


Fifth Annual Evergreen Re Managed Care Indicator





Evergreen Re Incorporated is a privately held healthcare consulting firm that provides reinsurance brokerage services, technical data analysis and consulting to health plans, PPOs, healthcare provider organizations and large employer groups. The firm's relationships with internationally recognized reinsurance carriers enable it to provide comprehensive risk protection and design customized coverage for members in 41 states.

Evergreen Re provides technical analysis to its clients through proprietary modeling programs. Recognizing the importance of data in all aspects of managing profitability, Evergreen Re first introduced the Managed Care Indicator in 1997 to identify issues and trends in managed-care contracting. This is the fifth annual study of capitation and managed care issues that affect healthcare providers and payors.

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Executive Summary and Overview

2001 was a challenging year for every person in this country and the healthcare industry in particular. The events of September 11 and the overall economic environment have impacted all healthcare entities. While the attacks in New York and Washington, D.C., did not result in large-scale medical expenditures for injured individuals, an increase in utilization due to stress-related symptoms did occur. In addition, the increase in office visits and emergency-room treatments for flu-like symptoms and antibiotic prescriptions in the wake of the anthrax scare hit healthcare's bottom line. Now, several months later, carriers' exposure in the property/casualty lines is causing further hardening in the reinsurance market.

In the five years we have conducted this study, physician groups, IPAs and hospitals have shown they are learning to better manage the potential profits and underlying risks associated with managed-care contracts. Managed care continues to be Darwinian. Larger provider organizations can negotiate more effectively with health plans and have more resources to manage their contracts and streamline operations. The study findings indicate there is room for additional profit as organizations gain a clearer understanding of the costs and frequency associated with each service they provide, know the level of risk they should retain and are aware of the role of reinsurance in enhancing predictability and protecting financial stability.

Among the Major Findings of the Study

- More than 60% of multi-specialty physician groups surveyed have capitation agreements. Single-specialty physician capitation has decreased to 44%.
- Hospital involvement in capitation has decreased to 31%.
- The average number of members covered by capitated entity has decreased for commercial and Medicare lines of business. Medicaid enrollment by capitated entity has remained relatively steady.
- The percent of revenue from capitation is expected to decline over the next two-five years.

Other Healthcare Industry Trends

- Employers continue to see double-digit increases in healthcare costs, and premium trends for 2003 will be higher than the previous year.
- More employers are turning to self-funded PPO plans, defined-contribution plans and employer coalitions to gain control over costs and their benefits structure.
- Congress has moved many healthcare issues off the fast track, including the patients' bill of rights. However, numerous states are mandating their own healthcare guidelines, including establishing solvency standards and risk-based capital formulas.
- HIPAA provisions relating to standards for electronic transactions begin to be phased in during 2002. Many healthcare providers are attempting to catch up to meet the deadline for electronic filing and sharing of information. Privacy is still a major issue in the HIPAA debate, and the costs are expected to be astronomical.

Evergreen Re's Assessment

- Providers are continuing to join forces and add specialty lines to stay viable.
- Hospitals are terminating capitation contracts because they have better negotiating power and find more profits in providing services at a percentage of billed charges or negotiating per diem contracts that revert to a percentage of charges at relatively low thresholds.
- There has been an excess supply of specialists that seems to be abating. This should not yet be considered a shortage; the numbers are simply coming into line with needs. Specialists charge higher fees, which means more pressure on capitation contracts and health expenses of health plans.

Survey Methodology

Evergreen Re commissioned Prange and O’Hearn’s Insights Inc., an independent research firm, to conduct the study. Interviewers used a random-sampling telephone method to survey via the telephone the “administrator or person in charge of managed-care contracts.” More than 300 individuals, 50% with physician groups and 50% with hospitals, participated in the study. As in previous years, the study was limited to markets with 30 percent or greater health plan penetration to ensure statistical reliability and the effective measurement of trends and changes in the industry.

Physician Group Overview

Of the physician groups surveyed, nine in ten (93%) were multi-specialties and the remaining 7% classified themselves as single-specialty groups. These proportions are much different from last year’s results, which yielded 84% multi-specialty and 16% single-specialty groups.

Most of the multi-specialties surveyed (90%) were large groups containing at least 50 physicians. The single-specialty groups were more evenly divided between small (44% had fewer than 20 physicians), medium (22% had 20 - 49 physicians) and large groups (33% had 50+ physicians).

