RECORD, Volume 27, No. 1*

Dallas Spring Meeting
May 30–June 1, 2001

Session 119IF
Current Topics in Employer Stop Loss

Track: Health

Moderator: DANIEL L. WOLAK

Panelists: RAYMOND J. MARRA
MICHAEL R. MCLEAN
JEROME WINKELSTEIN

Summary: *Panelists give their views on topics including current pricing trends, profitability, current updates, underwriting practices, consolidation in the marketplace, regulatory activities, and the outlook for the future.*

MR. DANIEL L. WOLAK: I'm the senior VP of group operations at General Cologne Re in Stamford, Connecticut. I've been there for three-and-a-half years, and before that I was on the direct side for 20 years. I've been involved with this stop loss product for 20 years. Next is Ray Marra, vice president and director of Integrated Medical Solutions at Hartford Life. He's been at Hartford since 1989. He previously worked at Travelers. He has a degree in math and actuarial science from the University of Connecticut.

Next is Mike McLean. Mike is the president of Medical Risk Managers (MRM), which is a managing general underwriter (MGU) firm specializing in specific and aggregate stop loss. Prior to being at MRM, Mike held positions at Hartford and Travelers, and he's a graduate from Virginia Tech.

Finally, we have Jerry Winkelstein. Jerry has his own consulting firm in Atlanta. He was formerly a principal at Towers Perrin in the health industry consulting practice in Atlanta. He's also been at KPMG and has been involved with Blue Cross/Blue Shield.

Let's discuss issue one—Where are loss ratios going? Where have loss ratios been?

We've been through an incredible time with stop loss, seeing loss ratios where we never thought they might be. We thought losses on stop loss of potentially five or 10 percent of premium would be the ceiling. We've completely blown through that. We've seen incredible numbers. So where are we today?

MR. JERMOME WINKELSTEIN: First I'd like to talk about definition of loss ratio, because a lot of times, when companies talk loss ratio, they're talking somewhat different numbers. I'm going to define gross loss ratios and net loss ratios as I understand them.

Gross loss ratios are pretty easy. They're the incurred claims divided by the gross premium or the premium that's charged. For net loss ratios, most of my clients use the definition in which the net premium is the amount of premium devoted to claims.

Therefore, if you're running a percent net loss ratio, you're basically making the profit that you intended to make in your premium. Some companies will take the profit out of the net loss—the net premium. I'm going to be assuming that a 100 percent net loss ratio means you're making the profit.

In the early 90s, running through '94, maybe '95, the industry had unprecedented profits. I would say that specific net loss ratios were somewhere in the 92 to 98 percent range. Companies were making more than they had anticipated, even in the developing of premiums. Aggregate net loss ratios were under 50 percent, maybe substantially under 50 percent.

Now we fast-forward to the late 1990s, '96 and later. The specific loss ratios went up fairly substantially but were kind of dwarfed by what the ag loss ratios did. The net loss ratios jumped between 110 to 130 percent, depending on the company. Obviously, a lot of my clients are struggling to get those back down to close to 100 percent at the end of the 1990s and the early 2000s. I have seen ag net loss ratios of 180 percent to more than 300 percent. So these have blown completely through the roof.

Again, we're talking about going from less than 50 percent to some more than 300 percent.

What caused it? I think the increased competition drove a lot of it. You have a very profitable industry. You have a lot of other companies coming into the market, trying to basically pick the money that seems to be growing off the trees, and you have the existing companies underpricing and shadow-pricing to get this inherently profitable business. And, as we actuaries know, when you keep pricing lower and lower to get profitable business, a funny thing happens. The business is no longer profitable as everybody is underpricing everybody else.
The ag loss ratio game is not the ag premium. It's the ag funding factor, or where

the ag liability attaches. The ag premium is typically 10 percent of the total premium. Maybe it's gone up a little bit now, to maybe 10 to 15 percent.

Some of my clients began to target an 80 percent net loss ratio for ags. They would slip the corridor from 125 percent down to maybe 115 percent. Most of them slipped it further than that, obviously, but that was their intent.

So we slipped the corridor 10 percent, and our ag loss ratios go up 30 percent. Mathematically though, in a theoretical model, if you take 125 percent aggregate margin and reduce it to 115 percent, your ag loss ratio is not supposed to go up 30 percent. It's supposed to go up closer to 200 percent to 300 percent.

They also became extremely aggressive, even more so on the ag, and we anecdotally saw a few of cases where the new carrier was quoting an ag funding factor that was supposed to have a 25 percent margin at a lower claim level than the case ran the previous year without any reason. There was no new PPO, no new change of benefits, or anything like that. There was a definite attempt to be very aggressive on it.

MR. MICHAEL R. MCLEAN: I definitely agree with Jerry's assessment. I remember looking at ag a long time ago and saying, "Well, you know, ag doesn't really matter." You really couldn't have an ag hit in the early 90s, and we never really paid much attention to aggregate prices or anything else. Somewhere along the way people started trying to compete with the total maximum liability of a fully insured quote, which is kind of a loser's game. Insured carriers get to keep all the premium, while stop loss companies keep only the spec and the ag premium. So, as you mentioned, the competition, when we started trying to match maximum liabilities dollar for dollar with the fully insured carriers, the aggregate loss ratios basically went through the ceiling.

We've done this survey three times. Table 4 includes the specific and aggregate loss ratios. The first time we did it was for changes in '94, '95 and '96, and while the loss ratios were still profitable back in 1994, there has been uniform deterioration in the loss ratios in '94, '95, and '96.

Table 1

Summary of Change In Loss Ratios (Wtd by Net Premiums)

	96	97	98	Total
Carriers	2 .8%	3.8%	9.0%	15.6%
Reinsurers	12.0%	17.4%	8.9%	38.3%
Total	9.6%	14.4%	8.9%	32.9%

The first time we did the survey for 1996 people thought things were getting better, and that they'd turned it around. They were being fairly optimistic. And then when we redid the survey a couple years later for 1996, 1997, and 1998; 1998 deteriorated more. 1996 deteriorated more than people originally thought it was going to.

