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HEALTH REINSURANCE

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- Retentions/stability of net experience.
- Underwriting/facultative and automatic.
- Valuation/adjustments for modern benefit features.
- Claims administration/interface of reinsured and reinsurer.

MR. EMANUEL HALPERN: Health reinsurance can mean many different things because there are many different health products. Most if not all of them could be reinsured. Why would any company wish to reinsure its health business? It may want to pass along part of the risk to another company in order to avoid an unusual drain on its surplus. Why disability income? Disability income insurance rarely results in a huge cash outlay at any one time but the reserve requirements on even an average disability income claim could be formidable for a moderate-size company. The disabled life reserve for a male who was disabled three years ago at age thirty-two under a disability policy paying $1,000 a month to age sixty-five, according to the 1964 CDT table at 3 percent interest, turns out to be $105,280. On the new DTS valuation table, the same reserve turns out to be $140,764.

A company may not be primarily a health insurer but markets an individual health line of business. That company might appreciate the help of the reinsurer's experience and expertise in one or more areas: (1) product design; (2) rates and rating structure; (3) help in filing the forms and rates with state departments. (It's a whole new ballgame for disability insurance.); (4) actuarial help for valuation purposes; (5) help in underwriting disability (this also has unique problems); (6) policy administration; and (7) claims administration, where determining whether or not a person is disabled could be tricky, depending on your definition of disability. The services of a reinsurer could therefore range all the way from accepting the excess risk that a company doesn't feel comfortable carrying to virtually a turnkey operation. For example, the reinsurer can furnish its client with generic policy forms,

generic rate books, underwriting manuals, occupation manuals, and other materials. The reinsurer may undertake training of the ceding company's underwriting personnel or claims administrative personnel, either at their own home office or at the ceding company's location.

Retention. The reinsurer and the originating company must negotiate mutually acceptable retention and binding limits. The ceding company would like the binding limits as high as possible and the reinsurer must feel comfortable with their request. The binding limits are frequently expressed as a multiple, such as two times or three times the originating company's retention. It may be higher for plans with shorter benefit periods and may be limited for substandard or rated cases. All cases above the binding limit are submitted facultatively, while others are automatic. The reinsurer and the company can also negotiate whether the claims are paid automatically or if they must be approved by the reinsurer before payment. Whether or not the claims are automatic and whether or not the acceptance of the risk is automatic need not involve the same criteria. Automatic privileges are largely a function of the comfort the reinsurer feels with the experience and knowledge of the ceding company's underwriting staff and claims administration staff.

Valuation. The reinsurer has to have a valuation system flexible enough to handle all the various benefits and forms written by different companies as reinsurance is accepted. If the reinsurer also writes direct business, it could integrate its reinsurance valuation with its direct valuation or it could have two separate systems. If they are to be integrated, flexibility is even more important. Valuation of modern benefits is interesting in disability income because so many differences are encountered these days.

(1) Pure income replacement. This is written by some companies in place of traditional disability. Many companies just reserve pure income replacement the same as regular disability. Others will consider that there is a little additional risk for payments due to partial loss of income, which would not be present under pure disability, and will increase their reserves by some arbitrary factor to take care of this.

(2) Partial disability or residual disability (the proportional type). If this is an optional rider on your basic policy, there's almost always a specific additional reserve for it. If we have residual disability with zero-day qualification, it becomes close to pure income replacement.

(3) Social insurance offset. There are two forms, the all-or-nothing concept and the dollar-for-dollar concept. We can treat them both the same as long as the amounts issued under this rider or this benefit are appropriately limited. The technique splits the benefit into two parts before the actual start of the social security payments and after. The part after the start of social security payments should be multiplied by a factor which is meant to represent the probability of not receiving social security, but still being qualified as disabled under the policy.

(4) Cost of living adjustments. This is a popular benefit which poses unique reserving problems. Cost of living requirements could be either

indexed or automatic and may or may not have a yearly or overall cap. Company practice in setting reserves on cost-of-living adjustments (COLA) benefits vary widely. Some companies set up no additional reserves on the theory that if there is inflation, it will bring higher interest rates, and the increased earnings will take care of the additional benefits. This is not appropriate if the benefit is automatic. Full additional reserves for the maximum benefit is the other extreme. An intermediate position applies a judgment factor to represent the probability that the maximum benefit will not be paid.

(5) Regular occupation endorsement. This is usually ignored for reserving purposes, but you could provide for it by increasing the morbidity incidence rate of your valuation table.

(6) Unisex rates or nonsmoker discounts, and other types of discounts. These are usually not provided for in the reserves.

(7) Guarantee of insurability. Theoretically, we should provide for this by taking the difference between the select and ultimate morbidity. However, valuation tables usually cannot provide for select morbidity. We can either try to get a select table, and estimate what the difference would be, or ignore it.

The most popular method of disability reinsurance is coinsurance. Under that method, the rates are a proportional part of the rate charged by the ceding company, less an expense allowance. The expense allowance is usually heaped in the early years. The reinsurer sets the expense allowance accounting for the commission scale and expense patterns of the ceding company as well as all of the following factors:

(1) The level of the ceding company's premium rate: If the reinsurer thinks that the company is not charging enough for its product, they will not be too generous with their expense allowance.

(2) The policy contract terms; They will examine the definition of disability, the existence of partial or residual benefits or pure income replacement, reviewability provisions, presumptive disability, guaranteed insurability options, cost of living benefits, and social insurance offsets.

(3) The underwriting practice of the company: These include issue limits, occupation classification systems, the physical criteria for underwriting, and the expertise of the underwriter.

(4) Claims administration: They will examine the company's administrative practices toward its claims and the claims experience.

(5) Retention formula: They will measure the risk the originating company is keeping.

(6) Administrative expense and complexity of the benefits: They will measure the administrative costs.

(7) Marketing thrust and target market: They will consider who is going to buy this product.

(8) Competition: This frequently determines the charge.

Other than coinsurance, extended-wait reinsurance is popular with individual disability, and the reinsurer will assume the risk only after a specified number of years, such as two or five years. In some cases, the ceding company will assume a larger risk during the first two or five years and less of a risk thereafter. The rates for extended wait reinsurance are set by the reinsurer. The reserves are determined by subtracting from the reserve for the full benefit period, the reserve for a similar plan with the extended-wait period substituted for the original benefit period. Other plans of reinsurance used for disability are the yearly renewable term (YRT) plan and the excess of risk plan.

