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Medical Reinsurance—What Has Happened to This Market?

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Summary: The panelists begin with a review of the recent history of medical reinsurance, looking at profitability, growth, and trends in the medical reinsurance market.

The panelists then shift focus to the current environment and issues, such as the increase in the number of reinsurers, problems in the small group medical reinsurance market, and increases in aggregate stop-loss claims experience. The session concludes with a discussion on future trends and what these trends mean to the market.

Mr. Michael L. Frank: The topic we're going to talk about is what's happening in the medical reinsurance market. I am a senior vice president with Management Facilities Corporation (MFC). Joining me is Mike McLean who will talk about stop-loss. Mike is the chief executive officer of Medical Risk Managers (MRM). Also joining us is Kevin Gabriel from Phoenix Home Life who will talk about special risk insurance. We added special risk as part of the discussion because in the reinsurance business, a lot of product lines tend to be cross-related. As we get through our discussion, you might actually begin to see how they start to relate with each other.

What is the state of the fully insured medical reinsurance market? There are different types of medical reinsurance that you can buy in the fully insured market. There's the traditional quota share, in which you're taking a pro rata portion of reinsurance. There's portfolio excess, in which you might be taking a high level

deductible on an individual or purchasing an aggregate stop-loss cover on the entire experience. In some cases in the medical business, you might actually develop layers where, as an example, you may reinsure up to the first $100,000 and you might buy reinsurance for the next $100,000 to $100 million. Another type of reinsurance is insolvency reinsurance. Many insurance departments require HMOs to buy insolvency insurance. The last type of medical reinsurance is financial reinsurance, which some of you may be exposed to. That often deals with some of the risk-based capital issues.

What are some reasons for purchasing reinsurance? (1) Avoiding risk-based capital (RBC) requirements. (2) From Wall Street's perspective, you might want to deal with showing a certain amount of prudence to protect yourself from catastrophic risk. (3) Certain states, like New Jersey, require you to have an insurance license in order to sell a point-of-service product. So if you're an HMO and don't own a New Jersey-licensed HMO insurance license, you might have to partner with an insurance carrier. (4) You want to attain market intelligence. If you're in kind of a micro area operating as an insured, you might be able to get additional intelligence capital via reinsurance. (5) Many of the insurers out there are seeing tighter margins. Because they have tighter margins, they've now looked at other avenues in order to meet bottom line objectives, especially as a public company.

Let's discuss the health insurance food chain. What does an employer group see when they're buying insurance? They may see the direct general agent or the sales agent of the insurance company, and then, of course, the insurance company. Behind all that, there are various roles and functions, including marketing, underwriting, claims, medical management, and compliance. There are a lot of different components. Within those components, there's also the risk taker who is responsible for the overall losses of the program at the end of the day. Traditionally, if you use a large insurance company, like Prudential or United Healthcare, all those functions are actually handled by one entity. In a lot of the reinsurance opportunities that we see in the marketplace, most of those functions are actually handled by various companies, and each of the items mentioned above could actually be handled by a different company. In most cases, we like to consolidate a lot of the functions, but in many cases, you may find multiple performers of medical management where the utilization review, case management, and demand management could be done by different companies.

In the insurance food chain, what does the reinsurer see and what doesn't the employer see? The reinsurer is actually going to be insuring the insurance company, which is somewhat seamless to the employer purchasing the coverage. In many cases you might have a reinsurance intermediary. Reinsurers may also buy reinsurance of their own. In some cases, you'll have reinsurers purchasing many

different products like quota share and excess of loss, the similar kind of policies that an insured would buy or a reinsurer might buy because it's part of spreading the risk. That would then put us into what we would call, for lack of a better term, the *retro* reinsurance market. In a retro situation, there would be a reinsurer of a reinsurer. From the retro reinsurer's perspective, you have many levels away from what the employer group is actually operating. You'll find that there's not a lot you can do with the front end as far as changing decisions at the employer group level. It's more a matter of picking your partners at the reinsurance level and the partners they pick in order to make sure they are meeting profitability objectives. Retro reinsurers might actually buy reinsurance for themselves, so the food chain is infinite.

How do reinsurers get their business? Marketing. Marketing could be done through *quid pro quo* relationships where reinsuring the life side gives us an opportunity to get the medical side. It could be golfing buddies, people that have gone through the actuarial profession together, and as they grow through their careers they might see opportunities to work with each other. Our biggest source in the marketplace is the reinsurance intermediary, which is different from the direct brokerage. The reinsurance intermediary is actually quasi-employed by the issuing carrier like the Prudentials of the world, and they contact the marketplace to buy reinsurance.

Other sources of direct marketing might be direct carriers and managed care companies. As managed care companies start to see their margins tighten, they'll look at ways of buying reinsurance to kind of dampen some of the impact. There are also managing general underwriters (MGUs). That's a term that's pretty common in the reinsurance industry and the stop-loss market. Mike will actually talk a little bit about what the MGU market is. Relationships with other reinsurers are quite common; for example, Kevin and I work on many programs together as different companies. We might be reinsurance support for him or he might be reinsurance support for us.

What is the state of the industry? In the traditional first-dollar medical program, everyone is seeing tight margins. HMOs are showing losses, especially those that are public companies. There's no difference in the medical reinsurance arena as well. Aligning the incentives of the different parties is always a concern. The risk takers are the reinsurers, and then you have the hired departments from medical management to the underwriting. What is their incentive to meet profitability? Are they driven on a revenue agenda, or are they focused more on the overall bottom line? Finally, there is the need for more effective underwriting and due diligence in the medical arena. It's very difficult to find profitable programs, but they are out there. You have to go through a certain amount of gymnastics to try to determine what makes a profitable program and whether programs meet those characteristics.

The next topic is changes in market capacity. As you've probably seen in newspapers, Berkshire Hathaway acquired Gen Re, Cologne, and National Re. Swiss Re acquired M&G and Life Re, which was another big merger. We anticipate there will be a few more mergers, based on what we hear through the grapevine. We won't know for sure until that comes to fruition but we should expect a reduction in market capacity of some of the major players.

There have also been some major players exiting the market. Swiss Re was probably one of the largest if not *the* largest medical reinsurer in the marketplace. It has elected to exit the medical U.S. reinsurance market. Health Reinsurance Management Partnership, Reinsurance Group of America, and Duncanson and Holt have also made commitments to exit the first-dollar medical reinsurance arena. They might still come into the stop-loss arena, which is something that Mike will talk about later, but right now these are some of the major changes in market capacity. In addition, many players, including MFC, reduced their block. We made some significant reductions in our block as bottom line profitability has become the mantra. The problems with being a retro reinsurer is you're too many steps away from the actual event happening, the employer group and the employees actually having claims. Being that many steps away makes it very difficult to invoke change when change is needed. Many players have actually exited the retro portion of reinsurance because of those issues.

