RECORD, Volume 22, No. 2*

Colorado Springs Meeting
June 26–28, 1996

Session 81PD
The Use of Small-Employer Health Reinsurance Programs

Track: Reinsurance
Key words: Legislation and Regulation, Reinsurance, Substandard Insurance

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Recorder: LISA M. GERACI

Summary: This panel will examine current issues involving disability income (DI) reinsurance, both the direct writer and reinsurer viewpoints, which includes:

- *Recent experience of DI reinsurers*
- *Current problems facing DI writers and what reinsurance can do to help*
- *DI reinsurers' reaction to recent claims*
- *The DI reinsurance market of the future*

Mr. James T. O'Connor: Many states have established small-employer health reinsurance programs in order to provide carriers with at least some protection from having to guarantee issue coverage to high-risk employees. This session looks at the structure and the experience of these programs and the use of these programs by carriers.

I am a consulting actuary with Milliman & Robertson. I specialize in small group and individual health insurance, and in particular, I have assisted numerous states with the pricing of these programs. I will talk about the plan designs and rate development used in these programs.

Our second speaker is Karl Ideman. Karl is vice president of United HealthCare and is responsible for the administration of most of these state-sponsored

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small-employer reinsurance plans. He will describe the experience of the various programs, including the enrollment statistics and assessment activity.

John Dante, our third panelist, is an assistant vice president of Managed Health Care for Guardian. He is responsible for directing Guardian's participation in these reinsurance programs. John will discuss the carrier strategies regarding the use of these programs.

Ms. Lisa Geraci is an actuary with Celtic Health Plans and has graciously agreed to act as our recorder for this session.

We are going to be looking at the design and pricing of the reinsurance plans. We are going to examine these in three steps: first, the types of plan benefit designs that are out there, second, legal restrictions that affect the design and/or the pricing of these programs, and finally, the pricing methodologies that have been used to arrive at the reinsurance premiums.

PLAN DESIGNS

Sometimes the minimum benefits are dictated by law. Some state laws are more detailed in dictating minimum benefits, and others have completely left it up to a plan design committee. The plan design committees are generally appointed by the insurance commissioner or governor, or in some cases the reinsurance program board will either appoint them or act as the committee itself. The program boards comprise a variety of different people representing the various communities that are affected by these programs.

The plan designs generally need to be approved by the insurance commissioners. Most of the states have designed a standard and basic plan. There are some that call for one or the other, but what they are called is really not all that significant. Some states have strictly come out with just the two plans, but no options to them. Others have come out with numerous options, including mostly deductible options, but there are also HMO plans that have been designed as well as PPO plans that differ from the indemnity standard and basic plans. We will see that there is a lot of commonality between the plans. However, there is a fair amount of variation in terms of the detail that goes into those plans.

Deductibles are common to all the indemnity and PPO plans that have been designed. Table 1 gives you an idea of how they are distributed amongst the 20 basic plans and the 25 standard plans for which I had information. You can see that the standard plans are bunched up around the $500 deductible level. There are some standard plans that do have deductible options, and some are reflected here, but definitely the $500 deductible is the most common of the standard plans. If we

look at the basic plans the deductibles are all over the place, ranging anywhere from $200 to $1,000, where $1,000 is the most common of the deductibles for those plans.

TABLE 1
PLAN DESIGN: DEDUCTIBLES
DEDUCTIBLE DISTRIBUTION

Deductible	Basic Plan	Standard Plan
$ 150	0	1
200	1	1
250	3	1
300	1	2
500	5	14
750	1	0
1,000	8	4
1,500	0	1
2,500	0	1
7,500	1	0
Total Count	20	25

We can move on to the co-insurance or the benefit percentage levels. Again, we see from Table 2 that the vast majority of the standard indemnity plans are 80/20 plans. States that have PPO plans often vary the co-insurance percentage from the standard indemnity plan, typical of what the market is also doing. The basic plan benefit percentages tend to be lower than the standard plan and are well spread between 50%, 60%, and 70%, and a couple of states are quite straight 80%. Again, there is a lot of variation in the basic plans.

TABLE 2
PLAN DESIGN: COINSURANCE LEVELS
COINSURANCE DISTRIBUTION

Coinsurance	Basic Plan	Standard Plan
50%	5	0
60%	5	1
70%	5	2
75%	1	1
80%	2	14
Total Count	18	18

Similarly, there is a lot of variation for out-of-pocket limits (Table 3). Under the standard plan, less than $3,000 is the most common. This reflects about a $2,500 out-of-pocket limit after deductible, but again, the basic plans are spread very wide as to where the out-of-pocket limits are.

