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Session 39 PD Health Reinsurance Market Update

Track: Health

Moderator: Patrick L. Collins

Panelists: Patrick L. Collins
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Summary: Even insurers and "self-insured" employers need insurance. This session provides a behind-the-scenes look at a behind-the-scenes—but critical—segment of the health insurance market. Panelists discuss recent trends in health reinsurance and employer stop-loss coverage, including:

- *The non-actuarial point of view: Negotiating stop-loss treaties*
- *What type and level of reinsurance does my health plan need?*
- *The impact of mergers and acquisitions on the health reinsurance market*

MR. PATRICK L. COLLINS: Mike Wozny is an assistant vice president and director of integrated medical solutions at Hartford Life based in Windsor, Connecticut. He's responsible for directing all the medical stop-loss operations, including sales and marketing, underwriting, financial, actuarial, claims and client services.

John Galbraith is senior vice president and reinsurance intermediary with Guy Carpenter based in Morristown, New Jersey. In his current position, John is responsible for service to existing disability and medical reinsurers, as well as new business development. John's current efforts are focused on specific and aggregate

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stop-loss, provider excess placements and other medical and managed care reinsurance needs.

Greg Demars has been an actuary with Allianz Life for 13 years. He's currently a vice president and divisional actuary for the health-care risk management division based out of Minneapolis, Minnesota. He's responsible for the oversight of all actuarial functions within the division, in addition to the underwriting function related to HMO reinsurance, provider excess and medical excess lines of business.

I'm vice president and reinsurance underwriter for American Re Health Care in Princeton, New Jersey, where I develop and manage U.S.-based medical reinsurance programs.

I've asked each of the panelists here to develop their own presentations to broadly cover some of the following topics: the reinsurance markets and what they're seeing today, the trends in the industry and what's being done to address them, the challenges they face and how they're handling them and, on the flip side, the opportunities that they see both now and in the coming years.

What I like about the panel is that it gives us a chance to explore some of these issues from varying perspectives. We have the perspective of the buyer of reinsurance, we have the perspective of the seller of reinsurance and we have the reinsurer perspective, both from a management underwriting, as well as actuarial.

MR. MICHAEL WOZNY: I have two goals in doing this presentation. The first goal is to scare any of you away from doing stop-loss that are interested in doing it. The second goal is to talk a little about what I look for in reinsurance and in intermediaries. I hope that you walk away with some appreciation for the challenges of the stop-loss theme today and how we turn to reinsurance to help us solve some of those issues.

These are some of the big challenges. These are not going to be new to you. A lot of you have been to presentations where you've heard about these. How do you pick medical trend? What does it mean on an excess program? What's happening out there with new technology? What are the things that are changing the way we do business? What are some of the new medical benefit plans and products that are out there that are going to affect the way we do business? What's happening on our legal and regulatory front?

Medical trend is a pretty complex issue due to the fact that in stop-loss we've got an excess program playing up the law of leveraging. But complicating all that, there are a lot of changes going on in how we underwrite our business. There's a lot of talk about the crystal ball and how far into the future we can work when we're doing our underwriting, what things like predictive modeling can do for us and what the disclosure process does for us.

There's also the challenge of a changing environment. It used to be in the good old days that PPO plans were all kind of the same. Now that's not the case. There are so many different arrangements out there. You used to see at least some stability around outlier provisions. Now we are even starting to see some deflation in terms of where outlier provisions are landing, some of the outlier provisions falling to lower levels and some reimbursement levels that are falling to lower levels once they see the outlier provision. So there are a lot of challenges out there in terms of how you price PPO discounts on an area-by-area basis. Combined with that is the challenge of where individuals will travel to receive their care. If you happen to be an individual in a zip code that's in a relatively rural location, where are you going to go to get your catastrophic care? Those are the kinds of challenges that we try to resolve in stop-loss care, but that takes a lot of care and a lot of resources. It's very difficult for us to solve those on our own. We go to our reinsurance carrier for help in that.

Then there's also the challenge of how we manage costs. The whole structure is a little topsy-turvy right now, in that not all of the individuals that are in the stream of processing claims have the same motivation that we do as stop-loss carriers. There may be rebates out there. There may be other programs that cause someone to be motivated to not necessarily drive that claim to the lowest level. Let's face it. When you have an excess program, they see it as not being their money anymore. How do we step in and get folks to help us manage costs down to the lowest level possible?

Then there are all the developing trends in health care. There are all the new types of treatments that are out there. Even the treatments that were standard two or three years ago have changed dramatically. One great example is assisted reproductive therapy. It was a huge problem three or four years ago, but now the reproductive medical community has responded, and you see very few situations where there are more than two or three eggs that are implanted at one point in time. So the risk has become much lower. The risk from gastric bypass surgery is a huge issue; there are a lot of complications that result from those.

Now there's a new trend toward substandard organ transplantation, where an organ from a donor that may have been considered a suboptimal organ in the past is now being used or transplanted into an individual as an interim measure until a better organ becomes available. We've got a lot of new trends that are developing that could really affect the way our business operates and the types of claims that we're going to see.

