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STOP LOSS

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MR. MICHAEL R. MCLEAN: I'm president of Underwriters International, which also does business as Medical Risk Managers. We're a managing general underwriter (MGU) that specializes in group medical stop loss. We underwrite about $85 million in annualized stop loss premium, $6 million of LTD, and $10 million of group life. We're also temporarily underwriting the stop loss renewals on a $75 million administrative services only (ASO) block. We're all anxiously awaiting the coming medical reform proposals. I think it's safe to assume that the current extent of underwriting in the small-case market will ultimately be reduced or eliminated. One critical issue is the definition of small-case, or the level below which employers could be required to join health insurance purchasing cooperatives.

One proposal by Representative James H. Cooper would require all businesses with less than 1,000 employees to join a cooperative, with states having the option of requiring businesses of up to 10,000 employees to join. Since self-funding has decreased state premium taxes, any state given this option would presumably elect the higher figure, assuming it could continue to collect premium taxes on fully insured business in the cooperatives. In advance of the federal reform, some states are extending their small-group reforms to include stop loss.

California realized that ERISA preempted it from regulating the underlying self-funded plan. To get around this, Assembly Bill 1672, which becomes effective July 1, 1993, requires the stop-loss insurer to make certain that the self-funded plan complies with the law if the insurer sells the plan managers stop-loss coverage. The law limits exclusions for preexisting conditions, late enrollees, and waiting periods. There are also some rating-ban classifications. *Business Insurance* mentioned recently that at least one larger carrier and one large consultant will not require their clients to comply with this law. They expect the law to be challenged in court.

Our clients use stop loss for various reasons. Some companies are primarily interested in a competitive stop-loss product to allow them to sell more ASO or claim administration business. These ASO carriers are competing with TPAs that have more than one column on their stop-loss spreadsheet. Many are not yet willing to bring in another carrier to quote stop loss over their claim administration, but an increasing number are. Another type of client uses stop loss to get the collateral line such as group life, LTD, or dental on a fully insured basis. A third type of client is interested in the fees that can be generated by fronting stop loss while heavily reinsuring it. Many carriers in the stop-loss market are heavily reinsured. The fourth type is in for the underwriting profit that can be made on stop loss. They are usually differentiated by dealing with TPAs (rather than ASOs) and having a lower percentage of reinsurance.

A couple of years ago, there was relatively little pressure on aggregate attachment points. You simply trended the claims and added a corridor. In the last year we've

noticed more brokers adding the soft dollars to the hard dollars and concentrating on the maximum liability. As a result, we're noticing a lot more pressure on the attachment points. This could also be due to smaller cases getting involved with stop loss and being more concerned about volatility and maximum exposure. It could be due to the increase in the number of competitors, including HMOs, exclusive provider organizations (EPOs), and PPOs.

It could be that carriers are now reacting to their relatively good aggregate experience of the last few years, as trend has come in less than expected. On our small group product (under 100 employees), we've only had eight aggregate hits for a total of about $100,000 over the last four and a half years. Small-group aggregate premiums were about $2.2 million for a 5% paid loss ratio. Even taking into account unearned premium and incurred but not reported claims (IBNRs), it's still profitable. A couple of years ago, the industry average stop loss close ratios for TPA-generated business were in the 4-6% range. Now I believe that the average is closer to 3% and declining.

Persistency has also declined, as any attempt to get a rate increase frequently results in the case being put out to bid. What any individual carrier sees for persistency is obviously a function of what it has done to its rating basis over the last year. If you've had good experience and lowered your manual rates and are requiring much less than leveraged-trend rate increases, your persistency should be better than the industry average. On TPA-generated business, average persistency rates are only in the 70% range. If you're renewing 90% of your cases, your block is probably getting further and further from manual rates. I've seen this happen on some large blocks where they were about 50% of their manual and the manual kept going up, but the rates did not. ASO business tends to have a lower lapse rate because the carrier frequently only loses the stop loss when it loses the ASO.

However, the trend to unbundling the stop loss and the claim administration is increasing. Because of the select and ultimate nature of stop loss (due to the underwriting), high persistency can be bad for the risk bearer, which is frequently the reinsurer. Of course, high persistency is good for any entity attempting to recover acquisition costs, such as a fronting company or MGU. In the large case market, the percentage of companies that were self-funded and the percentage of self-funded cases that purchased stop-loss coverage were both relatively constant from 1991 to 1992. In a Foster-Higgins survey, 67% of employers were self-insured in 1992, up from 65% in 1991, and 59% in 1990. In fact, the percentage of large employers that are self-funded has probably already peaked. The large group stop-loss market is now saturated. Some of the largest carriers have fewer cases and covered lives now than they did a year ago. The decline is partially masked by continued increases in premium from rate increases (thank goodness for inflation). Since HMO penetration is still increasing, even if the case count is remaining constant, the number of covered employees could be declining. While the number of MGUs started up in 1992 is below the breakneck pace of 1990-91, the number of carriers in the market is still continuing to increase. Since the self-funded pie isn't getting any bigger and there are more carriers wanting a slice, the average number of covered employees per stop-loss carrier must be declining.

Stop loss is rapidly becoming a commodity with relatively little perceived product differentiation. While it is a nuisance to switch to TPAs, it is very easy to change stop-loss carriers since the employees are not aware of the stop-loss company anyway. The only potential problem is the gap in coverage between companies as the in-force carrier is probably on a paid basis and the new carrier could limit run in and probably would require disclosure of known or potential ongoing claims.

There is, however, a continued trend to self-funding in the under-100 market, barring any federal or state legislation. I believe this is one of the reasons for the recent increased emphasis on advanced funding. While stop loss has traditionally been on a reimbursement basis, a 20 life company may not have the resources to pay the claim in advance, so it would require some form of advance funding before an insurer cuts the million dollar check for a shock claim. At a recent Self-Insurance Institute of America meeting, virtually all of the carriers were offering some form of advance funding, in particular to the smaller clients. We've offered advance funding for all of the four and a half years we've been doing small group.

