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WHAT'S NEW IN STOP LOSS

Moderator: RICHARD J. NELSON
Panelists: ROBERT G. MALLISON, JR.
JOHN I. MANGE
Recorder: RICHARD J. NELSON

This session will cover emerging experience, underwriting trends, PPO pricing, competitive pricing, financial, new products, and hospital and physician-only issues.

MR. RICHARD J. NELSON: John Mange with Travelers will speak first, then Robert Mallison of VASA Brougher will speak; and I will finish the session.

MR. JOHN I. MANGE: Let me begin by telling you about how The Travelers participates in the stop-loss market. We do so in three ways: through our in-house ASO directly over the Travelers plan administration, through our wholly owned subsidiary third-party administrator, and through two general underwriter relationships.

In conjunction with our ASO product, we have a $30-million block of stop-loss insurance. Group size ranges from under 200 lives to several thousand lives. Individual deductibles range from $30,000 to $500,000. Most stop-loss policies include both individual and aggregate stop loss, but we do have a few policies with just one or the other, which are generally sold to larger customers. The aggregate stop loss has generally been sold without any form of inside limit. We have a true immediate reimbursement of our individual stop-loss claims, and we offer a monthly aggregate stop-loss accommodation program.

Through our wholly owned TPA, we have about a $15-million block of stop-loss. Group sizes range from 50 to 2,000 employees. Deductibles range from $20,000 to as high as $250,000, and most contracts are sold with both individual and aggregate stop loss. A quick turnaround in the stop-loss claim processing enables us to create the appearance of immediate reimbursement, even though there is a stop-loss claim adjudication process going on. An aggregate stop-loss monthly accommodation is also available.

Through our two managing general underwriter (MGU) relationships, we have a $30 million block in which groups range in size from 11 to 2,000 employees. The individual deductibles range from $3,000 to as high as $250,000. One of those MGUs specializes in what's known as family stop loss, which is individual stop loss in which the individual is a family unit. But again most contracts are sold with both individual and aggregate stop loss.

Rich asked me to speak about the captive ASO market and how The Travelers works in that market. Historically, stop loss has been an outgrowth of our insured business. It's been viewed as an accommodation. It was generally sold at cost by using a percentage-of-claims formula in which the profit was captured through some concept of an all-source gain built into the service fees. Not surprisingly, the financial results of our stop-loss programs have been lackluster, in between modest profits and modest losses. Despite low profit objectives and the lackluster results, our rates have

been perceived to be very non-competitive by our field. We've recently taken some fairly significant action to rectify that situation.

We established the stop-loss business unit as a profit center within the employee benefits division of The Travelers. We had several reasons for doing that. Stop loss is a high-leverage business, and little mistakes carry big price tags. We felt the need to exert direct control over the management of that business. Second, it will provide the focus that we need to enable the product to reach its full potential. Third, it will enable our underwriters to develop the necessary skills to compete effectively in the market. Fourth, it will enable us to provide effective guidance to our field force at the case level to effectively sell both the self-funding concept and stop loss.

We have significantly tightened our underwriting guidelines. We've begun examining large loss information in far greater detail than we have historically. For new business we now require disclosure of large losses to within 30 days of the effective date. On renewals, we've tied our underwriters into the case management system of The Travelers, which enables them to get detailed information that the case manager documents in the system regarding large loss situations. We've also introduced lasering into our new business practices. Lasering is a somewhat controversial practice that tends to go in and out of fashion. It's particularly common among captive ASO stop-loss carriers. Our perception is that lasering may be going out of fashion right now, but we thought that with the price of competitiveness it would offer us, it was worth taking the risk, at least in the short term. We've also introduced new sold case underwriting practices to ensure that what we price is actually what is sold.

