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GROUP ASO AND MINIMUM PREMIUM PLANS

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A discussion of recent activities in the group insurance field regarding alternative methods of funding. Specific topics will include:

1. Background - the need and motivation for adopting such plans

2. Administrative Services Only Contracts

3. Stop-loss provisions

MR. STEPHEN E. WHITE: In increasing numbers, employers are implementing alternative means to fund their group benefits. Of great interest to us all are the reasons for this trend and the employer deliberations before the selection of one funding mechanism over another. The basic reasons for the trend toward alternative funding are well-known:

- Cost
- Cash flow
- Risk management

Several provisions have been introduced by insurance carriers to meet the cost and cash flow demands: premium drags, retrospective premium, limited liability LTD, and minimum premium. Interest rates on carrier-held reserves have increased. Where allowed, many carriers will amend contracts and release extended maternity reserves. Many policies provide for continued payment of life premium on disabled lives instead of requiring large waiver of premium reserves.

While these provisions can markedly improve an employer's cash flow, considerable room is left for reducing the cost. To do so, however, a careful analysis of risk is required. This analysis is facilitated by looking separately at the short-term risk and the long-term risk under a fully experience-rated policy.

As long as he stays with one carrier, the large employer bears the entire cost of his group benefits. Typically, this employer changes carriers only due to high retention or poor claims service. He views his carrier relationship as permanent and, on that basis, feels that he bears the entire long-term risk.

The short-term risk is well understood by the employer. He knows his maximum cost over the next year and can appreciate that guarantee. However, some employers analyzing risk see two factors limiting the value of insuring the short-term risk:

- Over the last 10 years, he may have seen his dividends or retroactive rate credits consistently near 10% of premium. The cash flow problem can be solved with a retrospective premium arrangement, but he would still ask, "Is the carrier assuming any significant risk?"

- Perhaps the employer had one or two poor years recently, but found that his premium rates were increased sharply at the next renewal rating. The full deficit was recouped in the following year, leaving this employer with simply a one-year deferral of the additional cost of his benefits.

The presentation of these situations is not intended as criticism of the insurance industry. While we as consultants have been striving to reduce carrier margin and trend assumptions, all of us recognize their necessity. The large employer also accepts the general underwriting principles, but often feels that, under his carrier's current renewal rating method, only a minimal insurance element exists in his group insurance policy.

One can trace the roots of this problem to the employer demand for full experience-rating. Perhaps we have come full circle to the point where large employers will seek some pooling of their experience. This is doubtful, although some employers might be willing to exchange higher risk charges for lower margins. However, as corporate policy has shifted toward increased employer risk assumption in the areas of theft, fire, and liability insurance, indications are that the short-term risk associated with group benefits also will continue to shift to the large employers. The long-term cost reduction due to the elimination of premium taxes and risk charges and to increased investment earnings on reserves is in many cases worth the assumption of short-term risk.

Naturally, not all large employers have moved to self-funding. The reasons vary:

- The employer may not be willing to assume the short-term risk. This problem can be alleviated somewhat by purchasing stop-loss coverage.

- Historically, the legal status of self-funding has been questioned. This problem has apparently been clarified by the Monsanto case and ERISA preemption.

- Labor agreements may specify that insurance will be provided, however, benefits for salaried employees can still be self-funded.

- Defense of benefits-related lawsuits would rest solely with the employer. A clearly defined payment policy coupled with an adequate appeals process mitigates this problem.

- The Connecticut benefits tax can eliminate any savings on Connecticut employees. ERISA preemption might not apply to such taxes, although it is being tested in court. If the tax is allowed, other states will surely follow Connecticut's lead, but such taxes could not be applied retroactively.

- Employee conversion rights might not be available to a self-funded plan. However, many carriers provide such rights as long as other coverages are insured with that carrier.

