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Problems and Opportunities in Reinsurance

Track: Actuary of the Future, Reinsurance

Moderator: THOMAS G. KABELE
Panelists: GARY L. CORLISS
KEVIN K. GABRIEL
THOMAS G. KABELE
Recorder: THOMAS G. KABELE

Summary: The panel discusses various reinsurance problems that have been reported in trade journals and the popular press. Topics include:

- *The London Circle and how it works; distinguishing the circle from a spiral*
- *Underpriced workers' compensation pools*
- *Underpriced medical stop loss*
- *Vertical pricing in reinsurance*
- *Other problems*

Mr. Thomas G. Kabele: Gary Corliss is the president of the American United Long-Term Care Solutions (AUL). He's going to discuss long-term care (LTC) and LTC reinsurance. He's been in the business about 30 years. He has experience in life insurance, individual health insurance, and LTC reinsurance. Kevin Gabriel has extensive experience, including medical experience; he worked for State Mutual as a medical pricing actuary, and at HRMP , he was manager of stop-loss facility. He was with Phoenix Home Life where he did A&H pricing. Currently, he's an independent consultant and helps a lot of us out in the business.

I'm with Guardian Life Insurance, and we do a lot of reinsurance. The last few years we have been doing a lot of A&H and aviation reinsurance. I'm going to discuss the spirals and circles and a little bit on Unicover type situations, although I'm not going to deal specifically with Unicover.

Mr. Gary L. Corliss: If you're looking at your program and wondering where LTC fits into the agenda, you'll notice that there's something at the end labeled "Other Problems." That's me.

Let's talk about the problems and opportunities in LTC reinsurance. As I make my comments, I'm going to put them into different categories. First will be the risks of LTC, so we can understand the mechanism and product line that we're talking about. I will make some comments about the types of reinsurance that are offered for LTC insurance, and then get into the problems. I will spend much of the time

talking about the success factors and how we've observed some problem cases, if you will, in the industry related to LTC insurance.

Well, what are the risks of LTC? The first one is morbidity. In another way, that's claim costs. What is the incidence rate, the lengths of stay, or the continuance on claim, once someone goes on claim for LTC services as covered by their policy? That happens to be one of the largest ones that we'll be talking about and of most importance. A second one is mortality. There's a double effect of mortality. How long do people hold onto their policies before they expire? The longer people live, the greater the probability that they may actually need to use LTC services. Once on claim, then the mortality factor becomes rather important, too, as an element of deciding whether someone terminates from claim or not.

LTC is a lapse-supported product. We found, to the surprise of almost everybody both in the LTC industry and management that's looked at it, people really hold on to these policies for a long time. It has some of the best persistency, maybe the best persistency, of any product in the marketplace. When you're pricing for a lifetime level premium, that has some severe ramifications. Expenses of course, are an issue with every product. Typically a high first-year cost is associated with acquisition of the business because much of the business is sold through the brokerage marketplace, and the compensation to agents is extensive.

A third item is the investment income associated with this product. A large number of claims are not expected in the first few years of a contract, as a matter of fact, not for almost 10 years. If you're selling to an average person aged 72, you don't really expect many claims until about age 82. If you're selling to an average person in their 40s, through an employee work site, we don't expect claims for almost 40 years. The necessity of earning the prescribed investment income as priced in the product is extremely important. If you look at the three items that are most important to the product, they are morbidity, persistency, and investment income.

Most of you know the varying forms of reinsurance that are out in the marketplace: proportional quota share, claims only, excess of loss and aggregate stop loss. Proportional quota share reinsurance shares in all of the risks associated with the product, and because a true LTC product has only been around for 15 years, most companies are most interested in proportional quota share. I took the 45+ companies that we work with at American United Life and asked, "How do these shape out?" By looking at the results, you can have an understanding of how the LTC reinsurance marketplace has developed.

First, we looked at the number of clients that we have. When separating those out, far and away the proportional quota share is the largest one at 90%. Claims only and excess of loss were each on 4% of our agreements. Then 2% of our contracts had some aggregate stop loss. What about by premium? By premium, aggregate stop loss, excess of loss and claims only are in the range of 1% of the total reinsurance premium that we have received over the years. Quota share was at 97%. The vast majority is in the proportional quota share. What that means in terms of the reinsurance effect is the reinsurers are sharing in all of the risks basically that there are under the product. If we want to understand what the

results are likely to be and what the problems are likely to be in the industry, then we don't need to look at some of the segments. We really need to talk about the whole product itself because that's where the results come from.

As we look at all the problems with LTC insurance, there have been a number of companies that have gotten into and out of the business over the years. If you go back to 1985, there were only about a dozen companies. By 1987 there were 75 companies. By 1989 there were almost 150 companies. It somewhat leveled off. It's around 120-125 companies right now. Why have companies made a decision to enter, and why have companies made a decision to leave? Well, focus has had a lot to do with both entry and departure. Companies that are trying to focus on the senior marketplace have decided that this is another product in their niche marketplace. They need to have products associated with that. Some companies have decided, "Well, it no longer fits." If they've decided senior marketplace is not where they want to go, then that has created a change in a decision for companies to leave.

In 1985 when I asked my compliance officer, "How many regulations are there for LTC insurance?" He said, "None." Now regulations are in place in every state. They're constantly changing. When our compliance people try to put together a generic product, which we always start with, they know full well that they're going to have to make 50 adaptations to that product. Some will take them up to two-and-a-half weeks to make a change to one of those products. Some will only take them a matter of a couple of hours. But the net result is there's a lot of action that's needed in the compliance department in order to be in, and to stay in, the LTC business.