Let's discuss the new reinsurance markets. Like anything else, as people exit markets, other people come into markets. We've seen significant growth in property and casualty (P&C) capacity. They've looked at historical profit margins and the volatility of the curves going up and down in this marketplace. Some of the P&C companies believe that there are some good opportunities. The non-U.S. markets, such as Europe and London, have been the big focal points. Some new and significant reinsurance capacity has popped up in the Bermuda marketplace. One of the things that we'll find, and Kevin might talk a little bit about this, exists in the special risk market. We're seeing a lot more business coming over from Europe, and for the first-dollar medical business, much more reinsurance capacity is in Europe and Bermuda. There's a lot of shifting of risks back and forth.

There is also the anticipation of a hardening market. We anticipate the market to be correlated to capacity changes. As people come, more put the underwriting on the reinsurance side, and we expect the increase of some profit margins. Of course, there's always going to be an ignorant capacity out there that may not know much about the program, and will sign on based on either just historical representation or some information without actually going through the due diligence process.

As a reinsurer of smaller medical programs we are affected by the consolidation of some of the bigger players in the first-dollar medical arena. Aetna U.S. Healthcare and the many companies under Foundation Health and Anthem/Blue Cross & Blue Shield have created a backlash and have created some opportunities for some local provider-sponsored networks. As a result, that has created more reinsurance opportunities.

There are challenges in the medical reinsurance arena. The number one challenge is finding programs that meet the profitability objectives. Of course, that's easier said than done. With the amount of medical reinsurance capacity in the market, there has to be something from the medical reinsurer's perspective that makes it stand out from the next guy so that price is not always the issue. That difference could be value-added services, whether it's providing actuarial support or helping them expand their local network. Or, it might be a turnkey product. We might be able to provide AD&D, a life product, or a carve-out workers' compensation program. Then you could help them in other lines of business, and, in turn, have the opportunity to get their medical reinsurance.

You also need quality due diligence of partners. As you know, there are a lot of partners in the process for marketing, underwriting, and sales. You need to go through the process of seeing how good the partners are: determine their modus operandi, the cost structure of the program, and the overall program manager at the retail level. One of the challenges we have is we're wholesalers; we're not retail, so we need to find a partner that's going to look at the program with the same interest and profitability incentive that we have, and make sure that all the other partners are being managed.

The reinsurance decision is really basic. You either quote or don't quote. But, with the capacity and the changing marketplace, there might be ways of restructuring the quote or coming up with alternative solutions. If you're taking on a rehabilitation project, you could develop a reinsurance arrangement where you don't necessarily take the run-in loss. Instead, you take it on a risk-attaching basis. After the underwriting decisions have been made, then you assume some of the risk.

Also consider that there are limited time frames in the reinsurance decision. Some of you are issuing carriers or buying reinsurance, and that's really the last thing on your radar scope. That's done at the 11th hour. "Oh, yeah, I need to get my reinsurance taken care of." If its quota share, it probably would be done a little bit sooner, but if it's portfolio excess, it is pretty much done at the last hour. So from the reinsurer's perspective, our window or time frame to actually make a decision based on the information we have becomes limited and the time frame is usually very tight.

Balancing wholesale and retail is important. As reinsurers, we do not have any contact with the underlying employer groups. We have to pick partners and make sure that our partners actually can address some of the issues that we might have without our direct intervention. The one thing you don't want to do is have duplication of work, because that adds more expense and may slow up the process. When there's chaos, there's opportunity: I've heard that expression a few times. You read in the newspaper about medical reinsurers and how everybody is exiting the first-dollar medical business so there has been a real scare in the marketplace, but there are still opportunities. As a reinsurer, we have the opportunity to kind of set more of our terms from a reinsurer's perspective because the amount of capacity is less. We still have to go through the same selective underwriting process, if not a better underwriting process, than in the past because the margins are tighter in this business, and reinsurers have benefited from some of the exiting capacity. Some of the types of business that I haven't seen in the past I'm now starting to see with better margins.

It's easier said than done to go through the exercise of pre-qualifying a program. From a reinsurer's perspective, MFC sees probably seven or eight reinsurance quotes a week. Other clients may see more, maybe Kevin's operation sees more than ours, but it's one of those situations of how do you go through and evaluate a program and define what those key ideas or criteria are in a program to make sure it meets the certain goals. If it doesn't, then you may want to decline it immediately as opposed to spending the resources that are involved in evaluating a program. With the ever-changing market and the different capacity in there, it's important to go out and actually see who's putting you on the risk. I call it the "trust your partners" approach. You can go through the due diligence exercise, but there's also the exercise of checking your gut to see if it seems to make sense. Do you trust your partners?

Let's discuss aligning incentives. Aligning an incentive doesn't necessarily make a program good. However, aligning incentives for profitability gives everyone a vested interest to make sure they're going to meet profitability objectives. The issuing carrier could transfer a certain amount of risk to the direct retail underwriter that writes the employer groups. Are they going to get paid based on a percentage of revenue or based on a combination that includes bottom line profitability?

Another way to align incentives is by improving provider contracts. We see provider health organizations or community health plans that have approached us that want a physician-sponsored health plan. To make a program like that successful, you often need to align their interest with everybody else's interest in bottom line profitability. Yet another possibility is reducing administrative

expenses. If the first-dollar medical programs at the Prudential or United Healthcare level can operate at administrative expenses of 20% or less, then it's important that the programs that we're reinsuring, while they might not have the same retention level, are meeting more compressed administrative expenses. The last one is incenting the program champion who is supposed to manage the program for the reinsurer at the retail level to make sure that they have the proper incentives.

Adapting to an ever-changing market is important. Just like any other first-dollar medical program, you have to adjust to new regulations, like the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Mental Health Parity Act, and others. You have new plan designs. Alternative medicine has become the new hot topic in the managed care environment. There is acupuncture, demand manage, and 24-hour hot lines. All these things might be buzz words but they're new enhancements that may impact the cost structure. Prescription drugs have become a big factor because of infertility drugs, contraceptives, Rogaine, and so on. Someone buying Viagra is an issue for a medical reinsurer as well as a first-dollar reinsurer, especially when you're looking at it on a quota share basis.

Here are some recent trends we have seen in terms of reinsurance requests. Programs with tightening margins are going to go out and buy reinsurance primarily because they're looking for fee income opportunities. They may become just a TPA or an underwriting manager, but in any event they would pass off some of the risk. We've seen managed care companies buy reinsurance for their Medicare risk products, or Medicaid products, or other new product lines that they venture into with the support of reinsurance. Provider health organizations and start-up arrangements have been another popular source of reinsurance clients. Associations and employee leasing have, surprisingly, been seen very regularly. Part of that is a lot of the employee leasing and associations were actually reinsured by some of our competitors, and their loss ratios have been driven through the roof and may have been part of the cause for the exit from the market. Those associations still in business are now looking for other reinsurance opportunities.

