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Session 3PD
Employer Stop Loss—What's Ahead?

Track: Health

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Summary: The employer stop-loss market has experienced turbulence in recent years. Panelists discuss their views on this market, including market size and growth, whether or not pricing is softening, claim cost trends and underwriting. Attendees gain an understanding of the current status and future direction of the employer stop-loss market.

MR. RICHARD NELSON: This session is called "Employer Stop Loss—What's Ahead?" so we're going to talk about employer stop loss. Our approach to this session is to represent each speaker's own experiences in the stop-loss marketplace, which do not necessarily represent the full marketplace. It is difficult to understand exactly what comprises the full marketplace of stop-loss insurance, so please keep in mind that the speakers will not be discussing any scientific studies.

We'll proceed in a topic-by-topic fashion, and each of us will jump in with prepared remarks. My name is Rick Nelson, and I organized this session. I have been with Tillinghast—Towers Perrin for several years. My interest in the stop-loss marketplace derives primarily from rate manual production. A fair number of our clients purchase specific and aggregate rate manuals from us, which provide a big source of annual activity, so I'm very interested in this marketplace. Also, we do consulting from time to time with our manual customers.

MR. GORDON RUSSEL HUGH: My name is Russel Hugh. I'm an actuary with General Cologne Life Re in Stamford, Connecticut, and am here to give the reinsurer's perspective, which includes my point of view, our company's and that of our clients and colleagues. We'll be approaching this session by topic, from profitability to new products, provider networks and so forth.

MS. CAROL ADAMS: I will get us started. My name is Carol Adams, and I'm the chief underwriting officer for Ace USA. Ace is a property casualty company headquartered in Bermuda with its U.S. division located in Philadelphia.

One of our core accident and health products is employer stop loss. We write employer stop loss both directly, with our own in-house underwriters, and through the managing general underwriter (MGU) model, with which most of you are familiar.

I'm going to talk about the marketplace. Some of my colleagues and I were trying to get our hands around the size of the premium estimate of the marketplace, and we came up with more than $4.5 billion in premium. I estimate the split between direct writers and MGUs is about 60/40, with 60 percent on the direct side and 40 percent on the MGU side.

In general, the marketplace is in a happy time right now. When I did a presentation like this a few years ago, it had a much more somber tone. Now people seem pretty happy; they've made some underwriting margins, and in the last couple years they've met their goals and objectives.

As long as the marketplace is profitable, most people are usually pleased. Of course, the big questions that are on everybody's minds are How long will the market stay at this kind of a consistent, profitable pace? Will rates soften? Is that starting to happen? We'll address these things later.

One of the things that has contributed to some of the changes in the marketplace recently is the large quantity of rating agency actions, on both the reinsurance and insurance company sides. A lot of issuing carriers have been downgraded from an A level to a B-something level, which puts them out of the stop-loss marketplace. A couple years ago reinsurance capacity was a bigger issue than it is now, when we see that the actual issuing paper is more important.

The few new entrants in the marketplace are usually people who were already in business and are forming a new organization, reinventing or restructuring themselves, but the same deck of cards is being reshuffled. So from my perspective I haven't seen a lot of new entrants in this marketplace. Again, things are going relatively smoothly.

MR. NELSON: Thanks, Carol. I put together some numbers that are approximate and informal, using a Towers Perrin Re and Tillinghast tabulation from 2002, which I augmented with survey data that I had put together previously.

We came up with approximately 25 direct writing companies. We excluded many Blue Cross/Blue Shield entities, since they would have increased the number significantly above that level. It seemed that about a quarter of those companies primarily write business for which they perform the self-funded claim administration. In other words, they do not use TPAs, so they have their own claim administration in-house. Again, most Blue Cross/Blue Shield plans are excluded from that tabulation, but they are certainly captive.

In 2002 stop-loss premium volume in this tabulation was approximately $2.5 billion. We also did a tabulation on the MGU side and came up with approximately 75 active MGUs. The claim administration for the MGUs is handled by TPAs. The 2002 stop-loss premium volume was approximately $2 billion in these 75 MGUs.

We identified about 20 different issuing carriers that these MGUs were using. I'm always stunned at the number of participants in this marketplace. Four or five participants are creating quite a bit of competition. When there are more than 100 participants, as we've identified here, the amount of competition is very intense, and will continue to be intense.

I did a few simple calculations for lives covered and cases that are a corollary of our tabulation. For direct business, if we assume $2.5 billion, and $250 per employee for a per-year premium, with an average case size of 900 lives—which I took from a survey that we ran last summer for direct writers—then we have covered a fairly big number of cases and employees. This may be up to 10 million employees covered, and maybe 11,000 cases covered by the direct writers.

If we go through a similar kind of arithmetic on the MGU side, assume $2 billion is a reasonable number, since the per-employee, per-year premium tends to be larger in the MGU business, where the average case size tends to be somewhat smaller. Doing the arithmetic, I found approximately 3.5 million employees covered, and 14,000 cases with this coverage.

