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Considerations for HMOs Entering the Small-Group and Individual Markets

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Summary: This session focuses on the HMOs setting their sights on the small employer and individual market. Panelists present various considerations that an HMO should be aware of regarding marketing, underwriting, and pricing of these products. Specifically panelists address:

- *A better understanding of the need to coordinate rating and underwriting procedures for small-group and individual business;*
- *An appreciation of the antiselection differences among the large group, small-group, and individual markets;*
- *Knowledge of the different rating structures and underwriting approaches used for each market.*

Mr. Henry W. Frantz, III: This is an open forum, not a panel discussion, which means that it's up to you in the audience to keep us going. We are merely the actuaries with the best seats! Gentlemen, please introduce yourselves to the audience.

Mr. Michael D. Bahr: I'm the assistant vice president and chief actuary with Intermountain Health Care (IHC). It's a 22-hospital, 2,000-contract, hospital owned

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provider health plan. We insure about half a million people in Utah, Idaho, and Wyoming, and we lease or self-fund another half a million.

Mr. James R. Swenson: I'm senior vice president and chief actuary for Group Health, Inc. We're located in New York, New York. We are organized under the same chapter of the insurance code as the Blues are in New York. We are not an HMO, which may seem ironic. I was, however, employed by IHC so I can claim some legitimacy to having some HMO experience. In addition, I can take some credit for muddying the waters as I was a regulator from 1987 to 1991 and served on the NAIC task force that created the first small-group reform model that limited, if you will, some of the rating activities that were taking place in the sense of the more aggressive tiering that was engaged in by a few companies.

Mr. Frantz: I'm currently with Coopers & Lybrand in Atlanta. Prior to that I was an actuary with John Alden Life Insurance Company, where I was responsible for many of the western states keeping products up to date that were hopefully attractive to the market and the regulators as well. I currently have an HMO client in an eastern state, Tennessee, as well as a PPO-type client in Florida.

Why bother with the small-group market? Market size is certainly a consideration. There's a perception that you can get into this market easier than some other markets. Wrong. You may have a competitive advantage either over other HMOs or certainly over PPO plans. That's basically topic 1: Why bother? I think we can organize all of the topics we want to talk about in terms of what are the challenges that a company needs to meet if they enter this market.

I've grouped them into three categories: market size, market access, and competitive advantage versus indemnity plans. The marketplace itself has certain characteristics. I'm thinking in terms of sales and marketing, insurance company requirements, and insurance compliance requirements. That, of course, means HMOs as well, and we've had sessions here in Maui dealing with various aspects of that.

Going to the first topic, Why bother? market size is a consideration. Table 1 features excerpts from Table 27.1 in the Employee Benefit Research Institute (EBRI) data book that you can purchase for $10 from the SOA. It's just chock-full of information. It is a listing of workers age 18 to 64 in 1995, and how these workers were covered or not covered by health care. You can see at the top that I start with self-employed, and then I have several categories of group size and a subtotal for the under-100 employees market. Unfortunately, the government doesn't do its statistics along Health Insurance Portability and Accountability Act (HIPAA) reporting lines. If you look at the column entitled "Covered Under Own Name,"

the subtotal for small group is 19.8 million workers. If you go to the left, you can see that that's out of 54.1 million workers. So, there's a relatively low coverage there for employees. Dropping down to 100 and up, the percentage increases significantly with 38.4 million covered out of 57.4 million workers. In terms of potential market there are just about as many workers in the small-group market (if you define small as up to 99) as there are in 100 and up, but in terms of participation the percentage is quite small with the large-group market being perhaps twice the size of the small-group market.

TABLE 1
MILLIONS OF EEs COVERED
BY FIRM SIZE – 1995
TABLE 27.1, EBRI DATABOOK

	Total Workers	**Total Covered**	**Covered: Own Name**	**Covered: As Dependent**
Self-Employed	12	6	3	3
Under 10	15.4	7.8	4	3.8
10-24	11.3	6.9	4.4	2.5
25-99	16.4	11	8.4	2.6
Subtotal	54.1	31.7	19.8	11.9
100 & Up	57.4	46.3	38.4	7.9
Total	111.5	78	58.2	19.8

I discovered in further preparation for this meeting that these are 1995 numbers. 1991 numbers are very significant in that between 1991 and 1995 all of these market segments went up. There were more workers in 1995 than there were in 1991. More people were covered in each category. A greater percentage of people were covered in each category. Because I tend to think primarily in terms of small group, not having individual policy clients at the moment, I left off the individual market. Let me just read a couple numbers to you. In 1995, there were 8.1 million workers covered with "other" private insurance. That means private insurance other than employer-based insurance. If you go to 1991, there were 11 million. So there was a drop in 5 years of 11 million to 8.1 million. Hopefully somebody will come forth with the reasons for that.

To summarize, why bother? The market is too big to ignore. The second point would be that a new HMO really doesn't have access to much of the commercial market, other than small companies. You might get lucky and get one or two large employers in year one, but then you're on your own, and you have to address your ability to access this market.

Here are some characteristics of the marketplace. Everybody's heard a lot of these before. Price, price, price. Agents, agents, and more agents. You may get by with

dealing with a handful of people to get business written for you if you're not in these markets, but if you want to write in these markets, you have to figure out how you are going to write with enough agents and the right agents to put business on the books? In any HMO or insurance operation claims is certainly a high volume activity, but in the small-group and individual market just quoting is a high volume activity. So, you need to invest money in systems to do quotes, to keep track of quotes, and to keep track of agents. Finally, since everyone needs to have some of the action here, there'd be lots of competitors, at least in the group market. It's my understanding that there are now fewer individual market competitors than there were five years ago, perhaps even more now that HIPAA's in place.

Insurance compliance requirements. As I indicated, there are a number of sessions that deal with lots of these issues. If I had known that quotes from 1960s and 1970s rock groups were going to be in vogue during this meeting, I would have had another Bob Dylan quote: "You don't need to be a weatherman to know which way the wind blows." You don't need to be an actuary to know that there are some states where you will not be profitable, in my humble opinion. Maybe this would be a good time to come up with some real-life examples. Basically, these are all areas that are regulated by the states. We had a session on risk sharing this morning. There was nothing much under market conduct, but it's typical that you cannot reward an agent based on the profitability of a piece of business. There's nothing that says you can't reward your marketing people for writing good business. But there are a lot of fine lines you have to walk, and each state is somewhat different.