The reinsurance market is no longer a relationship-driven business. This is a bottom line profitability business. As this business becomes more analytical, it creates more opportunities for an actuary. Actuaries have the same challenges here as they have in the first-dollar medical business: measuring premium adequacy, evaluating the impact of networks, and our favorite one, medical management. What's the value of medical management and how much savings are there? There are balancing market pressures. If a market drives a rate, can a cost structure handle it? As actuaries, we always have to balance the need and availability of data or even the quality of data. I don't know how many people have gone through a systems

conversion. Whether it's from a TPA level or an issuing carrier, you tend to have the same credibility or quality problems with your data.

In summary, it's a very competitive marketplace. Reinsurers face the same challenges and difficulties as regular medical insurers. Profit margins are meetable, but it's very critical to be selective. Last but not least, it's very important that when a reinsurer goes into an arrangement, they must balance the needs of all the parties as well as those that are taking risk.

Now Mike McLean will talk about stop-loss business. Although there are some differences, you'll see there's going to be a lot of similarities. In both markets, profit margins are tight and changing capacity may create some new and interesting opportunities.

Mr. Michael R. McLean: Actually, the margins are getting bigger. They're just negative instead of positive. The best line I heard about the state of the stop-loss marketplace was made at the reinsurance roundtable. Someone said that there's a lot of stop-loss underwriting going on without adult supervision. It's unfortunately true.

The good news is there's a continued migration to self funding, and I think this will even be exacerbated as the HMOs, many of which are losing money, seek fully insured rate increases. The fully insured blocks, other than HMOs, are also having some tight margins. As they increase it, having self funding and paying your own claims looks more appealing. As Mike mentioned, there is excess reinsurance capacity that is changing. The largest one, as he mentioned, isn't playing in that sandbox as much. The second largest one has dropped a couple hundred million dollars of street premium for stop-loss also. One thing I want to talk a little bit about is national carrier networks and getting access to some of those networks. Also, as Mike mentioned, there's consolidation going on not only amongst large carriers and gobbling up HMOs in million dollar transactions, but also at the MGU level.

Again, the good news is that the demand for stop-loss is good. If you look at a KPMG study by year, whether you're talking small cases or large cases, you'd see an upward trend each year. Again, this is for conventional plans. The same thing is happening on the PPO side. The KPMG study also showed that it's not only true for PPO and conventional indemnity plans; it's also true for HMOs and it's also true for point-of-service plans. So the percentage of plans that are self funded is increasing out there and whatever line of business you're in, you'll have to eventually deal with self funding.

That was the good news. The bad news is on the aggregate stop-loss side. Trend is definitely not less than expected. For many years trend was coming in less than expected, so we really had more than a 25% corridor margin out there. Life was pretty good. Our worst gross loss ratio on aggregate for the first nine years was still under 70%. That's not the case in our 1997 treaty year. Aggregate stop-loss hits are way up in the industry. One reason this is happening is the brokers are now coming in more than they used to, and they're trying to match HMO's maximum liability. There are a lot of reasons why we really can't do that. Why should we match their liability when they're losing money anyway? One study that said 57% of the HMOs are losing money, although I believe that's turning around as they're going out for double-digit rate increases.

Another reason why we can't match their liability is their discounts might be better than the PPOs that we're using. There are biases. HMOs also tend to have a younger, healthier group than what is left over in the self-funding block. Another important thing is if we're trying to match their total maximum liability, they can keep the money on the good case, but we're self-funded; we get a little $8,000 aggregate premium so while they're pooled, we're not.

We used to run into situations where HMOs were making so much money on the Medicare risk contracts. There's a rule that says that in order to do that you have to have at least 50% of your business in commercial business. So they would go out and intentionally lose money and not worry about it too much, just so they could keep 50% of their business commercial. Times are definitely different now. I talked to my Congressman twice to complain about the fact that the HMOs are getting too much money and maybe they went a little overboard. They're not making money on that now.

I don't think that the market is fully reflected yet. In the old days, before PPOs, you take the client, you trend them forward, and then you have some stability there. Now when you switch from one PPO to another, people don't really know the difference. There's a whole increased variability due to this switch, and I don't think that the aggregate premiums out there have fully reflected the new underlying uncertainty inherent in aggregate stop-loss. Claims are up and the bottom line is they're probably going to stay up because we probably won't figure out whether the PPO that one is going to is better than the PPO one came from.

There is more bad news: we're hearing rumors that stop-loss carriers are potentially sandbagging and slowing claims down. We also hear that the TPAs go in the other direction. They'll hit you with 10 months of claims one year and maybe 14 months of claims the next year. So my view on the aggregates is it's not going to get much

better. The reinsurance capacity still seems to be somewhat unlimited out there, unfortunately.

On the specific stop-loss side, the bad news is loss ratios in the industry have been up for several years in a row, and they're continuing to climb. One thing I want to talk about briefly is that trend is actually greater on shock claims than it is on non-shock claims. The other bad news is if you're in a marketing entity, the close ratios are down in the industry, and that's just a function of supply and demand. There are more thoughtless markets out there. In the old days, the TPAs needed us to approve them. In the new days basically we need them more than they need us. Words like *leveraged trend* are missing in action. Everyone says, "Oh, the market has turned; we're getting 8% rate increases." Then you start saying, "What do you think trend is and what do you think leveraged trend is?" The rate of deterioration in the loss ratios is slowing down, but I don't think that we've actually bottomed out or topped out in the loss ratios yet.

There's not much adherence to manuals out there. People lost faith in the manuals in the 1993–94 era, and there are certainly not irrational stop-loss marketplaces. It's very rational unless you happen to be taking risk anyway. As far as reasonable aggregate factors, we still see some crazy things going on there. Many of the risk bearers are having less fun than they used to have. We did a survey on year ago, and I'll explain why it doesn't really need updating. It looks at the change in the loss ratios from the 1993 to the 1996 treaty years, and if it's a January 1 treaty year, it indicates written and reviewed. In the 1996 treaty year, for instance, it could be a November 1, 1996 case with risk attaching through November 1, 1997. We looked at aggregate and specific combined, and we pulled about $500 million of gross premium for the direct carriers. The reinsurers represented another $1.3 billion in street premium. I didn't bother going to the MGUs because they would have lied to me about their loss ratios. I also didn't go to the fronting companies because they really didn't care. I might have 5% of the risk and got 5% fronting fees. They don't start to get concerned until the loss ratio hits 200%.

What we asked for was the change in the loss ratios, as opposed to the actual loss ratios, because some people would get a little nervous about giving that. I polled 12 different entities, and one of the entities actually had a drop in the loss ratio. That was good for them. Subsequent to seeing the survey, it was the only one that had a drop in the loss ratio over the period. They got very aggressive. Now they probably rectified that situation of a drop in loss ratio. Over the period, there was a net additive increase of only about 8% on the loss ratios for the six best respondents. It isn't until you get to the worst six that life gets pretty interesting. In fact, on the seventh worst one, loss ratios are going up about 18%, and the people at the worst one are starting to really lose their sense of humor because of a 26%

increase in loss ratio. In fact, it was during the 1995 year that the reinsurers lost their sense of humor. They just didn't know it until 1996.

