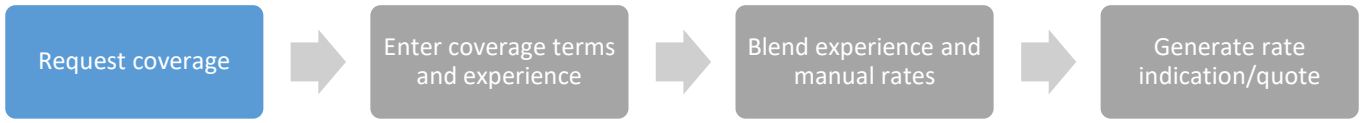
- Type of organization – Hospital, group practice, IPA, etc.
- Contracting information – Division of Financial Responsibilities (DOFRs)
- Coverage being requested – IP/OP, physician services, Rx, etc.
- Four (4) years of claim detail – By year and by line of business for claims > 50% of requested deductible
- Four (4) years of member months – By month and by line of business
- Tertiary care services – Key facility names and contracted rates, identify services without contracts (when known)
- Non-tertiary care services – Summary of contracted facilities and rates (when known)



SummitRe

RFP Components and Why They Matter

- Historical utilization/costs – Days/1,000 and average cost per day, past three (3) years by member type
- Non-network services - % of non-network utilization for hospitals and professional services
- Medical management – Describe utilization and case management programs
- Copy of current policy for last two (2) years, if applicable, including recovery reports
- Disclose material changes in risk over last two (2) years



SummitRe

Considerations for Coverage

- Covered members
  - Covers all population types insured under the providers capitation contract - Commercial, Medicare and Medicaid, as applicable
- Covered services
  - The division of financial responsibility (DoFR) outlines covered expenses which could include inpatient hospital, physician, home health care, outpatient services and pharmaceuticals, etc. There are myriad reimbursable services available.
- Deductibles
  - The amount of loss retained by the provider per person

SummitRe

Considerations for Coverage

- Maximum allowable charges
  - Varies at case level
  - Billed charges, average daily maximum, per diem, case rate, resource-based relative value scale (RBRVS), Medicare allowable, Medicaid fee schedule
- Standard liability period
  - Annually renewable coverage
  - Standard 12/18/19
  - Eligible expenses — claim incurred in 12 mos, paid in 18 mos, reported reimbursed within 19 mos
- Premium Rates
  - Rates are derived from actual claims experience or a blend of experience and manual rating
  - Expressed on a per member per month basis (pmpm)
- Experience refund
  - Optional elected benefit, payer/providers with good claims experience may receive a partial return of premium