The average number of physicians in multi-specialty groups was higher compared to last year’s survey (433 compared to 377), while the average number of physicians in single-specialty groups was similar compared to last year’s survey (44 compared to 41).

Physician Group Overview								
	2001		2000		1999		1998	
Specialty	Single	Multi	Single	Multi	Single	Multi	Single	Multi
Percentage of physician groups surveyed	7%	93%	16%	84%	16%	84%	29%	71%
Small (under 20)	44%	2%	32%	2%	27%	2%	54%	10%
Medium (20 - 49)	22%	8%	37%	11%	30%	15%	28%	19%
Large (50+)	33%	90%	32%	87%	43%	83%	17%	70%
Average number of physicians	44	433	41	377	47	320	26	290

Evergreen Re’s Assessment

- The Darwinian trend we’ve seen in the last few years is continuing. Larger organizations have more leverage with health plans, more revenue and more capital to invest in infrastructure.
- This is a positive trend. In the early days of capitation, many organizations did not develop the infrastructure to manage their risk. As organizations become larger, they typically become better at using processes to manage risk and predictability.

Hospital Overview

When we asked hospital administrators what best describes their organization in terms of managed-care contracting, the responses to the 2001 survey were more like the responses in 1999 than in 2000. The most common way in which hospitals classified themselves was “Independent Hospital” (48%) followed by “Contracting as an IDS/Health System that owns other hospitals and/or physician organizations” (29%) and “Contracting as a PHO with other hospitals/physicians” (23%).

Results for this question differ significantly from the 2000 findings, in which nearly equal proportions of respondents described themselves as an independent hospital (41%) or as an IDS/Health System (43%) and less than one in five (16%) classified themselves as a PHO.

Hospital Overview				
	2001	2000	1999	1998
IDS/Health System	29%	43%	30%	14%
Independent Hospital	48%	41%	45%	30%
PHO	23%	16%	25%	56%
Total	100%	100%	100%	100%

Evergreen Re’s Assessment

- We believe there is still confusion in this area. There is a continual evolution of hospital systems and organizational structure as health delivery systems seek the best structure to support goals.



Involvement in Capitation

While about half of both single- and multi-specialty groups were involved in capitation in 2000 (53% in single-specialty groups and 57% in multi-specialty groups), in the current survey, the proportion of single-specialty groups involved in capitation declined (from 53% to 44%) while the proportion of multi-specialty physician groups involved in capitation increased slightly (from 57% to 61%).

Involvement in Capitation				
	2001	2000	1999	1998
All Physician Groups	60%	57%	74%	65%
Multi-specialty	61%	57%	74%	65%
Single-specialty	44%	53%	73%	63%
Hospitals	31%	46%	53%	47%
Overall Involvement	46%	52%	66%	56%

Of all the provider organizations surveyed, nearly half (46%) were involved in capitation. Capitation involvement was higher among physician groups (60%) than among the hospitals surveyed (31%).

Involvement was significantly higher among multi-specialty groups (61%) compared to single-specialty groups (44%).

The continuing decline in single-specialty groups and hospitals involved in capitation brought overall numbers down (46% this year compared to 52%).

Evergreen Re's Assessment

- Multi-specialty capitation has remained at approximately 60%. However, hospitals and single specialists are dropping capitation contracts in favor of fee-for-service arrangements. The health plan renewal cycle had the effect of locking in capitation rates for hospitals, many of which were too low for the risk the hospitals were assuming. In 2000, hospitals had a better understanding of risk and began to realize that they needed higher rates. They are now making up for lost revenue by reverting to a percentage of billed charges and increasing their charge masters.



Number and Types of Contracts

The capitation agreements held by respondents covered several types of members: commercial, Medicaid, Medicare and others. Eight in ten (82%) providers involved with capitation accepted commercial members under such an agreement; 47% had agreements covering Medicare members and 47% contracted with health plans for Medicaid members. About one in sixteen (7%) contracted for some "other" type of member, such as a prison population or directly with an employer. These figures indicate a general decline in the number of Medicare contracts, while commercial and Medicaid contracts remained at about the same level found in the 2000 study.

Membership Types Under Contract, For Respondents with Contracts				
	2001	2000	1999	1998
Commercial	82%	85%	91%	91%
Medicare	47%	65%	65%	69%
Medicaid	47%	46%	49%	50%

The average number of commercial members declined for the first time since Evergreen Re's study in 1998. The number of Medicare members declined for the second straight year and the number of Medicaid members increased in each of the past three surveys.