With these problems in mind, we might expect fewer self-funded plans and more Minimum Premium plans. Although some savings can be realized through Minimum Premium, problems do exist:

- The status of premium tax is uncertain. While it appears that Metropolitan will win its initial California court battle on this point, the state will appeal, and the final outcome might still be that bank deposits are subject to premium tax. Such an interpretation could be applied retroactively in other states, representing a large build-up of a hidden liability.

- For some stock insurance companies, the reduction in premium reduces the 2% of premium U.S. income tax deduction and consequently increases the retention charge for federal income taxes.

Two additional points have been raised by some as key elements of self-funding that are not found in a Minimum Premium or insured plan. However, in most situations these factors appear to be of secondary importance.

- ERISA may exempt self-funded plans from state-mandated benefit provisions. While abuse could develop, the large employer generally is responsible and sees this flexibility merely as an opportunity to simplify administration.

- Claim control programs can be more effective. This may be rationalization more than fact since most programs could be implemented under an insured contract. However, an employer which dominates a particular city might reduce claim costs through bulk reimbursement arrangements.

After considering all of these points, the large employer who can assume the short-term risk is seriously considering self-funding some of his group benefits. The benefits chosen for self-funding vary:

- Many employers have self-funded part of their short-term disability income plan for years through salary continuance. However, federal income tax withholding is required which often discourages the implementation of self-funded weekly indemnity. An additional obstacle for many employers is the bonding requirement for self-funded state disability benefits.

- Medical benefits are often self-funded, and as dental plans become more prevalent and the costs become better understood, these benefits will more frequently be included.

- Federal income taxation of non-insured death benefits in excess of $5,000 generally rules out self-funded Life and AD&D.

Perhaps the most logical benefit to self-fund is LTD. The fact that LTD lags behind medical in the frequency of self-funding is due to preconceived notions about the LTD risk.

When viewed as a financial risk to many large employers, self-funded LTD is not as risky as self-funded medical. Certainly, the fluctuation in annual experience can be large when expressed as a percentage of expected LTD claims, but the dollar fluctuation would likely be smaller than the dollar fluctuation under the medical plan. LTD fluctuations can be dwarfed by the actuarial gains or losses under the pension plan.

In fact, it is probably a comparison to pension funding that best supports self-funded LTD:

- Positive cash flow to the fund for many years that results in a cushion for poor experience and allows a rational approach to the funding of a long-term commitment.
- Significantly higher investment earnings on large reserves.
- Avoidance of premium tax and certain other insurance carrier charges.
- Flexibility in plan design.

Self-funding is a significant element in the group market today and all indications are that it will become even more important over the next few years. While many employers are considering alternate funding, there is no rush to change the basic administration of group plans. Some employers have moved to third party administrators and others are now self-administering. But those employers who are satisfied with their carrier service have little desire to discard that relationship and consequently are quite interested in carrier Administrative Services Only Contracts.

MR. ALAN D. MACLENNAN: We have also become active in promoting and selling self-funded LTD plans. I completely agree with Steve that employers and segments of the consulting and brokerage fraternity, tend to think that LTD is an extremely volatile and risky coverage that is not appropriate for self-insurance. But cash flow patterns indicate that there is virtually no possibility that the plan could become bankrupt, even within five years, even if the experience incurred is 200% or even 300% of expected on a paid basis. In that perspective the LTD benefit is not quite the risk that most people think it is.

MR. CHARLES F. LARIMER: When a company is on the downturn, they often get more LTD claims, and that is when they can least afford them. How do you relate self-funded LTD to this economic factor ?

MR. WHITE: A declining company would clearly have problems with a pay-as-you-go plan. This is but one reason that self-funded LTD should be fully funded through a trust. Five-year amortization of an experience loss produces an increase in self-funded contributions similar to the increase in premium had the plan been insured and underwritten on the basis of experience over the last 5 years. Consequently, the employer would have the same difficulty meeting insurance premium payments. Of course, there does exist a significant distinction between insured and self-funded plans in that benefits under the former are guaranteed should the employer become bankrupt.

