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DESIGN AND COST CONSIDERATIONS OF GROUP HEALTH INSURANCE

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1. Credibility formulas.

2. Horizontal rating of medical expense coverage as opposed to vertical or geographical rating.

3. Recent trends in morbidity experience.

4. Cost containment.

5. Improving cost effectiveness to the policyholder.

MR. GEORGE L. BERRY: On September 25, 1980, the Wall Street Journal published an article about the sudden, unexpected surge in medical care cost trends. The tone of the article was pessimistic and indicated that the experts had been caught by surprise. The anticipated result is a substantial increase in health care premiums in 1981, probably extending into 1982. We can expect three major consequences.

First of all, it will be disruptive to the entire economy. Economic conditions are already unfavorable. It seems reasonable to assume that superimposing a substantial increase in medical costs in the form of higher health insurance premiums will be damaging to business.

Secondly, it is likely to make visible and to reinforce a public attitude that something must be done to control the so-called sky-rocketing cost of medical care. Health care cost trends have been relatively low for the past three or four years. A number of statements were made to the effect that cost trends had reached a plateau, or that the cost of medical care was now under reasonable control. Clearly, the public will be less willing to accept such statements at face value following another surge in costs.

Thirdly, and I think most seriously, it may convince government, business, and the public that the private sector financing mechanism cannot do the job. The private sector financing mechanism is the health insurance industry.

This surge in the cost of medical care has happened before. The last time it happened was in 1975-76. One of the results of that occurrence was a substantial shift by many groups from conventional insurance to some form of self-insurance. In effect, groups were deciding that they could do a better job financing health care themselves. For many of them, rate stability had been unsatisfactory. The risks involved had not been clearly explained. There were people telling them that the risks were minimal and that cash versus accrual accounting was acceptable. This created the illusion of substantial savings and reinforced the view that health insurance premiums really were excessive.

This perspective is reflected in my comments on pricing group health insurance. What I would like to do is to outline briefly the approach toward pricing which we have taken for the past several years.

(1) In the early 1970's we concluded that the past was no longer a reliable guide to the future. Since this was the standard group health insurance pricing technique, we had to find a viable alternative.

Our alternative was to develop a hypothesis about the future. We would then act on that hypothesis as long as it was confirmed by our knowledge and experience.

For example, part of the working hypothesis we developed in 1976-77 was that medical care cost trends would decline until late 1979 when they would begin to accelerate, primarily for economic reasons. A second element of this hypothesis was that such a trend pattern would be largely unanticipated.

The basic tool we used to develop such a hypothesis is something which I refer to as trend behaviour. This involves a detailed examination of trends with the objective of determining what it is that causes them to change direction. One of the things we concluded is that there is at least a tentative relationship which causes medical care trends to follow the pattern of the general rate of inflation but delayed by about eight to eighteen months.

(2) This hypothesis resulted in a pricing strategy which relies heavily on financial forecasting, simulation, and 3-5 year pricing scenarios. Timing is extremely important. For example, two of the most difficult things to explain to management have been the difference in timing between current financial results and current pricing, and the time delay before a change in pricing is visible in financial results.

The financial forecast is the foundation of the pricing strategy. Since the future cannot be predicted precisely, a multiple forecast is more realistic than a single forecast. Normally, we prepare three forecasts which cover the expected range of results from Most Favorable to Best Estimate to Least Favorable. This range is the track on which actual results and current knowledge are superimposed to identify how the future is emerging.

Data retrieval and/or actuarial staff limitations are perhaps the most common reasons given for not preparing a forecast. I think that it is most important to remember, however, that a forecast does not have to be perfect in order to be of value.

Simulation techniques can be utilized to evaluate the impact of different courses of action on a financial forecast, a marketing strategy, or on an experience rating system. One example of such an application might be to determine whether or not to change a credibility formula.

Our approach to 3-5 years pricing scenarios has been as follows:

(a) Develop a variety of claim trend scenarios for the next 3-5

years.

(b) Develop rate changes for each year for the particular group or rating system being examined.

(c) Isolate those trend scenarios which would cause unacceptable rate changes.

(d) Estimate the likelihood that such trend scenarios will take place.

(e) Decide whether or not pricing practices should be modified.

We try to use a computer as much as possible for any of these applications. To use words which are popular today, we are taking a macro view of pricing rather than a micro view. To put it in my kind of language, we are trying to look at the forest and not just at the trees.