Average Members by Capitated Entity				
	2001	2000	1999	1998
Commercial	27,479	36,822	35,610	6,733
Medicare	5,546	7,837	13,682	6,338
Medicaid	11,172	10,797	10,696	6,551
Total	44,197	55,456	59,988	29,622

Evergreen Re's Assessment

- The drop in the commercial members can be attributed to larger employers focusing on self-funded PPOs to gain control of costs, a drop in health plan enrollment and in certain cases, provider revolt against capitation.
- Medicare membership has declined due to plans dropping out of the Medicare Plus Choice program. The Centers for Medicare and Medicaid Services' annual payment increases for 2003 and 2004 currently are expected to be about 2%. However, the Bush administration has proposed a 6.5% increase for 2003. This would be enough for many plans to continue for one more year. However, without other changes, plans will continue to withdraw from the Medicare Plus Choice program and lead to a further drop in providers with Medicare capitation agreements.
- Medicaid risk is relatively stable. Various Medicaid subpopulations and children's health insurance programs (CHIPs) are gaining in maturity and momentum. In many cases, Medicaid-only health plans have hospital ownership structures that require capitation arrangements to appease regulators and show reasonable financial results. Health plans expect limited annual per member per month revenue increases from the states.

Turnover in Contracts

In the aggregate, about one-fourth (24%) of those currently involved in capitation added at least one new contract over the past year while about three in ten (31%) dropped at least one contract.

Number of Contracts Dropped and Added (Respondents with Capitation Contracts)					
	% Dropped (at least one)	# Contracts Dropped (of those dropping)	% Added (at least one)	# Contracts Added (of those adding)	Net Effect # Contracts
Commercial	20%	1.6	15%	2.2	+0.6
Medicare	12%	1.5	4%	1.5	- 0 -
Medicaid	10%	1.7	11%	1.8	+0.1
Net % making changes	31%	---	24%	---	---

Net change in the number of contracts was not significant year-over-year: Commercial contracts were +0.6, Medicare contracts showed no change and Medicaid contracts increased by a net +0.1.

Number of Members Dropped and Added					
	% Dropped (at least one)	# Members Dropped (of those dropping)	% Added (at least one)	# Members Added (of those adding)	Net Effect # Members
Commercial	20%	15,179	15%	7,213	- 7,966
Medicare	12%	5,646	4%	900	- 4,746
Medicaid	10%	10,167	11%	3,250	- 6,917
Net % making changes	31%	---	24%	---	---

All three categories of contracts showed a net decline in the number of members from last year's survey.

Evergreen Re's Assessment

- The increased number of commercial members dropped may be related to the general state of the economy and an increasing number of employers cutting back on benefits due to economic conditions and rising costs. In addition, some employers have shifted a greater percentage of the costs of healthcare coverage back to employees, who may elect to not take advantage of benefits.

New Agreements to be Signed in 2002

Considering physician groups and hospitals combined, about one-fourth (26%) of those currently involved in capitation plan to sign new capitation contracts in the coming year, seeking out an average of 2.2 contracts each.

The net effect, including those currently involved in capitation as well as those not currently involved, is that 13% of the healthcare providers surveyed plan to sign new agreements in the coming year. However, it should be noted that the proportion of providers who intended to sign agreements for 2002 was smaller than the previous two studies, continuing a trend toward lower anticipated involvement in capitation.

New Capitation Agreements								
Planned to Sign New Agreements	2001		2000		1999		1998	
	%	# Contracts	%	# Contracts	%	# Contracts	%	# Contracts
Providers currently involved	26%	2.2	26%	2.3	49%	2.9	65%	2.6
Providers not involved	2%	*	9%	2.7	15%	1.4	27%	1.9

*Too few respondents to report

Class of Members for New Capitation Agreements

Considering the type of members these new agreements will cover, 81% of those who intend to add contracts in 2002 said these agreements will cover commercial members. One in three (36%) will accept new Medicare members under such agreements, and 28% will add contracts covering Medicaid members.

New Capitation Agreements		
	2002	2001
Commercial	81%	71%
Medicare	36%	42%
Medicaid	28%	32%



Capitation Revenue

Overall, for the groups involved in capitation, the percentage of revenue generated through capitation averages 33%. This was significantly higher among physician groups surveyed (44%) than among hospitals (15%) and declined from prior years' findings.