Policyholder behavior is key to writing this business effectively, at least knowing what that behavior is. It's my understanding that in the individual market lapse rates are very high. What does that mean? In the small-group market it's my understanding that if you can write 1% a month lapse rates you're doing pretty decently— maybe a little worse than that when you're needing lots of rate increases; better than that when things are fairly stable. As you might guess, you're going to get some antiselection. You can measure the antiselection in a variety of ways. Two keys are the benefit cost variation by duration and benefit cost by group size in the small employer market.

Table 2 shows variation by duration and small-group medical insurance claims that appeared in *Transactions* (TSA) 1991 through 1992. What this does is express the relative claim cost with duration year two equal to 1.00. You can see that claim costs in the first year are on the order of 30% below what they will be in the second year. It goes up significantly thereafter. This time period is not only a pre-HIPAA environment, it's a pre-NAIC model, pre-1990s environment. So, underwriting was done with great focus. Rating was pretty much up to each company to rate their

business. There was not much in the way of regulation. The question is, if that's how it looked with underwriting, does it look significantly different in a guaranteed issue environment?

TABLE 2
SMALL GROUP CLAIMS COST
BY DURATION (CIRCA 1988-89)

Duration Year	SMALL GROUP SIZE 1	2-4	5-9	10-14	15-25	1-25
1	0.65	0.65	0.69	0.71	0.81	0.89
2	1.00	1.00	1.00	1.00	1.00	1.00
3	1.10	1.17	1.10	1.25	1.25	1.16
4	1.02	1.11	1.15	1.18	1.43	1.15
5	1.29	1.26	1.30	1.34	1.06	1.27
6	1.30	1.27	1.34	1.17	1.37	1.29
7	1.32	1.28	1.24	1.27	1.40	1.28

Table 3 shows the small-group claims cost by duration, by group size. If you look at the right-hand column, that's all 1.00. All of the costs are expressed in terms of the average for the 1 to 25 category, and you'll notice there's a dip for reasons not fully explained to me by anyone anywhere. The 5 through 9 employee size category has the best experience, whereas the smallest groups were in the worst category. At this point I'd like to ask Mike if he would step up here and go through some updated information based on what he's seen in Utah in a guaranteed issue environment.

TABLE 3
SMALL GROUP CLAIMS COST
BY SIZE (CIRCA 1988-89)

Duration Year	SMALL GROUP SIZE 1	2-4	5-9	10-14	15-25	1-25
1	1.05	0.95	0.95	1.04	1.18	1.00
2	1.12	1.01	0.95	1.01	1.01	1.00
3	1.07	1.02	0.90	1.09	1.09	1.00
4	1.00	0.98	0.95	1.04	1.26	1.00
5	1.14	1.00	0.97	1.07	0.85	1.00
6	1.13	0.99	0.99	0.91	1.07	1.00
7	1.15	1.00	0.92	1.00	1.10	1.00
1-7	1.13	1.01	0.94	0.96	1.06	1.00

Mr. Bahr: Let me give you a little background on Utah first because the idea of this is things for HMOs to watch out for if you're entering the small-group market. Utah had absolutely nothing but full medical underwriting up until January 1996. You could exclude employees. You could exclude conditions. It was basically the 1990

version of small group. They're a little behind the times there. What I'm going to do is go through some of the things that changed between 1995 and 1997 based on that, the things that we've identified, and the reasons for those changes. We won't be able to give you some of them because we still don't know.

Basically, this is our total medical expense per member per month (PMPM) for small employer. (E.g., approximately $58, $53, $60, upper $60s and $77+PMPM at 4/94, 4/95, 4/96, 4/97, and 4/98 respectively). The state legislation was very similar to HIPAA, except it had caps in it to the maximum uninsurables a carrier would have to take. They decided to eliminate those for the 1997 year because of the passage of HIPAA. Our medical expenses shot up dramatically. Because the state had full medical underwriting we found that two things occurred with our health plans. Because we are a hospital-based HMO, we have 22 hospitals, and we function in most areas of the state that have populations of over 40,000 people. One of the things we found is that the selection or antiselection occurred dramatically with us. We got a disproportionate share of sick people, as well as the people who had been excluded coverage coming onto our plans. Those both affected our cost in a significant way.

Basically, the biggest increase was our inpatient medical expense, and there were two areas that drove that. One, because our company is a not-for-profit, they've always felt that part of community service is to deal with things such as transplants and some of the services that our competitors didn't cover. Once we got to where we could not exclude people, we got a lot of those.

Mr. Frantz: Mike, can you indicate what the dates are? The left-hand date is January 1995.

Mr. Bahr: Yes, that's correct. What you're seeing here is a graph from January 1995 to March 1998. If you go back prior to 1995, actually the trends were pretty flat. We had less than a 4% trend in small group from about 1993 on. So, that's what we're looking at inpatient. (E.g., $11–12 PMPM for 1995 and most of 1996, increasing to approximately $16 PMPM by 3/98). The other place where inpatient went up a lot was maternity. One of the issues we were faced with was as an HMO, a hospital company, and a physician division, you're always at odds as to what to cover and what not to cover and how effective to be in that coverage. The decision of the company for years has been to provide the highest quality coverage, and for that reason they've made the news with several of the top 100 hospitals in the nation. People who are sick have a tendency to select that plan. We also have the only pediatric medical center in the area. So, we have a tendency to get a disproportionate share of children with medical problems.