TABLE 3
PLAN DESIGN: OUT-OF-POCKET LIMITS
OUT-OF-POCKET DISTRIBUTION

OUT-OF-POCKET LIMIT	BASIC PLAN	STANDARD PLAN
< $1,000	0	0
< $2,000	2	4
< $3,000	2	9
< $4,000	2	4
< $5,000	5	1
< $6,000	3	1
< $7,000	1	3
< $8,000	0	0
< $9,000	1	0
No Limit	2	0
Total Count	18	22

Finally, a million dollars is definitely the common maximum benefit for both standard and basic plans (Table 4). You will see, however, that some of the basic plans have some low maximum coverage. One plan has a $25,000 calendar-year-period maximum, and a couple have $50,000 caps. Those states were aiming at getting premium rates for these basic plans as low as they possibly could, and that is how they were able to affect it. The question is, do they really provide the type of coverage that these plans are intended to provide?

TABLE 4
PLAN DESIGN: MAXIMUM BENEFIT LIMITS
MAXIMUM BENEFIT DISTRIBUTION

Maximum Benefit	Basic Plan	Standard Plan
$ 25,000	1	0
50,000	2	0
100,000	1	0
250,000	1	0
500,000	1	0
1,000,000	11	17
$2,000,000	1	1
No Limit	1	1
Total Count	19	19

In addition to the cost-share items, there is also variation in the covered charges. Most of the plans, particularly the standard plans, are very similar to your basic street plan that is out there. However, the requirement to cover maternity is an important difference. Many plans on the street do not necessarily cover maternity or make it optional, particularly in the mini-group market (under ten lives). Certain benefits, like mental health and substance abuse, and some pet coverages are sometimes included in these plans, but they vary quite a bit by state. Coverage limitations are more common in the basic plans than in the standard plan. Many of you have priced these plans yourselves; you have seen all these benefit differences.

Let me now describe the reinsurance program itself. Most of the programs cover up to the benefits of the basic or standard plans. I think Karl may talk more about that. They are generally subject to a $5,000 reinsurance deductible and an additional 10% of the next $50,000 of claims. Generally the total retention or maximum liability of the carrier is $10,000. This varies by state too, but this is by far the most common of the cost-share features of the reinsurance programs.

LEGAL RESTRICTIONS

There are legal restrictions on reinsurance rates. When pricing these plans, we need to look at what the law is saying and the restrictions to which we must adhere. Most states follow the NAIC model, which calls for the development of a base rate. The base rate is a rate that we, as actuaries, would develop if we were going to sell this plan on the street, subject to a certain restriction. That restriction in most states is that the rates should approximate those rates that are charged to small-employers for coverage similar to the standard plan.

This clause varies from state to state, and the words that are used can make a difference in terms of how these reinsurance premiums are generated. I interpret this type of language to mean the average charge for plans to small-employers, not necessarily the street rates that are out there. That makes a difference because the street rates tend to be far lower than the average rates being charged to small-employers. There is at least one state that specifies that the interpretation of the language is that the street rate should be used. In that case, we would start with a street rate.

How do we get these rates? Fortunately, there is some information available. Unfortunately, all the carriers who are participating in the given state do not make their rates available to the state or to the people who are pricing these plans. Generally, we will look for whatever rates can be attained. We will later talk about how we use these surveyed rates to arrive at a rate that is representative of rates being charged to small-employers.

The second restriction on rates is one with which we are all probably familiar. If you are going to put an entire group into the reinsurance pool, the premium that you pay for that reinsurance is one-and-a-half times the base reinsurance rate, and if you choose to place an individual into the pool, then your reinsurance premium is five times the base reinsurance rate. These multipliers were devised as being representative of the average morbidity that might be expected to be realized by people being placed into the pool. Karl will have some statistics for us that will demonstrate how well insurance carriers are in fact using their underwriting strategies for placing people in the pools, in terms of whether they are paying too much for putting people into the pools.

RATING METHODOLOGY

Following is the outline of one rating methodology. The first step is an independent benefit rating evaluation of the plans. What we do is just like pricing any other plan. We evaluate the benefits and research the statistics you need for developing the expected claim costs for that given plan. We are not rating this initial plan for people who are going to be substandard. We are rating this for your average employer group, without the expectation of any kind of morbidity loads in the rates. Typically, when I am pricing these plans, I rely on the Milliman & Robertson Health Cost Guidelines to develop my expected claim costs for the plans, at least for the initial pass, and then compare the outcome of those results to the analysis of the market rates for similar plans.

As I said previously, the street rates are generally the only rates available for comparison. Not all those street rates are typically available, but a fair number are. We will try to amass the street rates for as many of the companies as possible, particularly those companies that are very active in that state, and compare those rates for similar plans. We will then make benefit adjustments to these plans to bring them to a common design. Typically the common design would be the standard plan that we are trying to price. Now the street rates are generally lower than the average rates that are actually being charged for small-employer groups because the average rates include in-force groups, as well as any new groups that are being added to the plan. We want to recognize that the street rates are not necessarily the rates to use, and that some kind of multiplier needs to be recognized in terms of how the average rate would vary from the street rates that we have.