A surprising difference was the change in loss ratio. People wouldn't tell me their loss ratios, because sometimes it's embarrassing. But people were willing to tell me about a change in a loss ratio. The most surprising difference we saw in the second survey was that there was much larger deterioration in the loss ratios of the reinsurers than there was in the loss ratio of the carriers. There was a cumulative of 38 percent deterioration in the reinsurers, which is probably why when I went back to go do the survey. None of those reinsurers were around to survey. Table 2 doesn't have any reinsurers in it. We just have carriers. In fact all of the reinsurers that we contacted are no longer there.

Table 2

Changes in Net Loss Ratios

⌘Company	1998	1999	2000	97-00
⌘A	+1%	+3%	+2%	+6%
⌘B	+4%	-5%	+10%	+9%
⌘C	-29%	+9%	-19%	-39%
⌘D	+31%	+6%	-30%	+7%
⌘E	+19%	-13%	-17%	-11%
⌘F	-12%	-22%	-5%	-39%
⌘G	+10%	+19%	-34%	-5%

We recently surveyed seven carriers that represent about $900 million of premium. The smallest carriers are Carrier C and Carrier F. Those are the ones that showed the massive improvement over the period. Part of the reason they showed the massive improvement is they needed to, and, in fact, they shrank their business.

MR. WOLAK: Of course the 2000 underwriting year is still somewhat immature, so they may have been giving somewhat of an optimistic view.

MR. MCLEAN: That's exactly right. When we did the first survey, everyone said, "Yeah, '94 was bad, '95 was bad, but '96 was turning around; but, lo and behold, '96 got a lot worse." And then when we did it again, they said, "1996 was bad, '97 was bad, but '98 is turning around." Now they say, "Yeah, '98 is bad and '99 is bad, but 2000 is looking good." At least there is some reason to believe that maybe there's some redeeming features in the year 2000, because we are getting some rate increases.

MR. RAYMOND J. MARRA: I think this has been an interesting decade for this line of business, and I think some of the reverse incentives that existed through the mid-90s have changed. I like to believe that companies have pegged the 2000 results a lot better than they've pegged prior year's and that we are on the cusp of a turnaround.

FROM THE FLOOR: Did you calculate the change in loss ratio as the 2000 year minus the 1999 year?

MR. MCLEAN: Yes. It's an arithmetic. On the net loss ratios, it's not what I would call very actuarial, but if you were running 130 percent, and you go down to 120,

that's minus 10 percent—purely the difference in the loss ratio, not the percentage change.

In my chart, 100 percent would be a break-even loss ratio as opposed to Jerry's definition that it is a permissible loss ratio.

MR. WOLAK: I would suggest that the reason reinsurers had a higher loss ratio is based on the kind of programs they were involved with. Basically, for a heavily reinsured program, you're dealing with a front company, broker, and MGU. There's less control of the underwriting. A direct carrier that has a significant amount of the risk has much more active involvement and lower expenses.

MR. MCLEAN: The survey didn't show the reinsurers actually had worse loss ratios. We might surmise they weren't having any fun. But we were just talking about changes in loss ratios and what was happening was in '96, '97, and '98. In particular, the reinsurers' loss ratios deteriorated dramatically.

MR. WOLAK: I have a question for the panel. Will the 2001 underwriting year be profitable for the majority of stop loss carriers?

MR. MCLEAN: I'm always pessimistic. So no.

MR. MARRA: I think it'll be profitable. I'm not quite sure it'll be a target profit.

MR. WINKELSTEIN: I think it'll be profitable for certain companies but probably not for the majority of companies.

MR. WOLAK: What are the average rate increases in today's market? Are these increases high enough, or are they just a partial catch-up from the losses we've incurred in the '90s? What will happen? What will these high increases do to market viability?

MR. MCLEAN: Here are the same seven companies in the survey, and if we scribble these down, you can see that there's a correlation between people that tried to get rate increases and people that had their loss ratios improve, which at least makes you believe in actuarial science.

Actually there are two numbers missing. If you looked at D, it would be plus six percent and plus 10 percent, in addition to the 44 percent.

Table 3

Average Rate Increases

⌘Company	1998	1999	2000	1/2001
⌘A	+5%	+15%	+30%	+45%
⌘B	+4%	+5%	+13%	+20%
⌘C	-1%	+6%	+28%	+39%
⌘D			+44%	+44%
⌘E	+8%	+18%	+43%	+42%
⌘F	+8%	+29%	+35%	+45%
⌘G	+19%	+30%	+46%	+45%

I'd say that by January 2001 there was a lot of consistency in the rate increases. Everyone except for one company was getting 39 to 45 percent rate increases, and I would assume that people weren't getting that just because they could. They were getting it because they felt that they needed it to correct their loss ratios, or they thought the leveraged trend was 45 percent, which I don't think was the case. They were getting it because they needed to catch up, and this was on top of some pretty big rate increases in the year 2000. I think you could surmise that nobody was having a lot of fun in this field.

Carrier B only got a 20 percent rate increase in January 2001, and actually was profitable throughout the cycle. They were selling larger deductibles primarily with ASO business with good networks. They didn't hit it that hard.

FROM THE FLOOR: Are those adjusted for change in deductible and/or plan type or not? Are those just straight rate increases?

MR. MCLEAN: I think we were asking for effective rate increases, but in the earlier years we did this, it wouldn't matter for changes in deductible because nobody was giving any rate increases. Nobody bothered raising deductibles. In the most recent years, we were looking for effective rate increase. So if you were able to get a deductible increase in lieu of a rate increase, that still counted as a rate increase. Whether people accurately took into account that you sold a lot of business first year at 12/12, and you renewed it on a paid basis next year, you needed a pretty big rate increase just to stay even in that instance. So I'm not sure that all people would have taken that into account accurately.