In determining the pricing impact of PPOs and EPOs on stop loss, we should remember that managed-care plans don't necessarily impact shock claims in the same manner as aggregate claims. The underlying plan design tends to impact the aggregate claims more than the specific claims. Minor variations in the deductible or coinsurance percentage have little direct impact on a specific claim. Of course, plan differentials can steer patients to more cost-effective providers, with a potential for reduced utilization. However, the manner in which fees are negotiated with the hospitals can have a huge impact on specific claims.

I've seen many PPOs with per diems or discounts that are wonderful, except for one little phrase, such as "if charges exceed $35,000, then bills revert to billed charges minus 10%"; so you can basically throw all your per diems out the window for all your shock claims. You could argue that a 10% discount could leverage to a 15% discount in the specific rates on preferred charges. But with a 35% PPO penetration, this only results in about a 5% overall discount. Someone is going to catch on to the idea of negotiating with the providers, with the specific stop-loss carrier's interest in mind. Perhaps some have and this is why we're seeing such large assumed discounts and such low rates.

Our first panelist is Mike Kemp, who is vice president and actuary at Duncanson & Holt. His responsibilities include pricing and managing the medical reinsurance product line, including reinsurance for specific and aggregate stop loss. Previously, he held several positions at State Mutual Life Assurance Company, with the most recent one being director of Group Medical Pricing. Our other panelist is Kevin Gabriel, who is vice president of operations and actuary at Health Reinsurance Management Incorporated where he is responsible for all of their internal actuarial work. He previously worked at State Mutual. Our recorder is Kevin Trapp, who is the actuary in the U.S. Group Department at Manulife Financial.

MR. MICHAEL A. KEMP: We're seeing a number of trends going on in the stop-loss market that we think may start to impact us and call upon some of the reforms that we're seeing in the small-group fully insured market. Some of what we're seeing are the same things that were abuses or potential abuses in the small-group market.

Some of these Kevin Gabriel will speak about later on. These abuses include carving out high-claiming individuals from coverage (lasering), extremely low new business rates to bring in business with very high tier rates and very high rate increases for business with bad experience.

I'd like to start out by focusing on some product issues that I feel are starting to have some effect. The first one is the issuance of stop-loss policies with internal limits that don't match up with the underlying plan document. One example is lower limits on the stop-loss policy for organ transplant coverage. Oftentimes the underwriting plan document will provide organ transplant coverage the same as any other illness, and the stop-loss policy will have an internal limit of $50,000-100,000. This is a technique to keep the stop-loss prices down, and it's a reflection of the extremely competitive market we find out there for new business rates. That strategy could definitely backfire when it comes time to pay a claim. Oftentimes the employer is ill-informed that the stop-loss coverage does not provide him coverage for all claims that he's going to pay under his plan document. If that employer has a bone marrow transplant and has a $300,000 claim in that year, there will be problems at claim time when he finds out the stop-loss coverage only provides $50,000 of coverage. If it's a small employer and that employer doesn't have sufficient funds to pay the claim, that claim could end up in the courts because the claim has not been paid by the employer for lack of funding from the stop-loss carrier.

Another product issue that we see, again primarily to keep renewal prices down, is the use of 12/12 renewals. By 12/12 renewals I mean that the stop-loss policy only covers claims incurred and paid in the 12-month contract period. That's a typical contract issued to a new group coming out of a fully insured program. Because the in-force first-dollar carrier pays all the runout claims, there is typically no gap in coverage. But once that self-funded employer goes through his first policy year and comes up for renewal, any large claims that were incurred towards the end of that first 12-month period are going to be paid in the subsequent 12-month period. If that employer renews with a 12/12 contract with the idea of saving costs, those claims would not be covered under a stop-loss contract, and again, the employer would be liable for those claims. For a new business case, discounts for a 12/12 contract can be in the area of 15-20%. At renewal, when we're faced with 30-40% trend increases, that 15% becomes very attractive to an employer. An ill-informed employer is going to find that it has a gap in its coverage. Another potential problem is that a lot of carriers are giving the full first-year discount for 12/12 cases when, in fact, part of that discount is a reflection of the preexisting limitations for a new business case. Those preexisting conditions limit the amount of claims coming in to a new business policy. You don't have the same type of protections for a group at its subsequent renewals, so you do not have the full effect of the first-year discount.

Another product feature that we have seen recently is offering two-year rate guarantees. This has become attractive. We've seen one major carrier start to push this product. At this point, I don't know how well that has been accepted in the marketplace, but again, it's a marketing tool being used to differentiate the product and also lends some potential appearance of stability to the policy. A lot of self-funded employers have been used to getting hit with 30-40% rate increases or higher at renewal, and the thought of a two-year rate guarantee has some attraction to that

employer. Also, with the controversy surrounding lasering underwriting at renewal, the two-year rate guarantee is very attractive.

The concern, however, is the pricing of the two-year rate guarantee. With the extremely competitive nature for new business rates, I wonder whether people are pricing these two-year rate guarantees properly. Effectively, we're adding six months worth of trend to that contract over a standard 12-month rate guarantee. With typical stop-loss trends of 30%, that adds another 15% to your first-year costs. Fifteen percent in this stop-loss market is a very big hurdle to overcome in terms of having a competitive product.

Besides the additional costs in the first year, the renewal costs when that policy comes up to its first renewal will be tremendous. Employers have a very difficult time understanding when they renew a one-year contract, and they get a 30-40% rate increase purely for trend. They just don't understand that the effect of leveraging, while offering a two-year rate guarantee, just exacerbates that situation. Instead of having a 30% renewal increase, we're now looking at a 70% renewal increase. I wonder how the persistency of those contracts will be when they start coming up for their first renewal.

Another concern is the potential selection. For just the six-month trend, we would see about a 15% load on those contracts. One of the attractions of the two-year rate guarantee is the avoidance of that first-year renewal and the potential for either a very large rate increase or some form of lasering or carving out of high-cost individuals. If a self-funded employer knows that it may have a large ongoing claim or a potential high-cost claimant, the two-year rate guarantee is going to have some attraction to that employer. It knows it's going to lock in its stop-loss contract for two years. Therefore, we think there should be an additional trend, beyond the six-months, for the potential antiselection against the two-year rate guarantee.