The other problem that we face is the rates vary considerably from carrier to carrier, and plan to plan. In order to say that a given rate is the representative rate level, we need to somehow come to an averaging of the rates that are out there, and that can be a bit controversial. Generally, we try to find a midpoint somewhere in that range of rates. Particularly we will look to see who we think is a driving force in that state in terms of their market share.

We then need to adjust the base plan rates to a pure premium basis. We need to back out the expense loads, because most of the boards have made a decision that whatever expenses they are going to include are not typical of expense loads used by carriers. The majority of the states have made the decision that they will include little or no expense load in these premium rates, and that they will collect whatever expenses that they have through the assessment process. There are some exceptions, as some states add a certain per policy or per individual fee for policies or individuals enrolled into the pool. Often this may be the per capita fee charged by the plan administrator. Others will collect even that fee through the assessment process.

In order to adjust to a pure premium, we need to determine the expected loss ratios for this so-called representative plan, and we will adjust the market rates accordingly to get to a pure premium. Compare the pure premium to the claim costs that were generated independently and make adjustments to those claim costs to bring them up or down to the market level.

Once we have determined the base premium rates, we can determine the base reinsurance rates. That involves an evaluation of the claim probability distributions for these plan benefits to adjust for the $5,000 up front deductible and the 10% coinsurance level, and of course, any type of adjustment for the maximum benefit plan.

There may be a need for a trend adjustment. Some states have monthly trends; others just have annual rates that they charge. The annual rate states tend to be the smaller states. The trend adjustment that we will use is generally representative of what we see being used in the marketplace as trend.

Application of age, gender, and/or geographic area factors depends on how the board has decided to structure its rates. Generally most of these rates vary by age, some by gender, though most probably do not vary by area.

Finally, we make the adjustment for expense loads, once we have developed the reinsurance rate. That adjustment from my experience has usually been zero. In one state it was $7 and so it is an easy adjustment generally.

The final step in rate development is multiplying the base reinsurance rate by 1.5 for the rate for ceding the entire group and by 5 for rates for an individual employee or dependent. The NAIC model and most of the states have followed this formula. Some states, like Idaho, have varied. When it introduced its individual pool, it made a change to this, where it still used the 1.5, but it lowered the 5 for individuals within a group and it now uses 5 for true individual policies.

One other thing that states have done, and the law does allow the boards to do this, is give consideration to managed care. Most of the states give the board some flexibility to recognize the impact of managed care and to vary rates accordingly if they wish. They have done that by developing HMO and PPO plans with the rates based on some implicit utilization or discount assumptions. What the pricing actuary or the board dictates for these discounts or utilization adjustments can have a definite impact on the reinsurance rate. By comparing the kind of discount you are getting or the level of managed care, you actually have can make a difference as to whether these rates are more or less attractive to you.

The problem that the boards have is that it is too difficult to evaluate each managed care plan out there because plans vary greatly in terms of discounts and their levels of managed care applied to their PPOs or HMOs.

Those are the pricing considerations and the methodologies that are used in developing the reinsurance rates. As you probably know, these rates tend to be very high, especially for individuals with that five-times multiplier. Annual rates for older ages can be as high as $30,000 for a $5,000 deductible reinsurance plan. That, of course, accounts for some of the problem with attracting carriers to reinsure these plans.

STATE POOLS ORGANIZATION AND EXPERIENCE

Mr. Karl Ideman: I am going to talk about the state pools in terms of their organization and experience. What I would like to do is give you an overview of the states with the reinsurance mechanisms as they were designed originally in Connecticut and then adopted with the NAIC model legislation. I will try to cover their structure, how they operate, and their key features. First, let's look at some of the key features of guarantee issue reform because I think we see quite a bit of standardization and similarity across the states. I will show you a few statistics that I am collecting about the uninsured population in the states in order to see how someone can evaluate some of the programs in terms of marketing by the carriers and in terms of the impact on the access to insurance for small-employer workers and their dependents who do not have insurance.

I will also give you some enrollment statistics on the reinsurance programs. I have broken down the pools into three categories: large-activity pools, medium-activity pools, and low-activity pools. I am not trying to connote goodness or badness by size, although I think that might be a very interesting topic that we might discuss at the end of the session. I will try to at least set the stage for some of that discussion. You will see that there are some large differences in the size of the programs, obviously because of their age. However, some of the ones that are low activity are

going to stay low activity and those that are large are going to tend to stay fairly large.

I would like to tell you a little bit about the experience that we have seen in the programs to date. The earliest program began in 1991, and we have some relevant information based on that experience. I am going to show the experience by large-, medium- and low-activity programs, looking at each category in the aggregate. To help some of that comparison, at least for me, I grouped the programs and looked at their financial results at the end of their first full year of operation, their second full year of operation, and their third full year of operation.