MR. MARRA: I would just say that we've seen some flight to quality in the marketplace, and the competitive constraints that existed a couple years ago forced carriers to go out with no change in inforce rates, or pretty modest rate increases have really let up. We're one of the carriers in the survey looking for increases in the 40s. Persistency is down from last year, but it's not down a lot. It's still running in the 70s, which is kind of where we'd expect it to be. So it shows that there's a lot less pressure in the market.

One TPA told me that the average rate increase he sold in the last six months across his book was 60 percent. I asked him how much business he was moving and he said he was shopping it, but the rates are coming back in a relatively narrow band around that rate offer, maybe 15 percent either side of it. He's telling his clients, "You're better off leaving it than moving it to save 10 percent or 15 percent and go through another disclosure underwriting process."

MR. MCLEAN: I have one question. I'm sure that TPA, who was getting the 60 percent increase in rates was not volunteering to lower his or her commission percentages to offset that.

MR. MARRA: You wonder who's making out best here when you look at the carriers.

MR. WOLAK: You coined the term 50/50—50 percent rate increase now, 50 percent next year.

MR. MARRA: Exactly, and I don't think we're out of the woods. Halfway through last year my sales folks were selling the increases as a one-time market correction, and I kind of jumped on that and said, "Well, it's going to take a while to correct the market." I think we're going to see a whole of these increases again as we go forward.

One of the things we're talking about is raising deductibles. Really we've seen very little of that in the last 18 months as we've been putting in higher rate actions, and we've actually talked about whether on a going-forward basis we actually should require those or not.

MR. WINKELSTEIN: To continue on with what Ray was talking about, I do have clients that have a process of forcing benefit decreases or, in fact, deductible increases on renewal for certain groups.

Most of the manuals I give my clients are pretty accurate in terms of what first year 12/12 business is rated as compared to the renewal paid business. It seems that a lot of the underwriters that use the manual really like the first year 12/12 rates because of substantial decrease depending on the deductible level. But they also said that we have a lot of trouble renewing, or going to a proper renewal rate,

because over and above leveraged trend, you're talking about moving from a 12/12 first year to a paid in 12. This can result in an increase of 35 percent or more. So you're talking about rate increases well above 50 percent caused by a change in former coverage.

They were thinking one of two things: (1) not offer 12/12 anymore, or (2) overrate the 12/12 in the first year, because they found it pretty easy to sell a 12/12 first year but found it extremely hard to get an adequate rate in the renewal year.

MR. WOLAK: What is the estimate for the current trend on stop loss business? Back in '96 and '97 actuaries were projecting negative trend. Costs were going down due to managed care. Is that still happening?

MR. MARRA: My sense is that the trend is alive and well, and if you go back to Tables 2 and 3, it shows me that underlying costs at a $50,000 deductible are probably in the high 20s, maybe even in the low 30s. One of the things we've probably all done on the back of an envelope is the calculation of taking first-dollar trend and looking at an average size claim for a typical stop loss contract, backing out the deductible. It leverages up to double, depending on what deductible you pick.

And while those mathematics certainly work, I would contend there's a lot of different drivers going on the high dollar claims in terms of transplants, in terms of multiple births, and babies having been born at lower weights. I think there's a lot more going on than just the mathematics of backing out a $50,000 deductible.

MR. WINKELSTEIN: I think I'm in disagreement with the other two panelists based on what I've seen of my clients. My estimate of leveraged trend is somewhat lower. At the $50,000 deductible, where Ray is talking about mid 20s to even 30 percent leveraged trend, I'm seeing leveraged trend at about 18 percent, maybe 20 percent, and I am not seeing the larger or the greater trend on the higher cost procedures. The higher cost items do not seem to be inflating, they seem to be inflating about the same as the lower cost procedures, the neonates, etc. It seems like the frequency isn't up that much for them, and the cost is inflating about the same. So my leveraged trend estimate at the $50,000 would be closer to the high teens—20 percent, rather than the high 20s or 30 percent.

MR. MCLEAN: The last large claim study sponsored by the Society of Actuaries showed that hospital in-patient accounted for about 72 percent of the claim. Hospital in-patient is where the action lies for a shock claim. I was listening to one speaker at this meeting say that for total claims for hospital in-patient are now about 23 percent of total cost. That might be true for total cost, but when looking at shock claims, hospital in-patient is still the order of the day. In fact, Dave Wilson at Apex has stated that, for claims over $200,000, hospital in-patient is 91 percent

of the total claims, and our claims would agree with that. I'm looking forward to the new Society of Actuaries large claim study that will be able to show whether or not hospital in-patient still is the majority of shock claims.

I think the major driver is what's happening to the hospital in-patients, since that's a large portion of the total. But it's not enough just to take the average trend on the hospital in-patient claims because, and this is where Jerry and I would differ, I think there is a very distinct difference in the trend. We're pretty sure this is based on what's happening to the small claims and the large claims. And the reason is that most of the networks' hospital contracts are constructed that way.

Basically you're getting about two percent trend on the small claims, and about 10 percent trend on the big claims, and it gets back to the outlier provisions, and it is something we'll bring up when you talk about PPOs. There are the other things such as frequency of transplants. Certainly, in the 90s, the number of transplants doubled. Other than that, there's been a recent upsurge in cardiac claims and a sudden influx of new high-dollar dialysis claims.

In general, I think that managed care has squeezed out most of the savings we're going to get and that the in-patient utilization has stopped declining. Basically we're not getting any more reductions in length of stay and we're seeing higher frequency. And I think the underlying leveraged trend is high. So I would pick a leveraged trend for a $50,000 deductible, in the 25 percent to 30 percent range.

MR.WOLAK: So Mike's answer to my question on what the trend is for a $50,000 specific benefit adjusted is 25 percent to 30 percent.

MR. MARRA: 28 percent to 32 percent.

MR. WINKELSTEIN: 18 percent to 20 percent.

MR. ROBERT E. BLUHM: I am from Arkansas Blue Cross/Blue Shield. We have agreements with hospitals that once you reach a certain claims level, we revert to bill charges. So, say you have a $75,000 limit. A $74,000 claim after a 20 percent discount goes away. I would imagine that would have quite an effect on the leveraged trends. Is there anything anyone is doing about that?