Let's talk about new technology. In terms of stop-loss, it's critical that you have a risk management program that's highly connected. Your underwriting team has to know what your clinical team is doing. Your underwriting team has to know what your claim team is doing. Your clinical team has to know what your underwriting team did. That has to be throughout the organization. Without that, you can't effectively manage the rest of this business. You have to tear down the silos in

order to be effective.

I mentioned predictive modeling. What does predictive modeling mean? Is it worth something? Is it not worth something? Is it the next tool in terms of how we evaluate risk and set our pooling charges? Or is it something that we just use to identify people potentially generating catastrophic claims so that we can get them in a large case management program, a disease management program or whatever it may be to drive their costs down to the lowest possible level?

The next item I would like to discuss is fraud and abuse. We live in a totally different world today in terms of how claims come in the door. I remember studying how you identify cases of fraud and abuse. You look for smudges on the claim form, or you look for White-out marks. Well, that doesn't happen anymore. Claims come in electronically. What does it mean to look for fraud and abuse in an electronic environment?

The other problem is PPO contracts. PPO contracts typically have some requirement of prompt payment. The key design is to satisfy the bill and get the payment out so that you don't lose the discounts. Do PPOs help, or do PPOs exacerbate the problem of fraud and abuse? Because we have to move so quickly to get the claim resolved, we don't have a chance to catch those along the way.

Claim history has been a challenge in terms of how we market stop-loss products. It's very difficult in most states to get ongoing health information or ongoing information about claims from fully insured groups or HMO groups. There are some states that have passed regulations recently that make it easier for groups to market their programs. Montana is one. Texas has just approved some legislation as well. I don't believe that it has been signed yet, but it's expected to be approved. It enables plan sponsors to regain control of the data related to their health plans and allows them to market it more readily.

There have been changes in medical benefit plans and products that are consumer-driven health plans (CDHPs). What do they need? Do they save money for us? Do they create more risk? Do they create more volatility? Certainly it creates the opportunity to have leveraged trend, not only on specific stop-loss now, but also on aggregate, because you're dealing with much higher deductible levels on the underlying claims. But because of those higher deductible levels, you also increase your volatility on the aggregate side of the equation.

I was at a meeting recently where a TPA, probably trying to garner a more satisfactory rate from its stop-loss carrier, stood up and said, "I was getting 10 percent discounts for putting consumer-driven health plans in place." I think that was the tail wagging the dog. But the fact is, is it something that in the short-term you're willing to give discounts for as a stop-loss carrier? What happened to wellness in all this? I thought we were trying to be proactive. Is that what disease management has become today? Those are the kinds of questions that I have to

ask to scare everyone away.

Another thing that we noticed recently was employers who insist on healthy-living practices from their employees. There is a CPA in Michigan who installed a nonsmoking policy such that they do random tests for smoking. I think that it was on CNN a few weeks ago. They showed the employees breathing into the tube for their testing. Do you know what that means to an employer? Now there's an employer who's thinking long term. Is acting long term something that is worthwhile to a stop-loss carrier? Those are challenging questions.

Within the last year, we have seen a huge marketing effort around transplant programs. How do we stop-loss carriers adjust for that transfer of risk to a third party who's offering that program on a fully insured basis?

Of course, we always have legal and regulatory issues along the way, too. Is nationalized health care inevitable? Is it improbable? Is it impossible? What does national health care mean? Are there association health plans? Are they going to happen? What does it mean? Is it a new opportunity? Is it ever going to happen? We have to wait until the Blues are actually ready to do something with that before it's going to happen.

Government medical excess programs were a topic from the last election period. It certainly creates a chill up my spine as a stop-loss carrier. How do you react to that as a stop-loss carrier? What's your reaction to those types of risks and those types of opportunities? Employee benefits within captives is another chilling thought. How do we react to that?

Let's talk about state funding for uninsurable risk pools. Although I did see that there are a few states that are actually running surpluses right now, it has certainly been the trend that states have run deficits in their general budget and tried to help alleviate some of that by assessing charges against stop-loss carriers on a per-capita basis, much as if the plan had been a fully insured plan. That, in essence, forces a lot of large employers out of the self-insured-with-stop-loss market and into a fully insured type of arrangement. When you see a plan that has \$2 stop-loss rates and their state assessments are \$30.00 per employee per month, it's pretty hard to justify to the employer that they should stay in stop-loss. We've got a couple of things whittling away at our market, not to mention that the fully insured carriers are making a great run in the last couple of years at gaining market share. It's a challenging market. Anybody who looks at financial reports and sees stop-loss carriers making gobs of money, just remember that that's from a couple of years ago. Those are all results that are playing out now. If I were to make suggestions about when to enter the market, I'd look for when profits are way down. Be a contrarian.

What do I look for in a reinsurance intermediary and in a reinsurance carrier? In terms of a reinsurance intermediary, I look for access to market. I look for

someone who has a number of reinsurance carriers that they can go to and bring reasonable quotes. I look for someone who can help with treaty development. I look for somebody who has a lot of knowledge in that area and who can administer the treaty to my needs. Someone who knows, of course, the whole reason we do reinsurance volatility and capital management assistance. They also would need to have a broad perspective of the marketplace and trends. Who's going to get me the information about what's happening out there? Who's going to help me prepare for what's coming down the pike in terms of competition?