A lot of you have seen your pharmacy costs go up, but I doubt most of you have seen them go up this much. (E.g., $7–8 PMPM for much of 1994-1995, $8–9 PMPM by 4/96, $10–11 PMPM by 4/97, $12–13 PMPM by 4/98). We had some pretty rich pharmacy benefits on our small employer plans. When you look at the PMPM numbers, and you relate them back to your lines of business, keep in mind that in Utah you have a lot of children. It's a rural state, and the religious background there results in a higher than average number of kids per household. Anyone who's rated a plan with one rate for three or more kids is aware of that. So, the PMPM is a little bit lower than what you would see. If you look at it on a per-employee basis, it's pretty competitive to what the other areas have. What we found in the past is our pharmacy plans have done very well. When HIPAA took effect, without knowing how much antiselection we would get we raised all the plans equally. The pharmacy costs went up much more than we expected, and because the pharmacy attracted a sicker population, the inpatient on the pharmacy also went up more than we had anticipated.

The same thing applies to the medical loss ratio by group size,. (E.g, for groups with 2-25 employees, loss ratios were in the 70–80% range for 1995, and the 100–130% range for 1997, with the 2–5 size category having the worst loss ratio.) When the state law took effect, which basically resembled HIPAA, a couple things happened. We had to treat our 2 to 50 groups the same as the rest of you did, and what we found is by raising everything evenly our smaller groups got a disproportionate share of the adverse risk. That only makes sense when you think about it because in a group of 20 employees, if you have a couple of very sick employees, you can rate the group up 10–15% and you're going to do ok. On the groups of 2 to 6 you can rate them to the maximum, and you're still going to lose money. That's what we found happened here. We're not doing nearly as well in small group as we were doing before. That's why when I was asked to talk about this my first question was, why would anybody want to write small group?

We also have three different panels. We have a large panel PPO. A medium-panel HMO has about 2,000 physicians. A small-panel HMO is around 1,000 physicians. If you look at those three panels, the antiselection also seemed to trend toward the larger PPO, which, again, is what you would expect in a health-care industry. If you have heart problems, you're going to select a plan that has your cardiologist and gives you the most choice. We saw that occur dramatically on the Health Choice product, which we no longer sell in small group, in 1997. That's carried over into 1998. We've had a couple of companies that have opted to pull out of the small-group business in Utah, and we tend to draw a disproportionate share of their sick employer groups as well.

Here is a loss ratio by deductible graph. The deductibles are $100, $250, $1,000, $1,500, $2,000, and $3,000. If you look at those loss ratios, you can see how well we priced them prior to 1996. (E.g., for 1995 loss ratios were in the upper 70% to low 80% range. For 1997, loss ratios were significantly higher (upper 80% and up) for deductibles through $1,000, and significantly lower (30+% to 50+% range) for higher deductible plans.) Our 1995 loss ratios were pretty consistent. Again, we raised the rates the same for all the deductibles as a percentage, and you can see what happened on the lower deductibles, and I think again that's expected. Something else that occurred is we had some groups that prior to the law change were trying to debate whether we should take them or not, and we decided, ok, we'll insure you. You're a borderline group. Rather than turn you away, we'll take you, but you'll have to take a $2,000 deductible plan. As soon as the law changed, those groups flocked to the lower benefit plans, so you can see we're doing real well on the higher deductibles, and we need to sell more of that.

This is our claims distribution. Basically, it's claims greater than $30,000 by year. From 1994 to 1998, those went up dramatically. (Approximately 4, 4, 3, 5.5 and 6.5 per 100,000 for 1994, 1995, 1996, 1997, and 1998, respectively). The biggest part of those were preemies, infants, and transplants. We took a lot of women who were pregnant that we could no longer exclude and the transplants because of the carrier. We had the facilities in the area that were theoretically good at transplants. We basically got a disproportionate share of those, and that has continued to this day. We had, for example, on our block of business about 18 leukemia transplants last year, and in the first quarter we had 13 alone. So, we've got some real concerns in our small group. As a health plan we're doing great, but with our small employer product, which consists of about 120,000 members, we're going to lose $10 million this year. We need to figure out if an HMO that has a physician area focused on quality can actually survive in a small-group market where the antiselection occurs.

Mr. Peter G. Hendee: The first few tables you showed us were fairly steep and had not leveled off by the current date. Your later tables show that your richer plans are really getting blasted. Are you in a death spiral? Is that what you see?

Mr. Bahr: No, we've intentionally avoided that. We like to think we're smarter than that. We'd rather lose it. Instead of all in three years, we'll lose a lot every year forever. Actually, we got hurt when a couple of carriers elected to pull out of the state. Our hope is we've done a lot of things with the legislature to prevent groups from moving to us when they need care to try and get them to make that intelligent decision. As I stated in one of the other meetings, we got some laws passed. One of them allows us to surcharge the groups 25% of a year's premium if they move off-anniversary. That's not enough to help us. Right now

what you see here has actually started leveling off a little bit in 1998. It's leveling off from an 18% to a 10% increase. We got a very bad risk mix from them, as well as a couple other carriers that have left the state.

From the Floor: Are you going to continue to subsidize the richer plans with the higher deductible plans?

Mr. Bahr: No, we've already gotten rid of the $100 deductible for 1998. We've gotten rid of the large panel PPO in small group for 1998. We've stripped down some of the choices the member has. We had some optional plans out there. What we really did is put ourselves in a great position in a medically underwritten market to provide the employers choice. In a guaranteed issue market that's a real disadvantage, so we've gotten rid of a lot of the plans that we had out there. The other thing we've changed is we had a richer pharmacy benefit than our competitors when we were medically underwriting. We've now gone to a pharmacy benefit similar to theirs.

Mr. Brian G. Small: I understand you have guaranteed issue. What about the rates? Can you rate up based on health status, and have you used that at all to encourage better groups and to discourage riskier groups?

Mr. Bahr: For our state we have a plus or minus 30%, and we've used every inch of it. Those of you that aren't aware, that'll come out to an 85.6% rate-up from your lowest rate, and we've used even the 0.6%. Also, we pay the broker the same. Again, if the group gets rated up, then they don't get the 85% of their commission on top increased as well. So, they're getting pretty much a flat commission for the group. On top of that we, as a company, have tried to start marketing more directly for the small-group and individual products.

From the Floor: Sounds like you've done about everything you could think of doing.

Mr. Bahr: Well, that's not what I want to hear you guys tell me.