So those are some rough numbers that we put together from internal tabulations. It's not a survey of the marketplace, and we did not go after these numbers scientifically, so my numbers came in near the place Carol was talking about, this $4.5–5 million type of premium volume in 2002. Volumes in 2003 will be somewhat higher.

Regarding market growth, the carriers who participated in the survey in 2002 reported about 15 percent per year in terms of premium. That is net of deductible increases. Going forward, at least into 2003, that's not likely to increase.

At Tillinghast, in addition to doing rating manuals, we also run surveys. One of our long-time annual surveys analyzes stop-loss rate. The average rate increase for January 2003 was pretty low. It was in the 10–15 percent range, which was a fair bit lower than what we recorded for the last couple of years. So I anticipate that market growth in terms of premium volume will be somewhat lower for 2003 than in the previous couple of years.

On the other side, we may expect to see a small amount of growth due to modest declines in HMO enrollment. One of our sister companies, Towers Perrin Health & Welfare Consultancy, puts together the Health Care Cost Survey. They track HMO penetrations in the large groups with which they do business. They've seen some slippage in the HMO penetration, with more people moving over to PPOs.

MS. ADAMS: Keeping in mind the happy market that I had introduced before, many faces don't look quite as happy in the late 1990s. Many of you are very familiar with those times, as you lived and survived through them.

The late 1990s were not a good time in general. Certainly some people made money then, but the market as a whole saw some pretty significant losses. In 2000 things started to turn the corner and change, to anywhere from breaking even to a more positive outlook. Regarding 2001 and 2002, we're coming off some pretty good underwriting years. People were making the margins that they put in.

You'll notice for 2003 that my personal viewpoint is I'm only a little less happy than I was with 2002 and 2001. The market in general might be a little surprised that results are not quite as good as they have been in the past. Perhaps trends are on the high side of what people are putting in. We'll talk about some of the other reasons later, but I just wanted to point that out.

My prediction for 2004 is that it will partly sunny and partly cloudy. I do think that there is an opportunity for people to make money. However, growth is the main objective. Unless you're acquiring books of business, you're going to have a tough time being profitable going forward. Growth is something that we've seen as one of the biggest challenges. A lot of our partners and our own in-house underwriters are renewing business, but writing new business has become more of a challenge.

Table 1 shows an overall survey of the marketplace from 1999 to 2002. As you can see, it has nicely declined below 100 percent, which is always a good thing.

Table 1
Profitability—Informal Market Survey

UW Year	Loss Ratio	Avg RI	RI vs. Trend
1999	78%	21%	Lower
2000	70	48	Higher
2001	63	38	Higher
2002	64	30	Same
2003 Est.	69	26	Lower

- Lower YTD renewal increases and higher anticipated leveraged trend indicate lower margins for 2003.
- Trend projections indicate 30 percent trend at $50,000 SIR and 36 percent trend at $100,000 SIR.
- Additional soft dollar rate increases needed to temper 2003 anticipated trend.

I have similar information on the aggregate side, which really spiked for a while. I think we really have cleaned up our aggregate, which pleases me. That's basically a pure underwriting exercise.

One of the things I have noticed recently, while talking about the aggregate side with my underwriters, is that the aggregate attachment point seems to be becoming more of a focal point of sale. That's not always an encouraging sign, when that becomes the difference between a case moving or not.

MR. NELSON: I also tabulated some statistics that I had in my file of MGU loss ratios across programs that we had reviewed over the years. Our progression is similar to what Carol was showing. As shown in Table 2, my numbers are gross premium loss ratios, not net premiums. So if you get above 70 percent, you're not doing real well.

Table 2
MGU Loss Ratios (Average across Several Programs—Not Survey Data)

Underwriting Year	Loss Ratio
1994	60%
1995	75
1996	81
1997	87
1998	77
1999	77
2000	62
2001	61

We should expect 2002 to be similar to 2001. Large rate increases continued into 2002 (average rate increase of 30–35 percent per 2002 T-TP Stop Loss Rate Survey), and many MGUs have maintained a strong lasering policy. Target loss rations would be 60–65 percent, and net reinsurance premium at about 70 percent of the gross.

At any rate, my numbers seem to have been a little better in 2000 than Carol's. The programs we had reviewed by 2000 had cleaned up and were progressing in a better loss-ratio pattern.

Based on discussions I had in late spring of 2003, I expect 2002 to be pretty similar to 2001 in terms of the loss ratios, which should be in the low 60s. The fairly large rate increases, from what I've seen, were continued into 2002.

One statistic that I pulled out from the 2002 stop-loss rate survey was that the average rate increases were in the low 30 percent range, and we're getting some fairly large rate increases into 2002. It seems as though most MGUs have continued to maintain a very strong lasering policy that started a couple of years ago, which has been as important as anything else in terms of improving the loss ratios. Target loss ratios are generally in the 60–65 percent range.

Some MGU programs in the 1996–99 timeframe ran in excess of 100 percent gross premium loss ratios, even though the averages I listed were certainly below that range.