MR. LAURENCE M. SWERDLOW: I'd like to spend some time discussing the various types of "pure" ASO arrangements available, as well as several actuarial aspects of ASO's. My presentation will be based primarily on the practices of one large East Coast Mutual company, but I expect that these practices are reasonably representative of the industry in general.

Eligibility

Eligibility for ASO offers is restricted to the larger size groups. As a rough guideline, we require that the group should be expected to produce annual incurred claims under the coverage involved of at least $500,000 to $1,000,000 depending on the types of services to be provided. Some other companies may be willing to write ASO's on groups with lower expected claims. In addition, the claim paying locations should be compatible with our benefit offices, the banking arrangements should be satisfactory, and the group should have a full understanding of the financial implications - funding requirements, cash flow considerations, etc. - inherent in a self-funded benefit plan.

Types of Services Available

Basically, two types of ASO arrangements are available: claim services only and full services.

The claim services only arrangement includes claim review, benefit determination and payment, and associated claim administration services such as:

a) notifying the claimant of a rejected claim
b) discussing a claim with a physician or other provider
c) obtaining COB information
d) certifying coverage to providers
e) preparing and printing standard claim forms

On the other hand, the full services arrangement provides substantially the same services which would be provided under a fully insured plan. The one major difference is that legal defense is not provided under an ASO if an employee or dependent of an employee sues for benefits under the plan. Under an ASO, the employer establishes the rules for determining benefits and the ASO provider is only his agent. Examples of services provided under a full services arrangement but not under a claim services only arrangement include the following:

a) development and maintenance of premium equivalents, i.e., the premium which would have been charged under an insured plan.
b) review of experience trends with the client.
c) analysis of the effects of changes in plan.
d) provision of runouts of incomplete and unreported claims and estimates of the employer's liability for incurred and unreported claims.
e) design and printing of the plan document.
f) establishment and implementation of procedures for obtaining exposure data.
g) design and printing of booklets.

Finally, the following services are provided, at the option of the client, in conjunction with either a full services or claims services only arrangement.

a) maintenance of employee eligibility records
b) provision of a conversion privilege
c) review and approval of statements of health on late entrants and on requests to reinstate health maximum benefits
d) provision of special claim reports and studies

Transfer of Existing Insured Case to ASO

As is normally the case with a newly issued group insurance contract, a newly installed ASO arrangement usually applies to claims incurred after the effective date of the agreement. However, groups currently insured often desire to pay all claims which are issued or cleared after the effective date of the ASO arrangement through the ASO employer plan bank account regardless of whether or not they were incurred under the terminated group insurance policy.

To implement this procedure, we require a letter from the group agreeing to reimburse us for any runout claim submitted to us for payment. In exchange for this, we are willing to hold zero I&U reserves in the final dividend calculation for the terminated coverage. The amount of the reimbursement is of course limited to the reserve that would normally have been held.

Pricing

Basically, our approach to pricing relies heavily on various types of retention charges made to insured groups. A major difference, however, is that retention charges in dividend calculations are determined retrospectively while ASO fee rates are prospectively set. This means the ASO rate must recognize the possible effects of inflation on expense rates.

The most significant cost element is the claim expense charge. This is determined by applying a per claim charge to the expected number of claim payments, where the per claim charge is consistent with the corresponding retention charge made to insured groups adjusted for inflation to the midpoint of the ASO contract year. The expected number of claim payments is usually estimated by dividing the expected claim dollars by an average amount per claim payment. If the group's own experience is available, the average size claim payment is determined from that experience; otherwise we have standard assumptions depending on the plan of benefits. Specifications often include the number of payments to be assumed, but we have found that at times this number appears to be impossible given the number of employees, expected claim dollars, and plan of benefits. In this situation, our rates will usually be based on our own assumptions, but we will also show for illustrative purposes, a second rate based on those of the consultant. Another possible problem is the exact definition of claim payment. For instance, some carriers may count claim drafts while others may count coverage payment; that is, one draft reimbursing for both a hospital and major medical claim would count as two payments. Levels of claim expense charges also reflect whether or not employee eligibility records are to be maintained by the employer or by the insurance company.