More recently we've started to have some issues arising where policyholders, or should I say their attorneys, or attorneys who find policyholders, have decided that there are certain issues related to LTC policies that have never been litigated, such as the language. So far there actually have not been any legal decisions that went through the full process of either jury or a judge's decision in a case. There have been a number of situations that have been brought up that have raised a specter of plaintiffs trying to make the contracts be more than what they were originally scheduled to be. That's made a number of companies obviously nervous. We're working with a very special group of individuals, a very protected group.

If you've been watching the debates, you notice that senior issues are the ones that seem to crop up as often as any other issue. Well, it's no different when you're getting into the court system. Seniors are a very protected group, and, therefore, individuals running companies have concerns about where some of this may go. Despite the fact that we're in a risk business, there are a number of executives who don't want to be in the risk business, and, particularly, they don't want this kind of risk.

The industry was formed on the idea that you could change rates under a policy. Policies are now guaranteed renewable. At one time they were conditionally renewable. There's been an onslaught at least in California to try to make premiums noncancelable. There have been issues related to rate stabilization over

the years under a variety of guises where obviously the protected group is looking to have their premiums protected. There have been rate increases under a number of policies. There's a publication that has taken all the states and all the rate increases by all the different policy forms (it's more than 1" thick) that relays all of those rate increases that have been filed and approved in the different states. It has become an issue for many companies.

Growth rate can be a problem. The whole idea behind LTC insurance when it started was to look at demographics. We were looking at a huge growing population. Therefore, over time what we can expect is that there's going to be the need for a lot of LTC. That creates the need for someone to pay the bills for LTC and, therefore, LTC insurance. People were expecting a large amount of growth associated with it, and it did not happen to the extent that a lot of companies needed. For those companies who have had a lot of growth, they've been looking at their results and noticing that the returns were not quite what they had hoped that they would be. It's made a number of companies make a decision that at least for this period of time there's not enough profitability in the product for them or they don't happen to know how to run the business well enough.

At AUL we've decided that there are five major factors that determine whether someone will be successful or not in the LTC business. The first one happens to be the underwriting process. We think that the underwriting process is the most critical factor, the day-to-day individual decisions being made by underwriters to determine whether someone should be accepted for coverage either on an individual basis or, in some situations, on a group basis. The second most important thing is the contracts. The contract language has to be written very clearly. The products were all priced under certain specifications, and it's necessary that those specifications can be held to at the time of claim. If that's put together, then the claim processors will be able to do the job that they need to do at claim time. Obviously, there needs to be a spread of risk. Actuaries understand the spread of risk. You need to have a large enough volume in order for there to be a favorable exposure or favorable chance of having the kind of results that you would ordinarily anticipate.

Sales volume is important. Doesn't necessarily have to be enormous to start with. You might like to grow it and measure it. But there certainly has to be a large enough volume.

I chair the SOA's Long-Term-Care Intercompany Study. One of the findings is, if you look at the companies that have provided information to that intercompany study, the companies that have the least amount of in-force business have the highest incidence rate. They seem to have the longest length of claim. There's an issue here around expertise which can affect the underwriting process, contract and claim process, but if you get sufficient sales, then that should be ameliorated in some way. Even though this is an actuarial group, we do put pricing as the fifth important item. We're not saying it's not important, but if the other things are not carried out in a somewhat responsible and reasonable way, then we're not anticipating that there will be good results.

I have several case studies to explore with you. The first is a company that was in the business from 1984-87, one of the first generations of products that were out there. Their particular underwriting process was looser than what you would expect to see today. It was a very brief application. Brief applications were the sense of the times back in 1984-87. If we try to look at some of the things that we said didn't work too well, they didn't follow up on negative history information as thoroughly as one might anticipate or as thoroughly as they should have.

Definitions of nursing homes have changed over time, and are difficult to relate to the terms used in those early contracts. That's made for an issue. Typical for a product at that point in time, it relied heavily on the physician to make a decision. Unlike the current contracts the company didn't really retain the right, as it should in a contract, to determine whether there's liability or not. It virtually gave that over to the physician. The contract was heavy in sales with a zero-day elimination period. Of course we've all learned about zero-day elimination periods for disability, and no deductibles for medical expense type coverages. We know what happens in those kinds of circumstances.

If you just looked at their claim process, you'd probably say it was rather normal. It wasn't bad for the type of products they offered at that point in time, but because they didn't follow up on the information, they couldn't do anything effectual in terms of any kind of rescission action. This was even pre-days where you were not allowed to do what's called post-claim underwriting. They did have a sufficient enough volume. I think the maximum amount it got to at one point in time was $25 million in annualized premium, about 30,000 policies pretty much spread out across the whole country. There was a heavy emphasis of sales in two particular states, one was North Dakota, which has some particular requirements for use of services, nursing home services in particular, and the other was the state of Florida.

Having reviewed some of the pricing, it was not wholly unreasonable. There are a couple of things certainly that we've learned over time that in retrospect we wished would not have happened. Persistency, at that point in time, was not anticipated to be as great as has been demonstrated over the last 10 years. The main issue was this company had a tremendous amount of early claims attributable, we believe, directly back to the underwriting. This is not related to anything we've seen; this is just us trying to observe, and we were called in to observe this business. We're thinking that the total losses on that block of business will probably be in the range of $30-40 million. In that case these are the things that we saw in retrospect that are a concern with the underwriting and the contract.

The second case study is of a company writing business between 1994-96. If we want to look at issues, the underwriting process was done by three different organizations during that period of time, first by one TPA, then by a second TPA, and finally the company decided it would do the underwriting. There were reasonable underwriting guidelines in place, but by the time the writing company started to do the underwriting on the business, they started short cutting some of those underwriting criteria, leading to not making the decisions that the underwriting guidelines would have expected.