MR. ANTHONY J. HOUGHTON: Some types of excess loss or specific reinsurance per person, are charges in excess of $25,000 or $50,000 per calendar year or per contract year usually on an all cause basis. Occasionally, one sees reinsurance on a per cause basis, which covers only the expenses of a particular medical problem, for which a deductible has been satisfied, with the benefit period running three or five years.

Reinsurance for the medical expenses of liver and heart transplants, which in the past have been considered experimental is being offered with full coverage and without a deductible. Many carriers now including these procedures do not want to bear the risk because of the lack of knowledge about the frequency or cost of the coverage. A reinsurance pool makes sense until the cost becomes predictable.

The third type of reinsurance involves coverage after a duration of confinement. Nursing home reinsurance might commence after the first twelve months in a nursing home. A reinsurer will pick up all, 90 percent, or 80 percent of charges after the first year through the fourth year of confinement.

There is a substantial lack of communication between ceding companies and their reinsurers. The ceding companies have not understood the arrangements for coverage, renewals, types of premium increases that might come into effect, when incurred claims would be the responsibility of the reinsurer, and when eligible people would be covered by the reinsurance contract. At inception of the reinsurance, there were often low premiums in effect and a low frequency of claims, so the reinsurance contract did not appear important. The ceding company was paying a price for peace of mind and did not expect much activity. But as the reinsurance premiums started to increase and some of these excess claims began to emerge, it became very important to determine the contractual arrangement exactly.

There is a need for complete understanding and written agreement between the ceding company and the reinsurer about the benefits that are included in the basic insurance contract and, therefore, in the reinsurance contract. This necessitates an exact definition of when

eligibility for coverage begins for individuals who are part of the group; when eligibility will end; what the definitions are of incurred claims; and what kind of extension there will be after termination of either an individual from the group or the group itself from the ceding company's book of business or when the reinsurance contract ends.

There are also problems related to the renewal practice of the reinsurer, both in the level of the premium increases and what happens if the reinsurer doesn't continue. This all involves the leveraging of trend factors, intrinsic to large deductibles. The trend factor for a $50,000 deductible will be 2.5 times the underlying trend for medical expenses. Therefore, a 30-50 percent increase is not uncommon. When the premium base is inadequate, the increase may be even larger.

In one instance, the reinsurance raised the premium in one year from $.50 to $2.15 for a $35,000 deductible and the next year, raised both the deductible and the reinsurance premium. With the deductible going from $35,000 to $50,000 and the premium going from $2.15 to $4.50, the net effect was equivalent to a 200 percent increase. The reason for these massive increases was an inadequate starting premium. The reinsurer had many other dealings with the ceding company and the excess loss medical reinsurance was not important financially at inception. Later, when the volume was larger and the reinsurer analyzed his book of business, it realized that those excess loss premiums were improper. Once the rates became realistic and financially important, the ceding company found that the contractual provisions were important because it might be changing carriers.

Another ceding company had a provision in its group contract excluding experimental and/or investigative procedures. When the reinsurance contract was executed, both the reinsurance and the ceding company would have believed that liver transplants were experimental and/or investigative and therefore would not have been covered. For a few years, that was a correct understanding, but eventually a time came when a particular insured needed a liver transplant. The ceding company decided that at this stage of medical development, the transplant was a proper procedure. They allowed payment for it, but the reinsurer refused to cover this reimbursement as a covered expense. The reinsurance position was that the ceding company was not obligated to pay for this expense under its contract because it had not amended the reinsurance contract to include transplants or paid the higher premium which would have been required.

Another company's specific coverage for transplants had no deductible but would pay 90 percent of all the cost of a transplant procedure. The question was when the transplant procedure began. The insured had a serious medical problem, was receiving medical care leading eventually to a transplant, and following the transplant, continued to have medical services provided. Some of the care after the transplant was related to or aggravated by the transplant. It is difficult to determine whether having to be hospitalized for a chest cold later on is closely connected with the transplant. Without policy language as a guide, it is impossible to determine the reinsurer's liability.

A ceding company had another problem with its nursing home reinsurance. They had instituted a policy which had a four year nursing home benefit, with appalling contract language. It was much too loose; they were going to have to pay a lot of intermediate and custodial care; and the four-year maximum period was going to cause problems. The company was not worried because they had inexpensive reinsurance for the period after one year of confinement. Nursing home policies, frequently have good experience during the first year, but then the claims begin to become more frequent and attain greater durations.

When the reinsurance company became aware of its growing liability for people who were in the nursing home and had not yet achieved the twelve-month deductible period but were becoming reinsurance claims, they complained about the claim administration. The reinsurance company was miffed because they hadn't read the contract carefully and possibly they hadn't had their own legal people review the contract. The reaction of the reinsurer was to raise the rates significantly and threaten to discontinue. As the reinsurance premiums changed from $1.00 a month to $2.50 a month to $4.50 a month, and with no future reinsurance coverage, they discontinued new sales but still had an in-force block of business to worry about.

In group contracts, disabled people present a problem. A new group reinsurer may not cover people who are not actively at work and the prior reinsurance will not extend coverage after the reinsurance contract is replaced. The reinsurance contract is not always the same as the basic contract. The reinsurer may cover retired lives except for lives who are retired because of disability.

In the partnership between a ceding company and a reinsurer on a multiple employer trust (MET) program or an Association Medical Program, I am taking the reinsurer's point of view. We have become involved in situations where there has been a financial problem with an MET program. The reinsurer may have offered aggregate stop loss to the ceding company for a very small premium. They will cover claims in excess of 75 percent when the target claims ratio for the ceding company is 65 percent which allows a 15 percent margin. At face value this does not appear to be particularly risky. The reinsurer believes that they are doing all right, then suddenly someone does the claim liabilities properly and the bad news is announced. The early growth in volume, select experience of the first few months of coverage, and inadequate claim liabilities disguised the adverse experience. The actual incurred claims turn out to be 85-95 percent of earned premiums. Then it is discovered that the ceding company did not have expertise in this area. They relied upon an administrator who convinced the ceding company that he could take a program marketed successfully and, just by raising the rates modestly, could generate great volumes of profitable insurance for this company. The company was convinced that this administrator knew what he was doing and they might have had an outside actuary give them some pricing information which they relied on. The pricing information may have been reasonable, but that did not guarantee the marketing, the underwriting, the claim administration, and the ongoing financial analysis. The problem has

been one of relying upon organizations which did not have intrinsic in-house expertise to handle this type of business. The reinsurers frequently did not use their own staff to review the financial analysis, nor did they use an independent consultant to monitor the activities and experience. The expert usually is called in when the problem is already apparent, and the bulk of the losses have already been incurred. Many people have not realized how dependent some of these programs are on the exact way they are being administered in underwriting, marketing, claim administration, and general administration. Nor have they realized how important it is to gather current statistical data on an incurred basis and to perform thorough ongoing analysis, so one can determine problems at an early stage.