Other elements of ASO charges are charges for administrative expenses and for contribution to surplus. The administrative expense charges are essentially the same as those made to insured groups, except that the ASO charges

reflect the fact that certain services, such as dividend calculations, are never provided under an ASO. The charges are determined in the same manner as on an insured group (i.e., by applying a decremental scale of expense percentages to the equivalent premium on an insured basis). For our largest clients, we will base their fees on cost accounted claim expenses. This is usually accomplished by determining a group specific cost per claim from our biannual claim expense study. Similarly, we will cost account exceptional administrative services, but will set non-cost accounted rates for the standard administrative services previously described.

Our price is usually expressed as a percentage of paid claims. This basis has an advantage in that if all other parameters remain unchanged, the impact of inflation will operate to increase claim dollars and therefore to reduce the percentage rate for administrative expenses and contribution to surplus. This, of course, helps to minimize renewal problems. In addition, we will consider making available various alternative pricing bases to meet the needs of various clients. These alternative bases include various combinations such as percent of claims for claim expenses and per employee for other expenses.

Rates are recalculated at renewal and at the time of a significant plan change, i.e., one which is expected to result in a significant change in either the expected claim dollars or the expected average size claim. Renewal rates are in a sense "experience rated" in that the average size claim payment used in estimating the expected number of claim payments is determined based on the group's own experience, with appropriate recognition of the impact of inflationary trend and plan features such as deductibles on the average size claim payment.

Legal and Tax Aspects

As Steve mentioned, ERISA appears to pre-empt self-funded plans from state insurance regulation, and would thus appear to resolve the previous uncertainty as to the status of ASO plans under state insurance laws. Of course, ASO plans are subject to the reporting and disclosure, fiduciary responsibilities, trust, and other requirements of ERISA.

The effect of ERISA is not clear when it comes to the question of taxation of self-funded welfare benefit plans. The pre-emption provision refers to state laws which regulate insurance companies. Presumably, taxation is a form of regulation. However, a state might impose a tax on self-funded plans without deeming the plan to be an insurance company. Because of the uncertain tax status, we require a "hold harmless" letter as an integral part of each ASO offer. In this letter the employer agrees to indemnify the insurance company for any taxes levied against the fee the employer pays.

MR. WILLIAM E. NEAL: It looks like ASO might be a good device for employers to use to avoid certain mandated coverages, such as pregnancy or abortion coverages. If the trend to ASO progresses, won't state legislatures recognize this and either bring them under or pass specific laws to cover them ?

MR. MACLENNAN: It is the intent of public policy and the regulators to lay down certain requirements with respect to benefit programs including mandated benefits, benefit extensions, and so forth. To the extent that public policy intention is thwarted through self-insured plans which do not conform with mandated minimum benefits, it does invite regulation and legislation.

Our particular point of view is that self-funded employers should conform to mandated minimum benefits. We are not always 100% successful in taking that position. We haven't found that an employer's motivation in adopting a self-insured plan really has very much to do with avoiding mandated minimum benefits.

MR. WHITE: There certainly is potential for abuse, but a lot of these provisions can be handled quite well through discrimination legislation. For example, there is no way to avoid pregnancy-related disability income benefits in states with labor laws requiring such benefits.

My experiences have been primarily with large employers who are quite responsible. Whereas they feel there might be some places to cut corners now, they don't feel it is fair to their employees. They are often looking at their benefits plan as a tool for attracting and retaining employees. In addition, these employers realize that if abuses do develop, then the U. S. Congress is likely to step in to correct that situation.

MR. ANTHONY J. VAN WERKHOOVEN: Do you require the "hold-harmless" letter as standard practice or is it only required in states where questions have been raised ?