There was also a very big dichotomy in that the direct carriers actually didn't do that bad. It was the reinsurers that really got killed. One of the reasons is because the reinsurers are seeing the data three to six months later than the direct carriers. They also relied on a lot of MGUs that might have been driven by volume instead of profitability. Even those that were trying to still do the right thing had a deterioration in the loss ratios. The loss ratios are up on average for the reinsurers; they're up almost 20%, and for the overall average they're up about 15–16%.

So the problem is that supply and demand are out of balance. While demand is very good for stop loss, supply is even more plentiful with carriers. One of my ex-employers dropped out of fully insured, but they stayed in stop-loss. One of the reasons you can stay in stop-loss is you're not having to compete with the Aetnas and Travelers networks. If you're in a fully insured market, it's hard to compete with United Healthcare, Aetna, CIGNA, and the local HMO. The TPA marketplace doesn't have access to these, so people are traditionally staying in the self-funded market. We're telling our reinsurers that if you're just capacity, you're part of the problem. If you provide value added by reducing the claim liability somehow, you're actually part of the solution. So we're trying to deal with entities that can help us lower our claim liability.

Let's discuss some of the corrective actions. The most appropriate one, in many instances, is to just sever the relationship and get rid of a lot of these entities. If you look at some of the loss ratios, you'd realize that they're not going to turn around in this millennium anyway. What you want to do is make sure that everyone's interests are aligned. I don't think this will actually solve the problem, but it will hopefully prevent people from intentionally being stupid. They might still be stupid, but what you need to do is put people's fees meaningfully at risk. A lot of people are getting rich based on fees while the guy at the end of the line loses money. Now the flip side of that is if you're going to play in this game, you ought to be willing to share the profits. The worst that can happen to you is no profits, which you probably don't have now anyway. There needs to be some reward for improvement and some sort of penalty for deterioration.

The things that you need to do sound fairly reasonable, but haven't really been going on in the industry. (1) You need to look at the relationship of the actual premium rates to the manual premium rates. I've seen blocks that were running 35% of manual, which is not a good thing. Now maybe their manual was also wrong, but something's very wrong when everyone's just playing chicken saying, "Well, I don't know where the rate should be, but I'll be 5% below the next guy."

(2) There are a lot of blocks where the loss ratio is running around 120%. The scary thing is if you're at 120%, and you want to get to 90% then you not only need a normal rate increase, but you also need to worry about regulatory increases by throwing in a load for HIPAA and a load for mental and nervous mandates. You might think that's not a big deal, but it's a bigger deal on specific stop-loss than it is on first-dollar because of leveraging. You might need a 55% rate increase on this block that's only running at a 120% loss ratio. That's really not attainable. So if you're at that 120% loss ratio, you're going to continue to lose money. (3) You also need to look at close ratios in the industry. Our close ratios used to be 6–8% a few years ago. Now they're running closer to 2%, so we have to quote 50 cases to get one. (4) You need to focus on persistency. Typical persistency will run 90% for ASO clients, and the TPA persistency runs about 70%.

Many of the ASO carriers and Blues are pricing on a percentage of claims basis. The problem is that the demographics of a case impacts shock claims at a much different manner than overall claims. If you need proof of this, go to the SOA study of the 1991–92 claims. We've seen hundreds of millions of dollars of our own claims; it's just not the right thing to do. It's expedient, easy, and it's right on average, but it's wrong on every case. If you're using a percentage of claims, you're loading when the rest of the stop-loss industry is discounting, and you'll get selected against. The reason the ASO rates are doing this is they throw all of the expenses under the ASO side, and then they'll say that, while the administration fees are too high, they don't have a problem with stop-loss rates. You might ask them what is their permissible loss ratio for stop loss? They might say it's 100%. Compare that with the stop-loss industry, in which the permissible loss ratio is 65%. While the Blues industry is saying it doesn't have a problem with stop-loss, actually, it does; they're just throwing all the expenses on to the administrative side. One of the other reasons the Blues can get away with this is because their discounts are typically better than the biggest local market share; as such these discounts can cover a multitude of sins from a pricing standpoint. It's still not the right thing to do on a percentage-of-claims basis.

As Mike mentioned, there's a lot of consolidation going on. Within the MGU industry, Houston Casualty Company (HCC) and Centris are actually the two largest. Centris recently bought VASA's block, but I'm not sure how much of that's going to roll over. Both Centris and HCC are making it a clear point of saying that they are fee driven. They are in this for the fees. Their literature says that they don't really want to take risk, but sooner or later they have to take the risk.

From the Floor: HCC actually stated in it's annual report that it is going to aggressively buy reinsurance.

Mr. McLean: One of the other things we want to talk about is access to national carrier networks. I'll talk a little bit about the history of managed care discounts and briefly talk about some of the clients we've seen. We had our underwriters actually on site at Travelers doing their underwriting and we have our underwriters on site at some Blue Cross organizations. We have a deal with CIGNA to get access to their networks. The point of all this is not to brag about the fact that we have big clients; it's the fact that we've seen some very good networks out there. We've also evaluated another couple hundred PPO networks. We've been tracking our loss ratios for over five years by PPO networks, and we came to the conclusion that there's a much stronger correlation between the loss ratio and the PPO network than there is between the loss ratio and the TPA. However, there is positive correlation between what we think are the better TPAs. Nonetheless, the conclusion we came to is like the conclusion about real estate being about location, location, location: Stop-loss is about networks, networks, networks. The other thing that we've noticed is the discounts the national carrier networks receive, including the Blue Cross organizations and some local HMOs, are generally vastly superior to the average PPO in the marketplace. This makes sense to me.

What is a PPO? Well, it's a lot of different things including utilization review (UR) but what it really boils down to is it's a mechanism for obtaining a volume discount. IBM doesn't pay the same rate for paper as I do. If you have a lot more volume, you can negotiate a better discount. So when I'm looking at this I ask, what are our options? We can perform an analysis amongst competing relatively poor PPO networks, or you can try to obtain access to a better network. We think the solution is to partner with these better networks. We need to steer bodies into these networks through preferential stop-loss pricing. An access fee might be $5, and stop-loss premiums might run you typically closer to $25 per employee per month. We can lower our stop-loss rates more than the entire access fee, and we think that this will hopefully steer bodies. Some of the national carrier networks out there, like United Healthcare, have spun off the Travelers plan. It used to be the TPA; it is allowing access to United Healthcare networks. I had heard secondhand that they had added 100,000 lives in January in the TPA. Much of that is because they have access to a good network. I heard they're also adding 40,000 lives a month so they're going rapidly with this concept. Private Healthcare Systems (PHCS) is allowing larger TPAs and their shareholders access to their nationwide network. Many of the TPAs that we talked to are using them. It's one-stop shopping, and they're growing fairly rapidly with the concept. The deal that we cut with CIGNA is projected to add a half a million lives with ING. Some of the Blues entities have given out access to their networks and HMOs have given out, in rare instances, access to their networks. Again, these are better discounts, and you want to align yourself with the better network to the extent that you can.