When asked to project revenue from capitation for the next five years, physician groups and hospitals both reported an expected decline in the percentage of revenue generated through capitation. Overall, providers estimated that capitated revenue would decrease from its current level of 33% to 29% in two years and reduce to 26% five years from now. These findings indicate a continued decline in the proportion of revenue generated through capitation.

Percentage of Revenue from Capitation Projected, Current and Historical					
	2006	2003	2001	2000	1999
Overall	26%	29%	33%	41%	42%
Physician Groups	39%	43%	44%	56%	50%
Hospitals	8%	10%	15%	19%	25%

Evergreen Re's Assessment

- Capitation revenue will continue to be a significant source of revenue for physician groups. For those involved in capitation, success requires a thorough understanding of the risk assumed and actuarial analysis of capitation contracts to evaluate adequacy of capitation rates.



Reinsurance Limitations

For respondents with reinsurance coverage, we asked about per diem limitations on in-network and out-of-network claims in their reinsurance policies. As shown in the following table, the average in-network per diem reinsurance limitation was \$2,310, and the out-of-network average per diem reinsurance limitation was \$2,279.

Average Per Diem Reinsurance Limitations	
In-network claims	\$ 2,310
Out-of-network claims	\$ 2,279

In protecting predictability and solvency, however, an organization must weigh the effectiveness of coverage as compared to potential cost. For example, the following chart identifies increases in daily average billed charges for categories of care at certain tertiary care facilities in 2002, as compared to 2001.

Tertiary Care Daily Average Billed Charges (Select Facilities)						
	New York		Pennsylvania		California	
	2002	2001	2002	2001	2002	2001
Neonate	\$ 5,278	\$4,954	\$ 7,218	\$ 5,119	\$ 9,758	\$ 6,468
Transplant	\$10,671	\$9,343	\$23,302	\$16,526	\$31,504	\$20,881
Other	\$ 5,994	\$4,973	\$ 10,311	\$ 7,312	\$13,940	\$ 9,329

Source: Reden & Anders, Ltd.

The table above represents true charges for “average” cases at tertiary care facilities. Aberrant claims or very severe cases at the same facilities could easily be twice the average daily amount.

Other areas of major concern are outpatient and home health settings, particularly pharmaceuticals and biologics. These treatments are often excluded from reinsurance coverage or subject to low daily allowable amounts.

Evergreen Re’s Assessment

- It is critical that organizations understand the underlying expenses and risks associated with high-cost tertiary care when structuring capitation agreements and reinsurance policies. If the costs are unknown or inaccurate, the reinsurance arrangements may provide far less coverage than anticipated for the potential liability.
- If the perception of per diem limitations in reinsurance contracts is true, this is dangerous territory for any managed-care organization that accepts risk. For tertiary care risk, providers generally do not have control over in-network contracts, much less, out-of-network risk. Having low limitations could result in 1) complete lack of contract predictability, and 2) the eradication of the provider or managed-care organization’s available surplus.

Case Study Implications of Contracting Methods on Reinsurance Structure

When an organization is purchasing reinsurance, it is vital to understand the limitations outlined in the contract. One area in which managed-care organizations often have difficulty is limits on tertiary care. Not understanding the challenges of limitations can result in retention of much more risk than anticipated. For instance, if an organization is at risk for hospital expenses and has a member confined in a tertiary care facility for a cardiac condition that costs \$13,940 per day, a 60-day stay would cost \$836,400. Within this same example is the assumption the member is also utilizing a VAD (Ventricular Assist Device) representing \$120,000 of the total cost.

However, if the reinsurance policy had a per diem limit of \$2,000, and excluded all durable medical equipment (DME), then total eligible charges under the reinsurance policy would not be \$836,400, but only \$120,000. After satisfying a \$75,000 deductible for hospital services, the organization retains 10 percent coinsurance of the remaining eligible charges. It would receive reimbursement of 90 percent of the remaining eligible charges, which amounts to \$40,500.

This means that the organization retains the first \$75,000, the 10 percent coinsurance, and then all the unallowed charges, which equal \$716,400. In total, this organization retains \$795,900 for the case.