SummitRe

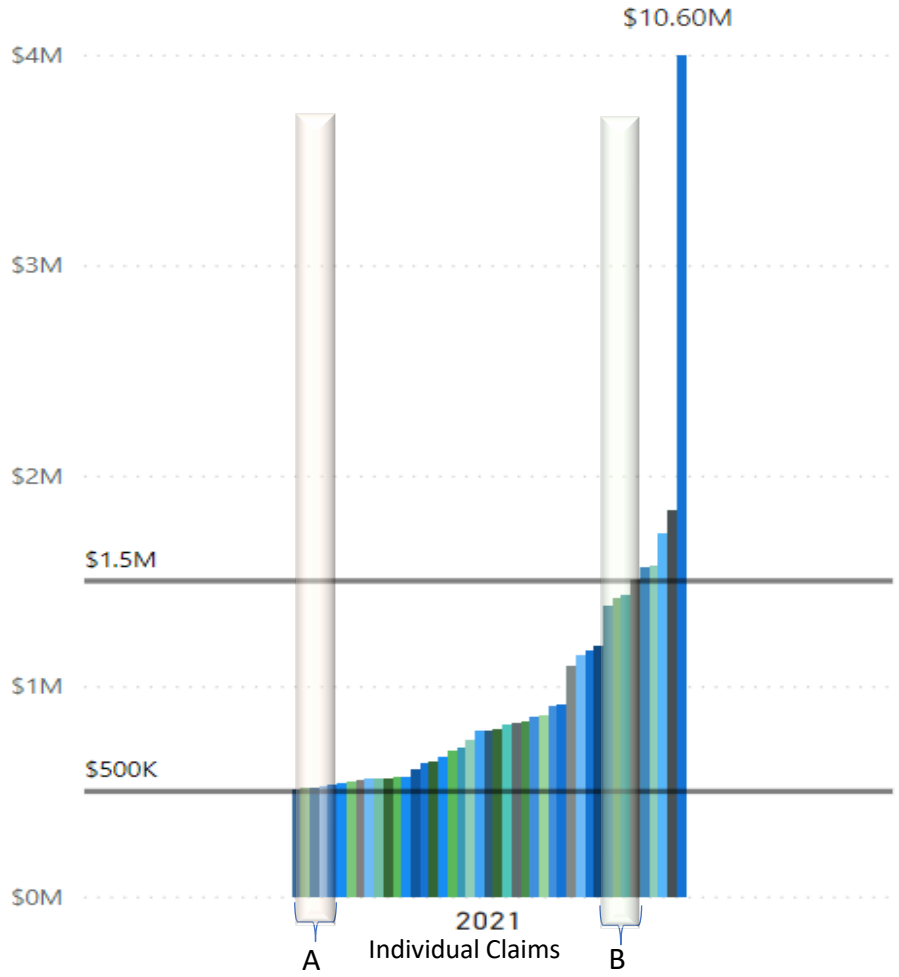
Considerations for Coverage

- Deductible carry-forward
  - Any covered services incurred during the last 30 days of the agreement period that did not result in meeting the deductible will be applied toward the subsequent policy period if policy is renewed.
  - Standard 31 days
- Coinsurance - the amount the carrier pays after application of deductible
  - Contracted and non-contracted facilities: 80-90%
- Maximum benefit per member per year
  - Varies at the case level up to unlimited

SummitRe

Underwriting Analysis

- Data is KEY - Claims experience and membership detail
- Plan experience - frequency and severity of claims.
- Member type and risk profile of membership
- Appropriateness of deductible requested
- Length of operation and financial strength
- Covered services to be reinsured
- Hospital facilities (locations and contracts/costs)
- How claims will be valued/reimbursed
- Effectiveness of the plan's managed care programs



Request coverage → Enter coverage terms and experience → Blend experience and manual rates → Generate rate indication/quote

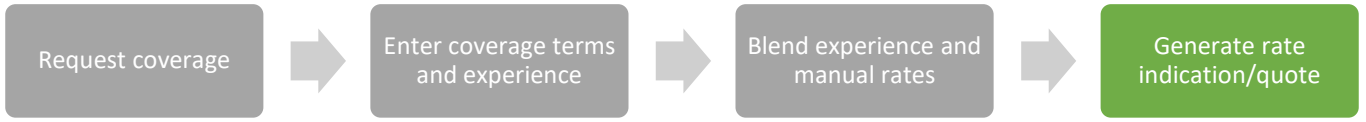
SummitRe

Underwriting Analysis

SummitRe

Pricing Methods

- Provider Excess Loss (PXS) contracts are priced by
  - Pooling the large claim risk for many providers
  - Adding enough providers to the pool, the risk becomes predictable instead of catastrophic
  - Adding margin for expense and profit
- PXS insurers can and often do assist their provider clients in pursuing initiatives to reduce cost, because both parties benefit
- The primary goal is to pool large claim cost
  - Provides stability from year to year
  - Avoids catastrophic losses for any client in any single year



SummitRe

Addressing Capitation

- For fully capitated contracts, an appropriate dollar value may not initially be assigned to domestic claims. Options to address include:
  - Carving out domestic claims
  - Assigning 100% (or another percentage) of Medicare to all domestic claims
  - Assigning X% of billed charges to all domestic claims
- When domestic claims are not carved out, they are sometimes covered at, say, 50% coinsurance instead of 90%-100% for all other claims.

SummitRe

Unique Considerations for ACO REACH

- *Complexity*: Starting in 2023, CMS optional stop loss program became complicated and difficult to monitor
- *Data Availability*: For new ACOs and service area expansions, CMS only provides historical data for newly-aligned beneficiaries, and does not include data on beneficiaries who would have been aligned to the ACO in prior years
- *Inpatient Claim Assignment*: Claims are assigned to a payment year using discharge date, unlike most other risk-sharing arrangements which typically use date of service or admit date

SummitRe

Summary

- Data is key
- Coverage can be tailored to align with risk tolerance
- Pricing is driven by pooled large claim risk across providers (manual rate) combined with provider-specific historical cost (experience rate)
- The ACO REACH program is growing and has unique challenges
- It doesn't cost anything to get a quote!

SummitRe

SummitRe

Stop by our virtual booth at VBCExhibitHall.com

Enter booth

VBCExhibitHall.com
Educational Webinar Series

Thank you!

Scott Machut
612-749-0190
smachut@summit-re.com

Rick Lassow
651-200-4340
rlassow@summit-re.com

SummitRe