Why would a national carrier allow competing TPAs access to their network? Oftentimes national carriers don't want to. The analogy I use is Apple Computer executives in the 1980s. They said, "We have the best operating system in the world. Why should we help the competition? Why should we give this out to people making clones of our product?" One person actually said something that I found humorous which was that there are people building computers in garages. When we were out trying to pitch this to some of the entities getting access, one of the entities said, there are people out there actually paying claims in garages, why should we do this? It kind of boils down to the fact that you could either be Apple Computer or you could be Microsoft. Apple thought it was going to rule the world. What it didn't realize was that all these other PCs would be made but they would not be based on the Apple system because Apple would not allow access to its operating system. Apple thought it was in the business of building computers, but what they really did well was building a great operating system which was arguably better than Microsoft's at the time. Many carriers think they're in the business of paying claims; in my opinion what they're really good at is building networks. Having dealt with large companies and small companies, I believe that the large ASOs are not particularly great at actually paying the claims. Their service is not the best and, in fact, their administration fees are three times the TPAs, in some instances. They get away with it by having great networks.

So I think there's this marriage made in heaven. You have the TPAs and the stop-loss companies out here including us. We have about 1.2 million lives covered for stop loss. We have all these bodies and we're saying, "I wish we had some good discounts." You have these HMOs and national carrier networks out there saying, "We spent hundreds of millions of dollars developing these networks. We need to put some bodies in the networks. We just want to try to get the two together." In the CIGNA deal, CIGNA Healthcare gave access to its great networks to its little sister, CIGNA Re, which then cut a deal with ING, one of its clients, to pass it on. We can pass it on to the TPA who can then pass it on to the broker who can then encourage or pass it on to his or her employer who can encourage its employees to go into the particular hospitals in the network. There are more bodies in the network, more claims being paid in the networks so they'll give better discounts to the CIGNA Healthcare networks. At least that is the theory behind the whole process.

What are the advantages to CIGNA in this process? They should get millions of additional members in their network and have better negotiating clout. Bigger really is better and there's virtually no marketing cost to them. It's not a United Healthcare network so that's good for CIGNA anyway. They get very high profit margins. They didn't have to go out and build any new networks or do any marketing for it. They'll get stop-loss reinsurance behind ING. Actually, on this

business, there really will be profits as opposed to a lot of the other business out there.

Let's discuss the impact of having better networks. Who are the winners? I think stop-loss carriers with access to a better network are going to win. I also think the TPAs that get access can differentiate themselves. Instead of a company like Aetna going out and paying a billion dollars for a block of business for a mid-sized mutual or another company that is looking to get out, it could just give access to your network and then become the reinsurer behind that. If you charge access fees and become the reinsurer, you can get half the profits without spending a penny. The losers are anybody that doesn't have access. I think it will also hurt the regional PPOs because eventually they'll be competing with the Aetnas, the CIGNAs and the Uniteds of the world once they give access to their networks.

We all know what leveraging is from one year to the next year, and we probably all know what the reverse of leveraging is. If you have a $100,000 indemnity claim and get a 20% discount, then the leveraging with a fixed $50,000 deductible takes a 20% reduction in claims and creates a 40% reduction in stop-loss liability. Life's great. The problem is you want to be sure to ask, "What is inflation now?" Some of our data shows that out-of-network percentage is actually higher on shock claims than overall claims. In other words, you'll go to the local hospital for your appendectomy, but you might get shipped off to the Mayo Clinic for a larger shock claim. It varies dramatically by network. What are your discounts? If the bill charges are going up, you can probably negotiate some discount, but it probably isn't going to be any bigger this year than it was last year. So out-of-network claims are trending at 10–12%.

If your PPO happens to be a percentage discount off of billed charges, which was 20% last year and 20% this year, then what's your inflation? It starts at a lower level and ends at a lower level, but your inflation on the percentage discount, if you had the same discount, is still running at 10–12%. You'd say that's true on percentage discount PPOs; they're not very good. The very good ones are out there, and they are the ones that are on the diagnostic related group basis or case rates or per diems. They could be better; however, almost all of these still have outlier provisions, saying these per diems apply unless billed charges exceed $25,000, in which case, it reverts to billed charges minus 25%. You had 25% off last year and you have 25% off this year, so what are your claims running? They're running about 10–12%. The bottom line is that virtually all the shock claims out there are, in fact, running at a fairly high rate. One of the entities we deal with looked at shock claims on a cost-per-day basis, and the shock claims, the overall claims, were only turning in the 5–6% range. The shock claims per day were trending slightly over 10%. So I think the underlying shock claim trend is actually in excess of 10%.

Then we get back to that leveraging. Leveraging doesn't disappear. When people thought the trend was negative, it wasn't that the trend was negative; you were just going from no discount to a big discount. What you ended up with is a big windfall in one year. After you got that windfall back in 1993 and 1994 with the mass migration to PPOs, you return back to a regular leverage trend after that. So if you have a stop-loss ratio running 120% and you think life's great because you're getting a 10% rate increase, well, if your leverage trend is 16%, then it's back to what I said. The rate of deterioration might have slowed down, but your loss ratios are still going to deteriorate. So what's the impact on stop-loss liability? I think there was a substantial, initial reduction from a PPO. Back in 1992–93 everyone said inflation was solved and we don't have any problems. From a shock claim perspective, inflation hasn't been solved. There was a huge initial reduction. The actuaries screwed up because they didn't discount for this initial reduction. People were giving out very small discounts, but everybody screwed up in the other direction saying, trend is low. Trend on shock claims is not low; in fact, what we see is you get this large initial reduction, but you don't get any subsequent reduction. If you're pricing off of your claims, you better have a pretty high trend factor in there.