The contract was probably written pretty responsibly, in what was typical in the early 1990s. It did have some new features. It also did have a zero-day elimination period as an issue related to the product. The claim process early on seemed to be fine. Once it got to the carrier there seemed to be some real issues. Although, there was a lot of language about plans of care and care coordination, those steps were not followed.

Sales volume was in the $12 million range, about 10,000 policies. Although it was put out and made available across the country, it was primarily sold in south Florida.

Several factors influenced pricing and there were a number of new features within the contract. Persistency, again, probably could have been a little bit stronger. The incidence rates turned out to be about three times what was expected in the pricing. The lengths of claim were shorter than expected, but in this case the incidence rate was the one that hurt it. We would attribute much of it back to the underwriting process that went on and somewhat to the claim process. That total loss could be around $40 million.

The third case is of business written between 1985-89. Similar to that time, it was very simple processes and reasonable underwriting guides. Follow-up was probably a lot weaker than what one would do today. It's equivocal on the underwriting side. The contract was very easy to make claims on. As in the first case, it relied heavily on physician certification that didn't allow the company to make some of the decisions it might have liked to make.

The claim process for the type of policy and the type of benefits was probably fine. There were about $8 million in premium and about 8,000 policies. That's not large. It's not small. Although available in a number of states, it was primarily sold throughout Florida and North Dakota. For pricing, if one goes back to the actuarial memo that was prepared on all the factors, they are very close to what actually happened, except for one item, and that was the length of stay. The length of stay was virtually twice what one would expect. It was twice what we are seeing in the intercompany study. If you put it together by cause, not just, say, one cause, but all of the 11 major causes reported on in the intercompany study, and you went down one by one, every single one of them was virtually twice what the intercompany study would look like. Our estimates are that that loss was probably about $25 million.

Now, this may sound as if nobody's doing anything in the business or making any money. That's not true. There are a number of companies that are making money, probably not as much as they hoped to have made. I would say the average well-run organization is probably making about an 8% return on equity right now, fighting to get it up to 12%. There may be one or two organizations that are around 16-20% return on equity. It's possible to make some headway in this marketplace, but you really have to have a back-room organization and a front-room sales organization that gets you enough volume so that all the pieces work for you.

Let me just give you an example of one thing that could seem kind of innocuous but becomes very important in the reinsurance marketplace. Some companies have put out a nursing-home-only product. Then they have allowed within their language that one could under certain circumstances receive home-care benefits, priced purely to be a nursing-home-only product. The language seems to be so open that we have a concern that it's probably priced half of what it should be, and that would be a circumstance in which we would say, you know, we don't want to participate in that business unless the contract is rewritten.

What about the process? Obviously, I think I've hit on it enough that underwriting comes up short in all the case studies that I discussed. We think that that is very critical to understand the underwriting process, as well as the people that are performing that process. Is it a mature staff that really knows how to implement those guidelines? Is the business growing so fast that they put on a lot of individuals who don't really understand the business? Those kinds of issues are important. Certainly are the premiums appropriate? Has the product been priced to make a profit? There have been a number of actuarial memos that we've reviewed where the profit target was 0-2%. Some companies are willing to do that to get into the marketplace and get going. I think we're seeing a lot less of that. We're more comfortable with our own assumptions. We're looking at less of those. In total, you look at the protocol of the whole organization, how it's put together, how it's measuring its business, and how it's doing.

Those were initial thoughts. What about on an ongoing basis? Certainly there needs to be oversight. Things are changing. New valuation tables are being created for LTC insurance. There are trends that are occurring. You have to be on top of this to know which way those trends are going. Several of them are going favorably. Several of them are going unfavorably. Some are not going the way that you might expect them to go. Are they going to continue to go that way?

Monitor the financial results over time. Stay in close communication, not only to keep them as a customer but also be able to help them on the cedents' part.

It took us a while to get enough data, but we did an actual-to-expected basis of earnings analysis where we can look at the investment gain, the morbidity gain, items related to persistency expenses and deferred acquisition cost. The two that come up time and time again as we review one client after another are the morbidity gain and the in-force gain. We're seeing what I think many well-run companies are seeing in the industry, that there's an offset between the two. As we reprice, we're able to put the persistency in the pricing at a much better level. We have an increasing comfort with what the morbidity results are.

As you're evaluating blocks of business, and it doesn't really matter what kind of blocks of business you have, looking at actual-to-expected is obviously the way we all need to go. If you're working with a number of companies like we are, that's a heck of a database to be looking at and playing with. It took us a few years to get it all in place.

LTC insurance is the only thing we do. We think this is important. The LTC marketplace is here. We think it's going to grow. Our whole issue needs to be, how do we turn the problems that we've seen into opportunities?

Mr. Kevin K. Gabriel: I think it's fair to say that the market is pretty bleak at the moment. The only good side is it's so bleak that it's inevitable that it's going to get better. The question is when, and who will still be around? Bear that in mind as we proceed.

I'll give a short course in stop-loss insurance, which is most of what the medical reinsurance market has been for the last few years. There have been a little bit of fully insured business and some other more limited medical plans out there, a certain amount student medical and whatnot, but I'll guess it's been 80% stop loss. I wouldn't say reinsurers have been too successful in any of these other things either, but most of what's causing the trouble has been stop loss. The problem has been just deliberate underpricing by everybody who was getting paid fees to sell the product with the reinsurer sitting at the end.