I will also try to give you some statistics on the diagnosis codes for the claims in the programs. I will show you the diagnosis codes that are producing the largest losses in the programs. That will conclude the experience section of my presentation.

Next I will talk to you about the pool's assessment experience. The numbers show better-than-expected financial results of the programs, with assessments that are lower than expected as a percentage of the assessment base in the states.

Next I will try to wrap up with some administrative observations that will be financially oriented and operationally oriented.

STATES WITH POOLS

Let's take a look at the states that have the pools. After Connecticut started in 1991, seven were added in 1992 and six or seven states were added in 1993. There are some other reinsurance mechanisms that we don't administer and that I did not include in these numbers. I am just talking about the 22 programs that we administer. Overall there are 26 programs in 25 states that look like the programs that I am talking about. The first program started in Connecticut in 1991, and we have had the latest addition in Texas in 1995.

They all started out with the design that was done in Connecticut and then incorporated it into the NAIC model. One of the factors that contributed to the Connecticut program's large size was that it allowed ceding from the existing book, but otherwise the programs are similar from state to state. Every state has a plan of operation that governs the program. If you went from one plan of operation to the other, you would see that many of the sections are identical and are intended to be that way.

STRUCTURE AND OPERATION OF POOLS

Each program has a board of directors. The structure of the board of directors can vary. Some programs, like Connecticut, have only the industry and the

commissioner as an ex officio member on the board. Others have representation from small-employers, and some have agent representation, in addition to the carrier representation. In all cases, where the insurance department is actively involved in the reinsurance mechanisms, I have seen some true partnership and collaboration. I am not going to make many value judgments here, but the insurance departments have been very helpful to all of the programs and to us in getting them started.

A few comments on how pools operate. As Jim said, they provide financial protection to carriers. What happens is carriers select risks that they feel warrant ceding to the pool. Carriers have to notify the pool of the risks they intend to cede. In all states they have to notify within 60 days of the effective date of the insurance. The carriers then have to pay a monthly reinsurance premium.

In response to that notification and premium payment, the pool accepts all of those eligible risks. As you can picture, the insurance indemnification of those risks is really done by the carriers that are members of the pool, so this is a closed reinsurance system. What happens next is that the pool, in turn, indemnifies those risks subject to the reinsurance coverage.

Another point related to the operation is that the pool automatically renews coverage provided that the carrier has continued to pay the reinsurance premium and has not decided on its own to withdraw risk. Reinsured risks cannot stay in the programs if there is no longer insurance. As long as a risk is insured, and the carrier wants to reinsure it and pays the reinsurance premium, then the reinsurance is annually renewable as long as the pool is operating.

Carriers that made the decision to cede risks to the pool then adjudicate the claims for reinsurance purposes and submit those claims to the pool. We get the claim information that the carrier has adjudicated and reimburse the carrier. When all of that is said and done, and after we add the administrative expenses and taxes for the year, we determine the net losses of the program. If the net losses are enough to warrant an assessment, then that assessment is made to all the carriers that are members of the program, and, in most cases, it is based on the current year's small-employer premium pro rata market share basis for the carriers that are members. In certain states some carriers cannot be assessed for the losses of the program, because they are approved for risk-assuming status. In other states where there is not an opt-out provision, everybody can be assessed.

KEY FEATURES OF REFORM

What I would like to do now is to show you the key features of guarantee issue reform and continue to show you that there is quite a bit of standardization out

there. The thing that distinguishes the programs most is the group size factor. The states that have groups of one recognized, and we have seven of them, tend to be the states that have quite a bit of reinsurance activity and also tend to be states that have some other aggressive insurance reform.

We have groups of two recognized in eight states, and then most of the other states have 3–50 eligible employees. We still have six states that are staying with 1–25 eligible employees. That, in our view, seems to be the area where most of the reinsurance activity is and where most of the risk selection issues come into play.

Some other interesting points on the key features of guarantee issue reform are found in the benefit plans. We have a standard plan in 16 states and the basic plan in 17 states. The other states have prototype plans. I think one of the key characteristics that affects the size of the pools and the amount of risk that carriers have to bear is "guarantee issue all plans."

OVERVIEW OF THE UNINSURED IN THE STATES

What I would like to do now is give you a picture of some of the statistics that I got from the Urban Institute. The Urban Institute has published a huge data book on the insured and uninsured population.

In the 21 states that we administer, we have 4.2 million uninsured workers in small-employer firms who have not had coverage in the last 12 months. The average percentage of the uninsured in those companies is 28.2%. Iowa and Connecticut have the lowest percentage of uninsured workers in small-employer firms at 16.6% and 17% respectively. There is a significantly lower uninsured population in small-employer firms there. Texas and Florida have the highest with 37.2% and 37.5% respectively.