(3) We consider it essential to involve marketing and management in the design of rating mechanisms. For example, the credibility formula or stop-loss formula determines the distribution of rate changes. Consequently, an influencing factor should be the marketing department's perception as to which distribution it can sell best. An important secondary consideration is the impact of the current rate action on future rates. Another aspect which involves both marketing and management is the balancing of rate stability for the group customer with stability of financial results and with competitive pricing practices.

Any rating mechanism must consider claim trend or projection factors, credibility and/or stop-loss formulas, margins, risk/surplus charges, retention, claim reserve estimates, and expected claims. As you know, all of these elements are interrelated. If one element is changed, it is likely that the other elements will be affected to the point where they may have to be changed as well if the rating mechanism is to function properly. This is why I think that simulation techniques are so valuable. In addition to the tradional elements which I have just mentioned, cash flow and special risk arrangements have become critical and often deciding factors in the marketplace. The actuary must now be prepared to consider the treatment of the claim reserve, contingent premiums, deferred premiums, split funding, aggregate stop-loss and other arrangements as an integral part of pricing.

Benefit variations introduce another variable which further complicates pricing. Some examples include pricing consistency between Comprehensive Major Medical and a Base Plan with Supplemental Major Medical, High Level Deductibles, and Stop-loss arrangements. In each of these cases, the underlying frequency distribution of claims is particularly significant.

The actuary cannot do his pricing in a vacuum. We must discuss these complexities with management, marketing, and frequently with accounts to make sure that they get what they want and that they understand what they get.

The actuary's objective has not changed. It is just more difficult to achieve. We are still trying to balance adequacy, equity, competitiveness, consistency, simplicity, time and facilities available, over time to optimize long-term growth and profitability, year-by-year fluctuations, and customer satisfaction.

One final element of this macro pricing which needs to be considered is the fragmentation of the marketplace which has occurred primarily for economic reasons. We might identify three major markets - large group, which is characterized by its emphasis on cash flow and risk arrrangements, medium group which is the shrinking stronghold of classical group insurance, and small group which is increasingly being influenced by mass marketing techniques. Once again, the actuary has to strike a pricing balance which is consistent with his company's surplus and marketing objectives.

(4) Communication has also been essential, particularly with respect to the education and training of Marketing and group purchasers. In my opinion, the level of understanding in the marketplace is extremely low with respect even to the basics of health care financing. My experience has been that both marketing people and group customers are extremely interested in increasing their knowledge in this area. Seminars, which deal with alternate health care financing, quantification of risk and comparisons of alternatives have been effective.

The area of communication touches on our professional responsibility as actuaries. It may be easier to do all of the pricing ourselves without input from others and without explanations. It may be easier to avoid examining the long-term effect of the group insurance practices being followed today. It may be easier to say nothing when we see ignorance in the marketplace. I think, however, that our professional responsbility demands that we communicate in each of these areas as effectively as we can. We are the risk experts. We know how to demonstrate the impact of a course of action under a given set of assumptions. We can do a better job of pricing if we obtain input from other disciplines. The challenge is to communicate in a non-technical manner which can be understood by people who are not actuaries. As much as anything, I think that this ability to communicate is what separates the professional actuary from the technician.

(5) Monitoring the experience rating system provides information for forecasting and for testing the working hypothesis. When the monitoring system is mechanized it is easier to use simulation techniques. The major purpose of monitoring is to verify that the experience rating system is working properly in total and by component.

The basic computer record for most of the monitoring systems we have developed is obtained from the renewal calculation and from the refund or settlement calculation for each group. Three examples of simple but valuable information which can be obtained from such a system would be the answers to the following questions:

(a) At the end of October 1980, how much of the total 1980 premium and how much of total 1981 premium can still be affected by the renewal process?

(b) How much of the 1980 gain/loss from operations was the result of deficit recovery and what are the expectations for 1981?

(c) If the actual claim trend exceeds the assumed claim trend by 1% or by 5% what is the financial impact in 1981?

A lot of the value of a monitoring system is that it increases the company's capability to act more confidently and more quickly than would otherwise be possible.

The approach which I have described is the one we have been using with several Blue Cross and Blue Shield Plans for the past several years. The two most significant departures from traditional pricing which I can identify are first, that is a multi-year rather than a year-by-year approach, and second, that it relies so heavily on clarity of communication. The latter is particularly important with respect to pricing assumptions which we, as actuaries, have to make although we, as actuaries, cannot influence the outcome.