To review stop loss, for those of you who are a little hazy on it, this is insurance provided to employers, not to individuals, that are self-funding their medical coverage. They've elected to do this, either to avoid insurance mandates, say, premium taxes, or save expenses. There are two types of stop-loss coverage. There's specific stop loss, and there's aggregate stop loss. The specific covers claims on individuals, excess of a certain amount. The aggregate stop loss covers claims on the entire group, exclusive of the specific claims that exceed what is determined to be expected claims plus a corridor. The corridor is commonly 25%, at least in theory. On smaller cases it probably ought to be a little more. On larger ones sometimes it's a little less. As you might gather on the aggregate side, there's a certain amount of haziness in exactly what those expected claims are. There are a lot of different ways to get to them, some of which are a little more rigorous than others. In theory you determine expected claims, add on a corridor, and what you should really be providing an employer is catastrophic protection in the case that he has just an unusually high incidence of claims, but none of them are very large.

Most of the reinsurance stop-loss business is marketed and underwritten by the infamous managing general underwriters. There are really not a lot of direct carriers writing the business, at least in the reinsurance world. Managing general underwriters (MGU) are independent entities that market, underwrite, and, to a great extent, administer stop-loss business. They will issue business on behalf of a primary carrier, and those are the carriers that are in theory being reinsured here. Many of them, as we'll see, don't really seem to want to be in the business too much, but they're happy to take the fees. You've got a bunch of reinsurers out there. You've got a large number of smaller companies mostly that are going out, because they don't have lot of infrastructure, commissioning these MGUs to write business for them and then getting a reinsurer or, more likely, a group of reinsurers to reinsure that business.

The number of people who are involved in this sales process is really something. I will attempt to try to describe the story a little bit. There'll be an employer. The

employer will have a broker who brings a third-party administrator (TPA) to him. Then there'll be possibly another broker who brings the TPA to the MGU. Then there'll be a reinsurance broker most likely who is involved in getting that MGU a primary carrier and then in getting reinsurers to reinsure that business. Very often those reinsurers may be a reinsurance facility that, in turn, has a broker who's placing his facility. Interestingly enough, many times the brokers who are bringing the primary carriers to the reinsurers are also the brokers who are setting up that retro pool. Fortunately for the broker, they get paid twice.

I would like to give you some idea of what the compensation structure is, and this is where we have been, more than where we may be at the moment. The TPA and broker receive 5-15%, but most of the time it's been 15%. There are even exceptions to that. I've seen some that go up as high as 20%. Commonly 10-15% has been about where it's come in most of the time. The so-called fronting carriers have usually been somewhere in the 3-5% plus premium tax, which is usually 2–2.5%. I'd say the upper end of that scale's been more common. Again, that may be changing. Most primary MGUs receive 10-12%, but there were some even more than that. For MGUs, their fees were very dear to them. I remember having a meeting with one MGU who was actually getting 15%. I explained that that seemed to be a bit much, and in order to improve his results we needed to get the figures down. The broker looked at me with a straight face and said, "Well, you know, he's running 150%, and I just don't really see how reducing the MGU fee from 15% to 10% is going to solve that problem."

If there's a lead reinsurer, that really means you've got a reinsurance facility where there's a fronting reinsurer and a pool of reinsurers behind him, he's going to be somewhere in that 0-2% range. Reinsurance brokers usually receive 2%. Usually it's 2% of the net reinsurance premium. But, there are a few out there that prefer gross. They're having a tough time these days. If there's a reinsured facility, he's usually in the 4-5% range. Of course, if you're the reinsurer at the end of the chain, you've got to attribute some expenses to what you do unless you work for free.

Now, just to talk a little bit about where we've been. As far as I can see it looks like 1994 was the last year that was reasonably good for most people; 1992-94 were good years. Trend seems to have been unexpectedly low, and most people were in pretty good shape. The transition years were 1994-96. Some people seemed to do okay. Others did not. But when we got to 1997 things really took a turn for the worse, and I estimated that the whole industry may have come in between 115–125%. You had a few people who were actually below the minimum and no small number that were above, but I guess somewhere in that range. I'm talking about relative to net premium here, not gross.

We thought 1997 was bad, and that it had to get better, but 1998 was a lot worse. I estimated that most companies came in between 125-145%. I personally was inclined toward the higher of those. It's pretty clear to me that we're headed for another loss as returns come in for 1999. It looks like it's not as bad as 1998. I'm guessing it'll be similar to 1997, which is a little bit of a disappointment to me. I thought it might be a loss, but I thought it would be better than 1997. Unfortunately, when you look at the rate increases that would be necessary in the 1998-

99 years to get us to profitability, I would tend to bet against it. We'll do a little math on that later. I think you may have more individual producers who may be profitable in 2000, but overall I'd be pretty skeptical.

One of the surprising things I've seen with some of the clients I work with is every month when I look at their results, and try to project out where they're going to be, it's worse than it was the month before. Particularly it's been a problem with facilities. You get reports in three years into a treaty year, and all of the sudden the incurred but not reported just went up. I have a hard time understanding that. It seems as if not only were the results worse, but they took longer to come in. You can come up with your own theory as to why that might be, but I'm going to guess there's some correlation to that. It's possible that some of these numbers may go up even some more.

What's going on in the market? Well, mostly people are getting out. A lot of the life and the health companies have thrown up their hands and said they can't take this anymore, and so they are out of the business or they've cut back significantly. In the meantime there's also been a great deal of merger activity, and that's driven a few more people out of the business. Most of the time I think in these mergers the health side of the business, anyway, has really been pretty much of a casualty. You have to look at the individual cases, but many times when there's a merger or an acquisition maybe only one or the other of these businesses, the life or the health remains, that's really the issue, and the other is essentially put into runoff.