We've also introduced a new rating formula. As I mentioned previously, we'd been using a percentage-of-claims formula, and we feel that that's led to a certain amount of antiselection within our book. We adopted a new formula that reflects the age, sex, area, and other characteristics of the stop-loss risk. We've also adjusted the formula to anticipate what we think the benefits would be of the tightening of our underwriting practices.

With respect to health care reform, I'll make a few observations. First, we perceive that a viable self-funded and stop-loss market will remain, though it may be forced to contract from today's level. Second, we perceive that comprehensive health care reform will mean a transfer of risk to providers, and we're currently examining alternatives to enter that marketplace.

I'd like to turn to the competitive situation. Let me look at aggregate stop-loss attachment points. We're finding that those are extremely competitive right now, and we've observed some highly questionable practices in the marketplace. An example is where a broker gave us a partial year of experience and a full policy year of experience. The partial year was running at about $50 per employee per month, and the full year was running at about $300 per employee per month. We weighed the two results in an appropriate fashion, but when we heard what the competitive quotes were, it appeared that competitors were relying entirely upon the partial year of experience to set their attachment points. We saw attachment points for that group as low as $90. We've been told that some competitors actually confessed to this fact, that when given multiple years of experience, they will choose the most

favorable year to set their attachment point. We've been told that some competitors handle large losses in a very aggressive fashion, at least in our view. If they see that the loss is nonrecurring, perhaps by the death of the individual, they will deduct the full loss and reflect nothing else in doing the attachment-point calculation.

Finally, we've been in a unique position in that we've been able to see what information competitors receive as well as what we receive from brokers. On the same case, we have received annual experience, while some of our competitors have received monthly experience. This has caused me to wonder whether brokers are actually selecting against us and our information requirements. If the brokers know that they can get by with giving us annualized experience, but they have to give monthly experience to the other guy, then the brokers will probably get a broader spectrum of quotes and be able to select against the carriers. I would urge caution in holding to your guidelines of information requirements.

Regarding financial terms, we're seeing a variety of terms designed either to reduce cash outlay or to limit rate increases. In terms of reducing cash outlay, we would call the situations we have observed premium risk sharing. For example, assume your manual comes in at a rate of $15 per employee per month on an individual stop-loss. You would offer a $12-per-employee-per-month rate, but if the plan's experience is adverse, then it would owe you $18 per employee per month for the entire policy period. It puts the plan sponsor at some additional risk on the individual stop-loss. Also, we're seeing an aggregate of the specifics in which all individual stop-loss claims are aggregated, and then a deductible is applied to that to determine what the eventual stop-loss reimbursement will be. Both of these approaches tend to lay additional risk onto the plan sponsor and take it away from the insurance carrier.

In terms of limiting rate increases, the most common approach we've seen is requests for rate guarantees of two or more years. We've also occasionally been asked to state a maximum rate increase for the renewal year. Of course, these require the carrier rather than the plan sponsor to accept more risk. We don't see a wide use of these approaches, but we do see some use.

We recently completed a study on the impact of PPOs on individual stop loss. We examined data that modeled both in- and out-of-network claims, and we segregated our medical services into three broad categories: inpatient, outpatient, and physician ancillary services. We observed the following as deductible increases. First, we observed that inpatient discounts tend to decrease as deductibles increase. The reason for that is that many inpatient arrangements have in them an outlier provision that gives the hospital additional reimbursement if billed charges exceed a stated amount, which might be $30,000 or $40,000. When you're looking at a stop-loss deductible in excess of $100,000, the outlier provision has to come into play. Thus the inpatient discounts tend to decrease as the deductibles increase.

Second, we observed very little variation in outpatient discounts as the deductibles increased. Third, we saw physicians' discounts increasing as deductibles increased. That is because sometimes physicians have fixed fees that don't vary much based on the complexity of the procedure. In this case you're actually getting an advantage as the deductibles increase, because as deductibles increase, the procedures will become more complex.

We saw very little variation in utilization of network hospital facilities as deductibles increased. Also, if you look at in- and out-of-network plans that had different out-of-pocket maximums, higher out-of-pocket maximums didn't seem to drive more people into the network.