The next few years will determine what happens to health care financing in the future. I feel strongly that the actuarial profession has a major responsibility and a major role to play in this area. The pricing decisions we make over the next twelve to eighteen months may well be the determining factor.

MR. WILLIAM H. LESLIE: Although the bottom line results of medical care insurance are influenced mainly by overall manual rate levels and experience rating trend factors, renewal rating methods and philosophies can decide whether a Group Life and Health line of business exceeds or fails to meet its financial objectives. Most techniques will center around how much and in what manner credibility is given to the group policy's actual medical care coverage experience. Any discussion of credibility tends to conjure up thoughts of mystical actuarial theory. Its real value, however, is that it also requires the use of judgement as a very important element in any pricing method. As had been noted, "Renewal Rating is an art, not a science".

There are different ways of using credibility in renewal rating a group insurance policy:

CREDIBILITY FACTORS

These can be used both retrospectively and prospectively. I believe that it is true that the more common use is in prospectively estimating the upcoming year's claims. You can base the credibility on the number of lives covered by the policy in the most recent year or years. The amount of premium may also be considered.

POOLING

If the policy is experience rated retrospectively, there will usually be major medical pooling, except for the very large policies. For the smaller, non-experience rated policies, medical claims will probably be capped before determining the renewal rates. In any event, less than full credibility is given to a large claim.

RENEWAL RATING PHILOSOPHY - Small Groups

In the under 50 or 100 life group, is there such a thing as a good or bad case? How far below or over standard rates should it be? I am quite sure many of you have had many discussions, quite heated at times, on this topic. How much credibility should be given to actual experience? How many years' experience should be considered? Should there be a minimum and/or maximum rate increase at renewal? What involvement is needed by Underwriting and/or Sales to add judgement to an otherwise Actuarial formula?

OTHER CONSIDERATIONS

When quoting new business, the available experience, if any, usually will not be as extensive or reliable as that for an in-force policy. If some form of credibility is to be used, the method may or may not be the same as that used in renewal rating. Usually, a margin is added to allow for any incompleteness in the data submitted. In addition, the period of time for which experience is submitted may not be extensive and undoubtedly will not include the most recent months.

PRICING OTHER HEALTH COVERAGES

Some coverages, such as Long Term Disability, require a much greater number of lives to permit assigning any significant amount of credibility. Except for the larger accounts, one should closely monitor the entire book of business to ascertain if any corrective pricing and/or product changes are necessary. Dental insurance experience will involve a relatively very high number of claims but can show several different patterns of year-to-year loss ratios when the case is first installed. The absence of large claim amounts eliminates the need for a pooling mechanism.

RENEWAL RATING

In actual practice, a judgement input will be necessary on any of the formulas for substandard risks. When the recommended formula produces a reduction in rates on the better cases, subjective input by the Experience Rating Supervisor will also be necessary. The objectives of the formula should be:

1. To introduce more equity in renewal rating action with the intention of improving persistency in general but with specific emphasis on the better cases and those with improving loss ratios,

2. After adjusting for large claim mitigation, to react to worsening loss ratios more promptly if risk review supports that action,

3. To allow for a controlled means to actually reduce rates on the better cases,

4. To permit some "settling in" of manual rates within geographical areas by allowing for more deviation from standard rates,

5. To moderate the rate increase brackets to lessen the impact of increases by offering more gradation in the table adjustments,

6. To cut losses on cases turning bad which will probably be lost at the next renewal after the risk finally shows an accumulative deficit.

The formula might use a cumulative weighted loss ratio based on the combined three-year cumulative experience with emphasis on the most recent year. The result is that the formula will respond to current year changes more readily. This means that if a risk is currently running poorly, more credibility will be given to the current experience.

RECENT TRENDS IN MORBIDITY EXPERIENCE

Starting in late 1979 and continuing into this year, most group insurance writers have seen an upsurge in medical loss ratios. Although the causes are difficult to pinpoint exactly, these appear to be the contributing factors:

1. A high level of inflation - this can be seen in the Consumer Price Index and specifically in the medical care items.

2. More large claims. It is no longer the rare exception to see very long durations of hospital stay in the attempt to sustain life.

3. Increased utilization. This is occurring in several ways:

   a. Employees sensing an impending recession seek treatment for an illness while still insured.

   b. The first people laid off are usually the newer, younger ones. Case premium decreases with only a minimal decrease in claims.

   c. Providers of medical care increase the frequency of their services in order to increase their income.