Some of the property & casualty (P&C) companies have jumped in. I saw an article recently where a couple of management consultants were arguing that there's about $100 billion of underutilized capital in the P&C business. These companies are looking around for other things to do. They're seeing all these life and health companies get out of the stop-loss market. They think they understand what the business is, and so they're getting in. Lloyd's has been in and out over the last few years. In the early 1990s the problems at Lloyd's, most of which were P&C related, caused a retreat. Unfortunately for them, I think they missed some of the better years, 1992-94, but when they pulled themselves back together, which really wasn't till about 1996, they seemed to write more business. They were always there to some extent, but I began to see a lot more of them in 1996 and 1997, and, to some extent, 1998. In 1999, I started hearing from them that things weren't going that well. Now they've figured out the same thing the rest of us have, and, consequently, for the last 12 months or so, there's been a real retreat. I think there've been some syndicates that have closed up. There were some other London underwriting agencies that have also closed up. They've had some problems beyond stop loss, but, again, that's been the bulk of what they wrote.

Reinsurance managers have been one big casualty in all this, and maybe it's worth talking about them. They're essentially wholesale MGUs. They typically are out underwriting on behalf of an individual company who then has a pool of companies behind it. There is an alternative structure where that reinsurance manager actually defines risk on behalf of the pool. That structure is what's common. The advantage of it is it's cheaper because you don't have to pay a front fee to the company you're underwriting on behalf of. The minuses are that it's a little bit more difficult to

organize, and you have certain solvency issues if somebody in the pool goes belly-up. The more common arrangement is to have a reinsurance manager. He underwrites on behalf of Company X, and there are some numbers of companies behind it. Also, there's been a big issue with control and whether the retro companies really have any control about of what's going on and whether they really want to be in that position.

The third problem has been with the decrease in the number of reinsurers. Practically every reinsurer in the business sees all the business that's out there. Why do they need to pay a pool manager six points to look at it for them? The old arguments, for managers were essentially that it was a better way to spread risk, that the managers had expertise and contacts that you didn't have. It was a very low cash-flow way to get in the business, that is, you didn't have to hire anybody. You didn't have to spend any money. Basically, all you had to do was sign up. Now, of course, there was a loss in cash flow. You just never saw the cash because they took it.

In any case, some of these people have been sold to reinsurers. Others, three or four of them, have gone out of business in the last year. There is a handful still left. I think they are still writing some business, but I'm not sure how much. Almost all of them have had to reduce their expenses. Others have transformed themselves essentially into excess carriers who are really quoting premium rates for high level coverage. Most of the business written by these reinsurance managers and most of the business we're talking about here is really quota share of the stop-loss business, not excess of anything any more than the stop-loss retention.

As far as the retail MGUs, as you might gather, they're having a tough time. Unfortunately for the reinsurers, the way problems work is they come down from the top to the bottom. Problems start with the reinsurers. They go to the facilities. Then they land on the retail MGUs. Most of these people have been telling stories for a few years now about how results haven't been very good, but if you just wait, they will figure out a way to fix them, and here's all the wonderful things they're going to do. Unfortunately, they never seem to do it, and for some of these guys after five or six years of red ink don't have anything more to say. I'd be very surprised if there were any reinsurers that really want to sign up for those programs. Who knows? There are always new ones.

There are fewer markets to go to. I had one reinsurance broker who gave me the list of companies he was working with, and I was amazed to see that none of these companies were in the business three years ago. None of them were companies that he had ever worked with. He's had to scramble and find a whole new set of companies to go to, and there are not as many. Because of the long lags, we're still seeing 1998 and early 1999 results. This is probably bad news for any thoughts of a near-term turnaround in capacity. I think senior management at reinsurers will continue to look at some pretty red numbers for at least another year or two. This means it's going to be hard to convince people to get back in the business when they're still looking at all this red ink. Unfortunately, I think some people will miss the boat because of that, but one needs to understand that you're usually looking 24 months in arrears when it comes to financials.

Fronting carriers have to take bigger shares of these programs than they used to. Typical retentions have been in the 10-15% range. There have been some fronting carriers that have actually retained 100% of some of these programs in the hopes that they will get it placed eventually, but they're also having to reduce their fees which I alluded to a little bit earlier.

What are the reasons for some of these problems? Well, I think most reinsurers now agree in hindsight that the biggest problem is the incentives. You have reinsurance managers, carriers, retail MGUs, brokers, TPAs, broker brokers, and other assorted people all getting paid percentages of premium, with absolutely no regard as to whether the business actually produced any profits.

In fact, I remember about a year ago I went into one of the better-run MGUs to assess his business. He said, "You really don't need to do a lot of work. The problem's simple. The rates are too low." They were, but he was happy to keep writing. As I said, retail MGUs were happy to write underpriced business. Everybody's been happy to take underpriced business. There were no incentives on any of these people for them to change. In a lot of ways this was in a death spiral, and we had a perverse situation where the industry was losing money, but people were still jumping in because the people who were jumping in were still making money.

The typical problem with most of these MGUs is they only write one product, stop loss. When rates go down they have two choices, go out of business or write underpriced business. They didn't have to think too long about that. Some reinsurers have tried to get MGUs to write other sorts of business. It's tough. A lot of them will pay lip service to wanting to write life business. I think some of them do. The problem is it doesn't generate a lot of volume, so they don't get paid a lot. Most reinsurers think LTD and LTC, require more expertise than they're comfortable letting MGUs write business for. There has not been a lot of movement for MGUs to diversify, and that continues to be a problem.