When I talk about the intermediaries, I'm really looking for measurement tools. When I'm talking about volatility and capital management assistance, what tools can they provide that will help me evaluate the program? Now when I get to the reinsurance carrier side, of course I expect their program to help me with those, but I like to have an intermediary help me evaluate what those programs mean.

Of course, the reinsurance carrier is also someone who can provide, I hope, assistance in terms of giving a broad perspective of the marketplace and some of the trends, as well as—this is probably the most important part of all—a consultative relationship. The reinsurance carrier is someone that I can call and ask, "What do you think about PPO outliers today? Where are they going? Who's coming into the marketplace? Who's doing crazy things right now? Where should I pull back in the market?" Is there something that they can do to help me be more competitive, more profitable and grow in the right places at the right time?

I've hopefully scared you away from stop-loss if you aren't in it already. If you're in it already, you probably know all of these things.

MR. JOHN GALBRAITH: Just to assess the audience quickly, could I have a show of hands for those who work for an insurance company? How about actuaries who work for a reinsurance company? How about consulting actuaries who sell to insurance companies or reinsurance companies? Finally, how many reinsurers and reinsurance brokers? I see a lot of the reinsurers and reinsurance brokers are in the back row.

A lot of this is dovetailing into what Mike just said. You know what people look for in a broker. You know that they're looking for someone to help them develop an appropriate risk management strategy, the capability to provide the company with appropriate tools, to assist in the program design and, now more than ever, the technical backup to provide some additional value-added analytics in order to make solid decisions based on cost-benefit analysis. Obviously we have to do all of the other things, which include taking it through the quotation process and, increasingly, the more complex contract-writing process, which has gotten more difficult since 9/11. There is also the premium claims and collections, which we found out after 9/11 isn't always as easy as it seems. I think the job has gotten a little more difficult for us, and we're trying to find different ways to differentiate ourselves.

There are a bunch of questions that they might ask. A lot of them are about developing the appropriate risk management strategy, such as capital management that Mike talked about. You know whether the incumbent reinsurer is providing the types of services that they need. A very large company like Hartford probably has a lot of excellent claim management services in house. But some of our smaller clients might not have an in-house organ transplant or an existing organ transplant relationship. They're going to be looking to augment that through an offering that a reinsurer might be able to deliver to them.

MediRisk is a sophisticated, proprietary, reinsurance decision-making tool. It has been in development for over 10 years. What we try to do is take the data that the clients have built up and provide them with meaningful output in order to make a more informed decision, based on risk management analysis that has occurred. Then, hopefully, they take that information and overlay certain reinsurance structures to decide what's the most efficient. Based on the client's needs, we determine what they feel is the best structure.

If we're going to talk about per person excess medical, we would just get the client's ground-up claim data over a period of years, get their particular trend assumptions (because they can differ by product line) and then run that through the model, along with the current reinsurance structure that they might have.

Risk profile is essentially not going to just show the mean outcome of what we expect to happen on average; it will essentially show outcomes from one to 100. The need will be in there as well. That also allows us to do some analysis on the standard deviations. Most of our clients want to be in a position to cede off the most volatile part of their program and maintain the parts with which they feel more comfortable. Again, we're just trying to provide some additional tools to what they do already in house. In addition, they want to know what risk of ruin. We were sitting down with someone the other day who said that the key thing to know was how big the claim was that they couldn't bring to their boss and not keep their job. I think that's always a good viewpoint. It's not necessarily a single claim in every instance, but it can be the overall results of the program.

We look at how the current program compares in structure to what we're seeing. That gives us the ability to do some benchmark pricing and to get a feel for the margins and expense loads that are currently in place in the reinsurance pricing. That would give them their implied return on capital. Again, everyone is looking to make money on this, including the ceding companies and the reinsurers. That's one thing that we have to keep in mind throughout this process, particularly in the post-9/11 era where most reinsurers are writing their programs on a net line basis. They're keeping all the risk that they write.

The next step in the process would be looking at an experience rating, which is fairly straightforward. The experience rating would be for the existing band of risk

in which they're operating. That just gives you a look back on what has happened. The key thing that we're trying to do when we're working with our customers is to ask, "What is the best structure going forward based on their history, changes that have happened in their portfolio and their expectations for capital and capital management in the coming period?" This is really a point estimate. What we try to do is take the MediRisk output, which I'll talk a little more about in a second, to look at the expected mean and continue the analysis from there.

First of all, the actuaries work with the customer with their claim data and with their expectations for trend. They've gone through the process of getting the risk profile. They ask, "Does this make sense?" There's a lot of inner activity. But then we look and try to decide which curve makes sense. That's just the starting point for us. We try to look at the results and put them in some distributions to analyze the data a little more. We start out with the medical before any reinsurance, which would be the gross results. Then we would proceed to look at the net results after the existing reinsurance plan. Then we would look at a viewpoint of the expected distributions. These are with 50,000 simulations, generally. We're looking to make sure that we're matching ceding with what makes the most sense for the customer, based on their capital needs and their concerns about the business. Some people would even say that this business is a little cyclical. I think that's what Mike was alluding to when he said that the profits today are from a couple of years ago. I think that's a concern for everybody.