MR. JOHN K. AHRENS: Prior to joining Lincoln National, I had assumed that all reinsurers were much the same, so that when it came to making a decision, price was the only factor. Even though there aren't a lot of group reinsurers, each is very different in many areas, and it behooves you to investigate and understand the differences prior to making any decisions. However, no two insurance companies are alike, so we scrutinize them also.

The direct writing company is called the ceding company, and it cedes business to the reinsurer. The reinsurer assumes the business from the ceding company. If the ceding company cedes business on a case by case basis, the reinsurer can accept or reject each piece of business. This is termed facultative. If the reinsurer assumes all appropriate coverage written according to the ceding company's underwriting rules at previously supplied rates, it is termed automatic.

Most reinsurance arrangements can be described by one of the following methods. Excess is the most common method in group under which the ceding company cedes risks in excess of an amount referred to as the retention level to the reinsurer. The term retention level is commonly used in life whereas the term deductible may be used more often in medical. The retention level represents the maximum claim for which a ceding company would be liable in a coverage period - not necessarily the maximum retention on an entire claim, since you could have overlap between two coverage periods. The reinsurer usually assumes 100 percent of the risk in excess of the retention level, but occasionally the ceding company may be required to coinsure and retain 10-20 percent in order to keep their interest in these large risks.

Excess risks are often divided into two categories: working excess and catastrophic or high limit excess. Working excess is when the ceding company's retention level is set low enough that many claims are expected to be reinsured. For medical, generally any deductible or retention level below one hundred thousand dollars per life would be a working excess. Catastrophic excess is coverage with low frequency and high risk. Some reinsurers will only cover catastrophic risks. The reinsurer would be more likely to suffer adverse experience under working excess coverage if the relatively high frequency of claims disallows a correct estimate of this risk.

Some excess medical agreements are on a refunding basis, especially

those at a working excess level. The typical refunding arrangement may be to cede all risks over $100,000 per person on a refunding basis, with reinsurance amounts in excess of $150,000 on a pooled basis. Refunding arrangements can vary in provisions and format as much as they do between group policyholders and insurance companies. However, in reinsurance, all of a balance generated is not usually returned to the ceding company. A refunding arrangement is not usually offered unless the amount of refunding premium is at least $400,000 annually.

Under the quota share method, the reinsurer assumes a percentage of risk, usually 50-90 percent, for a percentage of the gross premium charged by the ceding company to the policyholder. The reinsurer usually controls the premium rate to be charged. The percentage of premium which the reinsurer receives for its portion of the risk will almost never equal the percentage of the risk that it is reinsuring. The ceding company must be compensated for the expense of marketing, administering the business, and payment of premium tax. The amount which the ceding company can deduct from the reinsurer's percentage of gross premium is the ceding allowance. To the degree the ceding company can negotiate a ceding allowance greater than its actual expenses, it can significantly leverage the expected profit for a given risk and get a good return on equity.

Suppose a medical plan is being quota shared and the gross premium per employee per month is $100. The ceding company has negotiated a 25 percent ceding allowance from the reinsurer, and the reinsurer is taking 90 percent of the claims risk. The reinsurer would receive $67.50 ($100 x .9 x .75 = $67.50) per employee as premium and would reimburse the ceding company for 90 percent of all claims. Suppose claims are $70 per employee. The ceding company receives $32.50 per employee and pays $7 in claims, while the reinsurer receives $67.50 in premium and pays $63 in claims. If expenses are $25 per employee, the ceding company makes $.50 per employee or 10 percent of the total profit. The reinsurer would have a profit of $4.50 per employee which is 90 percent of the profit. Thus they are true partners. Suppose instead the ceding company's expenses were only $20 per employee but it still has a 25 percent ceding allowance. The ceding company would then make $5.50 per employee, which is 55 percent of the profit with only 10 percent of the risk, and the reinsurer would still make $4.50 but only 45 percent of the profit while taking 90 percent of the risk. The ceding company would have much less interest in the level of claims in this example. Because of this, the ceding allowance is usually the critical point under this method. The level of the reinsurer's rate should be important, also, since it will affect the competitiveness of the product in the marketplace.

Under a slight variation of the quota-share method, the reinsurer determines the net rate at once on its portion of the risk, and the ceding company may then determine what loadings to add to this rate for its proportion of the risk and for covering its expenses and profit. This can give the ceding company even greater flexibility in leveraging profits unless the reinsurer places a stipulation on how much loading can be added.

The third method is aggregate stop loss. Aggregate reinsurance is protection against total claims in an entire line of business or a specific block of business exceeding a specified level of claims. A ceding company may want aggregate reinsurance, so if incurred claims on an MET medical block exceed a 75 percent loss ratio when a 70 percent loss ratio is expected, the reinsurer absorbs the excess claims. In providing an aggregate, the reinsurer may require the same company to have excess reinsurance also, so only claims below the excess deductible are charged against the aggregate. Aggregate has not been a particularly attractive coverage for reinsurers because of its many potential problems, which are similar to quota share.

Many factors should be included in a decision on what retention level to choose for an excess reinsurance cover. The ceding company must assess the risk being ceded. The ceding company may perceive that some risks should not be retained because they are not fully understood, organ transplants for example. They may retain risks that they shouldn't because of a perceived lack of risk as in claims over $250,000. Because of the low frequency, many companies may assume that no significant risk exists and thus do not seek reinsurance when it may be prudent to do so. Choosing a retention level is also affected by the difficulty of knowing the actual risk. It takes about 400,000 certificates to be reinsured before one would expect to see at least one claim over $400,000. That's why it's difficult for people to understand that there really are large claims out there. Few group writers have that many exposures and do not see those claims unless the unexpected occurred. It does happen; a ceding company with only 3,000 certificates had a $450,000 claim.