MR. SWERDLOW: We require it in all states.

MR. VAN WERKHOOVEN: Do you also prepare an illustration for policyholders as to what the experience would have been on an insured basis ? Is there any demand by policyholders for that type of thing ?

MR. SWERDLOW: We have not seen too much of it. On what we call a full services arrangement we will maintain equivalent premiums and so would provide such an illustration.

MR. WHITE: The employer may also want to know the outstanding liability for incurred and unreported claims, particularly if a 501 (c) (9) trust is used, or if it is required for the corporate financial statement.

I would like to make an additional comment on the "hold-harmless" agreement for state taxes on these plans. It would appear that the only way ERISA would allow taxes on self-funded plans, if in fact the court cases support the Connecticut approach, would be to tax the employer directly. A premium tax levied on an insurance company is almost certainly pre-empted.

MR. TED L. DUNN: Larry, you said that your typical approach for expressing the expense of the claim settlement function was as a percentage of claims. How do you respond to the assertion that the cost of paying the claims in future years should not go up as fast as the cost of medical care goes up ?

MR. SWERDLOW: If we use the percentage of claims basis, all other things being equal, the percent would go down, which implies that the expenses are going up at a lower rate then the claims.

MR. DUNN: But you indicated that this has simplified your problem at renewal, and I gather from that that you almost have to renegotiate the expense rate for each renewal.

MR. SWERDLOW: That's true. When the renewal rate does not go down this is usually because of differences in the average claim size assumption. The renewal assumption is based on the group's own experience.

MR. DUNN: In transferring reserves on an existing group insurance plan that transfers to ASO, the typical approach at the Provident is to refund the funded claim reserve, this being the amount of statement claim reserve less the experience rating deficit. The reason most of our policyholders that have gone to ASO want to do this is because you effectively save the state premium tax on the amount of the claim reserve. Do you handle arrangements in the same manner ?

MR. MACLENNAN: In most cases we transfer over the funded reserve, just as you do. The reserve arrangements that we would have under a fully insured plan might vary. In some cases we have arrangements with customers where we will refund any redundant reserve after termination and simply swallow any deficiency in the reserve. In other situations we would return any excess and recover any deficiency, so that what we would do coincident with conversion to an ASO would in some measure depend on what our arrangements were in that regard.

There is increasing resistance to expressing all of our expenses on an ASO program as a percent of claims. This is because there is an assertion on the part of some customers and brokers that the insurance company is benefiting through virulent cost inflation on medical care at a rate that outpaces the normal cost inflation on their clerical salaries. It seems to be leading us towards an expression of our expenses on a per employee basis per month as opposed to a per claim or other basis.

MR. MACLENNAN: When I volunteered to talk about stop-loss at this meeting, I thought that it was time to get my company's act together. One of our people had run into an insurmountable problem and had phoned a friend in another company, and the fellow at the other company said he didn't know much about it either but that one of their people was going to an actuarial convention to find out how to do it.

About 5 or 6 years ago we reluctantly got into the ASO market, and our motivations were purely defensive. One of our largest policyholders was threatening to terminate if we didn't offer an ASO basis. So we did. The policyholder terminated a year later. Our product and understanding of the business was quite limited. Almost in spite of ourselves we now have 25 cases averaging $800,000 annual claims each. Over the next 5 years we are targeting towards achieving a 30% no-risk component in our health portfolio, chiefly by virtue of higher ASO sales and the conversion to ASO of existing accounts.

Last year we reached a deliberate decision to change our entire outlook and policy as respects this business. Rather than viewing ASO business as a defensive necessity we have come to regard it as an offensive possibility. We are trying to develop an enhanced ASO capability consistent with this new position. Here are a few of the more fundamental considerations which led to this position:

1. We are moving to a basis of financial management which defines a level of required shareholder equity for each line of business with an associated target return on equity.