Ms. Leslie F. Peters: In January 1996 when all these changes went into effect, what was the impact as far as the number of people covered? Did it address the uninsured problem in Utah or did it open the floodgates to people you previously excluded?

Mr. Bahr: The first year and a half we tracked it for the state and the groups that have insurance coverage. For every ten members they added, two of them did not have coverage before. So it did improve the coverage. The problem we've run into

is some groups just decided to drop out of the market because the cost went up so much. From the hospital side one of the advantages of being a system with a hospital is that we found that the groups on the hospital side, when we looked at the payer, our self-pay, or uninsured member payments, went from 3.2% in 1994 to 7.4% in 1998. So, either they are electing not to have coverage and deciding to fund it themselves or they don't have the availability of coverage.

From the Floor: Is it the general perception that other plans had the same results as IHC in the Utah market? Did it raise the average cost of health insurance in the state or was that something that was particular to your plan?

Mr. Bahr: Because of the antiselection we got hit a little harder than most, but with the exception of United Healthcare all of the carriers had an increase of around 20% over the 2 years, and United Healthcare, as I understood it, was about 13–14%. There were a few things they were doing prior to that. They would exclude the group as opposed to exclude a member of the group. When the law changed they didn't have to take the people on who they did not take originally. So, there were some things they were able to do differently.

From the Floor: Thank you.

Mr. Frantz: Other questions? I have one. Are you able to rate by group size outside the plus and minus 30% or is that included in the plus or minus 30%?

Mr. Bahr: We cannot rate outside of group size. The plus or minus 30% goes up through groups of 50.

Mr. Frantz: Any other questions about this Utah data? Anyone like to share their knowledge of what has happened in other states in the way of what happened to the market when guaranteed issue went in, either small group or individual? We haven't heard anything on the individual side yet. I looked at a United Healthcare filing, and the small-group market was getting well in excess of a 100% loss ratio, whereas it improved as you went up in size. Florida has even more stringent rating restrictions. You cannot vary at all. It's an adjusted community rating state where you can adjust for objective characteristics but not for health conditions.

Mr. Swenson: I do have some comments to make about the New York market, which is, I think, a somewhat unique market. I believe that health care is local, and, second, the regulatory environment or the environment that you have from a perspective of the law is very important. In New York, from an HMO's perspective, there was a tremendous advantage for HMOs to enter the New York market prior to 1996. HMOs were permitted to negotiate with the hospitals,

whereas other carriers, Blues included, were not permitted to negotiate with the hospitals but paid a state-regulated rate. The rates that the HMOs were able to negotiate were typically 10–20% below the rates that other carriers were paying. It's somewhat ironic. I likened it a bit from the perspective of a regulatory environment or public policy environment, as we're not-for-profit organized as the Blues, as to why regulation would permit an out-of-state, for-profit HMO to come in and negotiate more favorable rates than your local not-for-profit plans. I likened it to the New York Giants telling the Dallas Cowboys that they had five downs in which to make a first down rather than four, but be that as it may, in 1996 the laws were changed.

All carriers were then permitted to negotiate rates, and, in addition, there were a couple of taxes that were imposed on carriers to help fund pools to foster, if you will, the hospital environment. One of the pools covered compensated care. The other pool covered graduate medical education. In New York City, graduate medical education is a huge business. The tax that was imposed on all carriers, including HMOs, in New York City was about $130 per head per year. You can see that there was a very hefty tax that was imposed. Previously, HMOs were able to negotiate themselves out of that type of funding for graduate medical education which was implicit in the state-regulated rate, but beginning in 1996 they had to begin to pay that as well.

There was one additional but significant change made in 1996 where HMOs were required to issue a comprehensive individual policy on a guaranteed issue basis. Incidentally, New York State is a pure community-rate law state as well. Everyone pays the same rate for a particular plan, irrespective of age. This comprehensive individual product permitted Empire Blue Cross/Blue Shield to discontinue underwriting a very large block of business, which under the take-all-comers provisions, had created tremendous losses for that plan. When those plans or programs were required to be underwritten by the HMOs that business went to many of those HMOs and, as a consequence, it spread the cost of those very high-cost individuals more equitably, and, in fact, I think has helped to contribute to one of the large notable carrier's financial problems of the last several months.

There are a couple of risk adjustment pools in New York that don't work perfectly. One was a demographic adjuster. That is being phased out. The demographic adjuster, frankly, probably worked well except for the HMO's quid pro quo for agreeing to accept, if you will, on an individual basis the underwriting of this very comprehensive product, which was the phase out of the demographic pools. HMOs tended to have a younger population, and they were, in essence, contributors to the HMOs. My company and I think many of the Blue plans probably were net recipients from those programs.

Again, there are some revisions that are likely to take place with respect to the risk adjustment pools, but if you're going to have a guaranteed issue pure community rate market, it's very important that you have a very effective risk mechanism to reward those carriers that get a worse-than-average risk mix. I certainly endorse the efforts of the state to try to improve those pools. They are not there yet, but I believe that there are some modifications that are likely to take place. And, again, from the perspective of the HMOs I think the better those risk adjustment mechanisms work, the more adverse will be the effect on the HMOs, with the exception of, I think, some of the HMOs that have been in business for a considerable period of time and perhaps have some of the adverse risks that have accumulated over the years. Those are my general comments. Each state I think is unique. I don't envy the task of any national carrier trying to operate in each of the states, but I think that certainly, if you're considering New York, there have been opportunities in the past. I think the gap, if you will, is narrowing.

Mr. James E. Carter: I have a comment. I just wanted to briefly share our experience with small group and guaranteed issue. As you probably know, in July 1993, we went to guaranteed issue in California. We have about 500,000 people in the small-group market, and besides—the change we had to make in our policies to conform with the requirement that everybody have the same benefits, there was the break at 15 lives, we basically did not change our rates for small group, and we went to guaranteed issue in July. Our experience is probably about 1% of our market is actually guaranteed issue, so there has not been a major impact. Our experience has been pretty much the same before and after. In other words, we noticed no real big negative impact, and I think part of our decision to maintain the rates was to make sure that we held our existing market.

Mr. Frantz: These were the rates for what product line?