Another factor is the perceived cost of reinsurance. Ceding companies may be much more willing to reinsure if they perceive that the expected benefits are to exceed the reinsurance premium. This can be dangerous for reinsurers, group actuaries, and underwriters. This occurs frequently with a product like excess medical reinsurance because it is so difficult for the reinsurers to price. Some companies may choose a lower retention level when the price seems low than if it appears their reinsurers have priced it to expect a profit. This is much more prevalent under nonrefunding reinsurance arrangements than refunding arrangements, since most of the redundant premiums from the larger margins are returned to the ceding company.

The reinsurer may have minimum requirements as to the retention level in order to reduce antiselection from the ceding company, spread risk, or cover expenses. For excess medical, the reinsurer may not allow a ceding company with $50,000,000 of group A & H premium to reinsure claims in excess of $25,000 per person because the company should be able to absorb much more risk. Therefore, the reinsurer may require the company to retain the first $100,000 per person because of concerns that the ceding company must see the $25,000 rate as a bargain. Another reason for minimum retention limits, no matter what the size of the ceding company, is that a reinsurer is not comfortable pricing a lower deductible. The level of surplus may also affect a company's decision. A small company may have to have a much lower retention than it ultimately desires because of a need to protect its surplus.

This is especially common for companies that primarily write group business and have not developed a significant surplus. Allowable yearly profit fluctuation also affects the decision process. Excess reinsurance can reduce the potential for significant fluctuation in a product line resulting from a few large claims. The lower the retention level, the more stability in earnings. However, the reinsurance costs could become significant. Deciding on the potential earnings fluctuation that can be tolerated is complicated for medical, since each person is usually covered up to $1,000,000, and the potential variation in actual from expected results from trend alone can be significant enough to adversely affect the bottom line.

A refunding approach can affect the retention level dramatically. It provides less risk transfer by the ceding company in return for lower potential reinsurance cost. Under a refunding approach, the ceding company should probably consider the refunding portion as part of their retained risk.

For less than $15,000,000 of group A & H premium the normal retentions for medical are in the $25,000 to $50,000 range. Between $15,000,000 and $40,000,000 of group A & H premium, retention levels of $75,000 to $125,000 are most common. Most companies with $40,000,000 to $100,000,000 group A & H premiums have about $150,000 of retained risk. Some of these average retentions have been affected by certain reinsurers who have gone with minimum retentions of $150,000. These companies that may have wanted something lower weren't able to get it which tends to increase the averages. Companies between $100,000,000 and $300,000,000 of group A & H premium tend to have retentions between $150,000 and $250,000 per person. Finally, for those over $300,000,000 or more, retentions are between $250,000 and $500,000.

The degree to which it is important for the reinsurer to underwrite the risk varies greatly depending on the particular coverage and the deductible being reinsured. For medical excess coverage, with retention levels below $100,000, the ceding company's underwriting and marketing approach can affect the reinsurer's risk significantly, since many large claims can result from health conditions such as cancer and heart ailments. For retention levels of $100,000 and higher, the majority of claims are from premature births, car accidents, and other accidents like severe burns, near drowning, and gunshot wounds, which a ceding company's underwriting and marketing cannot affect to as great a degree. Therefore, we are much more concerned about a company's practices if the reinsurance deductible is below $100,000. For all excess risks, the geographic distribution of risks is critical to the rating. This is much more important to the reinsurer than it is to the ceding company since the variation by area for large claims is much greater than for the smaller claims that represent the bulk of claims for direct writing. The underlying plan of benefits doesn't have as significant an impact on retentions above even $25,000 unless it is particularly unique, such as a wraparound the Blues product.

Reinsurers must anticipate changes in hospital charges, which make up the majority of our risk. Cost shifting has an even greater impact on excess risks than on a company's total direct business. The leveraging

effect of medical trends is also much more severe on reinsurance than on direct business. For example, if you have a one hundred thousand dollar deductible, you can expect your excess cost, if you stay at that deductible, to increase by a factor of four to five times the trend that you would see on first dollar coverage. On top of regular trends, we have to worry about particular aberrations. Most reinsurers failed to anticipate the tremendous explosion of premature births and other catastrophe claims, beginning around 1980. The period from 1980-82 was dismal for most reinsurers. Reinsurer's current concerns are organ transplants and AIDS claims in addition to all the other claims we've seen recently.

Under quota share, the underwriting and pricing for the reinsurer is the same as for the ceding company. However, underwriting and rating of medical quota share is much more complex than accidental death and dismemberment (AD&D) due to the nature of the risk as well as the greater importance of claim and premium administration. The profit margins are so slim on medical quota share business that each point of the ceding commission has a large impact. The timeliness of cash flow between the ceding company and the reinsurer is also critical. The reinsurer must be very close to the ceding company, and there must be a good and straightforward relationship between the two companies if a reinsurer expects to make a profit. If the reinsurer dictates the rates and underwriting rules, it may have a greater chance of success.

Aggregate stoploss and specific medical excess are usually sold with an administrative services only (ASO) contract to insure individual, that is specific claims, in excess of a deductible, usually from $10,000 to $50,000 and are combined with an aggregate cover for all nonspecific claims in excess of 125 percent of expected claims (the aggregate attachment point). Lincoln National tends to reinsure this on a facultative basis, since each case is so different. This coverage is also usually reinsured on a quota share basis. The reinsurer is involved in setting the aggregate attachment point which is an underwriting function. Since the specific deductible level affects the aggregate, it is also set by the reinsurer. While those functions could be performed by the ceding company, the specific rate is usually always provided by the reinsurer. This is a product that is very difficult to price, and due to the quota share nature, reinsurers may actually be in competition with direct group writers in providing these products. The reinsurer's experience and attention to medical excess risk on a daily basis can give the reinsurer a significant advantage in knowledge on this particular product. However, this doesn't necessarily translate into a competitive price, since lack of expertise by others will usually result in lower rates due to the higher trends.

Group reinsurance has provisions and practices in regard to agreements and administration. In many ways the relationship between the ceding company and the reinsurer is similar to that between a group policyholder and the ceding company. Therefore, the ceding company, by dealing with the reinsurer, gets insight into how the ceding company's policyholders may view them. You would not like it at all if your policyholders treated you like some of you treat your reinsurer. Many of the characteristics the ceding company finds desirable in a

policyholder are what a reinsurer looks for in a client such as loyalty, not being extremely price competitive, cooperation, and two-way communication.