The use of physicians in network decreases as deductibles go up. That's mainly because some specialties were referred out of network so that as you look at the most complex procedures, more of those were being referred out of network.

Finally, the mix of services tended to shift toward the hospital with increasing deductibles, which is natural and leaves some interesting consequences. First, despite the fact that inpatient hospital discounts decreased as deductibles increased, the inpatient hospital discounts were still frequently the deepest discount of any of the three categories. The shift in mix of services toward the inpatient hospital actually produced an increase in the discount level. In addition, due to deductible leveraging, the discounts would increase still further. In many cases, we saw very significant discounts in individual stop-loss claims. It's important that you examine each PPO site individually before setting your individual stop-loss discounts.

MR. ROBERT G. MALLISON, JR.: VASA Brougher is an MGU operating through third-party administrators offering stop-loss coverage primarily to smaller groups. We think that by using stop-loss deductibles, which may even go as low as $2,500, even smaller employers down to ten lives can enjoy the benefits of self-funding, which have been limited historically to the larger groups.

We found that with the smaller groups it's better to use a manual rating process to determine the stop-loss charges rather than use the percentage of premium, which is fairly common for the larger groups. We have observed in recent years that medical cost trends have been low. Our rating process uses a manual, and our manual has an automatic trend adjustment in it. Our trends and our manuals have been conservative, and as trends have turned out to be lower than what we anticipated, our loss ratios have been good and we've had favorable experience. On the other hand, we have seen quite a bit of price competition because of the low trends. The big question for us is how low we dare go, because trends are obviously going to come up sooner or later and we need to be prepared for that.

Jim mentioned that lasering seems to be going out of vogue a bit. We have taken a stand that we're not going to use lasering, even though it can help to keep prices competitive. We think that a lot of risk is being borne by the plan sponsors. Particularly when we're dealing with smaller groups, we don't think it is appropriate to push that risk to the plan sponsor. We have seen increased flexibility in underwriting. Actively-at-work clauses, preexisting conditions, and waiting periods are frequently waived. Again referring back to the low medical trends, as long as trends are low, the market is going to remain flexible regarding underwriting standards. But again, what's going to happen when trends start coming up and the bottom line starts to deteriorate?

Regarding some of the special financial arrangements, aggregating specific has been used as a way for the employer to share in the risk and also share in the benefits of favorable experience. We do offer a two-year rate guarantee, and we suggest it as a

possible way to mitigate the large increase going from the first year to the second year of a contract. Cases that are going from a 12/12 contract to a paid contract will see a big jump, and the question is, is it better to give them that big jump from the first year to the second year, or would it be more beneficial to give them a two-year rate where they can level off some of that jump-in-contract change? However, this does create a larger increase in the third year.

Regarding health care reform, the market is taking the first steps in reforming itself as far as providers taking risks. We're also doing some research into ways you can help the providers manage some of that risk that they'll be taking on. Again, we're primarily in the stop-loss business for small groups. If national health care reform passes in its current form, most of these groups are going to go away. Self-funding won't be allowed for groups under 100 lives, and some bills set this as high as 1,000 lives. Consequently, we are looking at the need to diversify.

I want to emphasize that we think that smaller employers can have an opportunity to benefit from self-funding with the low level of stop loss. Our rating methodology is to use a manual, so that you have a fixed and a variable portion of the cost. We think that one of the nice things about that is it provides a balance with one part of the cost being community rating, which is something that somebody in Washington thinks is a great idea. With small-group and low-deductible stop loss, we think that we have a piece of community rating, but we also retain a piece of employer responsibility. It gives the employer some incentive to implement cost-saving programs and managed care.