KEY FEATURES OF REINSURANCE PROGRAMS

What I would like to do now is bring you to the reinsurance mechanism itself. Assuming that you have a picture of the uninsured population and the way guarantee issue and the reinsurance mechanisms work, let's look at what the carriers have actually done. For the 22 programs that we currently administer, we have 9,747 lives reinsured. Sixty-nine were reinsured with whole group reinsurance. Males account for 35% of the in-force reinsurance business. The average age of the reinsured lives is 43 years.

THREE GROUPS OF POOLS BASED ON ACTIVITY

We have insured 24,172 lives in all of the programs since inception. Bear in mind that well over half of these programs are only two years old, so you have many programs that are just beginning. Connecticut, Florida, and Colorado account for

the lion's share of the lives that have been reinsured. I grouped these pools into large-activity pools with current size potential to grow to 1,000 lives or more. There are some pools with large relative activity, because of the relatively high amount of reinsurance as a percentage of the uninsured small-employer population, like in Wyoming.

The next thing I did is try to define the medium activity. Medium activity pools are those with potential for more than 100 lives or they currently have more than 100 lives. They have reinsured a larger percentage of the uninsured workers than the low-activity pools and they have some relevant claims experience. The states that I grouped together were Massachusetts, Minnesota, North Carolina, Tennessee, and Wyoming. Texas is either going to become a medium or a large activity state pool.

The low-activity pools are those that are going to stay below 100 reinsured lives, their relative reinsurance activity as a percentage of the uninsured population is going to be small, and they have almost no relevant claims experience.

LARGE POOLS EXPERIENCE

In the first year, for Connecticut, Florida, and Colorado, we had paid claims of $8.5 million and a paid premium of $16.7 million. Most of the paid premium is earned premium. The incurred losses as a percentage of earned premium for those three states in the first year was 115%.

In the second year, we are not even close to 200%. Paid claims were at $25.5 million in the second year, with $23.2 million in paid premiums. Incurred losses as a percentage of earned premium was 122.1%. Florida's loss development has been closer to what we expected—in the 180–190% range—and there are probably a couple of factors for that, which I can touch on later.

In the third year for the large pools, it looks like we have leveled out. Paid claims to paid premium is running 106.8%. Incurred losses as a percentage of earned premium is 134.1%. What we see with the large pools is that the loss development has been slow. It has tended to be surprisingly better than we thought in the first year and it still has not been as much as we thought in the second and third year.

MEDIUM POOLS EXPERIENCE

The medium pools have some similar characteristics to the large pools, but down quite a bit. I looked at the first-year numbers, and I saw very little in the way of claims. In the first partial year it is pure cash for the pools, but in the first full year we only ran 21.8%. Because there was no claims experience, the medium pools just stayed at an assumed 200% loss ratio, which obviously is an issue that needs to be addressed.

If we look at the second year, paid claims to paid premium is 40.6%. On the basis of the third year, we see some consistency with the second year for the medium-sized pools, but once again remember there's quite a bit of a difference when compared to the large pools. They tended to all cluster around a paid relationship, about 47.2%, as opposed to what you saw for the large pools.

LOW-ACTIVITY POOLS EXPERIENCE

The low-activity pools, Alaska, Arizona, Delaware, Iowa, Kansas, Maryland, Missouri, Montana, Ohio, Oklahoma, Oregon and South Carolina, are mostly new pools, but some have been around since 1992. We have paid premiums of $753,757 and paid claims since inception of $41,269. That is one of the reasons why I separated the low-activity pools from some of the other pools' financial results.

CLAIMS EXPERIENCE IN ALL POOLS

Let's now look at the diagnosis code groupings that you would be familiar with. The diagnosis code neoplasms, or cancer, has generated $10.7 million of losses. There is a significant number of losses that are unclassified. The second-highest total claims dollar amounts since inception are diseases of the circulatory system at $9.2 million, making up 11.7% of the total losses, and infectious parasitic diseases at $3.4 million.

ASSESSMENT EXPERIENCE

What I would like to do next is cover some information on the assessment experience in the pools. For the large pools, inception-to-date losses have totaled $17.5 million and the remaining unused loss reserve is $23.7 million. Assessments to date have only been $7 million, and we have had paid premiums exceeding paid claims by $8.4 million. What has been assessed so far for the large pools is less than 1%.

On the medium-sized pools, the numbers are also similar. We have cumulative assessments there of 0.014% of one year's assessment base for the medium-sized pools.

The same answer applies to the low-activity pools, but obviously those expenses and losses are mostly administrative expenses.

SUMMARY OBSERVATIONS

To summarize, here are some overall observations. The pools are financially sound. In most cases they have cash and they have developed a surplus without assessment.

Another overall observation is that the reimbursement process is cumbersome and it may be affecting the lack of carrier claims submission activity in certain states. It has definitely pushed the HMOs away from participating in the reinsurance mechanisms, except in Minnesota, and it may be a contributing factor to the low loss experience.