MR. WOLAK: Issue five will get into that. Mike's done a lot of thinking about that question.

MR. PAUL FALLISI: I'm with Cairnstone. Over the years I've actually stood up there with Mike and explained leveraged trend and preached and said leveraged trend is real. This is how it works. I agree in theory about leveraged trend, but what I have to say is that in my actual experiences, I'm actually seeing more of what Jerry is seeing out there, that we're actually having higher trends with our lower

deductibles and lower trends with our higher deductibles.
I just want to make a comment so the panel can elaborate on this. My theory is that we're seeing lower trends with the higher deductibles because that's where we were getting the multiple births, the BMTs, so on and so forth, and all those $200,000 to $300,000 claims. Everybody here is actively managing claims. You're getting nurses on these claims and people to negotiate claim discounts for you. So in general, I agree with Mike, and I agree with Jerry, and, I guess, Ray, you're kind of right in the middle there.

MR. MARRA: Maybe what you're suggesting relates back to Mike's comment about the trap the industry got into in the early 90s when managed care had a one-time impact. With all this claims management on the large claims, is it an ongoing depressant to trend, or is it a one-time impact in terms of the value of managing those claims?

MR. MCLEAN: To some extent I would agree with you that the loss ratios have certainly been better at the higher deductibles. I think what you're saying is you're not seeing the trend there. Part of it is also what Ray said, that there was a huge savings when they switched to managed care, and we didn't fully reflect that. So it's been profitable all along. At the very high deductibles, a lot of these cases at a $100,000 to $200,000 deductible, for instance, are being written by Aetna, United, Cigna, or some other large HMO. They're simply getting some better discounts. So, I think we've got better underlying liability.

MR. STEPHEN LABOROE: I'm with Mortenson, Matzelle & Meldrum. Can you spend a little time talking about how much time you spend evaluating provider contracts? Specifically, when you're quoting different provider networks? To me, I don't see a lot of difference in rates when we put in
Provider Network A versus Provider Network B, but I know in reality that the provider network contracts, especially as they relate to high cost claims, differ greatly between provider networks.

MR. MCLEAN: In my opinion, there's a huge difference in liability between networks, and at the same time, you're right. There's very little differentiation between most of them, because for most part, when you hit the outlier provision, you get a 20 percent discount. So we were talking to your company, and it was your claim director who said he'd never seen a claim that didn't hit the outlier provision. So basically, all claims are over the outlier, and, therefore, they all get a 20 percent or a 30 percent discount. And you look at them and you say, "They're all crummy." For the most part they are, but not all of them are, and it makes a huge difference the way the contracts work. We've been evaluating networks since '92, and we've evaluated over 400 networks, and for each of those networks, we got them different discounts by deductible at many different locations within that. So we put a lot of time and effort into it. We think it's worthwhile.

MR. WOLAK: Let's move to issue four. Are reserves being set correctly? Has under-reserving contributed to the losses in the marketplace?

I don't know if our panelists want to answer the question. Have actuaries contributed to losses by using too-optimistic assumptions for reserves?

Claim Reserves

- Concept of properly matching revenue and expenses
- What is the actual incurred date? Is it important?
- IBNR and tracking open claims
- Examples of Aggregate & Specific reserve factors
- Completing recent months of incurral
- Warning signs of under-reserving (e.g., Is the progression of loss ratios logical?)

MR. WINKELSTEIN: The points above provide some more definitions. The way most actuaries in the industry talk about the incurred date, which is important in any kind of reserve discussion, is about the month that the policy was written. Like the early ones, when we're talking about loss ratios for 1997, we're really talking about policies issued in 1997 and the claims versus the premium they threw off in their 12 months inforce. So it's a 23-month period we're talking about.

There are some companies that like to talk about the incurred date of a claim rather than the policy month of the issuance, and when you talk about the incurred date of a claim, I have seen definitions that say the incurred date of a claim may be the date that a claim exceeded the deductible. So if you have a $100,000 deductible written in January, the bulk of your incurred date would be in the second half of the year, simply because you have to have a lot of claims to get up there.

Doing reserving like that, which I have seen a minority of people do, you will earn your premium ratably over the year, so $1/12^{th}$ of each month, but you will push back all your incurred dates of claims. Your premium is going to come in before your claims. If you continue to grow, this will understate your loss ratio dramatically. I think if you use an incurred date of a claim rather than accounting for everything back to the policy month of issue, you almost have to set up an

unearned premium reserve so you correctly match the revenue and the claims. So premium earned early in the year will not be considered earned until later in the year.

I have clients that go two ways in how they look at claim reserves. Most of my clients apply completion factors to paid claims. A minority of my companies also add what they call open claims to the paid claims. They call them actually incurred claims, where incurred claims, in their definition, is the sum of paid claims plus open claims where the examiner puts an expected amount of the payment for a particular diagnosis.

Typically, the people set this up conservatively. Then you have a strange phenomenon about 20 months beyond the date of issue in which you actually get completion factors that are over 100 percent, where the conservatism in the open claim reserve actually exceeds the small amount of real incurred but not reported (IBNR) remaining. But the clients that do use the open claim reserve actually are about a month or two further along in their knowledge of how well the claims are coming.

Concerning completion factors, business issued in January, which is really paid through December of the same year. For January, as of the end of the year, you only know on average 55 percent of that month's claims. Therefore, a lot of reserving is going to necessarily involve a setting of an assumed loss ratio for the many recent months since issue, which are just too incomplete. Even in this case, it could be argued that January shouldn't be set simply by using a completion factor of 55 to 60 percent.

The claim loss ratio for the last several months is the major driver of the claim reserves at any point in time. So as to the original question—has under-reserving contributed? I would say yes, through the overly optimistic estimations from the actuaries and their underwriter partners, on what recent experience is. It's almost like a magician pulling a rabbit out of a hat. First you put the rabbit in the hat, and you put the rabbit in the hat by assuming very aggressive and optimistic loss ratios for the latest couple of months. And lo and behold, when you calculate your claim reserve, the loss ratio for the year you're looking at is going to also be very low.