Then we take those same distributions and try to show them in different ways to make the most sense. We put this in a cumulative density function. The break-even is pretty high up, and that's because reinsurance generally costs money. There are expenses and profit margins for the reinsurer; it doesn't hit the mean like everyone would hope. We also compare different reinsurance structures based on the history. We try to provide that to allow for better decision-making.

Again, we'll also then frame out, through a cost-benefit analysis mechanism, where the various quotes come in. Then the ceding company makes a decision on what makes the most sense for them, based on their own specific needs at that point in time.

I want to spend one second talking about urban accumulations. You might ask, "Why would anyone do that?" But over the last four to six weeks, there has been a lot of press coverage about pandemic events such as the Asian flu, so we have been doing some work there. It's essentially a blend of work that we're doing on the life catastrophe side of the business and moving it over to medical catastrophe. There are components to the terrorism models that you have to be thinking about. We'll run models against where the population of a particular risk might exist. The lives are what the insured volumes are, because remember that often you're providing \$1 million, \$2 million or \$5 million of coverage. No one ever seems to hit that, but what would happen if there was an outbreak and something major happened?

With these models, the mapping allows you to show where the employee logs are throughout a particular region. We may depict a particular company's business in Manhattan, showing their risks in comparison to potential terrorist targets. Then we might look at the sample terrorism scenarios, which show what the deterministic outcomes might be, whether there was an aircraft crash, a bomb, a biological event, a chemical event or a nuclear event. Obviously the models are pretty new, so I think they're still trying to figure out the probabilities (1 in anything is pretty problematic, as we found out with 9/11).

MR. GREGORY C. DEMARS: I work with Allianz Life in Minneapolis, where I represent the division called Health Care Risk Management. Our focus and our core lines are HMO reinsurance, provider excess, employer stop-loss, medical excess (which is excess of loss over fully insured) and stop-loss risk that insurance companies are taking. The entire focus of our division is medical excess of loss products. My presentation is going to focus on the HMO reinsurance and provider excess marketplace. Our company has been in that market for the last 25 years. I was not a part of that for the entire time. The agenda that I'm going to walk through is going to cover the industry and marketplace trends, challenges and opportunities.

The HMO industry trends are continuing market consolidation. I would like to discuss four plans; each of these is a regional plan that has been gobbled up by the nationals in the last few years. All of them are plans with which we had reinsurance relationships. We no longer do, so you can see that there's a challenge from the perspective of a reinsurer in this marketplace. CDHP and health savings account (HSA) programs are on the rise. A lot of our clients, which are primarily mid- and smaller-sized regional HMOs, are still in need of reinsurance protection and are spending a lot of time on these types of programs. You've heard a lot about claim trends already in some of the sessions. They have been moderating, and we'll talk about that later. Patrick is also going to be hitting on higher-layer claim trends. There has been moderation there. There is some question about whether that is now starting to tick back up.

Hospital contracting is soft on the higher layers. We haven't seen improvements yet on that outlier front. When I started in this specific business seven or eight years ago, we saw a fair amount of fixed contracting on agreements out there. Currently, it's a rare find. Potentially, on a provider-owned plan, you'll still have a domestic per diem in place. But other than that, it's a unique contracting structure these days. Certainly more of those outliers are on a percent-of-risk basis that's going to impact significantly your reinsurance or excess of loss risk assessment.

Commercial lives are down and Medicare claims are up (from the plans that we're working with, anyway). We're seeing a drop in some of the commercial life activity. But we have seen some climb in the Medicare side. I think that the nationals on the commercial side are challenging these regional plans. As far as insurance company

and captive solutions, we've seen quite a bit of activity recently with these health plans. They are either starting up in insurance companies or companies are beginning to utilize the plans that they've had for years in a much more significant way by putting their PPO risk out there. Some of them are dabbling into the rating of stop-loss as well.

Let's switch over to the HMO reinsurance industry trends. Coverage terms are expanding. Historically this market has been a hospital-only service coverage. In the past, I think that was the sole source of catastrophic claims, and so that's what people had covered. That has been expanding over the years as more services are getting into that catastrophic realm. Outpatient and home and drug therapies and things like that are changing. We're seeing coverage terms expanding on that front appropriately. Continuation of coverage is becoming more flexible and is a state focus. It is a requirement by many states for health plans to have an insolvency protection provision within their reinsurance agreement. When a health plan goes insolvent, a reinsurer has this provision on the contract to come in and cover those folks that are inpatient until they are discharged, as well as for groups that have a premium paid-up period. They paid the premiums for their coverage, and now the plan is gone. This provision would cover those folks until their premium paid-up period is completed.

We've seen some states put additional focus on this recently by mandating certain liability totals they want on this reinsurance cover. They may say that they want \$10 million for this plan. I don't think that there is a lot of assessment as to what is the actual liability; they're just coming out with numbers. There are some interesting developments there. The market seems to be fairly steady. I know of one new entry here in recent history. It's a fairly small market. I think that there are 10 to 12 serious players, and a small handful of those really hold most of the market share.

Broker transparency is certainly a hot topic in the news. It certainly has its connections with our market as well. We work with a host of national houses, as well as some of the smaller shops that have one or two brokers. It's an interesting contrast how some of them have taken action based on recent events. I'm sure eventually your practices will merge. But as of right now, it's an interesting contrast.