Mr. Carter: For small group when we went to guaranteed issue in July 1993. Our experience before and after that has been consistent. The only changes we made were to comply with the changes in the law. The changes for HIPAA last year were not a significant change. We have raised the rates since then, but the rates have experienced, I think, nominal increases about 5%. Our experience with guaranteed issue, even though we've fought that along the way, has actually been extremely good. In other words, we have noticed no market disruption. Generally in California the rates got more competitive after small-group reform.

Mr. Frantz: How much does your company take advantage of the rating flexibility that California law allows?

Mr. Carter: Well, as you know, in July it went to a plus or minus 10%. It used to be plus or minus 20%. Initially, we went to having most of our best rates at the low end, and over a period of time we actually moved most of our business to the middle of that rating band. We take full advantage of the rate spread, and we think that makes a big difference. We see not as much difference between first year and renewal as we used to see before we got guaranteed issue, but we definitely see an impact from our underwriting.

Mr. Frantz: How do your benefits compare to your competitor's? Are they better? worse? about the same?

Mr. Carter: We introduced in January 1996 all copay plans in our PPO, so we have a fairly unique product. No one else has done that in the California market, so that plan design has allowed us to build marketshare. On the HMO side, because our major competitor is Kaiser, they're going to correct that situation. Basically, our plan designs are unique at this standpoint, so, that gives us a competitive advantage.

Mr. Bahr: I think one of the things that helped you there was you had, at least as I understand what you said, the majority of your groups moving to the middle of your bands when the law took effect. For us, we had about 90% of our groups at the low end of the band when we were medically underwriting. Shortly thereafter, of course, as we had more and more uninsurable groups coming in, we got a higher percentage at the high end.

From the Floor: You've been asking questions about the individual marketplace, and I thought I'd mention a couple things. First of all, you characterized the individual marketplace as one where people are in between group coverage. They will have pretty high lapse rates because as soon as somebody in their family can obtain group coverage, they're going to immediately lapse their individual coverage. You exhibited statistics that showed the individual marketplace has been narrowing and the group market has been increasing. That is a related event, that more individuals are being able to obtain coverage through their employers, and that's the reason for the shrinking of the individual marketplace. With respect to guaranteed issue under HIPAA, there are several different mechanisms that require a guaranteed issue in the individual marketplace. When you look at the federal fall back states where you're required to guarantee issue a couple of plans, to date we have not seen a lot of these individuals coming to us with HIPAA eligibility. It comes out to about 0.5%.

Mr. Frantz: I didn't get your company name.

From the Floor: Unicare.

Mr. Frantz: Thank you. Other questions? We still haven't heard anything about states that require a guaranteed issue of a substantial amount of their individual product business. I know that when Idaho went to guaranteed issue of basic and standard plans, the ink wasn't dry on the legislation before we were out of the market, but we were not strong in managed care at the time. Are there players in the individual market in those states? There are about a dozen of them. What is the situation in New York?

Mr. Swenson: In New York I think you find that probably a lot of the commercial indemnity carriers have managed to move out of the market. The HMOs, as I indicated, are required to offer this comprehensive individual product, and, in fact, that product is probably creating a tremendous loss for a number of those HMOs. Two of the major carriers asked for rate increases under those products exceeding 50% this year. This year, incidentally, in New York is an election year. So, you can imagine what happened to those rate increase requests. In all seriousness there were some surpluses that had accumulated under these risk adjustment pools. Those surpluses are going to be distributed this year among the carriers, and the word back to the carriers was that those are to be used to offset rate increase requests for products under the community rating type law. There is a provision under New York law that does permit a rate increase of up to 10% per year on a file-and-use type basis, which is more or less automatic. I think that's probably what will happen to those rate increase requests, but, again, in the individual market there is only limited product availability. It's a very comprehensive product. I think the state's going to have to figure out some way of helping to underwrite that product because, as it is, statewide it is probably a very poor risk, and I think that's going to be a major public policy issue that the state will have to face up to in the next couple of years.

Mr. Harry L. Sutton, Jr.: Just a word about Minnesota. Our uninsurable pool is the fallback for HIPAA. They've issued seven policies since HIPAA took effect, and the federal government is, of course, clamping down on administrative regulation of the training of agents and in some states forcing you to pay commissions on conversions and so on in order to improve the access to the people who are going to spend a lot of money. I have a question for the speakers. As I'm a little bit familiar with New York, I was interested in Utah. How many states' insurance departments and legislatures understand the problems they put all the carriers through when they change this? Most of them come up with data that disprove that you have a problem.

Mr. Frantz: Can we have a show of hands of those state legislatures that understand the problem?

Mr. Bahr: Let me give you a little feedback on that at least from my state. I work with the legislature quite a bit, and I was assigned by the Utah Health Insurance Association to try to kill a couple bills that were up there in committee. So I was in the committee meeting with them, and there was a lady who wanted to vote for the bill who was one of the state senators. She wanted to support the bill because it would only add 3% to the cost, according to our estimates, and all those people who run insurance companies make gobs of money anyway. The foundation for the decision really had nothing to do with whether it was needed or a necessary change. It had to do with what their interpretation or impression of what their constituents wanted regardless of the cost. In our state it's kind of a cycle. Right now they're really worried because they realize that because of some of the things they've done, such as the individual law they passed in Utah, all of the carriers with volume, except for two, pulled out of the state. We were one of the two that did not. So, again, I'm demonstrating our intelligence. They realized that they've created something that they now have to try to fix on the other side with the legislation, so what they've really done is create a lot of confusion among the carriers. A portion of them have very little understanding of what the impact is of what they've done. Some of them still have not even faced up to the fact that the state law that was passed for 1996 affected the cost.