The final product issue that seems to be coming into the marketplace (but isn't as critical as the prior three) is the offering of lifetime limits in excess of $1 million. The offering of the additional coverage isn't so much a concern. What is a concern is how it's being offered. Oftentimes we're seeing it being thrown in at little or no cost. A lot of people look at coverage in excess of $1 million as being pure sleep insurance. Nobody can conceive of a claimant exceeding $1 million in one contract year. Unfortunately, there are claims out there. In 1992 we had, as a reinsurer, our first claim that exceeded $1 million. In fact, that claim would have hit the $2 million lifetime maximum in one contract year if we hadn't been fortunate enough to have case management involved and get that individual into a Shriners Burn Facility at no cost. We were able to cap out that claim at $1.2 million. But there are claims out there that exceed $1 million, and you have to get the pricing for it.

There is one product development issue that's on a more positive note, and that's the area of 24-hour coverage for stop loss. Right now the market for that is primarily being driven in Texas. For those of you who are not familiar with the situation in Texas, it is one of the three states in the country that allows employers to opt out of workers' compensation. Anywhere between 50-60% of employers in Texas have opted out of workers' compensation. There are alternative coverages out there, primarily blanket accident products that are offered to these employers that have

opted out. What a number of the larger employers have done is taken the medical component of their workers' compensation and wrapped it into their regular group health plan. Effectively, they have taken out of their plan document the exclusion for occupational claims. Sometimes they pay the claims on the same basis as the regular group health claims. Other times they remove the deductibles and coinsurance, since their employees were not used to paying those under workers' compensation.

From the stop-loss contract viewpoint, there needs to be very little change. The change has to come in the plan document to incorporate these claims. The programs we've been involved with have treated those claims as any other nonoccupational claim, so there's been relatively little change in the actual stop-loss contract. The only major change was to tighten up the preexisting condition exclusion to specifically state that any accident that predated the effective date of the stop-loss contract was not covered.

The operation of the stop loss is a little bit different than what you would find on workers' compensation. Workers' compensation is geared towards a date of accident and date of injury. When employers have wrapped it under the stop-loss contract, we move back to the more traditional group health approach and treat it on a medical expenses incurred basis. We just cover the medical expenses as they are incurred and do not tie them back to a date of injury. What this avoids is the necessity of offering lifetime coverage that employees would have had under workers' compensation, so there are still gaps out there on the coverage. There are other sources of reinsurance for those gaps. We are not providing the lifetime coverage under the 24-hour package.

The pricing of the 24-hour coverage is a little bit different. Some of the early products we saw out in the marketplace were priced fairly simply, oftentimes as simply as taking a fixed percentage of the regular stop-loss rates for the nonoccupational medical. Unfortunately, that isn't the best way of pricing this product. There are a lot of different factors that come into play in driving the cost for an occupational claim. For any given claim there is a different slope of the continuation table for occupational claims versus nonoccupational claims.

We have developed a separate rating strategy sitting alongside our normal stop-loss pricing. The underwriter calculates separate rates for both the occupational and the nonoccupational coverage and then adds them together to come up with a total package price. In pricing for the occupational coverage, the base rates are calculated on the per employee/per month basis. There is no dependent coverage. We don't pick up another employer's occupational claims for dependents. The adjustments that are made to that base rate include some of the normal things that we would do under a regular stop-loss contract. For trend, we apply to the nonoccupational claims the same types of factors that are applied to the occupational claims. Perhaps there are some differences because you tend to see a little bit different mix of providers for occupational claims. They tend to be traumatic injuries. You see a lot of orthopedic claims and outpatient claims.

The area effect is the same between the two. We adjust the base rates for contract type, whether we're offering a contract on a 12/12 or 12/15 basis, and we adjust for managed care. On the occupational claims, managed care can have a significant

effect. We're dealing with a fairly low frequency but a typically higher-cost-type of claim. You have a lot of traumatic injuries, many of which are subject to case management, i.e., getting them into the proper care facilities, the proper plans of treatment. We got together with some case managers who are specialized in the workers' compensation area to help us in terms of managing these high-cost claims.

There are two major areas that we see different in the pricing for the 24-hour coverage versus the nonoccupational. One is the age factor. There is a different slope in the age factor for the occupational claims. The age factors for the occupational claims start out high and tend to come down as age increases, just the inverse of what we see on the normal stop-loss side, which is a low age factor for the younger ages increasing as the individual gets older. If you look at the frequency of accidents, it is higher for the younger ages than it is for the older ages. The younger people tend to be less well-trained and less experienced. They also tend to be the ones who are out on the shop floor working with the machinery. We see a higher incidence of claims and oftentimes a higher severity of claim with the younger individuals.

Perhaps the most important factor that affects stop-loss pricing for the occupational risk is the occupational classification of employees. That is the one prime driving force behind what your risk is for this coverage. Many stop-loss carriers adjust their stop-loss rating by the standard industrial classification (SIC) codes, although that's becoming less and less prevalent. When we started out pricing this component, we looked at SIC as being a basis for pricing the occupational component. We very quickly determined, though, that we should move into a more refined basis and started using the occupation that the employee is in, rather than the industry.

If you look at industry, within a given industry you can have a wide range or mix of occupational classes based on the way a company does business and the make-up of the company. The occupational factors are probably the critical aspect to pricing this policy and probably the most difficult in terms of developing.

I'd like to switch gears a little bit now and pick up on some comments that Mike was making earlier about the state of the stop-loss market and look at it more from the view of the reinsurer. Mike alluded to the fact that a large portion of the stop-loss business finds its way into the reinsurance marketplace. Unfortunately, that appears to be what's driving a great number of the problems in the marketplace.

If you look back two years, the number of MGUs for stop loss business was probably in the area of 75-100. If you look at the number of MGUs out there now, the estimates are that there are between 150-200, and it seems to be increasing every week. A lot of the growth in the number of MGUs has been driven by the regularly available capacity of reinsurance. When I talk about reinsurance for the stop-loss market, I'm primarily talking about coinsurance or quota-share reinsurance for stop loss.