If the reinsurance coverage did not include a limit on average daily charges, the organization may have to pay a higher premium up front to obtain that additional coverage. But it would yield a much different reimbursement. Using this example, all \$836,400 of charges would be allowable. The deductible and the 10 percent coinsurance would still apply, but none of the charges are unallowed. The result is that the reinsurer provides reimbursement of \$685,260 and the organization retains \$151,140 — Quite different than the result when the reinsurance policy has a low per diem limitation. The calculations are summarized in the table below.

Reinsurance Structure Implications Example			
		Reinsurance with \$2,000 Per Diem Limit & DME Excluded	Reinsurance Without Daily Limits & DME Exclusion
1	Days	60	60
2	Facility claim	\$ 836,400	\$ 836,400
3	Average cost per day	\$ 13,940	\$ 13,940
4	Per diem limit	\$ 2,000	No limit
5	Eligible expenses	\$ 120,000	\$ 836,400
6	Unallowed expenses (DME excluded)	\$ 120,000	\$ 0
7	Unallowed expenses (per diem limit)	\$ 596,400	\$ 0
8	Deductible	\$ 75,000	\$ 75,000
9	Eligible charges after deductible	\$ 45,000	\$ 761,400
10	10% coinsurance	\$ 4,500	\$ 76,140
11	Amount reimbursed by reinsurance	\$ 40,500	\$ 685,260
12	Amount retained by managed-care organization	\$ 795,900	\$ 151,140

This example shows how excess retention can undermine predictability of financial results. Excess retention is risk not covered—the result of covered charge or services limitations. In a reinsurance policy, an organization must weigh the net expected cost of reinsurance, not simply the gross cost of premium. If the reinsurance coverage structure was based on incorrect assumptions, the ultimate reinsurance transfer and unexpected liability retained may undermine the predictability of the managed-care organization.

Evergreen Re’s Assessment

- This is a recurring problem faced by risk-bearing organizations and is the reason Evergreen Re developed the Optimal Reinsurance Program. Organizations at risk for the delivery and cost of health services cannot make decisions regarding reinsurance coverage based on premium cost alone. Effective buying decisions should be based on the effectiveness of risk transfer based on the surplus position of the organization, underlying cost of services, and expected net cost of reinsurance.

Average Reinsurance Claims Turnaround

We asked healthcare administrators who buy specific stop loss for hospital and physician-services risk about the average turnaround of stop-loss reimbursements. The length of reimbursement time increased significantly compared to 1999 and 2000. In the current study, 48% of the respondents reported reimbursement turnaround of more than 90 days, compared to 37% in last year’s study and 31% in 1999.

Reinsurance Claims Reimbursement Turnaround			
	2001	2000	1999
Under 30 days	2%	16%	14%
30 - 60 days	25%	31%	29%
61 - 90 days	25%	16%	26%
More than 90 days	48%	37%	31%
Total	100%	100%	100%

Evergreen Re’s Assessment

- Slow reinsurance claims turnaround can severely impact an organization’s bottom line and cash flow. Slow filing of claims or filing incomplete claims can further increase turnaround time.
- Evergreen Re has a dedicated Client Services Department that works with each client to file “clean” reinsurance claims in a timely fashion. This allows our clients to enjoy rapid reimbursement turnaround and corresponding improvement to cash flow.

Evergreen Re’s Final Conclusions

Healthcare costs are rising more rapidly than other sectors of the economy. An aging population, advances in medical technology and continued introduction of new “wonder” pharmaceuticals and biologics will continue to fuel healthcare cost increases. Payors, including local, state and federal governments, are searching for the most cost-effective way to deliver quality care to their membership. Provider contracting methods will continue to change as the delivery of healthcare evolves.

Combined with the current reinsurance environment, managed-care organizations can substantially benefit from a more sophisticated approach to their reinsurance needs. Traditional reinsurance approaches, particularly for larger organizations, are not adequate to maximize financial predictability and solvency protection.