The nature of ASO business, even with stop-loss, is such that the amount of equity per square foot of business is lower than for conventionally insured business, at least in our opinion. Also, it is currently providing a very attractive return on equity.

2. A high proportion of our shareholder earnings are derived from Group Life and Health. Earnings stability from year to year is important, and ASO is one part of an overall plan to reduce the risk of our portfolio and stabilize earnings - without reducing our return on equity.

3. As with many other companies 1976 and 1977 was a difficult environment for us on the renewal side. Central to the renewal sale is the provision of benefit and funding alternatives to the customer. ASO and other no-risk alternatives were important in our arsenal of renewal alternatives, and conversion to ASO allowed us to retain considerable business which might otherwise have been lost.

4. For various reasons the market is trending to self-insurance and a stronger presence in the ASO market seemed necessary if we were to continue to increase our market share.

Our efforts to develop an enhanced ASO capability emphasize two points:

1. Provision of full administrative services
Superior in completeness and quality to those that are offered by third party administrators (but not necessarily in cost). We think very highly of our claims service in terms of timing and claims control savings. A greater emphasis of this capability together with an enhanced claims statistical analysis is part of our plot. We also plan to emphasize one stop shopping - from assistance in legal documentation, to booklets, to actuarial/costing services - which many third party administrators or smaller employers simply cannot provide. Apart from its advantage to the customer, I believe that if you attempt to price a multitude of services individually, there is a substantial probability that you will fail to recover your expenses.

2. The provision of a full range of insurance features
Life, preferably on a non-refund or fully-pooled basis is mandatory. In addition we offer health conversion and specific and aggregate stop-loss.

So finally I get to the subject at hand - ASO stop-loss. Why did we view an improved stop-loss capability as important?

- We think we can make money to supplement profits on the service side.

- It is consistent with our emphasis on one-stop shopping and will allow us to compete more effectively with third party administrators.

- Stop-loss broadens the market for ASO down into the smaller case sizes and less sophisticated brokers who may be largely ignored by the major companies.

- Finally, on a philosophical note, as an industry with a monopoly on insurance services, we felt in a very fundamental way that we should trade heavily on insurance features such as stop-loss.

> Our unique identity as an insurance company and our ability to compete with pure service organizations can only be enhanced.

In the development of premium rates we analyzed one years' claims experience on our entire block of U.S. medical care business, which took up roughly $150 million of paid claims. An individual claims frequency distribution was developed, and aggregate stop-loss premiums calculated using a conventional Monte Carlo approach. These were then loaded for contingencies and profit. (Incidentally, both our specific and aggregate stop-loss relates to paid claims within a policy year.)

We have reasonable confidence in the pricing of specific stop-loss. While there are certain imponderables such as inflation, and more important the increasing frequency of new and expensive medical treatments, these don't seem to me un-ratable.

However, my view of aggregate stop-loss is somewhat different. The pure statistical cost is nominal on a case of any size. What you are really rating is the risk or indeed the probability of occasional underwriting misjudgment. And if you do make a mistake, unlike conventionally insured business there is no deficit recovery mechanism. So my advice is to beware the pitfalls in disaggregating the investment, expense, and morbidity components of pricing. A purely statistical approach can be misleading.

In terms of underwriting rules, we require both individual and aggregate stop-loss on smaller cases. Most larger plans are written with aggregate stop-loss only. The attachment points for specific stop-loss can be selected by the customer within wide limits (up to 25,000 or even higher). With respect to aggregate stop-loss, we pretty well specify the level depending on case size, the availability and quality of prior experience information and other underwriting factors. However, we would not quote less than about 110 to 115% of expected claims. Generally we reimburse 100 percent of claims exceeding the attachment point with no upper limit. In some cases we may reimburse only (say) 90 percent of excess claims.

There are a few potential pitfalls which have to be covered off in underwriting or contract design.

1. The prior carrier's benefit extension is important in establishing the first year stop-loss levels and pricing.

2. Month by month claims experience should be followed closely, especially in the first year. A timely and well judged renewal is just as important, if not more important than on fully insured business.