MR. MARRA: We were talking before about large rate increases and shifting to higher deductibles at renewal. Table 4 says if you see that going on with your book of business, your reserving process needs to change with it, because as you move to higher deductibles, the claims are going to develop slower.

Table 4

Claim Reserve

⌘Completion factor% completed by 12th month

deductible:	low	medium	high
	68%	56%	44%

⌘By claim payor/intermediary

If you don't take that into account, you're going to unknowingly wind up under-reserving. It's going to take you another year to figure out that you didn't see the kind of improvement you thought you had. The other point I would make is that it probably makes sense to get into your book of business and slice and dice it a couple ways.

We probably have 10 to 15 percent of our book of business written over other carriers who are the TPAs such as Aetna, Cigna, and United. We find that those claims just come in at a very different development pattern than the rest of our book of business. I surmise that TPAs view that they're providing a completely bundled service to an employer, and they're viewing part of their job as making timely claim submissions to the stop loss carrier.

I think when you get in a world where you're writing over other carriers, you've got a broker who probably put the arrangement together. They're collecting their commission. They're off trying to write the next case. They're not necessarily spending the time servicing this account. The underlying ASO carrier is not looking to get a stop loss claim submitted to the stop loss carrier. So it's important to look at your book of business.

MR. MCLEAN: On this issue I absolutely agree with everything Jerry and Ray said. If you're selling very large deductibles or larger claims, on average, they take longer to develop. There are longer lag times.

One issue that people are a little concerned about now is the PPOs are not exactly repricing claims in a very fast manner. They've slowed down the repricing and that's

adding a little bit to our lags that probably isn't in our lag factors. This particular survey (Table 5) gives us the reserves as a percentage of gross premium.

Table 5

Reserves as a % of Gross Premium

Company	Specific	Aggregate	Total*
A	35%	70%	39%
B	45%	98%	50%
C	42%	135%	49%
D	11%	30%	13%
E	50%	25%	48%
F	36%	67%	39%

* Assumes 90%/10% wtd if not provided

Only six companies responded to this question. There's a large degree of consistency that the reserves should be between about 39 percent to 50 percent of inforce gross premium, with the exception of one carrier. Other than that carrier, there are two at 39 percent, one at 48 percent, one at 49 percent, and one at 50 percent. And there were reasonable differences to have 39 percent to 50 percent, if you're selling small cases versus large cases.

MR. WINKELSTEIN: On the prior table, where they had the 68 percent, the 56 percent, and the 44 percent, that's a spec–only completion factor. This is talking about both spec and ag.

MR. MCLEAN: And, in fact, a couple of the companies didn't tell me what their combined total was. So I just somewhat arbitrarily assumed that they were 90 percent spec and 10 percent ag. I can't be that far off. It could be 92 percent spec. But there is quite a bit of consistency.

Basically, you should be holding something on the order of 45 percent of your annualized gross premium, if you're average, because this is, again, seven of the larger carriers out there with $900 million, or at least six of the seven, with $900 million of premium. So if you've got a $100 million block, and you're holding substantially less than $45 million of reserves, then you could be doing some of the things that Jerry was talking about.

MR. WOLAK: Let's move on to issue five. *New York Times*, May 25, 2001, says the rising medical costs come from both new and familiar sources. The title is "Medical Costs Surge as Hospitals Force Insurers to Raise Payments."

A growing number of hospitals are becoming more powerful in their regions through mergers and acquisitions. As they take control of more of their local markets, they're using their enhanced market power to demand major increases in payments from insurance companies. Some have effectively fired insurers that refuse to pay up, refusing to accept patients covered by those plans. A few hospitals have demanded increases as high as 40 percent to 60 percent for some services.

So what is the impact of PPO networks on stop loss claims? What are the savings? Are all PPOs the same, as some on the panel believe, or are they actually different? Can actuaries do anything to control hospital costs?

MR. MARRA:. We don't make a lot of distinction in our pricing between networks, and, as Michael said, there's a lot of work to evaluating them in terms of looking at the underlying contracts. When you get into the outlier provisions, you find out that the per diems really become irrelevant in this line of business.

I spend a lot of time talking to my claim director about the kinds of claims he sees coming through. I would say that not all PPOs are alike. Looking at claim files, I find some PPOs will reimburse at the lesser of bill charges, the negotiated rate, or reasonable and customary (R&C). Some will just reimburse at the negotiated rate, and when comparing this with the R&C, you'll see they are miles apart. The negotiated rate is well over R&C. We found PPOs that aren't rebundling the bills before they're repricing. One of my big pet peeves is just seeing some of the drug charges that are coming through. It's not atypical for us to see drug charges for dialysis to come through at four times average wholesale prices. We caught one PPO whose outlier provision was a four percent discount. They didn't screen for R&C. They didn't rebundle. So no, they're not all the same, and if you're not spending time talking to your claim folks, I think you ought to, in order to understand what's out there and make your own assessment.

MR. WINKELSTEIN: How different is one PPO from another? In my opinion, and from what I've seen, PPOs are not identical, but they're pretty close in their effect.

Mike has a different take on it, but in most of the manuals I produce for my clients, the PPO discounts are considered to be the same from PPO to PPO. I think there are differences, and there are certainly bad PPOs, but the bulk of my clients who deal with the larger, well-known PPOs find they're very similar.

The last point concerning manual rates I think is very important, too. This happened

when managed care was coming into effect, and it was coming into effect in different states and different times. When I develop manual rates by actually studying the past experiences of my clients, to talk about what the PPO discount should be, you're basically saying what PPO discounts should be beyond what's already reflected in the manual. If the manual experience already reflects a savings from PPO, you almost want the manual to talk about incremental loads and discounts versus the PPOs that are assumed in the past manual rates rather than just blindly saying, "If they have a PPO, discount your manual by five percent."