Loss ratios for direct writers are harder to put my finger on because of the nature of the business and the programs we have reviewed. I certainly have the feeling that they're similar in movement and direction to the loss ratios for MGU writers, but my statistics on that are not as solid. I also think that a lot of the direct writers avoided the extremely high loss ratios we sometimes see with some of the MGU programs.

And, of course, there are quite a few niche programs. In particular, Blue Cross/Blue Shield programs may run an entirely different pattern than what we think of for the MGU marketplace, based on their dynamics.

We've tracked target loss ratios over time in our stop-loss survey, and they haven't changed much. I've always been miffed that the target loss ratios for MGUs haven't risen much over time, but they have stayed fairly low. I thought expenses would eventually get squeezed more on the MGU writers to make them closer to the direct writers, but that doesn't seem to be happening, at least in terms of my survey statistics.

MR. HUGH: Table 1 shows an informal survey of clients and colleagues who shared some of their experiences with me. The leftmost column is the underwriting year–based business versus specific stop loss from 1999 to 2002. A 2003 estimate is based on renewed January-February cases, with an incurred loss ratio estimate.

Some of my thoughts on the projections are implied here in the 2002 and 2003 business. If the average rate increase will represent hard and soft dollar changes, then rate increase versus trend is a relative indicator. What I'm getting at here is the question, Did the rate increases lag, meet or exceed expected or actual trend?

I found that in 2000 and 2001 the rate increases were substantial. They exceeded the trend, which was to bring down the loss ratio.

In 2002 the trend was moderated somewhat, or the rate increases were fairly in line with trend. Then in 2003 the early returns on the January-February business included price pressure. We find that we didn't get as much rate increase on the January 2003 business as on the January 2002 business. It may be due to increased competition, or employers not being able to continue to pay 30, 40 or 50 percent rate increases and so forth, and whether a 50-life or a 100-life employer can support a specific level going from 25 to 75 to offset the rate increase.

Projections and assumptions for leveraging at $50,000 are 30 percent, and at $100,000 they're 36 percent. In my opinion the trend doesn't appear to be slowing down. Later I'll discuss some modeling that I did to find the impact of leveraging.

So what's ahead? What's the takeaway? We need to get some additional soft dollar change. The whole idea is to get as much rate as we can, but we may not be getting as much with rate pressure like it is.

I expect the loss ratio to creep up a bit and not keep up with trend. It's still a happy time, but maybe not as much as Carol indicated. I think we're in agreement that things were really good in 2001 and 2002, and we expect them to be good for 2003—just not as good.

So, if we're not getting the rate, what are we getting? Are we getting a better lasering approach? Are we getting better case management? Lower expenses? More restrictive underwriting, etc.? Everybody's experience will vary in terms of approach.

On the aggregate side, since 1999 and 2000 the experience has been excellent, depending on the program. Gross loss ratios are as low as 20 percent in some programs, and as high as 50–60 percent in others.

The underwriting has been very sound on that front, and we've seen good loss ratios to show for it. If we're not getting the rate increase on the specific side, we will look to get the supplemental margins from the aggregate side.

Here are some characteristics from our own book of business. We have seen, over the past few years, that the average ceding allowance has decreased over time from the 30–33 percent range to the 25–28 percent range. This is mainly due to a decrease in average commission levels.

A lot of cases are being written at net. Depending on whether you look at your business on a net or a gross basis—our company looks at the business on a gross basis—the combined ratio is important. A case written at net is better for our bottom line than a case written with a 10 or 15 percent load on it.

Administrative costs to MGUs have stayed fairly flat. However, in issue and fronting fees we notice an increase, whether it's due to taxes and assessments, or a dearth of quality A-rated paper and so forth. Fronting fees might have been 3–4 percent a few years ago, but the norm is closer to the 4–5 percent range.

MS. ADAMS: Our next topic is pricing and underwriting. One of the first questions I get from colleagues or existing partners in the stop-loss arena is, What is your perspective on whether the market is softening? Or, When will the cycle turn?

My perspective is that the market's not actually softening. I do think, however, that it is relaxing a little bit. The market is breathing a sigh of relief. There were certainly a lot of pressures to produce profits. Now that that's been under our belt for a year or two, the market is indicating that we don't have to push as much. We still need to push, but just not as much.

I agree with Russel that rate increases in 2003 are down from prior years. So, where 30–40 percent rate increases compounded in 2001 and 2002, they dropped fairly significantly in 2003.

Our underwriting parameters are still tight. I don't think we're loosening them, maybe relaxing them in terms of not writing as closely to our guidelines as before, but there are still some pretty tight guidelines. Now people are monitoring their books of business much more closely than in the past. I think people are looking at movement in their sold ratio to their manual or benchmark, to predict what will happen going forward.

Lasering, as Russel had mentioned, is much more the norm now. It's become an accepted practice, which most carriers are continuing to do. There are rumors, however, that people are now stopping that practice to get a more competitive advantage. I can't really comment on whether that's true or not, but I am interested in

seeing if my colleagues think companies are still lasering on both new business and renewals, or if there is a drop-off in that practice.