4. Influenced by the federal anti-inflation program, carriers reduced their trend factors and only slowly brought them back up.

MEASURES TO BE TAKEN

To restore adequacy to your medical care insurance rates, several reviews should be made:

1. Check manual rate levels to determine the amount of increase needed.

2. Revise assumptions of inflation and utilization and adjust trend factors accordingly.

3. Review expense loadings and retention charges and compare them to the current overall effect of inflation on general insurance expenses.

4. Determine the current status of any major medical pooling arrangements.

RECENT TRENDS IN OTHER COVERAGES

Dental insurance results seem to be following the trends of medical

insurance, but the trend is more moderate. There also appears to have been a somewhat moderate impact on Long Term Disability experience as a result of the recession.

UNDERWRITING PRACTICES

In view of the deterioration in earnings that we are witnessing, it is more important than ever that we employ sound judgement in our underwriting of new risks and in the renewal of existing ones. Adherence to our underwriting guidelines is a "must" and any deviation from them should be a conscious decision reserved for the most desirable risks. However, for the "right" risks we should generally be willing to do what is necessary to meet the competition; be it to write a new risk or to retain an existing one.

While the problem is common to the industry, your ability to deal with it effectively may well set you apart from the others. Clearly, we have the people, processes, and products to meet the challenge without sacrificing the attainment of any one of our goals - profitability, persistency, sales - for another. It's important that you and your people understand this and that you manage your operation accordingly.

In this regard, the following summarizes a recommended posture with respect to certain underwriting practices:

1. Margin - In pre-sale we should attempt to include higher margins in our medical care rates. Generally speaking a 5% margin would seem appropriate for the majority of risks; however, on any given risk, we can consider reducing the margin to something less than 5%. The level of margin should be directly related to the desirability of the prospect and the accuracy and completeness of the information we are working with. In situations where we quote breakeven rates (0% margin) we should attempt to get a retrospective rating agreement equal to the difference between breakeven rates and rates inclusive of a 5% margin.

2. Claim Stabilization Reserves (CSR) - In renewal situations the CSR is available to offset part or all of the margin in our advance rates. Use of the CSR to offset a portion of the projected claim level is permissible to the extent of the dollars we hold above our CSR requirements.

3. Weekly Disability - You may want to project the trend in estimating future Weekly Disability (non-statutory and statutory) claim levels for rate determination purposes.

4. LTD - When underwriting this coverage, we need to be sensitive to the potential for adverse selection inherent in certain benefit designs. There is no substitute for prudently underwriting this line of coverage so as to minimize the possibility of being selected against by insureds.

5. Case Reviews - Monitoring inforce business on a monthly basis is an important aspect of our work. You should have an early warning system, especially for large policies.

REGIONAL TRENDS

Since the economy has such a great effect on our business, more attention is being paid to analyzing the outlook of each of the different regions of the country. Fundamental economic activity in the region is analyzed and described. This includes an analysis of the most important business sectors and the historical relationship of these sectors to state employment levels, national economic movements, and the general level of commercial activity in the state. Emerging trends are identified and considered within the terms of the local economy. The economic future of the region is studied within the context of the prospects of the businesses which make up its industrial base. The analysis takes into consideration the maturity of the industries, general demographic trends and the interdependence of factors such as the availability of resources, federal spending, and the general business climate (taxes, regulation, union activity, etc.). Growth industries are identified and their role and importance in the future economy is considered.

OUTLOOK

Deciding on the amount of credibility to be given experience as well as the methods to be used has been stated to be an art more than a science. Judgement is needed before testing the purely theoretical results in the marketplace. This problem is exacerbated by the recent economic volatility. Rates of interest, inflation, and unemployment are changing rapidly.

Pricing is difficult in any business, but especially so in ours where future costs are involved, many of which have no fixed limit. The future outlook is definitely one of uncertainty.

MR. MORDECAI SCHWARTZ: Containing health care costs is a national concern, and numerous proposals have emerged from the widespread debate. The following checklist for control of hospital costs emphasizes the need for efficient deployment of resources:

"1) Explore integration of services among hospitals in the same community to avoid costly unnecessary duplication.

2) Explore and control the relationship of ambulatory out-patient care to in-patient care.

3) Promote the most effective utilization of ... in-patient services.

4) Attempt to stablize ... workloads in order to most effectively utilize ... beds and personnel.

5) Study our long range needs to avoid overbuilding.

6) Take advantage of every cost control available."