MR. MCLEAN: First of all, I agree with my esteemed colleagues here on a couple things. They are correct. There is very little differentiation between most networks because most networks get a 20 percent discount on large claims

Once in a while you stumble across something in nature that's very good. Perhaps our perception of networks is different from some of the others because we've been fortunate enough to have some very large clients along the way. We've had our underwriters on-site at Aetna. We've had our underwriters on-site at United Healthcare, previously known as United and/or Travelers. We've had access to Cigna's networks. We were taking them to the TPA community, and we've seen what these networks can do. We've been on-site at Blue Cross of Massachusetts. We've got other Blue Cross clients.

We've seen what is possible in the world, and then we've also seen a lot of the "rent-a-PPOs". I think it's fair to say that they're different in liability. They're vastly different in liability. And there are some good regional PPOs in addition. But I'm not completely disagreeing with what you mentioned.

You're right in saying that it would be inappropriate to double dip in your manual if all of your experience was PPOs. If you have 100 percent of your block or 95 percent of your block in PPOs, it would be inappropriate to have that reflected in the experience and then double dip and get additional discounts. However, that doesn't mean that the difference between retail and even a lousy 20 percent discount leverages quite nicely to a fairly large PPO discount. So even if it's built into your experience, call it whatever you want, but you need to have an indemnity load rather than reflect an additional PPO discount. Our opinion of PPOs is that at a $100,000 deductible, for instance, a good PPO can easily reduce your stop loss liability fivefold. So we're not talking 5 to 10 percent, which is what the reinsurers were saying five to eight years ago. We're talking 80 percent reductions.

We're actually the risk-bearer, and in some instances when we were a MGU, we put our fees at risk because we believed in it. We put our fees half at risk, which is substantial. We were pretty sure that we could discount quite a bit, and we got away with it. We got our full fees and profit sharing in addition to that. So we think it works.

But, again, if you concentrate on hospital in-patient, which is where we think the action is for the large claims, we looked at 484,000 shock claims from the hospital discharge database of 17 states, and a shock claim is defined to be anything with bill charges over $35,000. So we're looking at many, many tens of billions of dollars of claims, to see what's going on. In fact, we looked at every commercial discharge at every hospital in each of these 17 states.

The most amazing thing I see is when you look at that, just looking at claims over $35,000, the average bill charge per day is about $6,000. It's a little over $6,000. And many of these hospitals had average bill charges per day of in excess of $10,000. That's just the average. And it was thousands of claims within a given hospital. It's not just one big claim. It's thousands of claims with an average of $10,000 per day.

When someone comes along and tells me PPOs aren't worth anything, I know if they're billing $10,000 a day, and I'm getting a 20 percent discount, and I'm paying $8,000 a day on the big claims, I also know that if I happen to have a $1,000 per diem in that account, or the network has a typical $1,000 per diem and if you're paying $8,000 on the big and $1,000 on the little, there's got to be a better way to do this.

Someone had a great idea to come along and get a $1,000 per diem. We looked at $1 billion of claims at Cigna when we had access to their networks. Well, we all know what's happened to bill charges. Over the years, bill charges have gone through the roof.

In virtually all of the hospital contracts in virtually all of the networks that we evaluate, there's this little asterisk that says these per diems apply unless bill charges exceed $25,000, in which case all bets are off. It reverts to bill charges minus 20 percent. It's the stop loss provision or the outlier, and that little thing kills us. So what's happened is, what's our stop loss liability on all these large claims? That's poorly drawn, but it's about 80 percent of bill charges.

In the Cigna data, if you looked at claims that were on the basis of a percentage discount off of bill charges, we looked at the cost from one year going to the next, and what was happening was claims that were paid as a percentage discount off of bill charges were inflating, about three years ago, at 10.2 percent a year.

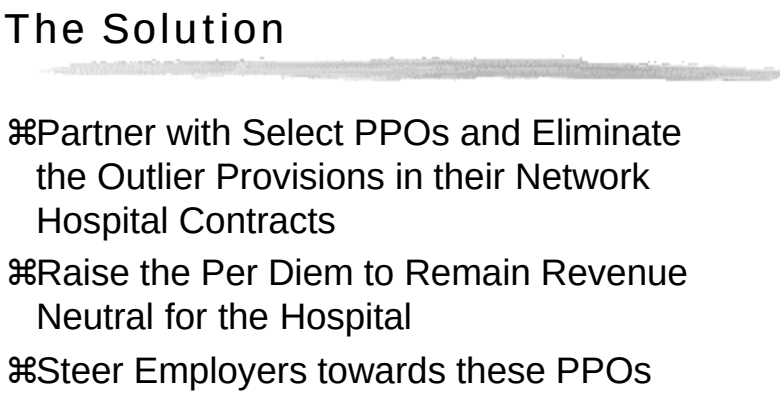
Why was that happening? Well, bill charges are going up 10 percent. You got 80 percent before. You got 80 percent after. It's going up at 10 percent. At the same time, claims that were paid on the basis of a per diem were inflating at about two percent. What was happening was the per diem was set at $1,000. It might go up to $1,050 next year. It might not go up at all. But on average it was going up to $1,020 the next year.

So what has happened over time was that per diems essentially haven't gone up in 15 years. The hospitals haven't had a raise on appendectomies in 15 years. It's $1000 a day, it was $1000 five years ago, or you might get those minimal 2 percent changes going on.

So the little claims are inflating at 2 percent. The big claims, anything over the outlier provision of $25,000 to $40,000, are inflating at 10 percent. And this is back when we thought hospital inflation was 6 percent. Well, it was, but if you took 6 percent and then leveraged that, you're in a lot of trouble because your claims for a specific stop loss were inflating at 10 percent. So, compound this difference over 10 to 15 years, and you get some really bizarre results.

Because we've evaluated 400 networks for many years we were noticing that we always were getting little discounts on big claims. Why was that? Well, we were getting a 20 percent discount. We got a 20 percent discount last year. We'll get a 20 percent discount next year.