Renewal persistency is quite high. Closing ratios on new business is about half of what they were a few years ago. I'm not sure where all this new business is going. Perhaps it's just recycling and staying with the same carriers, but we've definitely found that to be a problem. This is why I mentioned that I heard certain carriers, MGUs or entities are looking to significantly grow their book of business, whether it's 20–25 percent or some other number.

It's scary that, from our perspective, it's challenging to write at rates with which we feel comfortable. However, I'm not sure how that translates for someone who's trying to aggressively grow his or her book of business.

We have seen larger employers look to retain greater amounts of risk. It may be through a greater use of aggregating specific, where the employer retains an initial layer of the specific stop-loss claim, or increasing deductibles to offset price increases or trend. Either way, the risk shifting toward the employer is something we'll continue to see.

In Table 3 I've put together an informal view of how the specific deductible has increased over time. On the left-hand side there's the specific deductible, and on the bottom of the chart there are group sizes, which is where we see an overall increase.

Table 3
Claim Cost Trend
Specific Deductible Level

	$50K	**$100K**	**$200K**
Frequency	17%	24%	35%
Severity	6	6	6
Total	24	31	43

- Basic cost trend was 11%.
- Tillinghast manual recommends use of leveraged trend
    - Historical claim data supports use
    - Example using PPO-paid cost data

I think most people are trying to push up the specific deductible. It helps the sale and makes a rate increase more palatable to the employer. But, certainly on the larger accounts, there's a greater gap in those two lines. The larger employers, then, start to decide that they can retain more risk, or that it is not cost effective to purchase this reimbursement mechanism.

Similar to Russel's perspective on what's been going on with the expense side, I've seen commissions decrease, but they're leveling off. That helps to reduce the overall expense component.

I also think administrative expenses are decreasing. The market probably overreacted at some point on the MGU side and tried to press fees to a very minimal level. Perhaps they saw the rebound on the loss ratio side, where not having the appropriate underwriting or claims staff or a clinical perspective came back to haunt those who've really pushed down the expense or MGU fee.

I hear more and more about state assessments and am interested in finding out what other companies are doing, as well as how my colleagues think that whole issue will shake out. I hear that some insurance companies are actually fighting whether or not they have to pay the assessments, but our company has chosen to pay them. We have not taken the approach of thinking we could take legislative or legal action along those lines.

The way these assessments are eroding the benefits of self-insurance leads us down a dangerous path, where prices start to reflect these large sums of money.

MR. NELSON: I have a couple comments on the pricing. According to our January 2003 stop-loss survey, the average rate increase is quite a bit lower than in 2001 and 2002.

We were in the 12–15 percent average rate-increase level, which is significantly lower than the low 30s that we had for the prior year. There was no significant variation by deductibles or PPO, versus indemnity. They all seem to have fairly low rate increases.

This is slightly lower than some of the benchmarks in the national press about increase in basic cost trends of medical care. For example, the 2003 Towers Perrin Health Care Cost Survey shows that we're expecting a 15 percent increase in employers' cost for health care plans in total. It is an interesting phenomenon that the stop-loss increases are coming down, whereas some of the survey data from the employer side certainly show that the trends are still quite high.

One of the things that will save the MGUs and the direct writers is lasering. I don't have the impression that lasering is lessening, as it still seems to be pretty commonly applied at renewals. It's even more common among MGU programs, in contrast to direct writing programs.

I offer a few more ideas on some of the underwriting data that we collected in our July 2002 survey about lasering, exclusion and the like. Among the direct writers who participated in this survey, they all essentially laser new business. Also, nearly half of those direct writers lasered new people at renewal (thus, half of them did not do so).

I think MGUs have a much higher percentage of lasering new people at renewals, and I assume it would be close to 100 percent. Note that a few carriers offer aggregating specific in place of lasering.

One thing that we like to survey is the aggregate attachment point credibility. I find it interesting to survey this credibility by the number of life years. In this survey, out of 10 or 11 direct carriers, we had 100 percent credibility on average, after 474 lives. So

this showed that a 200-life group with two years of experience, for the average carrier, is 100 percent credible.

This is interesting to us from the rate manual side because we sell them, and wonder, for aggregate attachment points, how much people use the manuals. Midsized groups probably don't find manuals as important on the aggregate side as on the specific side. Smaller groups, however, may find that, underneath 100 lives, the use of a manual still has a lot of weight.

We also had the question about HMO issues. A minority of these writers would offer specific stop loss over a self-funded HMO. So only a few of these direct writers would make that coverage available.

In addition, the aggregate experience analysis for transfer from HMO to PPO is also interesting. What do people try to hone in on in terms of their underwriting evaluation? The four items most consistently given were medical management, benefit design changes, provider reimbursement level changes and demographic changes.

MR. HUGH: I agree with Rick's and Carol's comments about lasering becoming more of the norm. We see more requests for aggregating specific. However, a couple of things are becoming apparent.