I think that every market update throws aggressive pricing out there to scare the rest of you from ever entering into this market. I can't think of a market update that said, "Things are conservatively priced and we're making gobs of money." I'm not about to break that trend. As always, pricing is aggressive. I have to get that out there. We have seen a shift of risk from commercial. If we take a look at our block and what it has done over the last few years, it is a proportional split. The growing block happens to be our Medicare risk. Medicaid has been a pretty constant percentage of our risk over time. But again, this is talking to that commercial shrinkage that we've seen.

Next I'm going to talk about provider capitation trends. A couple of years ago, if we dug into the cases we lost, 95 percent of the time they were exiting capitation. It wasn't that we lost it for competitive reasons. It was that they exited capitation. We're not seeing that anymore. In fact, I don't know that we've lost the case for one here that was somebody's existing capitation. We actually are seeing pockets of new capitation, albeit small pockets. It's usually Medicare-based. It's professional focus, not hospital system. We're also seeing a few provider groups that are in the catastrophic world now that are adding a few managed care organizations (MCOs) as well. Those are some changes from our perspective.

What's happening on the excess side? Provider excess continues to be a broker-controlled market, contrasted to the HMO reinsurance world, which has a strong presence of a carrier direct-sale mechanism. On the provider excess side, it is primarily broker control. I think that it has to do with the resources that these provider groups have in place. They do tap a lot of that value that a broker can bring. It's a smaller market. We estimate it to be about half the size of the HMO market, with probably half or close to that of the players involved as well. But it's one where we've seen a heightened focus as of late by the carriers that are actually playing in that market. It has been, again, aggressive pricing, as you would expect.

I'm going to talk about our commercial block of HMO reinsurance experience and the sources of our claims on an overall basis. I haven't segmented this by layer risk, and, again, it's commercial. Interestingly, oncology leads the pack for us, although if I merge premature infant risk and congenital abnormalities neonatal exposure, they are certainly in that realm as well. We've seen escalation there on the neonatal risk side. I think that children's hospitals around the country have a powerful negotiating presence. It's a challenge for folks, I think, to contract with them. If I were to look at the Medicaid risk specifically, you'd see the neonatal exposure jump at least 10 percent. So it does vary quite a bit by type of member.

Oncology is more of a higher-frequency, lower-cost type of situation, and it doesn't show up at our excess claims. Not that we have volumes and volumes of claims in excess of \$1 million, thankfully, but it's a growing risk out there that I think a lot of us will be talking about more and more as we go on. Transplant and cardiac lead these, with the premature infant risk in a close third place.

I would like to talk briefly about the market needs for HMOs and providers. Some of this ties in with what Mike talked about. They're looking for appropriate coverage. I talked about how in the past, within a hospital-only type of coverage, we saw a lot of people move toward a more comprehensive, appropriate coverage. The other part of this is getting yourself into a cost-efficient coverage. John talked a lot about a tool that they're using to do that. When we buy our own auto insurance, we're not buying unlimited coverage. We're trying to buy a cost-efficient coverage for ourselves that makes our probability of ruin reasonable. It's all about appropriate and cost-efficient coverage. It's also not just the services that are covered, but

what are the claim notification requirements within the coverage? Watch out for some of those things within the coverage beyond the services coverage, because those can certainly have an impact if you've got a short claim notification period.

Mike also talked about the fact that consultative information-sharing can help them write more business more intelligently and more profitably. Risk management tools and services (things like transplant network, case management support and that type of thing), in addition to consistency in the service that they're getting, consistency in the underwriting and the pricing that they're getting, make a difference. Stability is important. Somebody that has the capital and wherewithal to be with you when needed is also important.

I have a case study that I thought I would use. The example is the power structure in attempting to bring that technical expertise. Again, we've been in the market for 25 years, so we strive to tap some of the knowledge that we do have and share it with the folks with whom we work. Top service and services talks to the claim turn time in doing what you say you're going to do as well as services, which are things like Life Track or transplant network. We have a proprietary network called Life Track that has a unique structure. It still has the majority of its contracts for the transplant phase on a fixed basis. That's somewhat unique. That protects most of the clients, and it certainly allows for a more favorable rate.

Care management support also falls into that. The regional and small HMOs that we work with see these capitation cases only a handful of times a year. We see this stuff every day and are able to tap that knowledge.

We also play in the arena of medical excess from the HMO, the provider, the insurance company and the employer side of things. In fact, we have some clients that cross all over those. It's an HMO that does some provider pass-through, that has an insurance company, and we also write the health system and the employer lives that are within that. You can see that within an organization like that, there's a lot of medical excess opportunity.

Underwriting consistency and rate predictability is critical, and we strive to do that, as well as the discipline behind it to make sure that we're going to be there for another 25 years.

Last, I'm going to touch briefly on challenges and opportunities in this marketplace. I put these together because often the challenges turn into opportunities for those that participate in this market. The regulatory issues that a lot of us have been talking about for the state and national reinsurance pools are a challenge. Some of these were discussed back at the election, but a lot of this is still going on. That hasn't ceased to be a topic. That certainly is not dead in any way, shape or form. In fact, our own state of Minnesota has entertained the idea, just on a segment of their small group population, of putting in a catastrophic protection pooling mechanism. That's a short step away from going on a much broader basis.