MR. NELSON: I thought I would relate a couple comments concerning health care reform I have received from some MGU clients. One is interested in diversifying, primarily in response to what Bob Mallison was talking about. If you have cases underneath 100 lives going away—and if you're an MGU many of your cases may be underneath 100 lives—then maybe you want to have some other lines of business. One client of ours decided it was going to market some other insurance products, and it was going to try to market travel accident. I think it is also going to market more life insurance. Whether these vehicles can produce enough revenue to offset stop-loss premium shrinkage, if part of its market goes away, is a big question. Certainly for many of the MGUs, national or state health care reform presents many problems. In the state of Missouri, where I live, the state legislature had proposed that the definition of self-funding would only be groups that did not buy stop loss. There would essentially have been no self-funding in the state of Missouri if the people with the department of insurance had gotten their way, but the legislature rejected the whole plan.

First, I will present some information on our most recent stop-loss survey (Table 1) that we are just completing. Then I want to get into talking about how we rate provider-specific stop loss; i.e., hospital-only or physician-only stop loss. We do our survey about once every six months or so to gather information on the stop-loss field, and we distribute the results to the carriers that participate and to others who are interested in the results.

TABLE 1
SURVEY FINDINGS
EXPECTED LOSS RATIOS

	Specific	Aggregate
Captive — no commissions	87%	82%
Captive — with commission	78	72
TPA	73	65
MGU	61	56

The expected loss ratios are separated into categories. Captive companies are carriers that both pay the claims and provide the stop-loss coverage. We have two other categories: a TPA writer is a carrier that would be working with a TPA directly, and then we have MGUs. The loss ratios are higher for captive business, intermediate for TPA business and somewhat lower for MGU business. The reasons for this are that higher commissions are paid on MGU business than on TPA, and higher on TPA than on captive, and there are fronting fees involved with MGUs. Also, MGUs use reinsurance to a greater extent, which generates some additional costs. The aggregate stop-loss ratios are generally less than specific stop-loss ratios.

The next topic is on renewal rating. The question is, in addition to your normal rating procedures, will you increase a premium if you know you have a large claim problem? There are some companies that say no they don't, and that's about 15% of the companies. Then 25% of the companies say that they will limit that increase, and that average is 50% among those 25% of the companies. Then approximately 60% of the companies say they will increase as needed.

The last point is whether companies are using a formal experience rating in setting their stop-loss premiums. That is, are they performing a procedure comparing premiums and claims for the specific stop loss itself and not premiums and claims for some basic level of cost? If you're taking your stop-loss cost as a percentage of your basic medical costs, and if you have high medical costs in one year, your stop-loss cost will be higher. That's not what I'm talking about. Here I'm talking about your premium and claim experience on your stop loss itself. Approximately half of the carriers state that they are using some sort of credibility arrangement on that.

People are interested in jumbo claims. In Table 2 we are restricting our attention to only those claims that exceed $100,000 above the specific stop-loss. The way this is calculated is that the $100,000 is actually included in calculating the percentages here. Probably about half of our contributors completed this, about 13 or 14 companies. These numbers seem to be reasonable in relation to other sets of data that I have seen.

The next question had to do with PPO rating and what their average premium discounts for their individual stop loss is. It varied greatly, all the way from some companies saying that they don't like to give discounts for PPOs to some fairly high amounts in excess of 20%, but the average was about 12%.

TABLE 2
SURVEY FINDINGS
LARGE CLAIMS (EXCESS $100,000)

	Percentage of Claims (S)
Transplants	6
Premature children	14
Leukemia	6
Cancer	17
Heart and stroke	19
Accidents	8
AIDS	3
Other	27

The next item has to do with the percentages of groups that carriers are quoting or have in force with PPOs. The average response for quotes was 55%, with the highest individual response being 85%. For in force the average was 50%.