One of them is that, indirectly, we see an increasing use of experience rating on the specific side. We might be running the manual, but in a competitive renewal, if we've got to match a rate to keep what we think is one of our better cases, we might end up with 10 or 15 points off of the manual for what we think is one of our better cases. So we're using the manual, and giving some underwriter discretion, but we're essentially experience rating specific.

The second point is that we see a number of instances where a lot of the new business opportunities come from cases that had HMO experience. It's very difficult to get the data from a specific standpoint. Do you not offer an aggregate? Do you offer ridiculously high corridors? Or do you go back with a provision that allows you to retroactively adjust an attachment point, midyear? Some strategies are emerging for dealing with cases where there are not much data.

Our next topic is legislative issues. It's clear that states are really looking to encroach upon the flexibility and operating procedures with which we've been used to dealing in stop loss.

One issue is the per-certificate assessments, with Indiana as the prime example. Some other states are considering or at least studying this concept. I think we're all aware that it impacts stop loss disproportionately because of the lower premium.

A number of states have premium assessments. Colorado has a per-head assessment, but it's known upfront. Indiana and some of these other states are looking at those that aren't necessarily known at the time a case is priced. This then becomes a big issue.

If, as a writer, you can't cover your premium tax assessment allowance, this will come out of your fees, or potentially out of your margin. For reinsurers, depending on how the treaty is written, this might be a cutoff on the expense, which is an issue to address with the writer upon renewal.

However, from a partnering sense it would impact the reinsurers as well because it would be a renewal negotiation issue for them, which would impact the margins for both. Since assessments are increasing, depending on your writings, if they are up to 10 percent or more, they will erode the margins.

The second point concerns state-mandated, stop-loss minimums. Typically I don't think many of us have reacted too strongly to this because our underwriting guidelines have been more conservative than the minimum 10,000, 15,000 specific, with a minimum of 125 percent in the corridor. So we haven't reacted too strongly, as a general comment about our business.

But the concern, at least to me, is the attachment creep. If it's $10,000 today, and we're okay with this and had no voice in deciding direction, who's to say it's not going to be $25,000 or $50,000 as a minimum stop-loss attachment next year? This is a way to steer the direction of debate back toward a fully insured or state regulatory directed environment.

Finally, the Any Willing Provider Law was upheld by the U.S. Supreme Court. I view that as impacting provider discounts, then ultimately pricing from our standpoint. On the federal side there are a number of issues, such as the Health Insurance Portability and Accountability Act (HIPAA), mental health parity, medical malpractice and provider antitrust. What's at stake as we think ahead is the battle lines. Where have they been drawn and where are they continuing to be redrawn? Who's going to control the direction of the regulation of stop loss? Is it going to be more at the state level? Is it going to be more at the federal level?

The NAIC has created a task force called ASSURE: I don't have what the acronym stands for, but they've put together a subcommittee to address lobbying at the federal level. So there will be a continuing and shifting debate over the control and impact of state regulation as opposed to federal regulation.

SIIA has had differing viewpoints with the Academy, with the Health Insurance Association of America, and so forth, especially over association health plans. However, in discussions with SIIA their view is the industry is being challenged for its survival, and states are encroaching, lumping stop-loss business together with regular health insurance. SIIA's view is that as an industry we need greater awareness of what's going on, and that freedom and flexibility are being encroached upon. A basic tenet of SIIA's stop-loss model act is the view that stop loss is not health insurance.

Then, finally, an interesting comment from SIIA was that their proposal for the stop-loss model act hasn't generated much reaction or buzz. However, on the flip side, you need to be a member or pay for the text, which doesn't help get out the word.

MS. ADAMS: The next topic is trends. Starting with medical trends, from what we see, what people are using is still in the 14–16 percent range. That's probably a typical indication of what people build in.

On the prescription drug side, we've started to see people back off of this trend. I still think people are using things in the 20 percent range, but it was creeping into the high 20s, and now perhaps it's more in the mid-to-low 20s.

I made a comment about the combined trend. As an underwriter it is certainly easier to use a blended trend when looking at experience. You might not have the information separated between medical and prescription drugs, but I caution everyone against that.

We started to see an increase in drugs as a proportion of total claims. Depending on how you're blending to get a combined trend, you could be significantly off. So, while it is easier to keep the costs together, which I fully recognize every day with my underwriters, I caution people to try to break out the experience by medical and drug and trend those sides appropriately. I skipped over leveraged trend, but it is a critical topic.

We've seen an increased incidence of large claims. That may be attributable to the advancements in transplant technology as well as the increase in multiple births. Something that's a little bit puzzling, which we're starting to see emerge, is the increasing frequency and severity of claims for children who are less than five years of age. I don't have a good answer as to why that's happening, other than the typical reasons for frequency and severity increase.

MR. NELSON: To show the claim cost trend from the Tillinghast perspective, I put together some numbers from a database to analyze the trend assumptions that we use or are considering using. We tracked PPO-paid cost data at different deductible levels, and split the increase between frequency, or the number of claims, versus severity, or the average size of the excess claim.