Another observation is that the reinsurance rules were designed to prevent gaming. Maybe we were too effective in forcing carriers to really guess who they were going to reinsure and also limiting the carriers as to when they could withdraw risks and how quickly they had to notify the programs of their intent to cede. Based on the results we have seen so far, we have not seen very much in the way of carriers doing splendidly in their reinsurance decisions.

What we are seeing is that the reinsurance mechanisms are being used by the carriers in some states. The big plus is that, if the times change, and there is a need to be able to provide some additional financial protection to the programs, the pools offer that. They exist and can be managed effectively by a board. They can be controlled fairly easily, they can take on additional risk, if that is necessary, and they can spread that risk.

It is obvious that they have been structured to avoid gaming and antiselection and have the ability to provide appropriate sharing of the cost of reform. Obviously one of the other important issues is the opt-out provision, because, if you do not have all the carriers participating in the program, there are some limitations as to how effectively you can spread the cost of the reform amongst all the carriers on a pro rata basis.

The last thought I will leave you with is something I have been pondering for a while. Does the better-than-expected loss ratios and low reinsurance activity in quite a few of the states mean that guarantee issue, even in the most aggressive states, has been shouldered easily by the carriers? Perhaps if certain people who want to see more aggressive reform also see how easily the carriers seem to be handling the reform, there may be some additional pressure to push harder on more reform. It certainly does not look like the industry has had too much of a problem so far.

A last summary comment is I think the carriers, although they have some administrative issues related to reimbursement which we are working on, still find the reinsurance mechanisms as something they can work with fairly easily.

Let me now introduce John Dante. He will give you some specifics on the carriers' perspective on the reinsurance mechanisms.

Mr. John Dante: As Karl said, I am going to talk about the reinsurance pools from a carrier's perspective. An analogy that I would like to make about the reinsurance pools and carriers is that, initially, they were akin to the Persian Gulf War. I mean this in the sense that going into it, the carriers thought that there would be heavy casualties, and I think the carriers were similarly afraid of the pools. As it ended up, the fears did not materialize, and although the war is not yet over with respect to the pools, there has not been the damage that we thought would be done.

I want to reiterate the objectives of the insurance pools. A major objective is spreading the cost of high risks in a reform environment. By reform environment, I mean the regulations that require guarantee issue, rating restrictions, no underwriting, etc. The reinsurance pool also enables carriers who would otherwise exit, because of an unacceptable level of risk, to remain in the market. This would be mainly the smaller carriers that could not compete in that type of environment without a pool.

The questions that the carriers participating in a pool need to ask themselves is, when is it advantageous to pool risks? And if the decision is made to cede a risk, how does one decide between ceding a group and ceding an individual? For the first question, when is it advantageous to cede? From a very simplistic point of view, it is advantageous when the cost of the expected claims above the retention limit exceeds the reinsurance premium. Additionally, it is advantageous when there are recurring specific high-risk conditions present. You want to think of the pools as long term, not as short term. This will impact the selection of which risks to cede to the pool.

What do I mean by the retention limit? The NAIC model has a $5,000 deductible. The pool then pays 90% of the next $50,000, so the total maximum liability for a carrier is $10,000 per life.

The second question is, when to choose to cede a group over individuals, and again from a very simplistic point of view, it is when your decision process tells you that there is a greater savings reinsuring the group versus the individuals.

Let's get into more details about the decision process itself. First, you need to estimate the claims for each individual and the group as a whole. Then you want to estimate the portion of claims that will be in excess of the retention limit. This can be derived using a claims distribution that has probabilities of claims at various amounts. You then compute the reinsurance premium for each substandard individual and for the whole group. At this point, you do your comparisons. If the portion of claims in excess of the retention limit exceeds the reinsurance premium, then you want to cede that particular substandard individual.

The same is true when you compare all the individuals in a group and all the claims in the group. If the total amount of claims in excess of the retention limit exceeds the reinsurance premium, it is advantageous to cede the group. How do you tell? Basically, it is based on the savings. Also, if there are multiple substandard individuals, you take the sum of them on each of the individuals and compare it to the savings on the group as a whole.

I made up a hypothetical example of a group of eight individuals that we consider ceding to the pool. The first step is to look at the claims cost, and in this instance, seven individuals have a normal claims cost (no substandard conditions) of $200 per person per month. We have one substandard individual who we believe is going to be 400% of the normal claims cost or $800. We need to see what portion of the claims are in excess of the retention limit. Again, the factors 40/70% could be derived from a claims distribution. We expect that for the seven individuals that 40% of their claims costs would be reimbursed by the pool and for the one substandard individual it is a much larger amount, 70%, yielding coincidentally identical answers in terms of the portion that we would expect to be reimbursed by the pool. So the total excess claims from the substandard individual is $560, and for the group it is just $560 plus $560, or $1,120.