Third, a lot of these MGUs were paid pretty good percentages of premium, way above their break-even. Depending on MGU size, I think the folklore is that to break even is somewhere in the 5-8% range. Since most of them were getting 10-15%, they were happy to take the premium. I remember walking into another small MGU who was looking to add a carrier and get more reinsurance, and he was startup. He was telling me about all the tough times he had. Then we went down and got in his Lexus and went to lunch. On top of that, startup costs have been virtually nil, and there are almost no barriers to entry for MGUs. There have been a lot of reinsurers who are the culprits here, by the way. Particularly the facilities have been very happy to put more MGUs in business because that means more income for them. Reinsurers would hand them a rate manual and writing guidelines and maybe some systems and whatnot, and they were in business.

The last reason for the problems is that, again, expenses are way too high, and here one has to consider the competition. You've got direct carriers writing this business, or at least carriers who are not using all these MGUs and they don't have this long food chain to feed. Their break even was simply a much higher loss ratio,

and that became the economic ceiling on the expense level. This meant that if you're writing business at a 65% loss ratio, and somebody else can write it at an 85% loss ratio, that's going to be a big problem for you.

Here are a few specifics about the problems. My personal guess is that speculative rates were about 40-60% of what they should have been. To a great extent it was obscured particularly by PPO discounts. One might ask, "How could they write 40-60% of manual?" The reinsurers would not let them get away with it. The three-part answer is: (1) The reinsurers weren't paying attention; (2) The MGUs didn't care; and (3) They rationalized it various ways. This PPO discount issue seems to have been the principal one. I'm not quite sure how they were really calculating these. My guess is they really weren't. Some of them had somewhat heuristic methods of coming up with discounts.

My favorite one, which was concocted by an actuary, was to take the ratio of submitted charges to paid, and that gave you your PPO discount. I have a big problem with aggregate attachments. Aggregate attachments were particularly a problem in 1997-98. I think there's been a little improvement on that. This became an area of competition. Not only were you going to quote a really low speculation rate that is the hard-dollar cost, but also TPAs and brokers were trying to sell total cost. If you came in with a low attachment point, the sale became easy. The loss ratios on their aggregate business were 200–300%. That was pretty common. Now, since aggregate of premium is probably only 10% of speculative premium that was not the entire problem. A lot of MGUs have solved this one. The reinsurer's have their eyes open to it a little earlier than on the speculation side. A loss ratios of 300% versus 150% is hard to explain.

Some people might not agree with me, but I think there was a tendency, especially on smaller cases with low specs, to simply buy claims. In other words, to issue a quote on a case where you knew you were going to get a claim and not really to do anything about it. The TPAs don't like that, but that's the way things are.

The PPO discounts were pretty much made up and not much rigor to what went on there. They could have used actuaries, but one of the things you have to understand about MGUs is that actuaries don't produce business. They have a hard time understanding when to pay them. I have a few points to share on underwriting lapses by the MGUs. These guys are always moving around. One MGU will tell you, "I lost a lot of money because so-and-so was incompetent and underwrote such-and-such cases, and then that so-and-so will go down the street and get another job at competitor." Again, many of these people have not made money for quite a long time, and it's hard to think profits.

I had one MGU who followed what I told him to do to the letter. During a whole year of business he wrote two cases, and he was rewarded by having his paper pulled, because he didn't produce enough business. That should be formula training. A lot of these guys are using old manuals that they pirated from one person or another and software that's not really up to date.

The reinsurer's been very passive. There have been some audits, but audits are tough. You go out 3–6 months after some business has been written. You look at a whole mess of cases. It gets very tiring. Then they say, "Let's go to dinner, and how about golf tomorrow?" Things dissipate from there. There hasn't been much in the way of place case reports. There's no instantaneous reporting of sold cases to reinsurers. They seem to be pretty content to look after the fact at what's going on, and I think that's really got to change.

Most issuing carriers are not in the business. At least they don't view themselves as being in the business, and that's one of the big problems. In theory, we reinsure a company because the company wants to be in the business. They either don't have the expertise or they have capital limitations. They may be new in the business, and they want to get some familiarity with it. But, nonetheless, they want to be in. Fronts really don't want to be in. They want fee income. They want an arrangement where there's no way in the world they can have a loss from the program because they only have 10% of the risk, and they've got a 5% fronting fee, and so their loss ratio has to be 200% or something before they have a loss. Therefore, they don't care, and, therefore, they don't exercise any diligence on some of these issues like underwriting standards, and so forth. On top of that, they impose production requirements because they want enough fees out of any particular MGU to make it worth their while.

There are signs of a correction after all this bleak news. Trends are up. Rate increases are up. Are they up enough? I saw an industry trade magazine recently that talked about 40% rate increases. That's probably not enough. We've done a little math that gives some idea if you're 30% underwater, and you've got 20% trend, you need a 71% rate increase. Actually, 30% underwater is probably less than many. The reinsurance facilities are going away. That's cutting out some expenses. We're going to have fewer retail MGUs, and terms are definitely hardening. Reinsurers have gotten to the point where they're saying, "Here are the underwriting guidelines. If you violate them, you're out of business." Four or five years ago any reinsurer that said that would have been regarded as just completely unreasonable. Some reinsurers have tried to say it in retrospect. That's creating a lot of problems for everyone.

In the future, we'll probably move away from MGUs to managing general agents, that is, people that produce business, but reinsurers will underwrite it. The quota-share reinsurance facilities will go away because they are uneconomical, there is no value added, they have the wrong incentives, reisurers have all the risk, and they can't make money. Companies will have to be in the business. No more companies taking no percentage of the risk. There were some out there. I'd be very surprised if any reinsurers are willing to stomach that. Reinsurance facilities may well continue only as an excess type carrier.