Mr. Swenson: I would like to respond to that question from the perspective of when I was a regulator. I believe around 1989 the first model law that limited some of the more abusive rating practices was adopted by the NAIC as a model. I brought that back to the State of Oregon to have them adopt that regulation. Most of the Health Insurance Association of America (HIAA) was supportive of the direction because it still permitted, I think, a fair amount of rating activity and underwriting activity, but it did place some limits, if you will, on some of the very aggressive tier and durational rating that was taking place. While I brought that back with all good intention to the legislature, it was subsequently and significantly modified by the legislature so that it would more tightly restrict the ability to rate, if you will, according to the experience of the underlying groups. To the extent that that type of activity takes place, it took place in large part because there were consumer advocates in Oregon's relatively liberal state who were advocating pure community rating. What ended up was more or less a compromise. The legislative process is not a pretty process, if you will, and we as actuaries can look at different public policy issues and share different perspectives than perhaps some of the consumer advocates, but in the legislative process I think the legislators are hearing from a wide variety of interests, and they're going to adopt what they think best suits the constituents' needs, not always having the full force of facts. And I have to say that I think that I had a relatively good rapport with our state legislature when those modifications to the law took place.

Ms. Susan E. Pierce: I just want to talk a little bit about what happened in Massachusetts. We recently passed an individual insurance law, and I can certainly say that the legislative process was very similar to what Jim was saying. The other thing about the legislative process is that there are deadlines, and a lot of times there are compromises made at the very last minute. These compromises tend to conflict sometimes with other pieces of the law, so you have contradictions in the law. There are some things that usually have to be ironed out, but I wanted to mention that in Massachusetts one of the things that they did in the law to keep companies from dropping out of the individual market is to tie the individual market to the small-group market. So, any carriers that had small-group coverage of more than 5,000 lives had to participate in the individual market. That actually increased the market in Massachusetts.

Mr. Frantz: Interesting. Other comments?

Mr. Bahr: The State of Utah was going to do that same provision, but because I actually objected to it, pointing out that you couldn't make anybody sell individual insurance unless you legislated how they pay commission, they decided not to. As it turns out, that was probably a mistake on my part, but they actually were going down that road initially.

Mr. Frantz: Well, we've spent some time talking about the external environment and heard a few solutions about adjusting rates and making use of the full flexibility that your state allows. Now we can get into some of the nonfinancial aspects of coping with small-group reform, HIPAA, individual reform. Teamwork must exist among four important components in an insurance or HMO organization: marketing, underwriting, compliance, and actuarial. It's actually best thought of as a pyramid, with each component on a vertex of the pyramid, and whatever audience you're trying to address, you tilt the pyramid and put them on the top of it. Here we have actuarial and marketing.

Mr. Frantz: We could tilt marketing and put it up at the top, but, seriously, a lot of teamwork has to take place. That just makes good business sense. And if you are going to certify compliance in the small-group market, you have to put yourself in the thick of things to know what is happening. I'm referring to *Actuarial Standard of Practice No. 26* which details some of the things you need to consider to certify compliance. Merely having filed rates that meet the test won't do it. If the agents are selling things that are out of compliance, your company's out of compliance even if you as an actuary filed something that was in compliance.

Mr. Bahr: Could I say something there on the marketing and sales side? If you're an HMO and you're getting into the small-group market, try not to look aggressively

for fast enrollment because those are the companies in our state that have really failed. They've targeted a certain number of 30,000 members a year or something, so they've tried to design benefits and have aggressive rates to get there, but they're in and out in four years because it just doesn't work. Try to go slow and make sure you know what works and what doesn't work and what kind of risk you're going to get.

Mr. Frantz: I mentioned the teamwork aspect. To me, teamwork and a lot of other management ideas were pretty much academic concepts until I actually got involved in helping deliver a small employer product. You really have to be a team. You must have frequent communication among all of the people in that pyramid and then some. The only way to have frequent communication in a busy professional life is if it's scheduled, although some of it can be spontaneous. All of the communication needs to be supportive. Especially when small-group reform first started, everyone was inventing the way that their company should respond. Companies that aren't in that market yet have the advantage of tapping into experiences that have been obtained in other companies such as the ones represented here, and I urge you to talk with your colleagues who have gone through that.

Moving on to the marketing piece of the teamwork, I don't know how John Alden would have complied with as many states it was operating in three or four years ago if their marketing force had not become compliance experts. Although their job was marketing, they understood right off the bat that if they were going to market properly, they had to understand the regulatory aspect of this.

From the Floor: I have a question along these lines. One of the things that we struggle with is the consistency requirements in the state small-group regulations. What I'm wondering is if under HIPAA companies are gathering more information in states where there's a rating band, and you still have to rate consistently, are companies gathering more information so that their model can be more sophisticated so that they can rate up those groups?

Mr. Frantz: It's good question. Is there a rational basis for rate-up? Is that what you're asking?

From the Floor: Well, I know in some of the states that we work in we have increased the number of factors that we include in our model so that we have the ability to get these groups up to the top of the band where maybe before we didn't have enough factors to actually bump them up, but now that they're guaranteed issue we want to get them up there.

Mr. Frantz: Ok. Anybody want to respond to that? The small-group laws or the individual group laws have a laundry list of the factors that you can use, and those have to be applied consistently. Some of them are labeled "case characteristics," such as demographics, gender, or what-have-you. Usually, if you're in a state that allows any variation those can be used with impunity to raise rates up or down. Outside of that you have bands where you can adjust the rate for conditions revealed in an underwriting process, and I guess that has to be consistent too. Are you asking if companies are tracking their reasons for adjusting the band within the band?

From the Floor: Well, really what type of factors companies are using. We've added what I would call more traditionally subjective factors in some states to our small-group models that we use within the band to be able to increase or decrease rates. So, for example, if a group has COBRA participants in it, then maybe we would rate up or down based on the percentage of COBRA in the group. Things that weren't traditionally case characteristic factors we're now using to increase or decrease rate.

Mr. Frantz: You're taking advantage of the flexibility of the band in a state that allows you to vary.

From the Floor: I'm curious if other companies are doing similar things to that or if they're just increasing the rates up to the top of the band if the experience looks bad or—

Mr. Frantz: I see help coming, on the way here.