The reinsurance agreement or treaty is the formal basis for determining the relationship between the reinsurer and the ceding company. Reducing any relationship to writing has pitfalls. However, it is important to both parties that all major items are covered by the treaty and that an executed treaty is in place as soon as possible after reinsurance is effective. Since group actuaries tend to be very busy and also group law staffs tend to get involved in the review of reinsurance, since it's a fairly unique arrangement, there tends to be significant delays between the effective date of reinsurance and when an agreement is signed.

In March of 1985, the State of New York addressed this particular problem in Regulation 102. Sections 127.3 affects a company licensed in New York, including both companies domiciled in New York and companies domiciled elsewhere and licensed to do business in New York, or an accredited reinsurer. If a company wants to take credit for reinsurance ceded, either (a) the reinsurance agreement describing the agreement must be executed no later than the "as of" date of the financial report in which the credit is taken, or (b) there must be a letter of intent executed by both parties on or before the date of the financial report. The agreement reflecting the letter of intent must be executed within ninety days of the date of the letter of intent. For example, if you file your annual statements say by March 1, then any agreement should be signed by then, especially if they had an effective date of January 1.

Some of the questions you should ask your reinsurer are: Are all insureds covered on the effective date, or are disabled or hospitalized persons not covered? Some reinsurers only give one approach, but what you want covered will depend on what the prior reinsurance arrangement was, since you may want to try to dovetail the reinsurance coverages. Another question is whether there are any groups or blocks of business to be excluded. Maybe you don't want to reinsure the excess risks on your ASO business. A good question currently is: Are organ transplants covered? Unless specified otherwise, reinsurance coverage tends to parallel the ceding company's coverage, especially under quota share agreements but this isn't automatically true. On excess medical reinsurance, it is more likely that the risk covered under reinsurance may not coincide directly with the risk assumed by the ceding company. An example is extra contractual damages. Since final claim decisions are left to the ceding company, reinsurers rarely will participate in extra contractual damages and never in punitive damages. Reinsurers however, may be willing to share the cost of outside claims or legal services.

Another area that requires close scrutiny is the termination provision. Although termination is not normally in the forefront of discussion at the time of writing a new agreement, it must be understood before the treaty is signed rather than when a relationship has soured and termination is being contemplated. Some of the questions to ask are:

"What are the ceding company's right to termination? Can you only terminate if your reinsurer increases rates? When can the reinsurer terminate? What business is affected by termination? What happens to covered persons after termination? What happens if some groups terminate, but the reinsurance agreement stays in force? A tremendous variation exists between reinsurers in the handling of termination or in recapture provisions. It can make a significant difference in the ultimate cost of reinsurance, so termination provision should be reviewed very carefully at the time of negotiating a new agreement to understand the coverage and to properly compare price.

Who the parties are to the reinsurance agreement is sometimes misunderstood. The reinsurance treaty is a relationship only between the ceding company and the reinsurer. For example, if a ceding company becomes insolvent, reinsurance proceeds would still be paid to the executor of the company and not any policyholders. In addition, the presence of reinsurance is not expected to be disclosed to policyholders unless they specifically request it due to concerns of the ceding company's solvency. Most ceding companies may not want their customers to know about the reinsurance and reinsurers expect privacy because such customers may not properly understand the relationship and come to erroneous conclusions.

A significant difference between reinsurance treaties and common policyholder contracts is that disputes are settled by arbitration, not in courts. Both parties are expected to be knowledgeable about the provisions and intent of the reinsurance treaty.

Proper administration of reinsurance is important to both parties for cash flow and proper control of the assumed risks. Reinsurance premium payment is usually expected within a month following the receipt of premium by the ceding company.

With ceding companies allowing longer grace periods, some reinsurers are requiring payment within a specified time regardless. If the ceding company has a 90-day grace period, the reinsurer may want its premiums sooner, usually within thirty days of the month for which coverage was provided. Some reinsurers charge interest penalties for late payments.

Reporting reinsurance premiums properly may require additional work in the underwriting, actuarial, and premium areas of the ceding company. Premium must be determined accurately. Most medical reinsurance is billed on a per employee basis. Getting an exposure count is most difficult since very few companies have computerized billings of their policyholders. Therefore, reinsurance premiums are usually based on some sort of estimate with later adjustments to make administration easier. Lincoln National doesn't spend an inordinate amount of time counting exposures. We're concerned whether the billing system a company uses to determine reinsurance exposures varies significantly from what they use for other management reports thus allowing for errors. If exposures were not properly determined or there was confusion about what business was being reinsured, claims might be denied.

Generally the reinsurer accepts the ceding company's decision on claim payment and pays the ceding company upon receipt of proof of payment and any other claim information it may request. The ceding company must receive reinsurance payment promptly because of the high potential cash outlay in paying large claims. This is also true under quota share. Slow payment by the reinsurer can cause problems, especially for small ceding companies. Everyone should have some kind of stated requirement for prompt payment of claims from your reinsurer. The ceding company must sometimes implement procedure changes to capture the claim information requested by the reinsurer. Some reinsurers set deadlines on notification of claims in order for claims to be covered. Although this requirement could cause a gap in coverage for a ceding company, it may be important from the reinsurers standpoint. It's not inconceivable to receive a request for reimbursement from a 1982 claim in 1985. Such late reporting could cause havoc with the reinsurer's financial results and ability to respond to changes in experience.

Traditionally, reinsurers have had a hands-off approach toward a ceding company's payment of claims. The reinsurer simply reimbursed the reinsured portion of the reimbursable claim expenses after they were paid by the ceding company. With the increasing number of large claims, some reinsurers have become more involved in claims because most of the claim dollars on the large claims are theirs. The reinsurer will see more of these types of claims than any particular ceding company would, and therefore, the reinsurer may have more expertise. Many reinsurers now have claim advisory services that involve rehabilitation specialists who advise patients, physicians, and employers on alternative care to reduce the cost of these large claims. More assistance can be expected in the future in this very important area of large claim management.