Interestingly, on these PPO data, a little bit contrary to what Carol may be seeing, the severity did not change a lot by deductible level. Ours was fairly constant. Most of the leveraged increase by deductible level was attributed to frequency increases from one time period to the next.

The basic claim cost data from the zero dollar level here was close to 11 percent. So you see the leveraging of 11 percent at the zero dollar level, up to about 24 percent at $50,000, 31 percent at $100,000 and 43 percent at $200,000 in this particular PPO data set.

In talking with our clients about trend, one of the problems for MGUs is that they don't believe they have enough volume. If there is $20 or $30 million worth of premium, there may not be enough volume to talk about tracking your own trend increases on your own block. So that is probably a real issue.

The other real issue, especially for MGUs, is the inability to get the full claim cost history from TPAs. Thus, there is a difficulty with the possibility of aggregating claim

history across many groups in order to actually do trend studies at different deductible levels. They just don't have access to the data.

A difficult thing for the average MGU out there to try to understand what the trend is by deductible level. That's why they look to us for industry manuals and other help. That is something we talk about often.

Other factors impacting the large claims include the hospital outlier provisions on PPO contracts, where claims that are initially paid on a per diem or a diagnosis-related group then revert to a quasi fee-for-service basis at some level. That certainly impacts our large claims and adds to the leveraging proposition.

Also, cost shifting from government plans has impacted our hospital payments over the last few years. Tenant Health Care came out with a statement in the last couple of months where they admitted trying to load cost into the higher-cost types of admissions. I think that activity would heavily influence our stop-loss products.

MR. HUGH: Table 4 is designed to illustrate leveraging. I have a database with which, depending on the specific level, the exposure could be anywhere from 1.5 to 5 million employee lives. Above 100,000 or above 200,000 it's generally in the 3–5 million member range, so it's pretty credible. Below 100,000 it gets a little bit thin.

Table 4
Claim Cost Trend

Deductible	Frequency	Severity	Cost PEPM
$25,000	2.7%	17.6%	20.8%
50,000	10.6	13.8	25.8
100,000	22.3	8.8	33.1
250,000	32.7	9.3	45.0
500,000	46.2	8.3	58.4
1 million	72.5	8.2	86.6

- Leveraging example using GCL database comprised of both fully insured and self-funded claims.
    - 16% first-dollar trend assumed
    - Leveraged trend by specific deductible and component illustrated.

The data here use composite numbers, so I wasn't able to split out employees from dependent persons. The table is a mix of stop-loss and fully insured business. The idea is to show from paid claim data the significance of leveraging.

The primary assumption is that the underlying trend, the first-dollar trend, was 16 percent. That reflects General Cologne's assumptions, which is what we recommend to our clients before we get into specifics on their provider reimbursement structure, strategies and so forth. The frequency really escalates as you get over $100,000.

It's not to say that severity is decreasing. In fact, for some services severity is increasing. However, because of the frequency that really impacts this, while their claims were well below the threshold in years past, now they're above them. The claims that now exceed the threshold are bringing the average severity down. That's what causes the severity increase percentage to decrease as the deductible increases.

The takeaway is that leveraging will have a big impact. The underlying trend assumption, the actual underlying trend, what providers are charging and what you're willing to pay your providers will dramatically impact the numbers in Table 4.

MR. NELSON: Here are a few comments on provider networks. At Tillinghast most direct writers attempt a differentiation between PPO networks. They have some leverage with the networks in order to get information. In discussions with many of our MGU clients, I've found that the amount of analysis of the networks with which they do business is relatively low, or even nonexistent in certain circumstances.

For the MGUs, however, the reinsurers are often helpful in terms of setting guidelines to help them with the discounts to assume in their rating, but they certainly don't have the wherewithal to do a lot of that analysis themselves.

Looking at Tillinghast's 2003 rate survey, we show an approximate 25 percent difference, on average, between indemnity and PPO rates. That has been fairly consistent over the years. It is certainly a pretty substantial discount. I've always been surprised that a bigger discount does not show up there because of the leveraging effect for PPO networks, since the discounts should be larger than on a first-dollar basis.

Some of the difficulties MGUs have in doing analyses include dealing with numerous networks to obtain data, and updating changes once they perform an analysis. Also, the spread of business over many networks reduces credibility.

We get asked from time to time, Are you aware of a data source for PPO discounts that people publish? I am interested to see if anybody has ever tripped across such a source of data, because I'm certainly not aware of any.

Regarding leveraged discounts and increasing discount as a deductible increases: In our 2003 rate survey I looked at the percentage of the writers who reflect a leveraged discount as the deductible increases. One-third of the writers reflect this type of discount, so two-thirds of them report a flat discount. That's interesting to me. I thought that there would be more writers using leveraging. The idea of leveraging isn't terribly important for an MGU or a direct writer who writes a narrow range of deductible levels. If you're not writing a full range of deductible levels, then the concept of leveraging isn't as important because you'll get used to a particular discount level that is applicable to the small range of deductibles that you write.