Association health plans certainly may be a future opportunity for folks in this market. We hear a lot about the first-dollar trend, but the challenging part for us is, what's the trend above \$150,000 or above \$250,000 or above \$500,000? How do we keep up with that? We use a lot of our own data, but our own data isn't credible like some of these layers as well. That is a huge challenge and opportunity of how we can do that better and smarter.

I talked about high-layer options briefly before and the concept that a few years ago nobody talked about. Most of our clients didn't care about claims in excess of \$1 million. It was not a discussion point or something on which you spent a lot of time. They are starting to think about it now, and I see a lot more interest in that currently.

Medicare Part D is fascinating just because of the size of this thing. It's the biggest thing in a long time from a risk perspective. For some of the health plans with which we're working, this is going to be a 20 percent revenue jump for them when they step into this from what they're taking currently. Revenue is usually tied to some risk. It's a 20 percent increase in some of the risk they're taking. What are the reinsurance opportunities there? Is it aggregate? Is it quota share? Is it some sort of specific? The federal government has all kinds of risk mitigators in some of the programs, so that takes some of that exposure away from them. But there's still a lot of opportunity there.

Clinical trials are a pocket of opportunity in which we see some activity. Medicaid is continuing to be a challenge for states as they try to manage their growing pools of Medicaid lives. They're struggling with their own budget constraints. Consolidation is certainly a challenge for us. What's the opportunity there? I'm not sure yet. We are continuing to work on that. Disease management programs, both on a commercial and Medicare side of things, pose some risk opportunity and some reinsurance opportunities. For those of us in this market, it is kind of a new and growing field.

MR. COLLINS: I'll talk a little about American Re Health Care and how we view medical reinsurance. I'll give some observations about the medical reinsurance marketplace. I will also talk about some of the trends that we're seeing and some of the challenges that we see being faced by our clients and by ourselves. On the flip side, I will discuss some of the opportunities that we see now and going forward.

When we looked at the medical reinsurance market historically, we noticed that it has not been a very attractive market over the long term. Many of the players who participated in the past are gone. When we look at developing and refining our own business model, I think it's helpful for us to keep this in mind. We want to try and refine our model so that it has a stronger chance to succeed over the long term.

Our model focuses on risk management. It's the predominant reason for most of the programs. We see ourselves as first and foremost a risk-taking entity. Speaking of risk management, I hear a lot of academic and nonacademic discussion about risk management. I think that it's interesting reading and great dialogue. I feel that for commercial risk-taking entities like ourselves, I could boil all the components of risk down into two basic ones. One is significant and permanent loss of capital, and the second is inadequate risk-adjusted return. I think that a number of the previous participants in the market are not here anymore because they didn't have a keen enough focus on these two items over the long run. I think that if we can ensure that every party that does business with us, including ourselves, manages their business appropriately and controls these two basic things over the long term, it gives us all a good chance of thriving over the long term. It's not intended to be a win/lose proposition.

The first thing we focus on is knowing the market and understanding the details of the market that our clients are in. We're not comfortable in participating unless we understand the market as well as we can. We have a number of different tools at our disposal. These tools are intended to help our clients do their business better by turbo-charging their operation. We try to evaluate new opportunities in a disciplined, detailed and sober manner. We focus on managing our current client programs effectively and dedicating the resources required to make sure that they continue to have some success. We also make sure that we have the proper controls in place to make sure that returns are achieved by everyone and that risks are managed. We want to focus on the fundamentals, not only just providing good service to both the clients and the brokers, but also to keep the emphasis on the business. We love sexy concepts and cutting-edge techniques; we thrive on those. But if you're not doing the basics very well, then focusing on those things tends to be kind of moot.

As you recall, I said that we have these tools that will help the programs operate better (see Collins, page 23, slide 2). There are some things that we have done and continue to do. All of them follow a basic philosophy of what we're trying to do, which is whatever we can to help our clients do their business better. We work with our clients to look at all of the aspects of their programs, and we'll do whatever we can, however we can, to help them improve.

If I had to categorize our business into different components, here's what it would look like. The specific and aggregate stop-loss is predominately with carriers who utilize managing general underwriters (MGUs). The fully insured quota share is mostly small group and individual major medical. The portfolio excess is mainly the small group individual and also excess on specific stop-loss.

I'll list these categories, but I think it's important to note that we don't really see these quota share or excess products that we're going out and trying to sell per se. We see ourselves as a risk-solution provider rather than as a seller of products. When we talk to a client, we first try to have a discussion about their needs and

their long-term objectives, and we work with everybody to jointly develop a solution that will fit. It may turn out to be quota share or excess or some combination thereof.

I would like to give you some of the perspectives about market and selected segments. I'll start with stop-loss. We're seeing that capacity is continuing to constrict even further. Any remnants of the "following lines" capacity, retrocession or facilities seem to be going away even further. I think what we have is that many of the reinsurers remaining in this market continue to have the scars and the bad memories of the last down cycle. They are intent on trying not to make the same mistake again. They're more actively scrutinizing the business of the reinsured, not only in their rates and the underwriting, but also in the way the business is managed.