Let's discuss some history of managed care discounts. For stop-loss in the 1980s, we had reinsurers that said they didn't want to discount any more than 8% for PPO networks. In retrospect, that's kind of silly. It's much bigger than that. When you track your indemnity loss ratios against your PPO loss ratios, indemnity's twice the PPO loss ratios from what we've seen. So the discounts are much larger, and there was very little differentiation between networks. In the early eighties, the average discounts increased and there was some differentiation. What happened from 1992 to 1994 was we saw unexpectedly high profits on stop-loss. The reason this happened is the discounts were great, and the actuaries and reinsurers didn't want to credit high PPO discounts. They were warranted; they just didn't credit them. Then we get into the mid-1990s. Nobody is giving big discounts, so people stopped believing the manual, and street rates were heavily discounted off the manual rates. By the mid-1990s, there was great effort extended in attempting to evaluate networks, and trend was understated. A couple of years ago we were hearing terms like negative trend. There isn't negative trend; there's a shift from unmanaged to managed or from no discount to a discount. That leverage is a huge discount. The problem is actual trend. Billed charges for shock claims are going up a lot. The reinsurer loss ratios are up a lot. By the late 1990s, reinsurers were losing some real money, and there was a lot of consolidation going on. Again, there is underwriting without adult supervision, and many reinsurers are reinsuring without understanding, and I think some reinsurance capacity is drying up.

Mr. Kevin K. Gabriel: We're going to shift gears a little bit and talk about a different animal. We've been talking about medical business so far. I'm going to talk about

special risk business, which I'm going to call personal accident (PA) for the purposes of this discussion. Much of what I have to say, or at least some of it, is probably applicable to medical business. One concern I have is that some of the bad news items I'll discuss will start cropping up in medical reinsurance.

What is PA? I define it as any medical disability or death cover related to accidents. Some examples are AD&D, workers' compensation either on an excess or full alternative basis, catastrophic covers, bodily injury carve-outs, student accident and medical, non-appearance covers, and travel accident. The thing to notice here is that they tend to be low frequency, high amount claims. It's not medical business where there's a fair amount of predictability. In medical, if you get it wrong, you may have a loss ratio of 110% or 120% and; if it's really bad, you run 140%. Here, if you get it really bad, you run 5,000–6,000%, and you don't want to do that. Because of the fact that the claims tend to be so large, almost all the reinsurance we're talking about here is excess. Consequently, it also tends to be structured in layers. Mike eluded a little bit in his presentation to layers in medical reinsurance where you might get people reinsuring in excess of $150,000, $250,000, or $1 million. On the PA side, I've seen 20–30 layers that go up to all kinds of absurd levels. Somebody will be pricing $50 million excess $50 million. I don't know how they do it, but these sorts of things are out there.

The state of the PA reinsurance market, in my mind, is bleak. Prices are depressed for reasons we're going to talk about. In particular, there's a great deal of capacity just like on the medical side, and there have been some very high profile debacles, many of which have to do with the presence of spiral players. There is a big difference between what's going on on the PA side and what's going on on the medical side. On the medical side, the problem is trying to get the pricing right. On the PA side, you have that problem but you also have the problem that there's some people floating around in the business who are basically looking to stick it to you. You have to be leery of them. I will talk a little bit later about how these things work.

The market tends to be dominated by insiders. Much of it is London-based; it's almost all generated by brokers. Many of these brokers have known each other for years. They know their chums on the reinsurance side, at least some of them. They went to high school with them. It is a very difficult business to break into. A good story I heard was about one North American reinsurer that became involved in this a few years ago. He thought he had a real good handle on it. He used to go over to London and teach seminars about how this stuff worked. Several years later he had some very big problems. It's just not an easy market to break into.

Underlying derivatives are unfortunately a way of life in this business so I'm going to talk a little bit about what those are. Suffice it to say that there are people out there who are setting up retro programs that have covers in them that are not just straightforward excess covers. When you sign up to reinsure these people, you can end up getting claims that you really had no clue that you were going to pick up. You have companies pulling out of the market. Some of the same people that are pulling out of the medical business have pulled out of the PA business. There are a lot of companies that are still in the business which, as far as I can see, are not aware of some of the things that are going on. They may discover soon that they should have been.

I'll talk a little bit about the structure. As I said earlier, it's layers, and you can divide the layers up into three levels. The working layer is the low level. I've seen retro programs that start as low as $5,000. Why they do that is a little beyond me, but they do. Suffice it to say that in the working layers, you're going to get a large number of claims. On the other hand, if you're at the very top, at the catastrophic (CAT) layer, you might think that you shouldn't get many claims at all. There's what you call your lower level, with excess of loss. There seems to be some disagreement about where that starts, but let's say that might run anywhere from $250,000 to $2 million or $5 million. Once you get above $5 million, I think you're pretty much dealing with CAT layers. Again, much of this is being fractured into a great many layers. There are different reinsurers playing at different levels so different people will play in different areas. One needs to understand what you're getting involved in if you do play in these layers. In general, the CAT layers have been profitable. It seems as if some pricing sanity does reign there, although there have been more problems recently. The working layers can be quite problematic. Many of the people who are playing in that business may be spiraling their claims up. You have to be very careful.

Other covers are what I referred to earlier as derivatives. A sort of plain vanilla one that the guys in London all seem to love is aggregate stop loss, 15% excess of 85%. I would take this if somebody wanted to write it on my block. I suspect Mike would too. Why they think that we should guarantee them 15 points profit is somewhat beyond me. As we'll see later, one has to be real careful as to how the loss ratio is defined and whether or not somebody may be contriving a situation where you are guaranteed to make a payment. There are also some people out there writing this stuff at incredibly low rates. There's one facility that practically earns a living writing this 15% excess of 85% for one-and-a-half points. How they can do that is beyond me.

A swing rate is a situation in which you quote an initial premium rate, and then have a provision that that premium rate will be adjusted based on the claim's

experience. It's often common to have a provision like you pay X dollars, and it's adjustable at 100 over 70 times claims up to some maximum level. Some people are playing with some real big swings. I've seen cases where the initial premium is $100,000, and it can swing up to $4 million or something like that. In London they refer to this as burning cost. There's also something called burning cost reinsurance, which allows somebody to buy reinsurance in case the person has to make that swing-rate payment. I've seen some funny games played with that, as I have with something called reinstatement premium protections. It's not hard to use these things to generate a situation in which you can make money if you get a burning cost claim or if you have to pay a reinstatement. I'll talk a little bit about what reinstatements are shortly.

Another one that's floating around that I've seen not only on the PA side, but on the medical side, is variable quota share reinsurance. Some people seem to love these, but I don't understand why anybody would write it. What it boils down to is the reinsured gets to decide how much of a certain risk he's going to put into your treaty. If you write a variable quota share, he may put 20% of one risk in your treaty and he might put in 50% of another risk. Obviously he's going to put what he doesn't want with you. I've seen one instance where somebody tried to sugar coat this by saying, "I have this pool over here, and I only want to write $X million per account in it. So if I write anything that's too big, I'm going to have a variable quota share over here in which I'm going to put the excess." What he's saying is: "I'm going to protect my original pool. If I want to write a big account and generate some management fees but it's really not good business, it won't hurt my core pool, but it will hurt these poor variable quota share reinsurers." In any case, it's not uncommon to see any or all of these on somebody's retro program. It is also common to combine them with spirals, which basically can guarantee some claims.