The suggestions are certainly sensible, and they may strike many of us as quite familiar. The noteworthy feature of this list is that it was presented at a regional meeting of the Society of Actuaries in 1959.

Medical care costs have been increasing faster than general price levels in the United States for at least three decades. In the fifties, the CPI rose at an annual rate of 2.2%, while hospital costs increased 6.4% per year. In the sixties, the CPI inched up at an annual rate of 2.5%, while hospital costs soared 9.3% per year. In the seventies, while the general inflation rate rose to 7.4%, the pace of hospital price increases climbed into double digits, 11.2% per year. With price increases compounded by higher utilization, the proportion of our GNP devoted to health care has risen steadily, reaching 9% in 1979. The consequence of the accelerating cost increases is not surprising. What in the 1950's was of interest to specialists in health care financing, such as actuaries, became a major political issue in the seventies.

The economic explanations of spiraling health care costs are straightforward. A brief review may place the myriad solutions in context. First, the supply of health care resources seems high to many of us. Tax policy that encourages medical research, government subsidy of physician training and the existence of non-profit players in the game all tend to foster more investment of capital in the health care business than a free market would produce.

In theory, an excess of supply, while producing high utilization rates, would also stimulate softening of prices. But the demand for health care services is distorted by the financing mechanisms which have evolved. Between Medicare, Medicaid and private insurance, the bulk of our health care bills, and in particular hospital bills, are borne not by the end user but by a third party. The trend away from indemnity plans to increasingly rich service-type benefits, a natural reaction to increasing concern with price levels on the part of the consumer, has only increased the artificiality of demand.

A third economic factor, perhaps as much a consequence as a cause, is the inefficient allocation of health care resources. Among the more frequently cited examples are the uneven distribution of hospital beds and of physicians relative to population, the tendency toward inpatient surgery when out-patient would do, and the notorious proliferation of apparently unnecessary CAT scanners.

Recent cost containment efforts have been very visible. Practically everyone is in the act. At the federal level, Medicare claims have been administered under more stringent definitions of reasonable and customary charges. Washington has continued the effort begun in 1973 to stimulate the development of Health Maintenance Organizations. The current administration has tried both legislative proposals and jawboning in a not too successful effort to control hospital costs.

At the state and local levels, the most prominent programs have been the Health Systems Agencies and state hospital regulatory groups. The Health Systems Agencies are local agencies with broad-based membership, whose primary role is co-ordination of services and facilities in the community.

A recent study reported in the New England Journal of Medicine looked at the impact of hospital cost control agencies in six states. In those six states with mandatory controls, hospital rates rose an average of 11.2% annually from 1976 to 1978, while the corresponding increase in the remain-

ing states was 14.3%, 3% higher. The results may be open to challenge but they suggest that it may be possible to motivate hospitals to operate more efficiently.

New Jersey is trying to promote more efficient utilization of hospitals through a new billing system. Hospitals must phase into a system of charging based on Diagnostic Related Groups, rather than using the traditional system of charges for daily room and board and ancillary services. The idea is to remove the incentive for hospitals to prolong confinements unnecessarily. On the other hand, the Diagnostic Related Groups system may encourage over-admission or a concentration of resources on the easier patients within a group. It will be several years before we have sufficient experience to evaluate the results.

As I indicated earlier, actuaries have been discussing approaches to cost containment since the 1950's. We have been well aware of the impact benefit structure can have not only on our claim levels, but on the type and amount of medical services actually demanded. Translating that awareness into strong actions is another matter, and only recently have insurance companies taken an aggressive stance on the cost containment issue.

The first area of attention is the traditional one of benefit design. To promote more cost-efficient use of resources, plans have begun to remove the financial barriers which encouraged, for example, in-patient surgery, when the job could be done as well on an out-patient basis or at a free-standing surgical facility. Payment for extended care facilities or pre-admission testing are other ways to promote efficient treatment.

We have also seen greater emphasis on preventive medical care. It has, for example, become more common for plans to provide full payment for physical exams or annual pap smears. It remains to be seen if greater emphasis on preventive care is cost effective. From my viewpoint it is not clear what inferences can be drawn from HMO experience, however, it is certainly worth testing if an ounce of prevention is worth anywhere close to a pound of cure.