In the small group and the individual, the participation by reinsurers is a lot more limited. There's a lot of market knowledge required to be successful over the long term. Having said that, a number of these programs had started to do well and to achieve their target margins, and, of course, that tends to pique interest and get some people interested in coming back.

The portfolio excess market is a fascinating market to me. It's one of the more interesting ones because it's one of those businesses kind of like reinsurance. It's pretty easy to get into, but it's pretty hard to do well over the long term. Doing it well requires a strong amount of discipline. You have selection bias all over the place. It's the classic, "If you don't have any claims in one year, well, then you have to make that fully credible, and, if you have a lot of claims in the year, well, that's bad luck."

Due to that, this is the segment that will be the most likely to ebb and flow with the market cycles. We try to price and manage these programs in a consistent and disciplined way and not get caught up with risky behavior or rash decisions. We're constantly analyzing and studying claim activity from all kinds of angles, and we look at the data from the programs that we reinsure, from our own large point in data and from our large industry database.

I put together a few graphs to give you a small sample of some of the things that we've observed. The first graph (see Collins, page 26, slide 2) shows one view of claim trends. The data in the second and third graphs (see Collins, page 27, slides 1 and 2) are based off experience in our industry database, and they reflect billed charge levels, so the direct impact of provider contracting is removed in the first graph. The one thing that jumped out to me in the graph is the drop in drug and overall claim trend in that 2002-2003 period. While we all like to puff ourselves up and tell stories about how great we are, it strikes me as very likely that a big reason for the recent success is that we had this happen along with corresponding steady increases in the premium levels in the last few years. You'll also notice that in the last two years or so, they dropped off toward normal levels.

In the second graph, which shows the same sort of trend analysis except on a leveraged basis by varying attachment points, you'll see that we have a similar impact here in leveraged trend. It's even more pronounced in that 2002-2003 period. This particular graph is using actual claims. I'm not trying to overly smooth data or tinker with it too much. I think it points out some anomalies here. You'll see them at the \$50,000 level and at the \$250,000 level, where they fall out of line. That highlights the experience that we see all the time, which is that when actual claims come in, they don't always follow expected patterns or follow exactly how the model is supposed to draw it up.

You may recall some discussion here about the federal government reinsurance programs. Interestingly enough, there's lots of discussion about that at the state level, as Greg pointed out. The Academy put together a team and drafted an issue brief to discuss some of those issues that you need to consider if you try to undertake this kind of an initiative. Copies of this are on the Web site.

During this exercise, we generated a third graph that showed various costs or percentage of total costs. I thought it would be interesting to see what it would look like if we used our own data instead of the Milliman data. I think that we expanded it to include more attachment points. While the graph is generally just slightly lower than the Milliman graph, overall it's pretty similar.

I'll now share some observations about the business, both at the reinsurance and insurance level. In stop-loss, the market is somewhat rational. It has gotten a lot more competitive recently. Growth is a big challenge for the disciplined players. New business sales are down. Renewal persistency is up. The interesting thing about the employer market is that there were benefit consultants talking about how they strategize with their employer clients about how they're going to handle benefits. They talked about medical as an exit strategy. We find that to be a little disturbing for our marketplace in general. We see that the employers in the self-funded market who purchased stop-loss are not growing in a significant manner either. Another influence on that might be due to some increasing competition from the fully insured side, at least at the smaller end of those groups. Many are trying some innovative things in terms of stop-loss to try and stimulate some growth. The bottom line is that if they increase cost, particularly in the short term, they aren't likely to be very popular.

There are some similarities in the small group and individual markets. Number one that's notable is that growth is a challenge, but these small and mid-size carriers in these markets have other obstacles as well. The markets are heavily regulated, as you probably know. The barriers and the cost to enter these markets are fairly high. In addition, if you want to succeed in this business today, you need to do about 20 things right, all well and all at the same time, to make your margin. It all goes downhill from there.

This moat effect that protects entrenched players has a dampening effect on

innovation and slows the start-up of new players. There's a little ray of hope with the consumer-driven health plans. Specifically, I'm referring to the high-deductible plans with the health spending accounts. It has been transforming the individual market, but in the small market it hasn't had much of an impact yet. That may change as the market evolves.

Our business has its share of challenges as well. In reinsurance, we deal with small and mid-size companies for the most part. These are companies that can benefit from risk solutions, value-added services, capital and so on. The consolidation and lack of innovation together reduce these companies. Potential client numbers get reduced, and that's not good. The reinsurance piece is generally easy to get into and hard to do well over the long term. There's always a chance that a few players can do some irrational things and disrupt the market for a little while, as you're seeing already. If the government decides that it wants to be a medical reinsurer, that will impact our plans.

Just like our clients who desire to grow their business, we all strive for growth as well. There's pressure at these organizations to keep writing business in order to preserve their jobs or even to grow at the expense of profitability. The biggest tool the reinsurer has is that it can say "No." Reinsurers can refuse to participate in the market, or they can even exit the market until the price-to-risk ratio gets a little out of balance. But there are some competing forces, because the reward system is a little different. Reinsurance underwriters generally aren't specifically compensated for business that they don't do. I have never paid an extra bonus just for saying, "Thanks for not doing that other program." The challenge in this industry remains whether we can remain maintain discipline during a downturn. Of course, we're all going to say that we will.