Ms. Karen Bender: I work for William M. Mercer, but in a previous life I worked for Employer's Health, which is now Humana. They're probably one of the largest underwriters of small group in the country, and they do it very, very successfully. I think the success to small group is not only initial underwriting but renewal underwriting. You can't just write these groups once. You can't just use your medical underwriting or your experience underwriting once because you're in competition with companies that have very sophisticated renewal systems that are enabling them essentially to re-underwrite these groups at the renewal process employing their claim information. You need to set up what I would call consistency or at least what I used to certify as being consistent. You have to have an underwriting manual. Either you use the debit system or some underwriting discretion. There has to be some objective criteria. And I don't think any of the laws preclude underwriting judgment as long as it's within a reasonable band. I can't over emphasize how important it is in small group to have renewal underwriting.

Mr. Bahr: We do the full questionnaire stuff initially. When the group renews we look three months before they renew at the diagnosis with the group, so we use the claims history as opposed to medical questionnaires. Would you consider that renewal underwriting?

From the Floor: Yes, I consider that renewal underwriting, and, in addition to that, you might incorporate the loss ratio experience, although loss ratio experience probably is not the best indicator, but it may be an indicator. You'd be surprised how many companies spend a lot of money, time, and effort doing initial underwriting, but then they don't have the systems in place to be able to do the renewal underwriting, and that can be disastrous in the small-group market.

Mr. Bahr: Yes. By that same token one of the things that we found is when groups renew, if you have minimum contribution or participation levels, you'd be amazed at how many don't meet them anymore.

From the Floor: You mean you send out a survey three months before to determine their participation? Is that what you mean?

Mr. Bahr: Actually, we audit their payroll records not of every group, just of groups that we're concerned with.

From the Floor: I think now with HIPAA it's even more important. Oh, you don't do it with every group? I didn't hear that.

Mr. Bahr: We don't base it on the medical experience, though.

From the Floor: But I think it's even more important now with HIPAA that companies do enforce the provisions of their contracts. That does mean minimum participation. A lot of companies, when they were using the full-force medical underwriting waived participation requirements because they were underwriting every individual in the group. It didn't matter to them, but now when you're in guaranteed issue and guaranteed renewal, I think you have to take full advantage. In your question regarding consistency you need to set up a criteria, and you need to apply that criteria consistently among all groups, but that does not preclude you from incorporating medical conditions as well as loss-ratio experience, whatever your criteria is.

Mr. Steven P. Clay: Although previously I worked for American Medical Security which wrote small-group business in 38 states, I certainly agree with everything that Karen is saying, particularly with regard to renewal underwriting and trying to in some way check participation upon renewal. I firmly believe there is a big game

being played out there to take people from small-group policies and to get them onto individual so that the small group can have a lower rate, but that's probably another whole story. In regard to the consistency issue of small-group certification there are a number of issues that come to my mind. The first is that every state, of course, has its own law, and you have to get into that law. Does the law say that you may only use age and gender as case characteristics or can you use any other objective criteria that the company deems reasonable by its experience? There are states that go both ways. In certifying compliance I think it's important that you set up reporting structures. Age and gender is a very easy one. The underwriter doesn't have a choice on how to assign the rate. The information on the subscriber gets put into the computer, and the computer assigns the rate. It's system driven. It's not driven by human judgment. So, whenever possible, in order to achieve the consistency that the law is calling for, it's put into a structure that can be monitored with your computer system.

Mr. Bahr: You mentioned a lot of games being played out there, and the first thing that caught my mind was how this children's health plan will affect people in different states based on how they structure it because in our state the way it's set up it's very easy for people to move dependents one place or the other based on their health needs, for those of you who haven't considered that.

Mr. Talmage: I have a question. Someone brought up the issue about auditing on the participation. How would you be able to do that in a kosher way, to actually look at the company's payrolls?

Mr. Bahr: How we do it is we actually know what the premium is, so if you get payroll records, you can usually tell what's being deducted from the employee's pay, so we actually go in and audit it on a percentage of the groups. It's not based on their health status. I don't want to make this sound like we go in and audit 30% of the groups, but if we have groups when we initially underwrite them that are very close to our minimums in either one, we will look at that. For participation it's really easy because right there you know how many employees are getting paid. For the payroll, as far as the contribution level, it gets a little more difficult, but we have found a couple. It's an area that we have a lot of concern with because we have a lot of groups that seem to meet it at one point in time when they're applying for coverage, and then they don't later on.

Mr. Swenson: In New York it may seem ironic that you can do renewal underwriting since there's only one rate, but you can make certain that the individuals who are covered under the plans are legitimate employees. We will secure WT4Bs, which is one of the indexes of employment, if you will, and require that the group, in essence, be requalified and that we'll audit randomly a select

number of groups, but we'll also try to requalify. That is permitted under New York law.

Mr. Talmage: So there wouldn't be any problems for someone like the insurer to go to the employer to actually audit the payroll then.

Mr. Swenson: That is correct. It is done.

Mr. Frantz: Let me summarize what I think I've been hearing, and that is you have to be darned sure that you're only insuring employees, that they meet all of your eligibility criteria. You need to audit the books every now and then in some way, either a sample or what-have-you. The point was made that you can't audit just the ones that have high loss ratios. You need to have some objective way of doing it. Maybe if enrollment went up or down too much, then you'd trigger an audit, or you can do everything.

Mr. Carter: I have a question, but I also have some comments. We have about 800,000 people in the individual market, and we built our small group out of our individual philosophy, which means we don't have renewal underwriting. It also means we don't do things like composite rating, and that has worked for us. I'm not disagreeing that renewal underwriting probably isn't important, but it has not been necessary, and that kind of leads into my question. One of the problems that we have going from a PPO structure to an HMO structure is to get full advantage of the underwriting that you do in the individual market and to the HMO environment because of the capitations. We have a number of creative approaches we've tried with that. And I just wondered if anyone had any comments on how you take full advantage of the underwriting in an HMO environment where you have some kind of capitated arrangement.

Mr. Frantz: Any responses? Are there any more comments about underwriting techniques or looking at data, what-have-you? I think the description of the meeting indicated that there would be a rating example. I assume people want to see a rating example. Yes? Ok. That was marketing.