Let's talk about what a spiral is. In general, the idea is a low-level plan gets passed up between two or more companies. I'm going to give you a demonstration of that shortly. These things tend to be settled on a quarterly basis, so every quarter one reinsurer will make a payment to another reinsurer. He has to get reimbursed and these things can take forever. One London underwriter told me that he had built a spiral that would last for 70 years. There may be ones that last longer than that. With the long lags, it may take quite a while to figure out what's going on. I've seen these with just about any of the types of PA claims that we described earlier. The frequency of spirals will depend on the contract terms. It may depend on whether you have unlimited reinstatements, or whether or not you have a one-life warranty, a two-life warranty, or a three-life warranty. Depending on what you have, you may end up with more of these. These things started pretty much in the P&C business where, from my understanding, they tended to be rare, but very large when they happen. On the PA side, there are a lot of much smaller claims that are being

spiraled. I haven't seen any in the workers' compensation alternative, but I have a strong suspicion that they may be coming, and that can also generate a great deal of activity.

Spirals came out of the London market. You may hear the term London Market Excess (LMX). There are a great many people involved in this, but I'm not in London. London created an unfavorable environment for some people so they left. There are some other people either here or in Europe, or in Australia that seem to want to get in on the fun. What are the reasons? First, these things are a broker's dream. Let me explain why. It's not unreasonable in some of the years that this has been going on for the total claims spiral to be somewhere around $80–100 million. These things have to work themselves through for years. While they're working themselves through, they sit somewhere in a bank. The brokers make the float off of them. A reinsurer was sitting in his office near the end of the quarter. He got a fax from a broker asking for a $5–6 million check to settle this quarter's claim payments. This guy couldn't write a check for that much money, he needed his boss to write it. Of course, the boss is on vacation so the reinsurer calls up the broker and he says, "I'm not going to be able to do that by a week from today because my boss is out." And the broker says, "Okay, well, I'll have to withhold your reimbursement for this quarter if you can't pay me." One way or other, they're going to hold the money. They protect against underpricing and they allow you to get a large market share. The reason for that is that they can create a situation that is much more a way of life in the PA business than it is in the medical business: You price for a gross loss, but on a net basis you make money.

On the medical side, I think it's fair to say you write the business, and you either make money or you lose money. There's another mentality that says that you're really a reinsurance arbitrage and that reinsurance exists to generate profits for you. Even if the business that you've taken initially is unprofitable, if you can cut a good deal with your reinsurer or you can create some sort of situation where he gets more than he thinks he's getting, you can make money anyway. When you can do that, you can write tons of business because you don't need to price it at an adequate level, and you can get a large market share. If you're a reinsurance manager, you can generate tons and tons of fees. That creates another problem for the people who aren't playing these games because if you try to compete against these people and you don't have these sorts of advantages, you'll just lose money on a net basis.

Table 1 represents a reinsurance spiral. Let's suppose that we have three companies, A, B, and C. Each of these companies has a reinsurance program with three layers: $40,000 excess of $10,000; $50,000 excess of $50,000; and $100,000 excess of $100,000. Company A cedes the first two layers to B and the

third to C; Company B cedes the first layer to A and the other two to C; and Company C cedes the first two layers to B and the third to A. Note that each company retains both the first $10,000 of risk and the excess risk over $200,000.

TABLE 1
REINSURANCE SPIRAL

Company A cedes: $40k xs of $10k to B; $50k xs of $50k to B; $100k xs of $100k to C.
Company B cedes: $40k xs of $10k to A; $50k xs of $50k to C; $100k xs of $100k to C.
Company C cedes: $40k xs of $10k to B; $50k xs of $50k to B; $100k xs of $100k to A.

	Gross Claims			Net Claims		
	Comp A	**Comp B**	**Comp C**	**Comp A**	**Comp B**	**Comp C**
1. A incurs a $100k claim	100	0	0	100	0	0
2. A cedes $40k + $50k to B	100	90	0	10	90	0
3. B cedes $40k to A, $40k to C	140	90	40	50	10	40
4. A cedes $40k to C	140	90	80	10	10	80
5. C cedes $70k to B	140	160	80	10	80	10
6. B cedes $10k + $60k to C	140	160	150	10	10	80
7. C cedes $20k to B, $50k to A	190	180	150	60	30	10
8. A cedes $50k to C, B cedes $20k to C	190	180	220	10	10	80
9. C cedes $50k to A	240	180	220	60	10	30
10. A cedes $10k to C	240	180	230	50	10	40

Observe what happens when Company A incurs a $100,000 claim. Company A starts by retaining $10,000 and passing $90,000 along to Company B, who then keeps $10,000 and passes $40,000 along to each of A and C. From Company A's perspective, this is now a $140,000 claim, so the $40,000 received from B gets ceded to C. This process continues back and forth among the three companies until, in the end, this single $100,000 event has created a total of $650,000 in gross claims among the three companies.

Now suppose that Company D has written an excess of $200,000 cover on each of Companies A, B, and C. The single $100,000 claim has spiraled into $240,000 of gross claims for Company A and $230,000 of gross claims for C, so suddenly Company D is responsible for $70,000 of the $100,000 claim! Company D may not have contemplated this situation when they set the premium for the excess of $200,000 cover. They may have based the premium on the expected frequency of single $200,000 events, without realizing the possibility of additional claims under the excess cover due to spiraling.

Note also that in this example, the gross loss ratios of Companies A, B, and C will be very bad. If any of those things that I alluded to earlier—such as a reinstatement

premium, a burning cost, or 15% excess of 85%—are somehow related to this gross loss ratio, then these things will be triggered. All of those reinsurers are going to end up paying when they might have thought their chances of paying were pretty slim. Notice that the final amount that gets paid is $100,000. We haven't invented any extra claim dollars here; nonetheless, there's a great many payments that went on, and it probably took a fair amount of time. Company D might be sitting out for four or five years, depending on the situation, when suddenly somebody walks up with a big bill and says, "Pay." If Company D had not been involved, he could see that the amount gets split between the different companies. This is referred to in the business as a leakage. You don't want to be the leakage if you can help it.

There are various things that I would recommend you watch out for. One is if you write this business and there's no LMX exclusion, you should be careful. If you think there's a possibility that you could get LMX business or spiral excess business, I would be very leery. Also watch out for one-life warranties. Let me talk a little bit about what a warranty is. It's essentially the minimum number of lives on the claim that you need in order to pay it. So if it's a one-life warranty, you only need one life involved; if it's a two-life warranty, then you have to have two people involved. Obviously, one-life warranties generate a lot more claims than something else. Also watch out for cases having little or no retention. I can't quite understand why some big companies are reinsuring themselves down to $5,000. If we did it on the medical side, people would think we are crazy. Let me talk about what a reinstatement is. Oftentimes, the slip will specify that only a certain number of instances of the cover are going to be covered. For example, if it's some sort of accidental death cover, it may say we're going to cover five of these and after that, there won't be any more. But then there may be another provision that says after we get to the five, you have the right to buy additional coverages, in which case we're going to charge you a premium. That's a reinstatement and a reinstatement premium. If you have unlimited free reinstatements, then there's absolutely no limit on how many of these things you can get, and there's absolutely no cost to anybody to reinstate the coverage. Combining a one-life warranty and unlimited free reinstatements is pretty much a formula for disaster because that means somebody can spiral as many individual claims up to you as they can.