In making group reinsurance decisions, ceding companies sometimes overload the service and advice a reinsurer can provide. Some reinsurers only take risk and provide no services whatsoever. A few will discuss market place trends observed through discussions with their clients and prospects. They might indicate specific information from one of their clients who permits it, or they may set up contact between client companies for the exchange of information and ideas. Only a few reinsurers have a significant direct group division within their corporation, and only some of them make their expertise available to reinsurance clients. This expertise can be valuable including underwriting and rating manuals, training in underwriting or claims, and help on specific questions or issues in policy language, claims, and other areas. For some companies, especially smaller ones, the value of these particular services could exceed the cost for reinsurance for the risks reinsured.

MR. HOBSON D. CARROLL: Metropolitan has declared heart-lung as nonexperimental, but Aetna is still claiming heart-lung as experimental. Will we ever get a definition that we can all hold to? What do the reinsurers see as experimental and when do you think it will change?

MR. AHRENS: We don't want to set policy or dictate what our clients will do. However, we provide them with Lincoln National Group Division's position which can be used as a guide or another opinion. From an excess medical rating standpoint, we have created four different categories into which we can group every particular client. There are those who definitely exclude heart-lung. We then actually put an exclusion into our reinsurance agreement and give a rate discount. Thus the reinsurer is protected since even if their exclusion won't work ours will. We will review their language as a service, although it is their final decision. The ceding company may not specifically mention organ transplants but may review claims on a case by case basis and rely on an implicit experimental procedure exclusion for questionable claims. We will have some exposure in that case and charge for it. With that language, when they do get a claim they may have an ability to negotiate with the hospitals or even deny some, so there can be some savings. There are companies that have explicit experimental exclusion wording, and they may even occasionally mention organ transplants as experimental. There we rate more for the organ transplant risk because in spite of that wording, we assume they are going to have difficulty in defending that position in the face of growing industry acceptance even though they may have some negotiating clout. Finally, there are the ceding companies that specifically cover transplants. We load a little bit more for them under the assumption that until the entire marketplace definitely covers transplants, there is some potential for antiselection. With such language, they will have almost no ability to negotiate significantly with hospitals on the charges. The ability to negotiate with hospitals on coverage questions is fairly important from the standpoint that hospitals still don't know exactly what to be charging for these procedures. With experimental wording, a bill for $400,000 may be negotiated for $250,000 or less. We do want to know what each of our client companies is doing on organ transplants. Unless we specifically exclude it in our agreement, we figure we are going to usually have to pay for it.

MR. HOUGHTON: Six months ago we had a client company which was considering covering transplants. To help them determine the industry position, we wrote a letter to twenty of the large group writing companies and received answers from sixteen. We prepared a survey which we distributed to the companies which responded. The survey indicated that 80-85 percent were covering liver and heart transplants; 55 percent were covering heart/lung transplants; and only 30 percent were covering pancreas transplants. We asked whether they cover the donor expense, travel expenses of patient and/or family, special restrictions, or special benefits. We asked whether the situation was the same for small groups, large groups, administrative services only (ASO) business, and what was the demand for the coverage by the public, regulators, providers, policyholders, and field force. The survey revealed mild or no demand. Most policyholders accepted the company's position on whether these procedures were now routine and not experimental.

MR. DANIEL WOLAK: A few reinsurers are now offering coverage for first dollar coverage for organ transplant. Is there a demand for this type of coverage, and might we want to offer it?

MR. AHRENS: We pride ourselves at Lincoln National in being market driven. Whenever somebody wants something, we will provide it. This is even more true if somebody else is already providing it. We don't want our competitors to charge particularly high rates simply because they are feeding off fears and therefore can make a lot of money easily. When certain reinsurers came out with a first dollar organ transplant coverage, our initial reaction was that it is a kind of a dread disease policy and simply a gimmick. From a selection standpoint, it didn't make sense theoretically that a company should have a different retention level for different coverages. For the same reason, we don't believe a company normally would have a $250,000 deductible on everything except premies and do a $100,000 deductible at preemies. From a selection viewpoint, such a variation would imply that the ceding company thinks the reinsurer doesn't know what they are doing (i.e. the rate is a bargain). However, ceding companies are uncertain, and they seemed to want to get rid of that risk if the price was right. We are not willing to provide it at 100 percent reinsurance. We developed a product but found a very low market interest for it. Many companies were interested but as soon as they found out what it was going to cost from reinsurers, they weren't really interested. They multiplied the rate times their total exposures and said there is no way they can have that many claims. The Blues seemed to be a little more willing to buy it. Thus, although we were opposed to it initially from a theoretical standpoint, we then asked ourselves what is theory worth in a competitive world. In summary, we do provide it although I will first try to talk you out of buying the coverage.

MR. ROBERT W. BEAL: Are there any new coverages or writers or definitions of disability that you see today that you as reinsurers are reluctant to assume?

MR. HALPERN: Yes we are seeing all kinds of really new coverages, but I can't think of anything specifically that we would not assume except looking at it as a case by case basis. If there is really a need for something, we will figure out a way to cover it.

MR. ROBERT M. BRODRICK: There isn't anything out there that we won't do as we try hard at being market driven. There are plans to provide lifetime benefits for someone becoming disabled beyond age sixty without reduction. We may start drawing the line if that actually happens. The high rates for such benefits may in fact cause very high antiselection.

MR. DAVID NUSSBAUM: You mentioned that reinsurers are becoming more involved in claim settlements and information. Yet, you do not cover punitive damage or extracontractual damages. How do you reconcile the two?

MR. AHRENS: Claims advice is an area of excitement and change. For more than two years, we have followed the service approach of advising clients. Most group writers are not willing to give up their claims function and especially will not give up their final right to make all claim decisions. Historically, and for good reason, reinsurers in group health are precluded from actually becoming directly involved in a claim and talking directly to an insured. We have the ceding company, if

interested, contract with Lincoln National Administrative Services Company which would perform or contract for the claim advisory services, therefore working on behalf of the client company. It would never go in directly as Lincoln National, take charge, and try to get a patient dismissed or have treatment changed. It is simply a means to bring in specialized expertise to assist the ceding company. The ceding company's claims people definitely feel that making claim decisions is their role, and we wholeheartedly support that position.

In terms of extracontractual and punitive damages, certain reinsurers are actually precluded in some states from taking punitive damages. Since they aren't directly involved and are not parties to such disputes, there is no valid basis for participating. Therefore, we are never involved. One must remember that the ceding company wants to make the final decisions.

MR. NUSSBAUM: If you gave advice to a ceding company, they follow it and then get hit with a punitive damage suit, and you won't pick up a share of it, how does that work competitively?