Mr. Thomas G. Kabele: The reinsurance industry in London uses P&C terminology. Instead of using the words "direct writer", they use the word "primary reinsurer" and "retrocessionaire" they are the same. Instead of "automatic" in London they use the term "treaty reinsurance". Basically it means no underwriting. "Facultative" has the same meaning; each case is individually underwritten. "Quota share" or

"surplus share" means basically a proportional sharing of risk. Excess of loss means you cover individual claims over a certain amount. For example, specific stop loss in medical is a form of excess of loss (XOL). For aggregate stop loss, the reinsurer pays if the total claims in a portfolio exceed a certain amount. We have this in the medical field as well. Franchise is a particularly dangerous form of aggregate stop loss that applies when a loss trigger is hit. The term "claims borderaux" just means a claims listing.

Lloyd's is not a single insurance company. In the popular press they often refer to it as Lloyd's. It's not an insurance company, but it's a collection of underwriters called syndicates. Each syndicate is like a separate insurance company, but, contractually each name is a separate insurance company. However, Lloyd's does have a central fund. They do have a claims office called the Lloyd's claims office. They handle mainly asbestos claims. There is also a policy signing office. Lloyd's syndicates write primary business, and they sometimes provide whole account reinsurance to other syndicates. Claims there are often settled by bordereaux.

I would like to explain what I call London reinsurance circles. They're also called spirals, but the word spiral is used to refer to things other than circles. Circles arise because of three conditions: A reinsurance agreement covers an underlying insurance and reinsurance program. Then the underlying reinsurance program, either directly or indirectly, assumes and cedes the same claim amount, and each time the claim is reassumed, either directly or by a remote cedent, the claim amount is increased. This is really a faulty definition of claim and claim amount.

To illustrate how this works, I start it out with reinsurers A, B and C. You start out with a primary claim of $102,000. Reinsurer A is, say, a syndicate or a London market, and it has $1,000 retention. Reinsurer A gives it to reinsurer B who also has $1,000 retention. Reinsurer A pays $102,000. Primary policyholder goes away. He's happy. He's not involved.

Reinsurer A gives $101,000 to reinsurer B. Reinsurer B says, "Okay, I'll pay this claim," and he has $1,000 retention. He ships $100,000 back to his reinsurer, which in this example turns out to be reinsurer A, who then says, "I've now seen two claims on this person who's really sick, but I've got my full retention, and it's $1,000." Reinsurer A ships it back to reinsurer B, and reinsurer B says, "this is a really sick person, but I've got my full retention." He ships it to reinsurer C, who says "This guy is really, really ill. There are three claim amounts on this guy, three independent claims, $102,000, $100,000, and $100,000. He's really sick, but I've got my retention." Reinsurer C ships it back to reinsurer B, and then reinsurer B ships it back to reinsurer A. Finally, it gets to where it goes over $500,000. Then they ship at least $1,000 to reinsurer C and $99,000 to reinsurer B. Reinsurer B ships the $99,000 back to reinsurer A, who ships it to reinsurer C. Then reinsurer C finally wakes up and says, "I priced my layer $500,000, $2.5 million in excess of $501,000, as sort of a catastrophic cover. Why am I paying first dollars of this claim?"

Now, it's actually more complicated than this. London brokers have told me they can have inner and outer circles. Reinsurer A goes to reinsurer B who goes to

reinsurer C who then goes back to reinsurer A. Once it gets back to reinsurer A, it goes to reinsurer D, and reinsurer D sends it back to reinsurers B and C. Then it gets back to reinsurer A again. Eventually, it goes to innocent capacity reinsurers E and F. Reinsurer E gets the claim on a risk-attaching basis, and reinsurer F gets the claim on a claim occurrence basis. There's double coverage. These are very complicated circles.

Magnification of claims. Once I figured out that the claims are actually double counted, I asked, "Can you magnify the total claim?" For a long time I thought you couldn't. Then somebody told me about an aviation reinsurer that reinsured some experimental flight, a recreation of a Wright Brothers flight across the English Channel. It was a $50,000 claim. They put it into the market, and it came back as a $500,000 claim. They rescinded their claim into the market, and then they had to pay the $500,000. It's actually possible to magnify these with brokerage, something called reinstatement premium protection. I figured out how you could do it with franchise, which I mentioned is a very dangerous form of stop loss.

I've distinguished claim circles from boomerangs and funnels. A reinsurance funnel's not very pleasant, but it's not a fraud or anything. Basically, you take a lot of business from several different cedents. You end up getting all of the risk when you only thought you were going to get 10% of it. A boomerang may occur in America. It's actually fairly common. The reinsurer might cede and then end up reassuming the same risk, but, unlike the circle, the claim amount doesn't increase the insurer's claim dollars. They're different.

How do you avoid claim circle? The London brokerage said maybe the best way is to drop out of London or else buy your own reinsurance from him. That was an interesting solution. You don't accept any reinsurance business. Remember, one of the three conditions was that you reinsure an underlying book of reinsurance. If you don't do that, then you can avoid some of the circles. However, maybe you can't do that because sometimes the real insurance companies at Lloyd's may buy direct insurance on risks that they write. Another variation of this is to only go down three layers at most.

I thought of a no-claim circle clause. I'm not sure this works. One clause I came up with is, you must trace all claims to the primary amount, and, if not, there's an additional premium, say 120% of the claim. Presumably you won't want to pay the extra 20%. Maybe you won't get them.

Problems. What can you do? Can it work? Reinsurers may say they paid all these claims. Of course, they probably didn't pay very much, but they went through the circle very quickly. Sometimes these paid claims go through instantaneously. You may have a big computer. They could pay a claim 10,000 times. An example of an earlier spiral or circle involved aviation or marine where one of the underwriters paid a claim 10,000 times. They say there's no central claims authority to trace claims. I called the Lloyd's claim office, and they say that they don't trace claims, but that's supposed to be done by each syndicate. One of the things that I've thought of is to exclude XOL on XOL. However, you could pass along remote claim circles by quota share. They're more obvious, though, because you have to show

the percentage of the original claim. One of the brokers told me the easiest way is just to exclude all reinsurance. He was absolutely right, and I pointed out to him that he could easily trace to primary once he did that.