One of the prime reinsurance sources for stop loss over the last few years has been the London market, and particularly Lloyd's of London. There's a corollary in the growth between the number of MGUs and reinsurance capacity in Lloyd's of London. A few years back, when you went to Lloyd's of London and wanted to talk to a

syndicate underwriter about medical reinsurance, there were maybe five or six syndicate underwriters who were recognized as being leads in medical reinsurance. If you went over there in 1992, you could probably find anywhere from 15 to 20 who are either recognized leads or claim to be recognized leads for medical reinsurance. Even the ones who purely claim to be recognized leads oftentimes could get their programs completed.

I had an interesting conversation with a Lloyd's of London underwriter a couple of years back. I was talking to him about how difficult the market was over here and how difficult it was to make an underwriting profit. I couldn't understand how Lloyd's of London underwriters could be making a profit since they were looking at the same blocks of business we were and they had additional expense levels beyond what we did. I further noted that we're a lot closer to the situation over here. We're dealing with these people day in and day out. They're 4,000-5,000 miles away. His comment to me was, "Well, perhaps you're too close to the problem." It was a short conversation after that.

We have seen some restriction in the capacity of Lloyd's of London in 1993. It's been smaller than we had anticipated, and it's been primarily due to the merging of London syndicates. Some of them simply have closed up and others that have not closed up have simply withdrawn from the medical reinsurance arena. We had hoped that would drive a change in this marketplace. Unfortunately, it hasn't created the change that we thought was coming. A lot of the capacity that has been withdrawn from Lloyd's has been picked up quite readily by domestic reinsurers and also the addition of European capacity.

This seems to be a ready market for stop-loss reinsurance, even with the results that the direct writers have seen. One thing you need to keep in mind is that, although the direct writer might be making a small underwriting profit -- and a number of people I talk to say we're making money -- we're not making what we would like to. If the direct writer is making 2-4% underwriting profits, the reinsurer is losing money. The reinsurer has its own internal expenses and oftentimes has reinsurance brokerage expenses. Unless the direct writer is making 5% or more, the reinsurer is not making money. Now, I won't go around the room asking how much people are making, because I would tend to believe that there are not many large blocks of business making more than 5% underwriting profits.

We still have hope that the reinsurance marketplace will start to turn around. Once the results start to come in, there should be some constriction on that capacity. Our own results have not been that favorable. Back in 1988-89, we managed to lose quite a bit of money in reinsurance of stop-loss programs. We made some very strong corrective actions in 1990 that got our business back down to about a break-even level in 1991-92. We're making a little bit of money, but we're having to work extremely hard at it.

Unfortunately, at the same time we started to turn the profitability around, our volume declined. When we recognized the losses that were coming in during the early years, we started to take strong action. As Mike alluded to earlier, a lot of carriers have different reasons for being in the stop-loss market; i.e., they want to have a product to lead into their ancillary products, or they want to help support and have some

control over their own ASO business. It seems that there are fewer and fewer companies who are interested in being in the stop-loss market to make an underwriting profit.

We started to put pressure on to get an underwriting profit both for the direct carrier and for ourselves. However, a lot of that business found homes elsewhere with reinsurance capacity that either had not seen the problems that we had or were just unwilling to recognize them. In 1991, we had roughly $55 million of reinsurance business on the books for stop loss. In 1992, we're estimating we'll see about $13-15 million when it finally completes. That was a significant reduction in premium for us, but one which we felt comfortable with because our determination is to make an underwriting profit at the end of the day.

Will the reinsurance capacity start to come down and start to help turn around the stop-loss market? I haven't seen signs of it yet. We saw one major new program that came into the reinsurance marketplace for 1993. This company had well over $100 million of stop loss business in force (a significant block of business), and it came to the reinsurance market because its field force was putting pressure on the company to offer and deliver a more competitively priced product. That was the sole reason that this company was coming into the reinsurance marketplace -- because its own internal people felt that they could not deliver a competitive product and still produce an underwriting profit. The company's hope was to go to the reinsurance marketplace and find support for a competitive street rate. The company was willing to give up 90% of the risk for a company that was willing to come in and do that. I don't know whether that program ultimately was placed. If it was, it's going to take a lot longer time for this marketplace to turn around. If it wasn't, there's a ray of hope down the road for the stop-loss marketplace.

MR. KEVIN K. GABRIEL: I might start out just briefly giving a little background on my orientation. Up until about two months ago, I was with an insurer and had a first-dollar orientation toward things. Now I'm on the reinsurance side with Mike, just about three and a half years late, and I have a little bit different perspective. You might find during my presentation that I switch points of view maybe without letting you know. I'm going to talk about first, some unusual stop-loss product variations, and second, two alternative ways to price specific stop loss and maybe a little bit about renewal underwriting.

I wanted to pick up on something Mike ended his talk with, which was the reinsurance market. I can only echo exactly what he just said. There seems to be a lot of reinsurance capacity out there that at least has been willing to accept business. Carriers are basically coming to reinsurers and saying, "We'd like to make some ASO fees, but why don't you take all the risk for us and hope that you make some money?" We have not been too keen on that either, and we can only hope that, in the reinsurance market, some discipline is imposed on carriers that are going to have to be willing to be in the stop-loss business and make an underwriting profit.

First of all, let me talk briefly about what is typical stop loss. Basically, it can be two sorts of situations. One is what one might sell to an employer, which would be standard specific and aggregate. You have a specific stop-loss product with a given deductible on an individual person. Claims are incurred if that particular person

exceeds the deductible. Second, you usually have an aggregate, which is usually a percentage of expected claims for the whole group less what's paid on the specific coverage.

Traditionally, these things are written on what I'm going to call a fully-insured basis, even though that's a little bit foreign to the stop-loss market. By that, I mean the stop-loss carrier charges a rate that is designed to cover the full amount of claim it expects to pay on either the specific or the aggregate part of the premium. Usually what you find is the specific premium is substantially greater than the aggregate premium. Many stop-loss carriers pride themselves on having few or no aggregate claims. I knew one stop-loss underwriter who claimed in 15 years he never had an aggregate claim. I'm not sure whether he's right on that, but that's what he claimed. Anyway, that's the standard product that's usually sold to an employer.

The other situation I'm going to be touching on some is a portfolio excess product. This might be marketed by a reinsurer to an insurance company or an MGU who has a large portfolio where there's a high specific deductible. Basically what you're looking to do is cover catastrophic claims for that particular insurer. I said I'd talk about three product variations, the first of which is one called split funding. It also masquerades under the name of minimum premium stop loss from time to time, or it may be called aggregated specific.