MR. AHRENS: The key is the advice. No one wants the reinsurer to get in and start dictating terms. To my knowledge, no reinsurer does. However, the idea of advice has been around for a long time. A lot of claims people call each other, so the idea isn't new. We don't feel that there is any risk to the reinsurer where we are simply giving advice which could not be taken. In addition, there are no penalties or any differences in the reinsurance benefit.

Some of our very small companies don't have experienced claims personnel who are willing to make difficult decisions on their own. Since we are concerned that the decision they make may not be in our best interest, we are considering a totally new approach whereby they would actually contract out their claim decision making authority to an experienced outside party and would be bound by that party's decision. That standpoint would actually help protect the reinsurer more since a more experienced party is making the decision. Then, whatever company they would contract out those claims paying decisions to could be involved in extracontractual damages for their actions. Punitive damages usually come from gross acts the source of which would be a ceding company's claim handling or its agents or brokers. The reinsurer or an outside party that they contracted with would not be involved in those acts, so we don't see any reason why they should have any involvement in punitive or extracontractual damages. This next evolution in claims advice could be a real possibility for these smaller companies and result in lower reinsurance premiums because of them. We would not take such an active role as a reinsurer but instead recommend a separate company which would be providing those services.

MR. JOSEPH R. GALKO: From a reinsurers standpoint have you participated in any health maintenance organizations (HMOs) or preferred provider organizations (PPOs), do you expect to, and what impact do you see them having on the reinsurance business?

MR. AHRENS: The whole health care delivery system is dividing into those various directions. At Lincoln National strategically we don't want to put all of our efforts into one particular market segment. Obviously, the insurance company market has been a major source of business, and it is our traditional line of business. However, at Lincoln National, we are also a major reinsurer in all those alternative markets. For example, when you talk about PPOs, we are very large in the aggregate and specific stop-loss market. The larger, self-funded (or ASO) employer is an ideal area in which PPOs will be more aggressive. Thus, a lot of growth could come from it. We aggressively price both aggregate and specific depending on the particular PPO arrangements and encourage those kinds of arrangements. It is an interesting process of deciding which PPO is good and which is not and for those that are good, what the key factors are.

MR. JAMES T. O'CONNOR: Could any of you comment on the activity on individual medical expense insurance concerning inflation-sensitive, comprehensive, major products? What different things does a ceding company look for as opposed to a group company?

MR. HALPERN: As a reinsurer, we are not interested in taking that kind of business. As a ceding company writing comprehensive medical, we are finding that it is not that easy to find companies that will do exactly what we want. We are presently reinsuring our comprehensive major medical and have had several different companies that were willing to bid on it but on their terms. It probably is getting more scarce as time goes on.

MR. BRODRICK: We do some excess medical coverage for individual policies and portfolios, and I don't think there are differences between considerations for buying a group cover compared with an individual policy cover except that individual is more expensive than group. Even for high deductible reinsurance coverages, the individual underwriting process can't overcome the antiselection process, compared to what you are able to achieve in group.

MR. HOUGHTON: Certainly a company should understand the contract with the reinsurer. Years ago some of the excess reinsurance rates were so favorable that the ceding companies could not go wrong by purchasing such reinsurance. But now reinsurance prices are most realistic and represent a significant expense, especially with the enormous volumes of business some companies are selling. Ceding companies should arrange some type of refund provision. They may or may not receive refunds, but it is certainly worthwhile to look into. Now that the rates are adequate, it makes sense to negotiate refunds.

MR. AHRENS: A key point in evaluating the terms of individual and group reinsurance coverage is the group reinsurer's ability to get off the risk. In group reinsurance almost all coverage is on a calendar year accumulation basis. Five to ten years ago, there was a lot of per disability coverage. Actuarially, it was difficult to price, so much so that it was almost impossible to determine proper rates. The market moved to calendar-year plans. This coverage can be bad for certain

group writers who have a very large ongoing claim such as a hemophiliac with large expenses that could continue indefinitely. The group writer may not want to drop that case because it is one of two thousand lives that have been with the writer for twenty years. The way group reinsurance is structured now, you may have to satisfy a new deductible every year. Plus, if you terminate your group reinsurance you may lose future coverage on that claim. You always have to be concerned with the difference between your reinsurance coverage and your own underlying risk.

Because of these potential differences in coverage and risks, as a reinsurer we try to assist companies that are considering adding some provisions. This is why we are against organ transplant riders. It may be fine now if you can find a reinsurer who will take 90 percent of the risk. However, after you get all those riders out there, will the reinsurer guarantee that they will always renew their coverage of the risk at terms you can accept? Upon investigation, you will find they won't. Then a year from now if the reinsurer decides that the price was too low and starts raising it all of a sudden and you can't afford to reinsure it, you may be out there with a benefit you wish you didn't have.

The same problems exist with million dollar maximums. Some people say they want unlimited coverage or they want a $5,000,000 maximum. We may provide it, but we don't guarantee renewing that coverage forever. It may become an unacceptable risk even to a reinsurer. You always need to be concerned about the possibility of a long-term relationship and the long-term coverage you can get from your reinsurer.

MR. CARROLL: Should the reinsurer take their share of the conversion policies? Why is the industry trend that conversion follows the life insurance? Are you all saying as reinsurers that there is a need for higher limit conversion policies? How long will the group conversion trust last as an entity when the states finally start to look into it? What are the risks involved, and what are some creative solutions to problems in the future?

MR. AHRENS: At Lincoln National our initial concern on conversions is to make sure that we decide at the onset of an agreement whether we are going to pick up the excess risk under the group reinsurance agreement or if converted to an individual policy, it goes to your individual health side. We are more than happy to pick up the excess on conversions as long as we know in advance. We don't like a company wanting a lower deductible on conversions than on other business because we question its motivation.

We will provide the group medical conversion policy issue service to a company. We actually issue conversions on Lincoln paper and take over the administration of all functions related to conversions. Conversions can be very difficult for every single company, and it would be good for the industry if one or two companies decide to take on all the work and approach the industry's problem that way. That could be even more important in the future if we have to get away from the trust approach and companies need to go with individual filings.

For that, you need creditable experience by state. Therefore, we believe Lincoln National is in a position to move either way.

MR. WILLIARD WITHERSPOON, JR.: Would you comment on offering reinsurance to groups under ten lives? How do you all handle disputes with ceding company actuaries, including pricing and underwriting?