Then we move on to calculating the reinsurance premium. As Jim explained, the market rate is tied to the existing rates in that particular state. When it comes down to the actual reinsurance premium, if you reinsure an individual, it would be 500% of the market rate ($100) or $500, and if you decide to reinsure the group, it's 150% of the $100 or $150. The total reinsurance premium for that one individual is $500 and the group of 8 is just $150 times 8 or $1,200.

Then in the end, you do your final comparison. We start with the individual. We see that we expect to get $560 of claims reimbursed from the pool, but we are only paying out a $500 reinsurance premium; therefore, it is worthwhile for us to cede to the pool because the savings is $60. On the other hand, for the group we expect to get $1,120 back from the pool and we are paying $1,200. There is a loss of $80, so it is not worthwhile to pool the group. When you have multiple individuals, and you are considering reinsuring multiple substandard, you have to take that first $60 and add it to the other pieces when you do your comparison to the total group. If you were making $100 for the group, and you were making $60 and $20 on two individuals, then it would be more advantageous to pool the group.

The next topic is strategies of carriers with respect to reinsurance pools. I would not really say that all these strategies are ones that I would advocate anybody use. I think that these are some of the strategies that I have been made aware of or that I've seen along the way. I think it results from carriers going through this whole

progression in terms of initially being fearful. Out of this fearfulness some irrational behavior resulted, but now things have settled down. Some carriers tried initially to pool all their groups. Obviously, this did not last very long. The alternative for other carriers is to participate in the pools, but not cede any lives. It could be that they are waiting on the sidelines for their experience to sour and maybe then they might put a few individuals in. As Karl mentioned, you cannot put in-force individuals in for most of these pools, so you have to tighten up on your new business. That is not really going to be effective in combating or lowering your loss ratio.

I have known of one carrier whose decision process was to exit the state if there was guarantee issue in the state but no reinsurance pool. I do not know whether its strategy is still the same today.

Then there are HMO considerations. An HMO that prides itself on claims management would obviously be more conservative if it had to live by the same rules as the indemnity carriers do. HMOs believe they have things under control themselves, especially where there is capitation. There is not much of a need relative to the indemnity carriers to put groups or individuals in the pool. I think the bottom line really depends on reform. As you go from mild reform with rating restrictions within plus or minus 35%, to the extreme where there is guaranteed issue on all of your plans, and not just on the basic and standard in the particular states, then your strategy needs to be adjusted.

If there are states that have a plus or minus 35% rate band, we will not consider reinsuring or even asking the individual medical questions to groups above 25 lives, because we feel that for the larger groups, we would not be subject to the same risks as with the smaller groups.

In most states you can decide whether to be risk-assuming or reinsuring. Risk-assuming means that you are not going to participate in the pool and that you basically retain 100% of your risk. Reinsuring means the ability to cede individuals. Typically, you must make the choice when the pool is first established and there is limited ability to change later. The NAIC has a two-year initial period and five-year period thereafter. Typically, when the plan of operations is approved, you have 180 days to make your initial designation. In at least one state we wanted to be risk-assuming, but we missed the date and had to be reinsuring for a couple of years until the next period.

The important issue to consider when you are deciding to be a risk-assuming or reinsuring carrier is the nature of the reform. As I said before, the range goes from mild (where you have the plus or minus ratings and you can rate for health) to

extreme (where you have guarantee issue of all your products and there is no health rating or underwriting allowed).

The average size of groups is important too. A carrier with an average group size of 5 lives would have greater reinsurance activity than a carrier with an average group size of 30 lives. Another issue to consider is the adequacy of the administration systems. Can you keep up with what is needed at the underwriting level? Can you handle the double adjudication of claims? Our company uses a test system to do the double adjudication of claims. A test system is a system that is a copycat of the claims system, but does not flow to the financial statements.

I was at one board meeting where a carrier was asking for an exception with respect to its administration because the person who usually does the pool was on vacation and some things were missed. You have to ask yourself when you are making a decision from an administrative point of view, is this going to be a hassle for you or can this be handled?

The plan of operation of the pool contains the rules of the game and it is important to read them. It is akin to reading the rules in a board game. I think that we would all rather just play and not bother with the rules, but we found out in Minnesota with their short time frame for submitting claims that we had a few claims rejected. We just thought Minnesota was just like all the other pools with an adequate period for submitting claims, so this is important.

Other considerations would include sales and lapse rates. If there is significant turnover, there is a question as to whether you should invest the money in the pool. Risk tolerance is also a consideration, although some carriers, especially small carriers, may not have the choice. To be a risk-assuming carrier, you need to submit a lot of financial information. I think the pools want to see that you can handle not being in the pool from the risk point of view.

The quality of your managed care network is an important consideration. If you are confident that you are getting discounts and your claims are under control, that is a decision parameter. Either you do not have to get involved with the pools or you can take a more conservative approach in terms of ceding when you do get involved.