The basic idea here is we don't have what I earlier referred to as a fully insured plan. What you'd otherwise pay if you wanted full coverage, pay that to us every month, and then you self-fund claims up to a given level. Let me give an example. Let's say you're a reinsurer coming to an insurer and saying, "You want coverage at $500,000 specific. It's going to cost you $2 per employee per month. But, if you want, instead you can pay us $0.50 per employee per month and then self-fund another amount," which, for purposes of this example, is $1.50. "You self-fund $1.50 per employee per month of claims, and only when you've exceeded that $1.50 will we, as the reinsurer, kick in."

Let me give you an example of why that would be a prudent thing to do. Basically, what we're looking at here is a case where the insurer thinks it's going to have good experience. Let's take total premium. Suppose that $2 per employee per month is going to translate into $100,000 a year of stop loss premium, but instead the insurer can pay $25,000 a year of stop-loss premium and in effect self-fund $75,000 a year of claims. Again, that's of specific claims over whatever the insurer's deductible is. If you don't have any claims, you win. If claims go over that $100,000 level anyway, you pay $100,000 and you're where you were before. The reinsurer or, if you're an employer, the stop-loss carrier, is going to be on the hook.

I might add that usually another part of this contract is that there will be some minimum premium that is going to have to be paid. The reason a stop-loss carrier will do that is to protect himself from cases where you have quite a bit of shrinkage. Let's pretend you're an employer with 200 lives. If you shrink down to 50 lives during the year, for whatever reason, the stop-loss carrier tends to have the point of view that the 50 who are left are, on the whole, less favorable in terms of experience, and therefore they're going to ask for a minimum premium to be paid to

them. This is usually expressed in terms of per employee per month rates, but it's easier thought of in terms of total premium.

Why would one be willing to do this? Obviously you're betting on good experience. Whether you're an insurance company, an employer or whatever, you're betting either that you have superior utilization review (UR), better large claim management, a superior PPO, or some other managed-care arrangement. I'm going to talk about the managed-care issue later, and Mike already alluded some to it, but if you're going to be willing to venture into this sort of deal, you've got to have a good idea of what your claims are. You have to understand how strong your UR or your large claim management is. If you're whistling in the dark on those things, this may turn out to be a little bit surprising for you.

The second variation is really a subvariation of what I just talked about. In split funding or aggegated specific, once claims reach this self-funded maximum, the stop-loss carrier or reinsurer is then on the hook. Everything over that up to the contract maximum is going to be paid by the stop-loss carrier. There have been a few quotes kicking around lately that put a new wrinkle in this. Some people have now interjected three levels into this scheme by saying to the insured, "You self-fund the first part, then we'll kick in and cover what we would regard to be as the next layer, up to a level that would be fairly unlikely to be reached. Nonetheless it's not open-ended. If claims go past that level, you're back on the hook." Again, let me give you a little bit more specifics on that.

The insurer might say, "I'm going to determine the expected specific stop-loss claims for your product. You'll have to retain 100-plus X% of those specific claims, say 110-115%." Then they'll say, "The next 30-50% of expected claims that you incur I'm going to be on the hook for." Now we might be up to 140-160% of expected claims. At this point, the insured is back on the hook. Usually in this case the stop-loss carrier will ask for some sort of minimum premium to be paid up-front.

This gets into the issue of something called minimum and deposit premium. The stop-loss carrier says to the insured, "You have X number of lives in force as of when I'm taking this over. I want X dollars per employee per month up-front. Then at the end of the year we're going to do an accounting. I won't take less than that, but if you've had quite a bit of growth, we're going to have to settle up at the end of the year." If you are the insured in this sort of arrangement, you're gambling that your claims are not going to be bad. If they're real bad, you're going to get stuck. You, as the insured, whether you're an employer or an insurance company who's being offered this through a reinsurer, have to do a careful study of exactly where you expect to be. If it's an employer and you're marketing this kind of product to the employer, you want to make sure that that employer understands exactly what it's on the hook for; because if claims are just awful, the employer is going to pay.

The last product that we've seen in recent months, and I've only seen it in terms of being sold to self-funded employers, is an aggregate only product. Going back to that typical model of stop loss that I discussed earlier, we've dispensed with the specific coverage. We say to an employer, "We're just going to cover 115%, 125%, 135% of expected claims. That's going to be it." Now, you might ask "Why do that? I

thought that specific and aggregate were supposed to interact; that specific protects the aggregate and so forth."

The idea is you go to an employer and you say, "There's going to be a maximum amount of dollars that you're going to have to spend in any case, even with this aggregate only coverage, and you're going in rate is going to be less than the total premium you'd pay if you had specific and aggregate." The specific, remember, is substantially more expensive, in general, than the aggregate. Even when you don't have a specific up-front, you're probably going to pay less for the aggregate only.

There are a couple of other wrinkles to the product in terms of the way it's managed, at least that I've seen, that attempt to try to make this a more budgetable product. Usually with stop-loss insurance, you may settle up with the stop-loss carrier monthly in terms of reimbursements from him to the insured. Aggregate only might have weekly requests for advances. Second, on renewal, in at least one case I can think of where somebody is marketing this, there may be a pooling of the large claims so that you're not sticking somebody for the fact that he gets some bad specific claims.

Theoretically, the up-front cost of this is probably going to be less. If things go badly, it's not necessarily cheaper. In fact, if you have just real good experience but maybe just a few large claims, it's going to cost the employer more, and it's going to be, again, important that you explain to that employer exactly how this is going to work. In fact, I'd say in about all three of these little wrinkles I've described – the split funding, the modified split funding, and this aggregate only -- all we're doing here is offering somebody a lower going in rate in the hopes that he's going to have good experience and that he will be able to share in the fact that he has good experience. If he has bad experience, he's not going to necessarily be better off. In fact, if he has certain patterns of bad experience, he may be worse off.