Evergreen Re

Transferring Risk for Healthcare Organizations is All We Do

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Stronger Analysis Means Greater Predictability

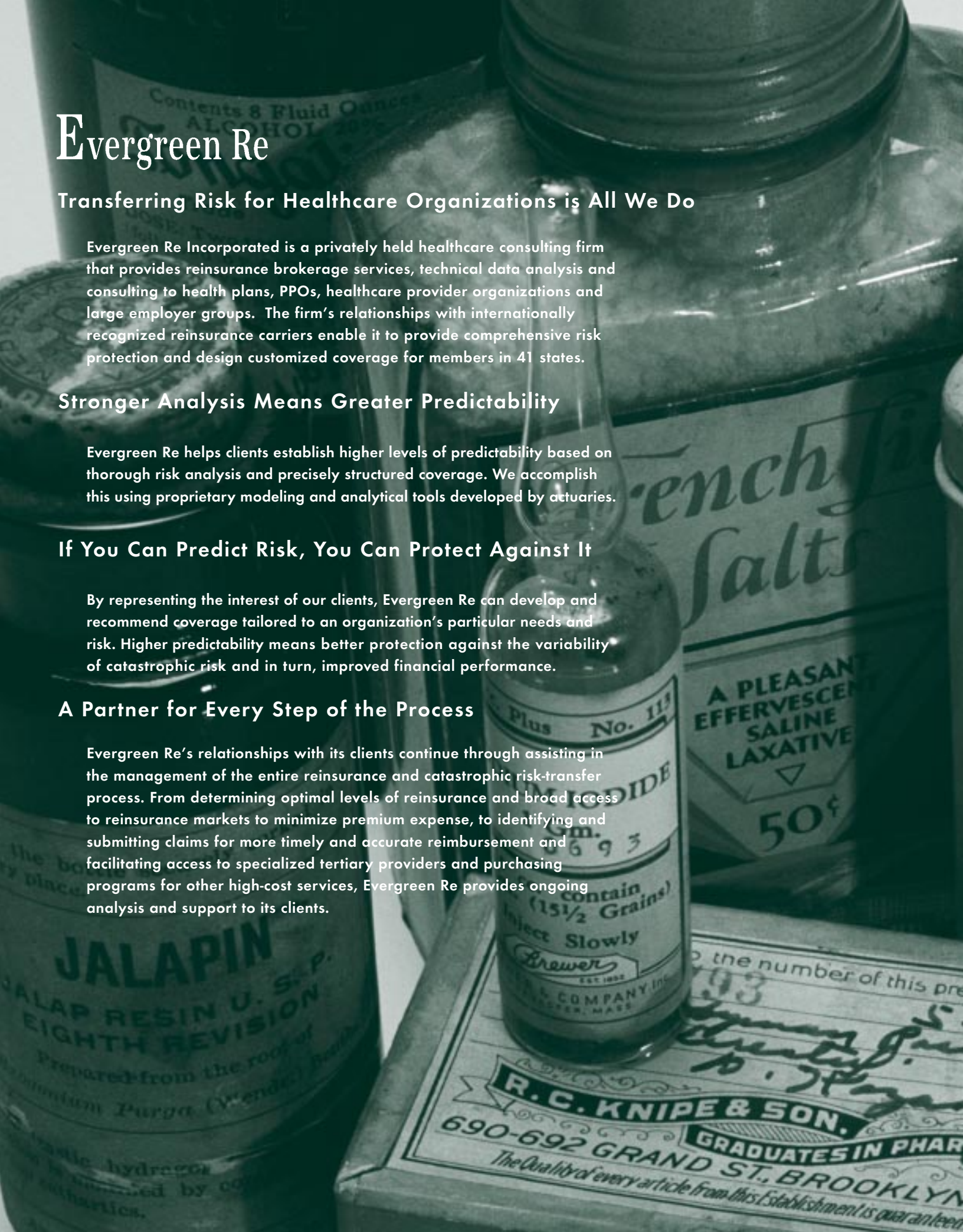
Evergreen Re helps clients establish higher levels of predictability based on thorough risk analysis and precisely structured coverage. We accomplish this using proprietary modeling and analytical tools developed by actuaries.

If You Can Predict Risk, You Can Protect Against It

By representing the interest of our clients, Evergreen Re can develop and recommend coverage tailored to an organization's particular needs and risk. Higher predictability means better protection against the variability of catastrophic risk and in turn, improved financial performance.

A Partner for Every Step of the Process

Evergreen Re's relationships with its clients continue through assisting in the management of the entire reinsurance and catastrophic risk-transfer process. From determining optimal levels of reinsurance and broad access to reinsurance markets to minimize premium expense, to identifying and submitting claims for more timely and accurate reimbursement and facilitating access to specialized tertiary providers and purchasing programs for other high-cost services, Evergreen Re provides ongoing analysis and support to its clients.





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