MR. HUGH: I've got just a couple of comments. We risk takers want to and should differentiate between provider networks; we need to do this. Unfortunately data usually reflect only limited analyses, or are time sensitive, so they tend to become dated.

Data from the network itself tend to be limited in quantity, or vast in quantity, but limited in value. Liberal outlier provisions in hospital contracts make it necessary for us to have more conservative leveraging assumptions, at least until the contract can be proven.

The last point is that a Medicare-based reimbursement schedule would allow us to price more predictably, at least with a scheme that is more transparent, from our perspective. This could be a plan where the percentage off the bill, such as 60 percent, doesn't hold a lot of meaning because we don't know the billing level. Perhaps it could be 200 percent of the usual and customary.

MS. ADAMS: In talking about new product features I will take a different twist. Russel and Rick will mention the consumer-driven health plans, which may be one of the first things that come to your mind.

I pulled this information from a presentation I did three years ago about new product features, and it's still applicable today. These are still new product features. Certainly there are organ transplant programs. There was a trend toward taking a catastrophic claim, whether it's neonates or organ transplants, carving this out of the employer's risk and offering it on some type of first-dollar basis. Is disease management still a trend for the future? It's something that we see on the fringes, but it hasn't taken off.

During my presentation three years ago I predicted that this would have become more of the norm, and there would be a different type of employer stop-loss product. I still think this might be on the horizon, but I wanted to share a different twist on what I'll call new product spin-offs.

MR. NELSON: I will share couple of ideas. I have one MGU client who claims that the company is trying to offer a stop loss for some of these fixed benefit programs, which are generally sold in the marketplace for industries with high turnover or low wages.

So the type of coverage is often scheduled with low maximums and can be a couple hundred dollars a day for a hospital stay, and up to $10,000 or $20,000 per year for total coverage. It's a very limited benefit type of product, and the employer is buying a specific stop loss in conjunction with it.

The employer would be self-funding some level of these basic benefits, even though they are already reduced benefits. It's kind of an odd bird. But my MGU client claims that he's actually sold a couple of these packages to certain employers. It creates all kinds of interesting rating dilemmas because the claim continuance with which you're used to working includes full dollars of surgical and hospital fees.

What do you do if you suddenly cut the benefits to a couple hundred dollars a day, for example? This plan would throw away all claim continuances. Therefore, my client had a real challenge in trying to come up with a stop-loss rate that was applicable for this particular type of risk.

Another idea coming up is consumer-driven health plans. There's not enough of them right now to make a difference, but an issue that will eventually arise will be the assumed favorable utilization patterns that everybody uses for pricing. Will they apply to large claims? Maybe, maybe not.

Another issue is, Are the consumer-directed healthcare programs' (CDHPs') PPO networks as efficient as the standard networks'? What I've heard from the health and welfare consultancy within Towers Perrin is that this is not the case, generally speaking. The PPOs that are being used by CDHP vendors offer discounts that are not as good as those from local PPO networks. So these PPOs may not provide a very attractive stop-loss risk.

MR. HUGH: Questions may be, How will aggregate and specific costs be impacted? Will inflation assumptions be impacted? In some presentations used to illustrate consumer–driven health plans, studies indicate that prescription drug claims and physician office visits will be lower.

A question for the larger catastrophic claims is, How will this impact utilization? Will it have any impact in the first year? Will it have a longer-term impact? Will it have any impact at all?

Intuitively I expect aggregate claims to decrease in total. At this point I don't have enough information to modify any pricing assumptions.

MR. MICHAEL MCLEAN: This question is for each of the members of the panel. In the case of a high deductible and a good network, what is an aggressive discount that you would recommend from indemnity?

MR. NELSON: A discount from indemnity for, say, a $50,000 deductible?

MR. MCLEAN: Or even higher.

MR. NELSON: I would say somewhere in the 30–35 percent range.

MR. CHARLES FUHRER: When I put together some pricing from aggregate work I did a number of years ago, I concluded that there is a tendency to understate cost. This is because of the nonindependence of the risks within a group. That principle also applies to the whole portfolio, and to a lesser extent to specific. Putting it in a simpler way, in the years that you misguess trend, when it turns out to be a lot higher than you thought, you will have a lot more aggregate claims.

In the years in which trend comes out close to expected amounts or below, you won't have many aggregate claims. In a bad year you will also have more specific claims. It seems to me that the product pricing and accounting ought to take that into account and take a multiyear approach.

Therefore, in years when good profits are made, it would be appropriate to put up large reserves for release in poorer years. I wonder if any of my colleagues have been doing something of that nature.

MR. NELSON: I have not seen anybody put aside reserves for a stop-loss business. In fact, I've never seen anybody save anything in particular for the down year.

MR. HUGH: We expect to shy away from a multiyear approach because the reinsurance treaties go year by year. In the good year we will do much better than our target margins to anticipate the down cycle when it comes, and it will arrive. Then in the lean years we can hope to break even and wait for the up cycle.