The fourth product variation I'd like to talk about is organ transplant reinsurance, which is not so much of a funding game as simply a carve out of a coverage. I keep getting conflicting stories about whether this is still a hot issue or not. We're still seeing some activity on this, so I'm going to assume it's still hot. There are several organ transplants that tend to be covered under this standard. They're heart, heart/lung, lung, pancreas, liver, and bone marrow. Usually they're part of a standard organ transplant program.

The idea with organ transplant is that you're going to carve out expenses relating to organ transplants from the stop-loss program. You have a totally separate coverage. It's usually put on a specific-type basis; that is, it depends on expenses incurred by a particular individual, and I haven't seen any attempt to put this on an aggregate basis. I might mention that other carve outs for other conditions are extremely rare. I've only seen a couple of them, and with all the reform activity going on now, I wouldn't be surprised if they disappear completely.

The main reason for undertaking this coverage, which a lot of people are looking at, is not so much the cost of these procedures as the utilization of these procedures. A lot of these things are experimental, or at least have been experimental. We're seeing a gradual evolution in medicine, and they're being done much more frequently. The one in particular that's been an issue is bone marrow. I'm not a medical authority,

but my understanding is that there is now technology where transplants are done with bone marrow taken from the person that the transplant is being done on. This eliminates the problem of trying to find a donor, a problem which does hold down utilization.

On the bone marrows in particular, the number of reasons that physicians are finding to do these things is multiplying. In particular, now it's being used as a breast cancer treatment, and not only is that a frequent occurrence, but also it has, in some cases, become a politically charged issue, and I'll refer to that a little later.

The claim costs on these things are not real difficult to predict. These tend not to be killers as far as individual transplants go. Though they can run into the six figures, an individual transplant is certainly not going to be a seven figure dollar amount. The unfortunate problem is much like our old friend, in vitro fertilization. There are times when it doesn't take the first time, so the parties decide maybe we ought to do it again or again. In that case, you can run up a real big claim, partially because the condition of somebody who's having to have a second one of these is probably not good and it's going to be real expensive.

As far as the contract types that you'd see with these, your typical specific is going to be 12/12, 12/15, 15/12, whatever. You do see the same with organ transplants, but very often they're written in a form that covers all expenses incurred some number of days prior to the actual transplant and then commonly a year after the transplant. Usually somebody who's having a transplant will incur expenses that are related to the condition that brings about the transplant for a few days beforehand and then some number of days afterward.

It's common under these programs to include transportation and storage costs related to the transplant. Sometimes they'll include the cost of a hotel for relatives to stay or if somebody has to be transported somewhere to do the transplant. There may be certain underwriting restrictions imposed, however, on the transplant. For example, getting back to a problem I alluded to earlier, the number of transplants may be limited. Two is very common. Another is that one may require that the person receiving the transplant had to be employed for some period prior to the transplant. Six months or a year is common. Obviously one wants to avoid a situation where somebody is hired purely to avail himself of the fact that he can get transplant coverage. So those sorts of things are fairly common. What Hillary Clinton might have to say about them you can only guess.

If you do decide to carve out organ transplants from the stop-loss coverage, one has to consider the impact on the ordinary specific program. The amount of that impact is probably going to vary depending on what the deductible you have on your specific program is. I point out that on these organ transplant coverages it's common to see a deductible anywhere from $50,000 to $150,000 and then coverage up to somewhere in the neighborhood of $250,000 to serve as the basic protection. If you raise that coverage up to, say, $1 million, then you've really totally carved out the organ transplants, because they rarely run that high. Nonetheless, based on all these factors, you'll want to figure out what discount you really ought to be getting off your basic specific plan.

I'd point out that there are a variety of PPO-like or center-of-excellence programs being marketed these days for people to have these things. A lot of insurance companies that have their own UR or large-claim-management departments may actually be doing their own negotiations, but there are several independent organizations that are kicking around out there.

Most insurance companies try to protect themselves by saying we don't cover experimental treatments. For example, baboon heart transplants are usually not covered. But one ought to be careful about the fact that technology is changing and what's experimental today may not be experimental next year. This has actually been something of a hot legislative issue. Especially with these breast cancer, bone marrow transplants, some states have seen fit to meddle in the issue of what is experimental and what isn't. There is actually a legislation in a couple of states I can think of that says we will decide what's experimental, not you. One really needs to be careful about feeling that you're covered because you have language in your contract that says, "We're not going to cover it if it's experimental."

Switching gears, I'd like to talk about what has, for a lot of carriers, been an issue in terms of pricing of specific stop loss. Should we use a manual approach, or should we use what I'm going to call a percent-of-expected-claims approach?

I can only echo what you've already heard from the two Mikes here -- that the stop-loss marketplace is getting a lot more crowded and we've got more carriers and MGUs leaping into the fray, all with different points of view about how they want to do pricing. It's a fair statement that the MGUs tend to incline toward the manual approach, and the carriers have tended to incline toward the percent-of-expected-claims approach. That may be changing some.

What I'm calling the manual approach really is based on the idea of we are going to build a separate stop-loss manual that is not in any way tied into the first-dollar manual that we already have. In determining the rate, the calculation is going to be done in a way very similar to the first-dollar manual, but the numbers that go into it are going to be completely different. First of all, you're probably going to start with a base claim cost. That number is based purely on one's experience or expectation of claims over certain deductibles.

Usually one would expect to reflect in this number the form of the specific stop-loss contract; that is, are we talking about a 12/12, 12/15, 12/24, whatever, and what kind of underwriting is going into this? Is there an actively at work provision, or is there not an actively at work provision? The other approach is, you start with a certain base claim cost that's just one contract, and then you stick in some multipliers based on whichever one of these contracts and underwriting requirements you have. But the idea is you want to reflect all these things in your base rate.

Second, consider the age/sex adjustment. This is a big difference between the stop-loss situation and the first-dollar situation. In the stop-loss situation, males are always more expensive than females. There are no maternity claims, in general, for stop-loss and so you don't have this little blip in the female curve in the younger ages. You can develop age/sex factors based on large claim experience, stick them in your

manual, and you don't run into any funny anomalies as you would in the first-dollar approach.

Then one might adjust for area, and you might wonder what could be the difference. There can be some differences in terms of very large claims between areas. For example, places where there is a prevalence of teaching hospitals or hospitals that specialize in burns or other claims that are likely to break specific deductibles.