Some of the derivatives I alluded to tend to be buried in the retro programs of some of the people that are writing this stuff. I can tell you that there are some retro programs out there that you would not believe. They take pages to depict. I've seen schematics of these things that take three or four pages. We're not talking about somebody writing a simple $1 million of excess of $1 million and leaving it at that. Retro business of any sort is something to be careful about because you don't know what you're going to get. I know I get frustrated, even on the medical side, when I occasionally write some kind of excess. Then I find out what somebody

wrote and I say, "I wouldn't have written that." The problem here is a little more profound than that. You just have to be real careful that you know what you're going to get.

There are some people out there that are more likely to play games with you than others. What are some ways to protect yourself? As we just mentioned, don't do one-life warranties or unlimited free reinstatements if you can help it. One exclusion that's going around is LMX. I've seen some people play what I call the reclassification games where the LMX business goes out of London to some other place, and then they say it's not LMX. Yeah right. Demand meaningful retentions. Inspect the reinsurer's retro program. Whenever I get one of these quotes for these 15% excess to 85%, I always ask that question, and I never get an answer so I never quote. Avoid variable quota shares. Don't write some of these derivatives like burning costs. You may not know what you're dealing with. Avoid retro business. Write direct writers. If you're writing a direct writer, you know what you're getting; if you write retro business, you don't know what you're getting. Be careful following people that you think are spiral players, and also be careful of competing with them because they may be able to quote a price or take on a risk, because of their retro agreements, that you can't. Finally, and most importantly, only do business with the people you can trust.

Mr. Dennis Corrigan: You made a comment about aligning interest with respect to profitability of the fronting companies, the MGUs, the carriers, and the reinsurers. The brokers and the intermediaries weren't mentioned. They are like the rake in a Las Vegas poker game where in every pot the dealer will take a couple of chips and sort of drop them down the slot. We might think about making broker and intermediary compensation profit-based as well.

Mr. Gabriel: It's a good question.

Mr. McLean: Three months ago we were owned by an intermediary so I couldn't agree with that then, but it's probably not a bad idea. They'll fight kicking and screaming to not put at risk their fees, saying it's not their fault, but it's probably not a bad idea.

Mr. Gabriel: There are definitely more opportunities to do that now.

Mr. Hobson D. Carroll: In the stop-loss business, you're talking about the non-direct company business, which is still largely dominated by MGU-type situations. Fronting carriers and MGUs are the ones that benefit from the broker finding the reinsurance capacity. Maybe they're the ones who should be paying the fees out of their allowances rather than the reinsurers being expected to pay out of their

margins. If we go back to 1974, and add up all of the ultimate net risk taker profits in the stop-loss business and compare that with the monies taken out by brokers and finders at the reinsurance level, which is obviously not the retail level, I think we'd find an interesting disparity there. I think it's the one product in the history of insurance that has been largely reinsurance intermediary controlled and driven, and something must be done about those guys.

Mr. McLean: From 1989 on, we're about $73 million ahead to the risk bearers which, in our instance, is more than the intermediaries were able to collect out of that. Oftentimes, intermediaries will get 2.5% of net reinsurance premiums, so we're a little ahead. But that's not true in every instance and it's certainly becoming a lot tighter nowadays. Everyone is standing in line including the TPA and the regular broker, and the intermediary and the MGU is getting rich. It's the risk bearer at the end that's getting killed.

Mr. Gabriel: I have a couple of other comments on that. First, one thing that may happen if the brokers won't agree to putting their fees at risk is some reinsurers may start taking that situation into their own hands and start putting these deals together without the brokers. And the second thing is, I don't know about you guys, but it seems like the amounts the brokers are asking for seem to be going up. It used to be two-and-a-half a net, and now I'm seeing two-and-a-half a gross with great frequency.

From the Floor: The other thing that's peculiar about the intermediary is they don't have normal brokerage fees scaled down as lots get bigger. You can have a $100 million stop-loss block, and somebody can be making 2.5% of gross premium on it. They probably have to scale back fees.

Mr. McLean: There was one instance recently in which that sort of thing was basically forced on the broker and I guess it didn't go over well, but it has happened.

Mr. Daniel L. Wolak: There has been a period of time in which stop-loss rates have decreased. If trend has actually been in the 15–20% range, rates in the prior year have remained level or have decreased. I guess the underlying loss ratios probably would have jumped a lot more if you would take the rate decrease plus the add trend. Probably some of the programs I've looked at just sort of take in simply what the loss ratio was last year, what the rate increases have been, and it is sort of solving for trend. It seems like it has only been maybe 4–12%. Of course, there's managed care, and there are other things happening within that number. Any other thoughts on where trend is among the panel, or was it the trend that you were

talking about? Or is it more of a peer analysis comparing apples to apples from one year to the next?

Mr. McLean: I agree that if leverage trend had been 15%, the loss ratios would have been a lot worse. What offsets that is the fact that even over the last few years, there has still been a net migration into managed care programs. If you simply separate that out, and if you take that away and that has a huge reduction in the apparent trend, when you actually look at shock claims per day, the large claims on a per day basis are trending fairly rapidly. It is higher than your overall average trend.

Mr. Frank: I would say that on an aggregate stop-loss basis, attachment points are probably 12–13% indemnity based, and a PPO is probably 9–10%. You might have an increased trend at the spec levels as you start to go to higher specs. Isn't the average Standard Insurance Retained deductible $25,000? So you're working on 16–17 points? That's what we've seen in our book.

Mr. Gabriel: What do you guys see for trends? I guess my only point was that people think things have turned around because you're getting 8–10% increases on your specific stop-loss and that's not necessarily a great thing.

Mr. Frank: That's unless you've had such bad underwriting where they were able to cancel certain amounts of business that were killing them. Unless there's rapid improvement in underwriting you're right.

Mr. Gabriel: I think that is true for a lot of people. Most people have a 1998 treaty year that is worse than 1997 and 1997 is worse than 1996, which was worse than 1995, and 1994, and 1993. I think your point is we weren't getting rate increases back in 1994 and 1995. Everyone saw zero rate increases or negative 2%, and there was still trend. During the period of 1992–1996 there was still an awful lot of net migration into PPOs. If you segregated them out, the loss ratios and deterioration on the ones that were already in a PPO were very large. We're not getting any more net migration into it, so you could already if you go to better networks. But if you're just following everybody else's networks out there, the trend is a pretty high number.