I think it's implied in some of that pricing that in the good years we want to do really well, and we think something's wrong if we're not doing fantastically well. Does this answer your question?

MR. FUHRER: Maybe it does. Essentially you're saying that the general surplus of the insurance firm covers it.

Now onto the second question. One of the things I've asked our consultants to tell our clients is to encourage them to purchase aggregate because the specific doesn't really meet their needs. This is because there could easily be a very large amount of dollars worth of claims that happen to be up to the stop-specific limit.

My perception, from when I worked in insurance, was that the companies didn't really want to write aggregate by itself or even with specific, unless the specific was pretty low level. The response from our consultants is consistent with this, which is that aggregate's fine, but it's not available. Is there any movement toward a little more free writing of aggregate in the stop-loss industry?

MR. HUGH: We are seeing a little more traction—the concept of writing aggregate only, but not in the traditional sense where you're covering claims in excess of 125–130 percent. For example, the attachment point might be somewhere around the expected claim level. You're going to charge significantly more for a premium than traditional aggregate coverage, where you getting $10,000 on a group to cover potential losses in the hundreds of thousands of dollars.

However, a hybrid product like that tends to work better in smaller groups than larger groups since there's a moral hazard and lack of information because it's too easy to miss the aggregate attachment point.

The stakes are too high with the larger group, but with a smaller group the lack of credibility may offer more of a manual approach. There is, I think, more traction and ideas involving a hybrid of a specific and aggregate where one collects more premium for a lower attachment point.

MR. LEONARD KOLOMS: I'm a little confused regarding my understanding of outliers. Don't they normally go off of a percentage of discounted charges? If that's the case, what is the difference between the amount of claims we'll get under a PPO versus under an outlier? Will they be the same, or will they be different?

MR. NELSON: A PPO can have a basic contract, where, unless your billed charges are greater than $50,000 or so, your claim is paid as a per diem. Then for claims that exceed $50,000, the charge reverts to a fee-for-service basis, or a percentage off a fee for service.

MR. KOLOMS: So it is the same. Once you hit the outlier there's no difference between a PPO and an indemnity?

MR. NELSON: A discount could still be applicable.

MR. HUGH: The PPO will receive some discount off of the indemnity charges, which are what they are. What are really at issue are the pricing assumptions. If you assume, for instance, that for claims above and below the outlier threshold an average hospital charge is $3,000 per day, depending on the mix of hospital claims, with an outlier threshold of $30,000, if you come in at $29,500, the average cost per day might be $1,500–2,000. If you go a dollar over that $30,000, you might revert back to dollar one on the billing and pay $6,000 per day.

MR. KOLOMS: I understand it, but let's assume we have a $100,000 bill coming out of a hospital, which is in the outlier provision under a PPO contract, or somebody else has an indemnity. If two people walk into the hospital with the same injury or illness, and one's under a PPO that's in the outlier and one's under an indemnity, will the hospital get paid the same amount by the insurer?

MR. NELSON: I would say no.

MR. KOLOMS: Why? What would be the difference? Won't one patient be offered a discount?

MR. NELSON: The indemnity wouldn't necessarily have a discount applicable.

MR. KOLOMS: I thought somebody said they were expecting 30 percent off of indemnity.

MR. NELSON: Mike asked the question in terms of pricing. If you had a $75,000 deductible indemnity plan versus a $75,000 deductible plan involving a PPO, what would be the pricing difference?

MR. KOLOMS: The billing would be the same, but the PPO would have a discount.

MR. NELSON: Yes.

FROM THE FLOOR: The difference in discounts between PPOs on large claims is strictly the outlier provisions. Has anybody done a study by a PPO to see if there is a discount on outlier claims?

FROM THE FLOOR: Has anybody seen any differences first-hand, or any studies that compare these discounts? If we look at a normal PPO, trends in first-dollar plans are substantially different. The difference for outlier claims depends on the discount.

MR. HOBSON CARROLL: It depends on the attachment point of the outlier. Outlier creep sometimes comes down in the contracts, which means that the number of cases that hit the outlier actually increases, along with an increase amount over that. They are playing lots of games these days.

We used to call this carve-out, which went along with the idea of an eye surgery, when they did the radial keratotomy with the blade. Then we went onto the laser surgery, and now we have a laser carving out people from our health plans.

I wonder about the panel's comments on the linkage between what we do in our industry and its future, plus its connection to movements toward universal care, because I think that's our weakest link.

MR. NELSON: The lasering is getting tougher, as opposed to less inclusive. So we seem to be going counterstream to greater universality. We might go along for a few years like this though.

I can't imagine anything changing over the next couple of years, or any kind of mandates saying you can't laser anymore. I think the industry is comfortable with the lasering and won't willingly give it up.

MS. ADAMS: I agree that lasering is here to stay, at least for the near-term horizon. However, I agree with your comment that it is contrary to the concept of universal health coverage for all people.