One bullet here I will mention. You need to invest in agent education if you're in a market where HMOs and their types of products aren't well-known. You need to have educated people selling your stuff. And invest in a good quote system. We've talked some about this already. Everyone has to understand why data are being requested. The marketing people have to understand that the agent has to understand it. The actuary has to understand that there are limits to the questions that you can ask for your rating practices. You need to be involved in all of this, what data gets selected, how it's used, etcetera. Compliance. We mentioned some

of this already. It's a collegial effort. The person who's labeled compliance officer is only one part of the picture. Everybody who has any function in a company has to understand how compliance affects them, certainly underwriters and marketing people particularly.

I've mentioned through this what the actuarial role is. We had not mentioned any particular rating structure. Obviously, that's a central task of our profession. And, in general, substitute group-specific facts for planwide impressions. If one PMPM fits all, then you have to do it, but if the state lets you be flexible, be flexible; otherwise, you're selling your company short by not taking advantage of every variable that the law allows. Do it on the basis of what the group demographics are.

Write on them, not on what you think your entire portfolio looks like. Obviously, use health status, if permitted. And the question was asked about how do you translate impressions into numbers? It's something that needs to evolve. Point systems are used. A variety of techniques. But, once again, underwriters, actuaries, and marketing people have to be in the same meeting to agree on the right thing to do.

You need to manage the rating process. You can't set rates and walk away. I didn't see that in the insurance companies I worked with, but some of my clients have the impression that if I file their rates, they don't need me anymore. I'm trying to disabuse them of that notion. You need to meet routinely with the team. I mentioned this earlier, but your product is a work-in-progress. You can agree on doing something, and something will go wrong in three months or you can see a better way to do it, maybe even a shorter time frame than that. Tables 4–6 are a rating example representing one of many ways that you can do this. If you're from an insurance company background, this is pretty routine stuff. If your only background is with a federally qualified HMO, then this should be new to you. What I'm suggesting here is that you have a plan that has 3 options, a high, medium, and low option, and a starting base rate of either $120, $105, or $95 PMPM. You're operating in three different service areas where, because of contracts or prevailing charges, prices are a little different, so, you'll need to adjust the plans, in this example, 3% downward in Area 2 and 11% downward in Area 3. Maybe it's not that simple. Instead of two vectors maybe you need a 3x3 PMPM rate matrix if the relationship between your plan and the discounts is pretty complex, but usually two vectors is enough. If you're rating an environment where your reimbursement is subject to provider prices that you have no control over, you need to build in a trend factor. Some companies do it monthly. Some do it quarterly. But something is needed.

A RATING EXAMPLE

TABLE 4

Plan Option	Base Rate PMPM	Service Area	Area Factor	Effective Date	Trend Factor
High	$120.00	1	1.00	3rd Q-98	1.00
Medium	$105.00	2	0.97	4th Q-98	1.02
Low	$ 95.00	3	0.89	1st Q-99	1.04
				2nd Q-99	1.06
				3rd Q-99	1.08

TABLE 5

Number of Employees	Size Factor	Underwriting Class	Underwriting Factor	Adjusted PMPM =
1	1.20	1	0.80	Base Rate x
2-5	1.10	2	0.90	Area Factor x
6-9	1.00	3	1.00	Trend Factor x
10-24	1.00	4	1.20	Size Factor x
25-49	0.95			Underwriting Factor

TABLE 6

Billing Rates	Adjusted PMPM x		Demographic Factors					
Employee Age Bracket	Single Employees		Employees with Spouse		Employees with Children		Employees with Family	
	Gender of Employee		Gender of Employee		Gender of Employee		Gender of Employee	
	Male	Female	Male	Female	Male	Female	Male	Female
1	$	$	$	$	$	$	$	$
2	$	$	$	$	$	$	$	$
3	$	$	$	$	$	$	$	$
4	$	$	$	$	$	$	$	$
5	$	$	$	$	$	$	$	$
6	$	$	$	$	$	$	$	$
7	$	$	$	$	$	$	$	$
8	$	$	$	$	$	$	$	$

If you're in a state that allows you to rate by group size, then I think we've seen enough examples indicating that you should take advantage of that. I'm assuming here that you can have reasonable variations in your rate based on group size. They ought to be supported by some sort of data, and abundant data exist. If you're in a state such as California that doesn't allow group size rating, then that would have to be folded into your plus or minus 10% variation that you're allowed from your manual rate. But in this example the manual rate includes an adjustment for the number of employees. And finally, we have, I'm assuming, a fairly simple structure where your best groups have a factor of 0.8. Your worst groups have a factor of 1.2, so you have a nice rate spread there. This presupposes some rules, a debit system or what-have-you, where an underwriter can routinely come up with some points or what-have-you to put the group in its rate class. Your next-to-last step is multiply all those things together and to get an adjusted PMPM.

Mr. Gordon R. Trapnell: What do you find in the states that allow you to vary rates by class, in addition to other factors? What kind of definitions do they use of class?

Mr. Frantz: The NAIC model law in many of its variations allows rating by class. Class has to be something pretty traumatic like a block of business you took over from another carrier. There are other situations where class is used.

Mr. Bahr: In our state, if it's marketed through a different distribution method or if it's an association, it would be a separate class, but you couldn't use things like health status, participation, or group size. So, it's pretty restrictive on what you can define as a class.

From the Floor: Negotiable with the insurance department?

Mr. Frantz: Well, you have to file it, and they have to approve it, of course.

Mr. Bahr: Right.

Mr. Frantz: But if you were allowed different classes, you would have several versions of this rating example, and the variation from one class to the next would be restricted by the state law. What we've done up to this point is adjust the PMPM. You need some way of exploding that rate into various demographic cells, which would allow you to finally obtain your billing rate. The equation up at the top of Table 6 is your billing rates, your adjusted PMPM times your demographic factors. I suggested eight age brackets. Some states allow you more; some don't. The bottom one is usually all employees under age x, with some teenage or 20ish x. You also need brackets to cover Medicare, primary, secondary, etcetera. In this example you have the option of rating employees differently from spouses. Male

employees are different from male spouses and female employees are different from female spouses, for a variety of reasons, including, I guess, coordination of benefits with other coverage. That's kind of a rapid-fire rate example.