What happens is this just doesn't make any sense. Just because this is the way that things happen to be structured, and this is the way it falls into your lap, doesn't mean it's the most efficient thing for the stop loss carrier. What we found the solution to be is to go to a couple networks and say, "This isn't a lot of fun. We're not having fun at $4,500 a day or $5,000 a day." So we partnered with these networks, and we've modified the contracts basically to become more stop-loss-friendly.



MR. WOLAK: Well, Jerry, I get the feeling that you may not totally buy into this solution. I mean, what are your thoughts?

MR. WINKELSTEIN: My thoughts are that it's an intriguing concept. You are raising very, very low per diems that go away with the outlier provision to a flat per diem that's higher, that doesn't go away with the outlier provisions. The hospital remains virtually revenue-neutral, and, as Mike correctly stated, the specific stop loss rate just drops through the floor because you don't have the large specific claims.

I think it's a zero-sum game from the employer's point of view, because the employer is responsible for claims under the ag limit and is responsible for the fixed dollar spec. So the spec premium goes down, but the ag claims go way up, and it's almost offsetting. There may be a little three or four percent margin one way or the other, but even from the stop loss carrier's point of view, when using this type of network, you will go out with extremely aggressive spec rates—more than half or less than half below your competition. But your ag funding factor will be very high, considerably higher than that of your competition.

So I am not convinced, thinking what my clients would want, whether or not this is a more attractive way to be in the market—in other words, a much higher ag funding factor with a lower spec premium or the way it is currently. Also, from the employer's point of view, the employer doesn't make out that much better. This is basically for the benefit of the stop loss carrier, not for the employer, and I think the employer is the ultimate client here. If you don't keep the employer happy the thing will collapse, but that's my opinion.

MR. MCLEAN: There's a natural reaction to think, "Well, if the hospital's revenue-neutral, and the stop loss carrier's much better off, the employer must be the loser." Right? It's a zero-sum game.

Let me give an example. Let's suppose we have a decently successful stop loss friendly network, and claims less than the deductible before were $90, and claims greater than the deductible are $10. Well, what's the employer's liability? Well, first of all, if your claims greater than the deductible are $10, we better be charging about $15. My contention is that the employer's expected liability is $90. He's responsible for claims less than the deductible, and he's responsible for premiums in addition. So his expected liability is $105. If we change this so it's $95 for ag claims and $5 for spec claims, my contention is if it's in their ag, the employer pays $1. If it's in spec, we're going to charge him $1.50. So for this example the spec premium is $7.50.

The way the contracts are structured there's unnecessary dollar swapping going on. It's certainly inefficient for us. But it's also very inefficient for the employer. If you go from $95 and the claims are $5, if you leave your premiums alone and don't do Anything, you're right, the employer is worse off. You've simply raised his attachment. You've raised claims towards the aggregate. And you're greedy charging $15. Of course you've got a 33 percent loss ratio, that's great, but it's not

sustainable. Ultimately, if your liability is cut in half, ultimately if you were happy at a 67 percent loss ratio, for the most part you'll be charging $7.50. You're employer's expected liability will go down to $102.50 from $105.

MR. WOLAK: So you have also just suggested a 50 percent pay cut for brokers, TPAs, carriers.

MR. MCLEAN: That's what drives it and us, but the point is once you do it, it's done. It's no different than when HMOs came along. They had a different model, lower liability, and they paid fewer commissions. This is what drives it. The reason there's two and a half dollars less of liability in this instance, you've passed the entire reduction in expenses onto the employer. Do you need to pass it on to the employer day one? Well, probably not. But the point is, if you have $5 of liability, and the competition has $10, it's not a lot of fun to be on the opposite side of that.

MR. WILLIAM R. LANE: I'm from Heartland Actuarial Consulting. Mike, I'd like your comments on a phenomenon I've seen. I agree with what you're saying about the hospital contracts, but it's been my experience that most of the outlier provisions, at least the majority of them, aren't a fixed dollar amount, which means not only do you have the mechanism going on that you're talking about, but over time, more and more of the claims actually fall into the percent off of billed as opposed to the per diem. So the inflation for the hospital is even greater than you might model if you just kept them in the two buckets.

MR. MCLEAN: That's correct. Actually, its kind of humorous because what happens is, on the one hand, the network doesn't want to go back and talk to the hospital since it has an $800 per diem. They don't want to talk to the hospital and open up this contract. The hospital's squeezing in on these claims since it can charge whatever it wants on the large claims. So if you extrapolate out, you're exactly right. We'll have a wonderful $800 per diem that is never used because every claim is going to exceed the $20,000 outlier provision.

MR. HOBSON D. CARROLL: I'm from Vector Risk Analysis. I just wanted to make a comment about reserves. Has any reserving contributed to losses in the marketplace? I certainly agree that going back four and five years, that certainly was the case, because I don't think they were reserving correctly. They predicted losses coming in lower, so they kept rates where they were.

The stop loss industry has kind of a split personality. It's got the large old-line companies that have been in the stop loss business since the early, early days, the Safecos, the Hartfords, etc., and then you have your managing general underwriter (MGU) marketplace, which is highly dependent upon reinsurance. But I think that is connected to this because of the inability of a lot of naïve reinsurance capacity, going back into the mid-90s and forward, to be able to understand what it was they were reinsuring. They had been sold by the intermediaries, and their inability to

actually take the data and analyze it correctly led to their believing that these losses weren't there because the reserves weren't being set correctly, and that's led us to the dearth of reinsurance capacity that exists today.

MS. JOAN P. OGDEN: I'm from Joan Ogden Actuaries. I spend a lot of time looking at claims. To what extent does the creative billing practices of providers and the relative unsophistication of many payors feed into the problem of claims above a specific stop loss or even at the aggregate level? And what do you do about it?

MR. WOLAK: That's our issue six. From a poor claim payer's standpoint, what can they do with claims coming in regarding unbundling? Ray, you see that in your shop.