A helpful clause is to include in a treaty two-life warranty. Two-life warranty doesn't eliminate circles, but it reduces the amount. However, you should have a minimum of $25,000 per life to avoid a $1 million claim on one person and a $0.50 claim on another one. If they can invent circles, they could get around two-life warranties. Another helpful clause is using a limited number of reinstatements. No unlimited anything including no XOL on XOL. That helps. Apply time limits on claims. A lot of experts have come up with these clauses, and basically I've given a lot of the solutions. They're very interesting.

The claim circles, as I said, differ from the spirals because the word spiral is used generically. It can mean any time where you have a reinsurance arrangement where you have more than one reinsurer, and it can be nasty things like circles, or it could just be linear reinsurance.

What do you do for the workers' compensation carve-outs? How do they arise? How do you avoid them in the future? It doesn't have to be in workers' compensation. It could be anything. For example, workers' compensation is one of the two big lines in the P&C industry. The other is auto insurance. Auto and workers' compensation are two good lines to get. On the life side, health is a big line, and you might expect some things on the health market.

Here's a generic example. You have a reinsurance facility. It operates like a regular facility, writes regular reinsurance for a few years. Then it gets a three-year reinsurance deal. It puts out a little pamphlet to the second or third level reinsurers. There's going to be $110 million of premium, 7% profit, and it will hire a lot of experts. Instead, it writes $1 billion of premium priced for 20% loss and ignored the experts.

Solutions. A lot of experts say having a compensation cap makes a lot of sense. If the manager can't make money, he won't write. Primary lead reinsurance contracts put in premium caps. I like exposure caps better than premium caps only because I was always afraid of some underwriting manager taking $1 billion of loss for $1 million of premium. A million dollars of premium is less than a premium cap. You end up with $1 billion of losses. Maybe in addition to premium caps you use exposure caps. Requiring cedents to have retention doesn't seem to work. There have been losses even there. Even when the cedents take 50% of the risk, facilities still manage to lose. There are things you can do like checking your pricing manuals.

Kevin did an admirable job on medical stop loss one so I won't expand on it.

Lack of adjustable premiums used to be in the P&C industry. Reinsurers quoted a flat rate based on a certain volume, and then they wrote 3–4 times as much or 50 times as much.

Vertical pricing is very interesting. Brokers go to the airlines and say, "We're going to write $10 million of premium" but, then they go to the following markets first. They get the following market to accept $700,000 for 10% of the risk, and they tell the following market, "You're getting the best rate." Then they go to the next market, and they might say, "Well, here's $800,000 for 10% of the risk," and they tell them, "Well, you're getting the best rate," which is a true statement. They "keep on going up the ladder till they finally find a claims lead" who might get $1,300,000. The problem with this on aviation insurance, the guy who got $1,300,000 wasn't making any money. The guys that were getting $700,00 were getting clobbered.

One of the solutions to vertical pricing was to stop writing, drop out. Become a leading market. Join with a leading market. Developing a good pricing manual. In aviation, I did develop a very good pricing manual. I think that helps. The problem is that some of the risk may be uninsurable. Finally, demand the best terms and conditions. This is an interesting way. It may lead to dropping out. In other words, you could demand the best conditions from the brokers. They'll tell you you're not going to get it, but maybe, they're doing you a favor. Maybe dropping out is a good solution.

Retrospective solutions. Suppose you get into one of these five problems. What do you do? Well, then you have to call lawyers, reinsurance lawyers, hopefully specialists in reinsurance, not general lawyers. You can choose a menu of defenses when you get into a problem. For example, the rate was unconscionably low. You were under duress. There was undue influence, fraud, misrepresentation, lack of good faith, lack of capacity (ultra vires) is a good one. Or you made a mistake when you signed a treaty. It's enforceable, a pact to commit a crime or a torte. This one is maybe an interesting one. It's just underpriced business, but I hear from lawyers it's not illegal. Breach by the other party, or automatic discharge. Lack of utmost good faith is very important one. This was used in some of the circles that were avoided by arbitration. They didn't use utmost good faith, and utmost good faith is stronger than just good faith. Insurers are supposed to voluntarily tell you what's going on. A lot of times they don't, but theoretically they're supposed to. Insurance is almost a fiduciary relationship.

Finally, the thrust was you don't need state regulation, but a few things could be done. You're supposed to do cash-flow testing anyway. If you had cash flow tested, some of the requirements may force you to take another look at it. Some of the workers' compensation pools, however, apparently did that, and it didn't seem to work. Require disclosure of client lists may have helped. Anti-circle clause traces all claims to primary. I think that is a very interesting one. I'm not sure quite how to draft it.

From the Floor: Gary, what is going on with state regulations on LTC?

Mr. Corliss: For a number of years the NAIC has been constantly trying to get at rate stabilization. There have been a number of activities associated with that, and it just keeps on being one of the issues for LTC insurance. Most recently the NAIC has come up with some regulations that are putting rather onerous new

requirements on insurance companies if they find out that they do need to raise rates at some point in time. Just briefly, the loss ratio regulation, which has been highly a part of LTC and other health insurance, is being done away with. At time of original issue the company is able to put together a product. They may price it any way they wish, but if it comes to having a re-rate needed at some point in time, they're only allowed to have a 58% loss ratio for the first year and 85% thereafter. It's really putting the squeeze on how much can be paid out in expenses and how much could be recouped going forward.