Next, consider the underlying plan. Some states actually mandate that stop-loss rates vary by the underlying plan, even though one might feel that the difference among some underlying plans isn't a lot. If you start in this manual approach with just a basic rate, you probably are starting with some assumed average plan, and you'll want to try to develop differences for that underlying plan. My opinion is that there's no reason for the underlying plan to be an enormous difference in the rates.

Also, consider adjustment for managed care. With the stop-loss marketplace getting a lot more competitive, people are just writing in minus 10% PPO or maybe minus 20% or even minus 30%. If you're a reinsurer, you really scratch your head.

Managed care, I'd argue, is a lot more sensitive issue in the stop-loss marketplace than it is in the first dollar principally because the leveraging effect from the discounts that one might have on a PPO is magnified when you start talking about large deductibles. For example, you have a $200,000 expense with a 20% discount on it. That's a 20% reduction in claims. But if you have a $100,000 deductible, instead of being a $100,000 claim it's $60,000, which is a 40% reduction. At least that's the theory. The question is, does it really work that way?

I might also add that pricing for PPOs can become complicated because you have to consider the fact that if you go in network it's 100%, or if you want to go out of network it's 80%, relative to an indemnity plan. It's a question of whether the discounts that you get in the PPO plan sufficiently offset the fact that you're paying a lot higher coinsurance and have probably lower deductible in network. But when you're talking about a very high claim, it's 100% one way or the other, and all you really have to talk about is the discount.

Again, in theory these discounts ought to make a big impact, but you have to be careful about the PPO to make sure that the information you and somebody who's pricing that stop-loss product have is accurate. I recently had somebody come to me and say, "I have this PPO out here. So-and-so, my competition, is slashing the rates 30-40%. Why don't you take a look at this information and tell me whether it makes sense?" I looked at the information, and it was a physician directory. In one case, which the PPO claimed to have shown that it saved 40%, it included claims that it had denied as not medically necessary. It was very vague to me whether or not any indemnity program that had UR wouldn't have also denied those claims, in which case it sure wasn't a 40% discount.

One has to be careful of the source of the information that you're working on. One always has to be a little bit leery when UR and large-claim-management areas produce their own reports about how effective they are. If you don't understand what they did, you're probably going to be behind the eight ball.

Nonetheless, if you have a good PPO, there is a strong chance that it will significantly impact large claims. But I would also add that you have to be careful. Large claims are a unique animal. You need to understand just how complete that PPO is. You may have a PPO that's strong in terms of basic services and claims, but when it comes to these particular claims that are likely to generate $200,000-500,000 amounts, they may not be in network, in which case you don't have any discount. Last, you need to understand just what the network utilization of that PPO is. Again, just like for first dollar, if people aren't going in network in the first place, it's useless.

After the managed-care adjustment is trend adjustment. When you have a manual approach, the trend adjustment is very simple. Usually there's a table based on deductible amount. It's fairly easy to vary the trend by the deductible. The higher the deductible, the higher the trend. You may or may not make an industry adjustment. Mike Kemp touched a little bit on that. I haven't seen this adjustment made as much in the stop-loss marketplace as the first dollar. Some people do, and some people don't.

Let's go on to what I'm going to call the percent-of-expected-claims approach. You determine first-dollar expected claims, and you apply to that a percentage that is based on what portion of claims you expect to occur over whatever the given stop-loss deductible is. In theory, I suppose this makes some sense, especially if you're a carrier that's familiar with the first-dollar marketplace. You come up with your rate, you look at your table, and say, "I expect X percent of my claims to be over whatever the specific deductible is." You apply that to your rate, and there's your specific rate. This is not an off-the-wall approach, but I have to come down on the side of it being a little more difficult to manage and work with for reasons that will appear soon. Demographic adjustments can be made with this particular approach. All the adjustments I talked about earlier can be made with this approach. However, the first thing to note is that, while you've already adjusted for age, sex, area, or managed care in your first-dollar rate, you're going to adjust for it again in your percentage. You better take account of the fact that you've already made that adjustment in some way. That can get to be real confusing. First-dollar claims obviously follow their own demographics, as I eluded to earlier. If you're going to come along now and say, "We'd like to make a stop-loss adjustment in our pricing for these," you want to be careful not to double count.

In particular, I'd note that in first-dollar claims you really have problems there that don't translate into the stop loss. But the point is, when you're doing this percent-of-claims approach, the "stop-loss rate" is the percentage. One problem that you can run into when somebody comes to you and says, "Could you assess the competitiveness of this rate structure" and they give you the percentages, you don't know what the rates are.

If their first-dollar rates are a function of their manual, then you need to understand their manual. If they're a function of experience, then you need to understand how they're underwriting the experience. This becomes a two-step process and really requires a lot more work and a lot more thorough understanding of what's going on than under the manual.

There are other items in my comparison. The percentage method requires frequent updating of rates for trend. Let's say you start your stop-loss program using the percent-of-expected-claims approach. You determine your first-dollar rates and then you determine these percentages that show here's how many claims we expect to be above different deductibles. Six months later, those percentages are not good anymore. If you don't change them, you do pick up first-dollar trend, but you don't pick up deductible leveraging. The higher your deductible, the farther and farther off you're going to get from where you want to be. It's really necessary to look at those percentages maybe once a quarter or whatever and make sure that they're still in line.

Second, this percentage-of-expected-claims approach introduces a certain interdependence between low-cost claims and high-cost claims. That is, your rate for claims over $100,000 is a function of how many claims you had over $200, because it's a percentage of your total. It has never seemed to me that you really want to be taking low-dollar claims into account. Under the manual approach, you have a rate for claims over whatever the deductible is. You don't have to worry that your percentage is too high or too low because you had, for some funny reason, lots of low-cost claims, or lots of people who didn't have any claims.

Last, I would point out that you want to be careful in looking at your specific experience because these two coverages, specific and aggregate, do interact. You want to make sure that your specific deductibles are appropriate, that your aggregate attachment points are in line. You can have funny situations where one coverage or the other looks particularly bad because actually you've made a mistake on the other. Again, you've got to be careful.