MR. MARRA: I don't have a quantification of it in aggregate, but Table 6 shows some recent examples.

Table 6

Provider Billing

- One day hospitalization = $96,000
- Dialysis charges
- Private Duty nursing = $161,000/yr.
- Gel foam sponge = $97,000

I probably get a claim example a week from my claim director. The first one up there was a one-day hospitalization. It was $96,000. They implanted a defibrillator in a patient. They charged $120,000. Well, we got 20 percent off of that.

The defibrillator was invoiced to the hospital at $27,000. They billed it out at $78,000. We've kind of taken the position that R&C for equipment is 15 percent or 20 percent over invoice. So we push back to our TPAs on those and say, "You've got to be screening these things out. That's an unreasonable charge."

I talked before about the dialysis charges. We're seeing them come through at $25,000 a month. You start looking at what they're charging for the medications related to that or how they've unbundled all the services with it, and you've rebundled the thing. It's worth $10,000 or $12,000 a month, not the $20,000 or $25,000. In fact, in some cases, what you'll see them doing is billing it through a

central office out of Philadelphia or New York, and so you wind up applying an R&C for a metropolitan area when you find out it was done in the rural section of the country.

We had a claim that was running at $160,000 a year. When we inquired further, the response was they needed full-time private duty nursing because they were suctioning fluid from the lung, but the catheter that they were using wasn't going to get anywhere near their lungs. So we said it wasn't medically necessary to have private duty nursing. They weren't suctioning the lungs with that piece of equipment.

And the last one's probably my favorite of all of them. There was a $10 sponge that the hospital charged $97,000 for. So you're right. There's not a lot of sophistication. I probably could make a list that's a couple pages long of these things. These things aren't R&C. They're not medically necessary. They were billed in error, and we're not reimbursing for them. And probably half the time, they're successful in going back and getting reimbursement.

MR. WOLAK: Are you increasing your expense loads because of the cost for this, Ray?

MR. MARRA: We're in a big campaign to look at what PPOs we think aren't doing a good job rebundling and screening for R&C, as well as what TPAs we think have enough sophistication to continue to play the game, and we're just embarking on this to figure out how to weed them out and the ask, "Do we continue to do business with them or do we change out pricing?" So we're just starting there.

FROM THE FLOOR: I'd be curious on your opinion in terms of the market. I think a lot of the reason that we're in the market right now and that we'll continue to be in this market is that most carriers still differentiate themselves on price only, and most employers are bottom feeders. So when they're looking at selecting Carrier A versus Carrier B, they're looking at maximum claims liability and what they are charging for premiums. To me, I think the long-term successful carriers will be more than just differentiating themselves on price. They'll be differentiating themselves on service, managing high cost claims, being proactive, being consultative with the employers. Can you talk a little bit about your opinions on this and maybe respectively where you're going as firms?

MR. MCLEAN: My feeling is, if you're a reinsurer, and you're just capacity, you're part of the problem.

If you actually can provide a value added that reduces the claim liability, if it's what you're talking about, as a reinsurer to your carrier, then you're part of the solution. If you can come up and give a stop-loss-friendly network access to that, or if you can give them access, and you've done analysis on centers of excellence, if you can

do some extra form of LCM, if you can affect the claims, then you're part of the solution. If you're just capacity, well, we've all had enough naïve capacity in the late 90s. We don't really need any more new naïve capacity.

MR. MARRA: I continually question how price-sensitive employers are and how price-sensitive the intermediaries are. I think whether you're talking about stop loss or you're talking about life and LTD that I've worked on over the years, I tend to think what happens is you get the broker who's afraid of losing business, who feels that their value added is to drive the lowest rate to the employer. That's where you get the price sensitivity coming into play.

What we've tried to do is build relationships with our TPA partners in terms of helping make their lives easier, in terms of making the actions we're going to take predictable to them, so that when they're going out to an employer, they can say, "Hey, Hartford's 10 percent more, 15 percent more. We've worked with them for a long time. We have a relationship with them. We know how they work." I guess I view it as trying to tackle that price sensitivity at the intermediary level as opposed to the employer level.

MR. WOLAK: That's a very good point, Ray. I think there is a significant difference between the stop loss carriers. There is a lot of differentiation from Ray's company to Mike's company. You're different companies. For the brokers, the easiest, simplest thing to sell, whether it's stop loss, life insurance or disability, the easiest thing to sell is price. It doesn't take any brains. So part of it is educating or at least developing the brokers, networking with the people who will understand your differentiations.

MR. WINKELSTEIN: Obviously I agree with the point that if the carriers can differentiate themselves on utilization management (UM) or utilization review (UR), it's a better product. A lot of the UMs and URs among the leading companies in the industry are very, very close.

Another thing is, if our views are correct, the market is hardening now. So, in the past, price was a major driver when you talked about distribution of premium quotes for the same case being—20 percent, 40 percent, 50 percent apart. In a harder market, which I think is what we are in and are going to, then the prices will be closer, and possibly differentiating on terms of UM may even be a more important item.

MR. HARRY L. SUTTON, JR.: I'm from Alliance Life. I was very interested in Mike's analysis of what the costs were. Now, Mike, could you tell me how you determine from a hospital or from the data that you had what the hospital's real cost of the claim is? What method do you use?

MR. MCLEAN: Well, as far as the hospitals, there are some American Hospital

Association (AHA) databases that do that, but we've stayed away from their data for the most part. A lot of hospitals don't have a very good cost accounting structure. A lot of the hospitals we have talked to, including the Stanfords and the Dukes and all the others we have contacted, which total over 500 hospitals, understand that they are losing money for claims under the outlier. They're losing money on the capitation. They're losing money with some of the Blues. And they're losing money collectively for claims under the outlier. They know that they haven't had a raise, but it's OK, because they make so much money on claims over the outlier. And you could be pretty far off on your expense allocation and still know that you're making a lot. I mean, when your costs are $2,000 a day, and you're billing $10,000 a day, you're probably doing pretty well, no matter how you're allocating the expenses.