MR. AHRENS: Our approach on under ten lives gives us another competitive edge and is one of our strengths. There are definite risks with this market, especially with lower deductibles. There is a lot of concern about underwriting excess claims especially in the MET market. Our clients are in that business, and they have to have reinsurance, so we will provide it. A reinsurer that backs away from more dangerous risks is not helping a ceding company at all. We account for the level of underwriting, plan provisions, and the peculiar nature of the MET risk. For an entire MET block versus a normal group block business of over twenty-five lives, the excess medical reinsurance rates would be different and indeed higher for MET business. We would never force a company out of a line because it was not able to get reinsurance on any particular block of their business.

With regard to disputes over pricing, any time there is a buy-sell relationship, there is the potential for a difference of opinion. Lincoln National has a "trust me" approach. We think we are in a position, through our broad risk exposure and technical expertise, where we understand the excess risk better than most group writers.

When reinsurance rates are too low, it is amazing how low everyone's retention is and of course everybody wants a nonrefunding approach to get the lowest possible rate. Once the reinsurers get to the point where they are realizing profits, the attitude changes. Of course, the profitability of the reinsurance market swings, yet a company that has sent me $400,000 in premium and only had a $100,000 in claims may have come to me at the end of the year and say they sure would have liked to have been on a refunding basis. They may even forget the prior year when they paid $100,000 premium and had $300,000 claims. The problem with experience swings in excess medical on a refunding basis is tremendous. One problem is the claim reporting lags. The difference in time between when claims are being incurred, when the ceding company finds out about them, and when they are reported to the reinsurer is tremendous. There could easily be six, nine, twelve months or longer lags from the first day of hospitalization to the date a reinsurer is notified. The only way any reinsurer should do a refunding approach is on an incurred basis. If the experience is good, the reinsurer might consider giving 100 percent of the profits back. If it is bad, the reinsurer runs a deficit termination risk if they carry the loss forward. What is needed are different types of credibility blending in refund procedures. This becomes very complex, and most ceding companies would rather just raise their deductible and keep it on a nonrefunding instead. However, some companies don't feel comfortable taking too much exposure under these high deductible levels. If a company is ceding a significant amount of premium and results can be given some credibility, we are willing to go refunding up to a certain level. We don't want to make excessively large profits only

because the medical trends were not as we had anticipated them. We are conceptually in favor of refunding approaches but recognize they are very difficult to do properly. Various reinsurers' refunding procedures are wide ranging so the ceding company should be careful when examining a refunding approach.

MR. NUSSBAUM: What effect have you seen on cost containment in reinsurance cost, and which particular types of cost containment have proven to be best?

MR. AHRENS: You're asking me to divulge some of my secrets. I prefer to say there can be a tremendous difference. At deductibles of $50,000 or more, most cost containment is not going to be particularly effective. Most cost containment measures affect the majority of claims, not necessarily the high risk claims. For a particular company, claims above $50,000 are maybe 2, 3 or 5 percent of their total claims. Therefore, they are not as worried about saving costs there, as they are about saving costs on that 90 percent of their claims between $100 and $25,000. Some cost containment efforts can make a tremendous difference. However, the commercial insurance market is probably in the least advantageous position to implement the types of cost containment provisions that can save dollars on excess medical costs. We have found cost containment to be much more effective in some of our other health care delivery markets.

Case management can occasionally make a big difference on the larger claims. Someone can come in and work with the doctor, the hospital, and the family or parent to agree to the procedures, and that person can suggest things that might be an extra contractual benefit. If you can get someone involved in claims early enough who is competent enough to effect changes, the savings may be significant. An advantage to a major reinsurer which handles an enormous amount of business like that is it can afford to either acquire a staff or the contacts in different cities to create an effective program.

MR. HOUGHTON: Excessive services or utilization occur because of lack of management. There are patients in hospital beds, in some instances, because no one has been able to find an extended care facility to accept these patients even though there is no meaningful treatment taking place at the hospital. They are there on a default basis because no one has found a solution for the proper care. Obviously, a cost containment procedure, such as preadmission certification, is not going to help on claims in excess of $50,000. For those patients the savings will depend upon the treatment plan.

MR. AHRENS: By definition, large case management would be very effective. If we as a reinsurer have complete confidence in either your ability or in your contracting out to someone we recommend, we will reduce our reinsurance rates prospectively. The difference in excess claims can be on a level of 50-100 percent between a company that does very little and a company that does a lot on large claim management. Therefore, a tremendous difference in your reinsurance costs depend on your claim people and their abilities.

MR. HOUGHTON: Some techniques do not relate to medical treatment. Some organizations negotiate prices with prompt payment being a carrot for a bargain price. Sometimes the carrier can obtain expensive drugs at a wholesale price in lieu of a normal mark-up which is reasonable for a $2 per dose drug, but not reasonable for a $200 per dose drug.

MR. JOHN R. GOVERNALE: A couple of years ago, a discussion about premature birth would really have sent reinsurers into a panic, losses were excessive. Right now the question is whether we can win the prematures. Is there any way in which you can put a cap on what the premature birth is going to cost? It is getting to the point now that the average cost is $400,000 to $500,000.

MR. HOUGHTON: We have talked to people about limiting the covered expenses during the first year an insured person is covered. This would apply to all employees and dependents, not just new-borns. A $1,000,000 maximum plan would have a first-year maximum of $150,000. As far as I know, none of our client companies has adopted this approach.

MR. AHRENS: We have two clients who have done it, both on insured contracts. Our attitude was that it is an interesting idea but that it is really a little too late for the industry as a whole. They both put the cap at $100,000, and they called it claims in the first year of life rather than premature births. Rarely do people consider employee benefits in general and medical maximums in particular to be critical in choosing jobs. Now the potential cost of premature births is high enough that $100,000 really doesn't do the job. It is a very real social need and from that standpoint I am not for a cap at $100,000. If a company wants to do it, though, we will put an exclusion or a limitation in our reinsurance agreement and give them a rate break for that limitation.

MR. HOUGHTON: This might happen more frequently in the self-funded area. Then, if an employer decides for some reason he wants to pay more than the $150,000 limit, he can go ahead and do so outside of the medical plan. It used to be popular some years back to have a maximum per year and a lifetime maximum. Some people have thought about going backwards that way by limiting any one year's benefit to $250,000 with a $1,000,000 lifetime maximum to handle this problem.