3. The renewal of individual stop-loss should reflect the heavy price compounding effect of a fixed attachment point in a circumstance of rapid benefit cost inflation.

4. Contract design should be attentive to the impact of a decline in the size of the group such as may result from the spin-off of a division or a strike.

5. Benefit amendments obviously affect the level of claims and should be accompanied by a change in the attachment point.

6. Accounting should be based on a full twelve months, with no off-anniversary accounting should the customer terminate the contract at his option on other than an anniversary date.

Turning now to the legal aspects, we have had earlier versions of our stop-loss contract filed and approved in several states. Now we are in the midst of a general filing in all states, and I cannot yet report completely on our success. Basically the issue here revolves around the question of whether the stop-loss contract is:

1. a reinsurance contract, in which case my understanding is that it is not subject to any state filing, or

2. an indemnity contract, in which case the company must have general power to issue such contracts, or

3. a health insurance contract, which it may or may not be depending on the particular state law and the interpretation placed on that law by the state.

My company has filed our contract as a health policy, an approach we think will be successful in the areas that we are most active. From our experience and that of others, I believe that Arkansas, Florida, Maine, Pennsylvania and New York, will approve the contract only as an indemnity contract. Georgia and Mississippi will probably not approve it as either an indemnity contract or a group health insurance contract. Some states are still a question mark. For example, we have had difficulty filing in Michigan on a health insurance basis whereas there are other companies that have had no difficulty at all. Pennsylvania and Florida apparently take exception to the reinsurance approach.

MR. DUNN: When a group case has a substantial lay off, the remaining lives in the group can be expected to have a higher claim level. Would you just pay off on the stop-loss under this circumstance ?

MR. MACLENNAN: No. I referred to that as one of the points to watch in contract design in particular. We would lag the exposure. This means that the exposure as contractually defined for a particular insurance month would relate to the greater of the number of employees insured in the previous month or the number that were insured four months previous. So that does cover you off in the event that the group declines in size. Furthermore, a grandfather provision could be inserted in the contract to the effect that if the group increased or decreased in size by more than so much percent in so many months, that you had the right to re-establish the attachment point and the pricing.

There are a number of things that can happen that don't necessarily involve an amendment to the plan that can cause you difficulty on stop-loss side. For example, you could have a situation where midway through the year the employer changes the contribution basis of the plan and that gives rise to a significant change in dependent participation. You do have to have some flexibility in case the ballgame changes for reasons like that.

MR. THEODORE W. GARRISON: I worked out some aggregate and specific stop-loss premiums using a somewhat different method. Based on my study I came up with considerably higher stop-loss premiums than those prevailing in the marketplace.

Consequently, we've been making these quotations on aggregate and specific stop-loss coverage, and have not been selling any business because the rates which came from my studies appear to be higher than what most other companies are charging.

MR. HENRY W. SIEGEL: First of all, the fact that your rates are uncompetitive doesn't necessarily mean they're wrong. My observation of stop-loss rates in the marketplace suggests that there are a lot of people in it who don't know what they're doing. There aren't enough people in the market yet to be sure that the market price is the price that ought to be charged.

MR. MACLENNAN: I second that. There are a few companies that at least in our opinion do not know what they're doing, and their prices are out of court. Our specific stop-loss premiums also seem very high in relation to competition. I won't pretend that they're absolutely right. They are based on a significant claims exposure, but even so only a small percentage of them are over $25,000. That is still significant if you believe your own claims experience is indicative of the fundamental character of the business that you're writing.

The pure statistical claims cost on aggregate stop-loss is quite nominal, something like a quarter of one percent. Up around 1500 lives or so, we would never charge a quarter of one percent because this pure statistical cost is misleading. What is being priced is underwriting misjudgment, whether it is predicated on, or whether it derives from, inadequate or incomplete experience information submitted at the date of quotation, or just plain error.