Table 3 has to do with trend factors. We asked for actual experience in 1993 over 1992 and for projected future experience. The third column is a calculation of premium rates submitted for 7/94 divided by the premium rates submitted for 7/93 by contributors. We see some interesting things. The actual experience in 1993 over 1992 seems to be higher than my third column, and that surprised me. I would have thought that the first and third data columns would have been similar. The trends for future periods are lower than for prior years, but I think that those are probably not going to be able to be realized. The manuals that people are using will be cut back to reduce those trends. From some of the data that we look at, it looks like 1993 experience is coming in reasonably close to 1992 experience and that the financial performance is OK, but below target margins.

TABLE 3
SURVEY FINDINGS
TREND FACTORS

Specific Deductible ($000)	Actual Experience 1993/1992	Projected for Future Experience	Increase in Rates 7/94 over 7/93
10	15%	18%	8%
25	17	19	9
50	18	21	10
100	20	25	13
200	26	30	15

We wanted to talk about hospital-only stop loss and physician-only stop loss. Let me first talk about hospital-only stop loss. This I picture as having two different contexts. One, you could be selling hospital-only stop loss to the HMO that has a capitated arrangement with its physicians or is only interested in reinsuring its high-amount hospital claims. Second, there are hospitals that want to take capitation, and they may want protection against high-amount claims.

The key elements in our rating procedures for hospital-only stop loss are the stop-loss deductible, a per-diem-limit (if applicable), discount level, and quality of the managed-care organization. The last item is a softer element, and I will come back to it later.

We first set up a net claims costs table. We can set this up on an employee, on a family, or on a PMPM-type basis. The rates illustrated in Table 4 are for a specific point in time and would have to be adjusted for area. The cost could then be adjusted for demographics of your plan, effective date of the reinsurance, the maximum benefits available under the reinsurance, coinsurance, and the contract basis of the reinsurance.

TABLE 4
EXAMPLE — HOSPITAL ONLY
BASE NET MONTHLY COST

Deductible	$50,000	$75,000	$100,000
Per member/per month (PMPM) Cost	$10.81	$7.40	$5.77

As you can see in the upper left-hand corner of Table 5, with a zero discount and no per-diem maximum we have a pricing factor of 1. As you move down toward the bottom right, the pricing factor gets smaller and smaller for lower per-diem maximums and deeper discounts.

TABLE 5
EXAMPLE — HOSPITAL ONLY
PRICING FACTOR PER DIEM MAXIMUM

Discount	None	$4,000	$3,000	$2,000
0%	1.000	0.883	0.774	0.588
10	0.809	0.753	0.651	0.523
20	0.641	0.627	0.541	0.452
30	0.486	0.486	0.439	0.363

For example, assume (a) that the discount percentage for network hospitals is 20%, (b) 90% of services are in-network, and (c) the per diem maximum is $3,000. Then the composite pricing factor is $0.9 \times 0.541 + 0.1 \times 0.774 = 0.564$. The PMPM claim cost for a $100,000 deductible is $0.564 \times \$5.77 = \$3.25$ PMPM. This is a simple rating example.

We have not talked about quality of the managed care organization; i.e., how good is the network that is using these stop-loss tables? This is a judgmental thing, and I think that it should take two different approaches. You have to look at the protocols, and the utilization procedures. If it's an HMO, it should be gathering stop-loss experience. If you get up to 60, 70, 80, 90, or 100 claims under your stop-loss provisions, then that should start to be credible. I think those two elements—the protocols and the utilization review procedures that are inherent in the network—need to be combined with the experience of that HMO's stop loss to further adjust this pricing factor that we've just used. Conceivably you might even go lower than the

manual if the utilization review seems to be producing stop-loss claims that are lower than what is inherent in your manual.

For physician-only stop loss (Table 6) we have a list of items similar to hospital stop loss; i.e., stop-loss deductible, discount level, quality of the managed-care organization. It's essentially the same procedure as with the hospital only. We develop base PMPM costs and/or single/family costs for various physician-only deductibles. Then we apply a pricing factor (Table 7).