We have also seen a renewed interest in deductibles as an incentive to avoid unnecessary utilization. Perhaps the most visible element of benefit design aimed at constraining costs is reimbursement for second opinions prior to potential surgery. The idea is to encourage the patient to make a more informed decision on the real need for proposed surgical procedures. An interesting twist, designed to provide greater usage of second opinions, reduces subsequent deductibles or co-payments if the insured obtained a second opinion prior to surgery.

At the same time that they are encouraging improvements to plan design, the carriers are supportive of employer interest in promoting better general health. This takes various forms, ranging from general health education for employees to explanation of new prevention-oriented benefits, or from installation of exercise facilities to hypertension screening. One pointed way to encourage employee interests in cost containment is to have them pay a portion of the premiums, though this can backfire if they decide to get their money's worth or if they anti-select in joining the program. Carriers are also working more closely with providers of medical care to promote a proper balance between sound treatment and cost effectiveness.

In one version of hospital utilization reviews, the carrier contracts with an independent review organization to certify in advance of **hospital** admission the medical necessity of hospitalization and the indicated length of stay. The reviewing physician works with the attending physician and may certify a longer confinement in the event of complications. The key to such a program is obtaining co-operation of the local hospitals and gaining the services of a suitable review organization.

Another way carriers can affect provider behavior is by developing profiles,not only of physicians but of hospitals. Providers who appear to be encouraging undue utilization may be influenced by discussions with the carrier or with major employers in their community.

Professional claim investigation also helps to contain costs. This service includes the careful enforcement of co-ordination-of-benefits provisions, an objective determination of reasonable and customary price levels, and courageously stepping into the sometimes murky waters of "medical necessity".

Finally, insurance companies have begun to connect their role as major lenders with their interest in health care cost containment. This may mean providing funds for hospital construction or expansion only where a clear-cut need exists.

In my general survey of cost containment activity, one area I have not touched on this morning is the numerous proposals for Federal legislation to solve the problem. The proposals range from those ostensibly designed to promote competition and consumer choice in the health care market, to those designed to do away with the free market for all practical purposes. Looking back to the 1959 discussion of spiraling medical care costs, I was struck by the similarity of concerns then and today. But in the current political environment it seems unlikely the private sector will be afforded another 21 years to solve the problem.

MR. DONEL KELLEY: Mr. Berry, you said earlier that you had forecast the rate of increase in medical costs to decrease until late in 1979 and then to increase. Would you be prepared to give us a forecast of the future now?

MR. BERRY: My best judgement at this time is that sometime in 1981 the trends will start to decrease. I reserve the right to revise that statement if something else happens to the rate of inflation.

MR. WILLIAM CUNNINGHAM: Are you referring to utilization or cost inflation when you speak of trends?

MR. BERRY: We have begun to look at trends as a composite. We hypothesize that physicians in particular have learned that they can increase their income either through increasing their charges or through performing more service. Since there is considerable pressure on them to moderate the increase in their charges they have turned increasingly to performing more services. Therefore we feel that the underlying economic inflation is at the root of both types of increase.

MR. ROBERT PEBLY: Has anyone seen any evidence that the hospitals are raising their rates for ancillary services faster than their room and board rates

as a means of achieving rate increases without attracting too much publicity?

MR. CUNNINGHAM: Pacific Mutual has conducted some studies comparing the first half of 1980 with the first half of 1979. We break our business into three groups based on size. Our study indicated that the room and board and the ancillary charges increased equally.

MR. GARY D. MCDONALD: At Occidental Life we have had much the same experience.

MR. BERRY: In examining experience rating systems we have observed that there are serious problems of equity by size, because of competitive pressures. The smaller the group the greater its surplus contribution to the point where I believe that a number of companies get their entire contribution to surplus from the smaller groups. This bothers me because the public, our small group clients, are eventually going to decide that we have overpriced our product and they will be right. We are not asking the larger groups to pay their way.

MR. CUNNINGHAM: Mr. Berry in your modeling what allowance do you make for geographical differences?

MR. BERRY: Much of our work is with local Blue Cross and Blue Shield plans however even locally there are significant differences which we will reflect whenever we can measure them. In the work that I have done on groups across the country it is apparent that there are significant differences in both the timing and the amount of increase by geographic area. Some areas are just getting ready to take off.

MR. RICHARD H. BURD: What would have been a good pricing strategy 12 months ago, given the rising trends we have seen?

MR. BERRY: I have found, in getting into this subject, that it becomes confidential very quickly. One way of preparing is to soften your position in the market early so that you can toughen it later. Rate positioning is the key. Decide when you want to be aggressive in the market place and when you do not.