MR. HOBSON D. CARROLL: I'm another reinsurer of stop-loss business. I have just a couple of comments. First, I think that we all know that the MGUs don't use either a manual or a percentage-of-claims approach. They use the "how low do I have to go to get the case" approach, and that's basically the truth of the marketplace. It's basically a commodity product, and that's why I coined the phrase SPAG for specific and aggregate. It's similar to Spam, and they're both canned meat these days.

A lot of these product differentiations that you have been talking about -- the two-year rate guarantee, the aggregate only, and so on -- are all reprocessed ideas from years and years ago. Rate guarantees were tried back in the early 1980s. They didn't sell. The aggregate only was tried by the same MGU at that time, and that didn't work. I studied an aggegate only program in the mid-1980s, and then before I went to the street with it, I took it to some TPAs to find out what they thought about it. I found some interesting things out.

The TPA said, "Interesting concept. We won't sell it. Number one, it means less commission to us, because it is less fixed cost." They were honest. The second thing that I found interesting was in the nature of the product. Specific and aggregate are two products that are completely separate in terms of their risk element, and one of them has a clean effect on the other, but they stand alone as far as loss experience is concerned. Here, you've combined them and overlapped them, so you now have two chances of one subsidizing the other and so obviously the fixed cost goes down. Somebody has to pay for that. Somebody has to balance the risk equation, and that is the employer who now has more of a chance for his

aggregate to subsidize his specific. The TPAs told me they don't like that because it negated one of their big selling points. They always had a story out of their notebook that they'd pull out when they were talking to a prospective self-funded employer. This story is about the guy who bought the specific and the aggregate and paid $50,000 in premium and had a $25,000 specific deductible. None of his employees submitted any claims all year, so he had no use of his aggregate and his wife, the employer's wife, had a $500,000 claim. The TPA did not want to not be able to use that story any more.

It's kind of interesting to see what will happen. It may be that today is a different environment and that MGUs can find a way to sell through that with certain TPAs on the fixed-cost piece. These products do introduce a lot of elements where we can actually bring some aspects of actuarial analysis and risk theory and some other things into play, if you so choose to get involved in them. I highly recommend, for example, on the split-funded product that Kevin talked about, that you do some risk-theory analysis from the macrostandpoint before you go charging a $0.50 premium and $1.50 funding for a $500,000 deductible that only generated $100,000 of manual premium. You say, "I'm no worse off in the maximum case as the risk taker, and I offer the employer the opportunity to be better off and so it's a great deal." Right? Well, you're forgetting that you theoretically need that premium when you would win and he has no claim to subsidize somebody else's losses.

MR. GABRIEL: Yes. I was actually waiting for somebody to ask the question of should the $0.50 and the $1.50 really add up to the $2.

MR. CARROLL: Well, I think it can, but I think it should be reversed. I think you need to study and analyze the product from the global standpoint and come up with a matrix of parameters in terms of the volume of the premium, the deductible size. Basically, what you want is a case where you can reasonably expect to pay out some claims. Let them self-fund that because if you can reasonably say that's going to happen, you're not costing yourself anything. But when you have a truly pooled level because the deductible is high and the premium is low or some other combination of factors, you probably don't want to split that. Then it becomes a marketing decision because I don't think it works out well from an actuarial standpoint.

The last comment I would make is I'd like to see if anybody sells the rate guarantee again. What I've heard from the TPAs when it came out was, again, it's a great idea, but we don't want to pay anything up-front for it. Of course, the rate guarantees are always a one-way street. Loss ratios are up. Trends are down. What do you think trend is on specific now these days?

MR. MCLEAN: On your rate guarantee, we offer a two-year rate guarantee. In retrospect, we might as well have offered it a couple of years ago because we haven't been able to get any rate increases anyway. It's kind of like group life insurance. If you had offered a five-year rate guarantee, that's good, but they don't go shop for it every year. They'll just stick with your relatively high rates. We're not selling much of it though. We tried to get the true leveraged trend that you would need and throw a couple of extra points in. It just basically didn't fit.

On the aggregate and specific, I would agree that a good case for aggregate and specific is a case that has a relatively high expected frequency of claims. If you have a very large case, a lot of employees, and a relatively low deductible, you have a lot of expected claims. This is a good case, and why just swap dollars and throw expenses on there? Let them self-fund a portion of it. I've seen some carriers out there that are doing aggregate and specific on any case with a deductible over $50,000. That is not a good idea, in my opinion, and I've seen another large carrier saying any premium over $100,000. As Hobson pointed out, if you have a $500,000 deductible, $100,000 of premium has no credibility.

MR. KEMP: If they have a $50,000 specific and they have a reasonable expectation they will pay a certain number of claims, they might as well just buy a higher specific deductible and not worry about the self-funding aspect of the aggregate and specific.

MR. GABRIEL: Who's doing lasering or not? There's a tendency now to generally have a little more pooled on the renewals. We do try to come up with lots of different bells and whistles, again, but from what I'm seeing, if somebody has a nickel better rate next door, employers really don't care if you have a family deductible or whatever. You can have some relationships with TPAs, but those relationships usually aren't worth more than about 10%.

MR. KEMP: I definitely agree with that. There are relatively few bells and whistles that you can add to the product that really make a true product differentiation, and the few that are out there have such a price impact that employers just aren't willing to pay it. They are looking to save every dollar they can off their stop-loss perks.

MR. GABRIEL: Just to follow up on some things I was saying, the bells and whistles that are out there are just artificial ways to get the going in price down in the hope that you won't suffer later.

MR. DANIEL L. WOLAK: A comment you made at the beginning of the session was that stop loss is being sold more as a commodity nowadays since we've increased the number of MGUs. One thing I would throw out here to challenge the group is to understand how your product is unique and different. If you're just purely a commodity, you're probably not going to last real long. You're just selling on price only, and there's always going to be somebody else there that's going to come in lower. The key is to develop an understanding of how your product is different in the customers' minds.

MR. GREGORY W. PARKER: I'd like to just offer a comment. I think there are a number of product variations that do actually create a true product differentiation, as Dan was suggesting, but unfortunately, like Mike says, nobody cares. It doesn't matter. If you have a contract or offer services that are well above the norm in the marketplace, nobody wants to pay for them -- kind of like your two-year rate guarantee.