The quality of producers also has an impact. Are your producers going to bring you the dog cases or will they bring you quality business? There is a fine line with this, because in a state where there is no underwriting allowed, you cannot directly or indirectly encourage your producers to do the underwriting at the field level.

The advantages of being a reinsuring carrier are: you have the ability cede risks to the pool; there's catastrophic risk protection; there are subsidies from other carriers if you are profiting from the pool; and, for the small carriers, it may be the mechanism that allows them to stay in the market.

The disadvantages of being a reinsuring carrier are: pool assessments are needed to cover losses; there's the administrative burden from the claims; there's the double adjudication and the additional level of underwriting; and if you are not profiting from the pool, subsidies are needed to other carriers.

The advantages of being a risk-assuming carrier are: there are no assessments and no additional administrative costs in terms of the underwriting and double adjudication, and you do not get into cross subsidies with other carriers. It is not always true that there are no assessments, because as Karl had mentioned, some of the expenses get pro rated over all the carriers, not just the reinsuring carriers. Then with respect to losses, although we have not seen tremendous losses in the pools yet, there is a tier formula that first goes to the reinsuring carriers and then kicks up to all the other carriers doing business in that state. Certainly the assessments would be less as a risk-assuming carrier than as a reinsurer.

The disadvantages of being a risk-assuming carrier are: there's an inability to cede risks and responsibility for catastrophic risks. There are other things with respect to my own company as a risk-assuming carrier: If a particular state needs more revenue or has more substandard individuals, you need to find other states or other premium income to balance it out, and that is not always an easy thing to work out.

Finally, what are the strategies for the future? Much like the Colorado Avalanche that just won the Stanley Cup, you have to master the game, be selective in your ceding, and try to profit from the pools. If you profit from the pools, you have your rates subsidized by other carriers. If you do not, consider becoming a risk-assuming carrier.

What we have seen initially is that these strategies in some instances were somewhat irrational, but I think carriers have settled down. I think these days we are seeing more carriers being selective with their ceding, and there are more applications to become risk-assuming carriers being submitted.

Mr. O'Connor: Either they are not putting in the work to make those assessments, or they just believe that the cost is too much except in some very clear cases.

Mr. Ideman: Just some feedback that we have gotten in a couple of the board meetings, and it does indicate, not surprisingly, that the amount of marketing

activity in the lower end of the small-group market and groups of, I would say, less than three, tends to be uneven in the marketplace. It probably is borne out by what we see as some of the impact on the activity, and that is feedback from carriers that have come to several board meetings.

Mr. Dante: I think we addressed the accessibility issue, but the affordability issue has not been addressed yet. Our company has only 26 standard or statutory plans in the country and half of those are in New Mexico with the alliance. So we have a dozen statutory plans throughout the country for a carrier that is in most of the states. I am leaving out states like Maryland, New Jersey, and Kentucky, where statutory plans take more of a prominent role. Part of it could be that we have a large portfolio of offerings, and the statutory plans do not hold any edge over our existing portfolio.

From the Floor: Is this $5,000 deductible for the calendar year or policy year?

Mr. Ideman: It is a calendar-year deductible.

Mr. Joseph W. Moran: This is going to be a question prefaced with a little bit of preamble. I'm a consulting actuary. Back when the reinsurance pool design was first being concocted, the fundamental objective with reinsurance should have been a device that would enable carriers to be essentially risk neutral in their marketing of small-group coverage. In other words, the carrier should not be financially penalized because it has a disproportionate number of high-cost business in its small-group portfolio. Once the concept of a reinsurance deductible was introduced, for understandable reasons, mainly associated with the HMO business, the parameters suddenly changed, and every carrier that happened to get a disproportionately large share of high-cost risks, ended up with a significant expected financial drain with respect to the first $5,000 of claims costs on those risks. The result was that the carriers had to continue to try to avoid high-cost risks. They were trying to avoid having too many of them. When I was on the board in Connecticut, we were just beginning to get into the question of market conduct review as an element of policing the marketing practices in the small group market. To what extent do you think that failure to adequately police market conduct activities, such as a delay in handling applications and shuttling groups to other brokers, may have contributed to the failure to achieve effective penetration among the small groups that are high-cost risks, which have resulted in reinsurance programs that are less costly than expected? That is a question for all of the panelists.

Mr. O'Connor: I think that one of the things that can be observed with the carriers that I have talked to is very few have sold standard and basic plans, so that they are

not subjecting themselves much to the guarantee issue. It may be very likely that the reason for this is that they have effectively had their agents do field underwriting. I do not necessarily think this is deliberate. The process of being trained and selling their regular products over the years has led the agents, for the most part, to continue to promote them.

The other thing that is diminishing the activities in the pools is simply the high cost of the program scale. People are not sending groups or individuals in the pools simply because those premium rates, coupled with the $5,000 deductible and the 10% co-insurance is a very high cost.