It's not all gloom and doom. There are plenty of interesting opportunities out there. I find it interesting that the big spurts of innovation and change seem to come from government initiatives. I find that fascinating. The Medicare Modernization Act has provided a number of different entities, including start-ups, with the opportunity to grow and develop new concepts and products. That, in turn, gives us some opportunities as well. In the disease management world, with initiatives like Medicare support, there may be some needs and synergies.

The interesting thing about disease management and reinsurers is that we understand that six core morbidities drive a lot of the same large-claim activity: asthma, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, diabetes and kidney.

When you see large players start to consolidate, what generally happens is that interesting niches fall out of it. Those niches can be exploited by certain players in the insurance market and the reinsurers consistent with that.

In addition to the association health plans, you may have also seen that there's

some initiative to have programs choose by which state they want to be insured. Initiatives like the accountable health plan, depending on what they look like, when and if they ever come true, may provide some opportunities in the reinsurance space.

To me, this business is a fascinating and challenging one. If the last 10 years or so have been any indication, I think that the predictability of the business will continue to be twain. But I hope we'll enjoy its dynamic nature instead of being afraid of it.

MR. HOBSON D. CARROLL: You used the term "irrational" when you were referring to some competitive actions. Greg, can you expand a little on the term "aggressive pricing"? In my experience, anyone who had a rate lower than mine was being aggressive. But I'm wondering if "aggressive" is a euphemism for "loss leader"?

MR. DEMARS: I would agree with your assessment that "aggressive" meant anybody who is underneath us. The market is amazingly predictable with where the rates are going to be on most of the business. Experience and rate are very closely correlated, and so when you see wild swings from that, it really stands out. We've seen a fair amount of that. I don't know what they were looking at differently than us. You're getting the same information. But it's that type of activity that people see in all of these markets that we participate in.

UNIDENTIFIED SPEAKER: I always thought "irrational pricing" was the carrier who could figure out which case I was making money on and figure out a way to write it at a lower premium than mine. I think that there are a lot of definitions to that. But we see it.

FROM THE FLOOR: Michael, you were talking about how challenging it is to forecast trend and to figure out what kind of trend to use in pricing. I wonder if you could give us some insight on what methods you would recommend and where to look to find first-dollar trend and so forth?

MR. WOZNY: I'm no actuary, but it makes sense to look across a large number of sources of information, whether it be government resources, trend studies that are done by various producers out there or even going to your reinsurer. We get a lot of great information about what's happening from a trend perspective from our reinsurance markets.

UNIDENTIFIED SPEAKER: I'll answer that a little differently. I've seen a lot of tools designed by a lot of companies, and, in particular, by actuaries and other managers who are watching and monitoring their business. I would say that in terms of the tools, they're not all that bad. What I've noticed is that what actions happen as a result of those tools is probably the more important thing. We probably have all seen this.

Let's say that the numbers that come through are not quite as good as you expected. Your leveraged trend is 22 percent, and your increases are 15 percent, so then you go into a state of denial. There's something wrong with the model. The actuary's completion factors are wrong. Trend isn't right. Then you go through this phase where the evidence looks even stronger that things aren't going right. Then the selection bias kicks in. Well, if we didn't have this large claim or if they didn't write this class, we'd be fine. Then, of course, it gets a little worse, and you take some small remedial actions and you say, "Well, that's going to be enough to do it." All the while, in many cases, these models were pretty much telling you what you needed to know.

MR. HARRY L. SUTTON: John, I was interested in your discussion about layering and looking at layering to discuss with people how you might take advantage of changing limits of top or bottom. I had two questions. One is, when you look at that, do you show that data to the carriers from whom you're asking for bids so that they might know that you're recommending that a change in covered layer might lower the cost or increase the cost and ask them to take that into account? Second, in that whole list of everything you did, there was no question of what the commissions are likely to be and whether they change or not depending on whether they do what you want.

MR. GALBRAITH: Generally, layers don't come up in the discussions that we have regarding the data or with the ceding company. We do use those, particularly when we're talking about layering and whether the attachment point should be increased. What could the impact be? It's quite interesting to see the differential in pricing that various reinsurers will have based on their view. When you talk to them about what they do, they will tell you. Patrick will tell you that they've got a manual rate by band, and they've got to adjust that for the mix of business. If they think that that one large \$2 million claim was an outlier, they may put their manual rate in for that, rather than the actual claim cost, to see what that does for the rate. I haven't had as much technical discussion on some of those things as I have with Patrick and some of his colleagues. ING Re will model it by deductible point to see if that sloping curve that Patrick had is consistent with what they see. Therefore, the more consistent it is, probably the tighter they feel their risk margins have to be.

With respect to commissions for reinsurance brokerage, Guy Carpenter has a full transparency of doctrine. It keeps getting bigger. Essentially, before we get quotes, it's disclosed. We'll now have a year-end letter to the clients telling them what the annual commissions will be. We talked about trends here. You'll notice that I didn't talk about trends for reinsurance brokers. I think that long term that's going to be good for everybody. I think that it's going to provide the transparency that people are looking for. We're going to have to strive to provide value in the deal, in terms of the advice that we're giving and the analytics. We take advantage of analytics and relationships. It is the same game, different year.