TABLE 6
EXAMPLE — PHYSICIAN ONLY
BASE NET MONTHLY COST

Deductible	$10,000	$15,000	$20,000
PMPM Cost	$3.10	$2.04	$1.48

TABLE 7
EXAMPLE — PHYSICIAN ONLY
PRICING FACTOR

Discount	Pricing Factor
0%	1.000
10	0.756
20	0.546
30	0.372

For example, assume that the discount percentage for network physicians is 20%, and that 90% of services are in-network. Then the composite pricing factor is $0.9 \times 0.546 + 0.10 \times 1.000 = 0.591$. The PMPM claim cost for a $15,000 deductible is $0.591 \times \$2.04 = \$1.21$ PMPM.

MS. BARBARA R. POSNICK: I'm from Blue Cross/Blue Shield of Massachusetts. I have a question for you Rick about Table 3. It looked a lot like something I just showed our product and marketing folks and got questioned on. In the stop-loss area your actual trends going from 1992 to 1993 were lower than your projected experience trends for all of the deductible levels. What is there specifically that we're seeing in cost, utilization, or technology that would lead us to believe that the future trends are going to be higher than the experience trends?

MR. NELSON: I am somewhat puzzled at that table as I told you when I was presenting it. I was expecting the projected trends to be lower, also. Rate increases have been lower than projected trends.

MR. DAVID P. MAMUSCIA: I'm from Blue Cross/Blue Shield of Michigan. We don't laser; could you explain that to me? I'm not really sure I understand it.

MR. MANGE: Lasering refers to setting a separate, higher deductible for one individual within a group. You need to keep in mind that stop-loss indemnifies the employee benefit plan and has nothing to do with the employees' coverage. So the employee

continues to receive full coverage, but the stop-loss plan just reimburses after a higher deductible for a given member.

FROM THE FLOOR: I got the impression that laser meant you just took them right out, but you say you limit the coverage of the stop loss. Are some lasered out completely?

MR. MANGE: Generally I distinguish lasering from excluding people, but yes, occasionally you will see some policies where a person is totally excluded.

FROM THE FLOOR: This is a question on the physician hospital organization (PHO) kind of stop-loss coverage that you were talking about. What type of company is used: casualty, accident and health, or reinsurance?

MR. NELSON: I have one product in front of me and it looks like it's going through a casualty company.

FROM THE FLOOR: What I've heard is that the half dozen or so carriers that are in the market today are mostly doing it through reinsurance agreements. They have basically revised their HMO reinsurance agreements. There are some who think that the provider should be filed and no one is really certain how to file it, either as accident and health or as property/casualty.

FROM THE FLOOR: Did you say they reinsure it just in the instance where there was an underlying HMO? From what I understand, PHOs aren't necessarily HMOs but are only subcontractors to HMOs and don't necessarily have the HMO enabling charters.

FROM THE FLOOR: That's correct. All they're doing is taking their HMO reinsurance and marking it up so that it now looks like a provider-excess arrangement. They simply use that marked-up version of it. They think the variable language is there to let them do that.

FROM THE FLOOR: I want to follow up on that comment. I'm from CNA Insurance. We're looking at coming up with a provider excess, and we plan on filing it as a casualty product.

FROM THE FLOOR: Bob, on your low stop-loss deductible levels, have you encountered any problems with the groups still being considered self-funded, even with the level as low as $2,500, and being able to escape state mandates?

MR. MALLISON: It varies from state to state. However, most of the states allow it as long as we're indemnifying the employer's plan document and not providing any coverage to individual employees. Some states have a limitation of a minimum specific stop-loss deductible of, say, $25,000. That makes it unfeasible for smaller groups to self-fund in those states.

MR. DAVID WILLIAM DICKSON: I know that in Missouri and Kansas, the state insurance department bulletins have attempted to regulate out anything below, say, a $10,000 specific and a 125% aggregate saying anything below that would be subject to state mandates, premium tax, and small-group-reform laws.