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Session 5PD
The Future of Individual and Small Group Medical Insurance

Track: Health

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Summary: This session covers current and likely future issues relating to the health and viability of individual and small group medical insurance. This includes implications of market consolidation, regulatory issues and demographic trends. The impact of consumerism on this market and the potential decline of the larger group market is considered. The panel also addresses underwriting and profitability issues.

MR. WILLIAM F. BLUHM: My name is Bill Bluhm. I'm a consulting actuary with Milliman in Minneapolis. We're here to talk about the future of individual and small group medical insurance.. We're going to discuss what we think is going to happen. We're not allowed to decide what's going to happen today. So, there's no antitrust stuff going on.

We have three speakers—Jim Oatman, who's a senior VP and actuary with Fortis Health Jerry Winkelstein, who is a VP and actuary with Blue Cross of California and myself.

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I get to tell you what I think is going to happen. But part of what I'm going to do is update you on a task force that I'm involved with for the Academy that is trying to help the future on the individual market. So, first of all, I'm going to give you some of my perceptions. This isn't research-based stuff. I'm going to talk a little bit about the market and then tell you about this task force.

Current trends. There has been a lot of market consolidation. The market seems to have shrunk, but it seems to have pretty much stopped shrinking in my judgment. Dabblers largely seem to be gone in the commercial market, although they do appear now and then and sort of throw everything into a mess for a couple of years until they lose a bunch of money and go out of business. In my judgment, HMOs are likely to be the next group to be consolidated. I'm also seeing some regenerated interest by national carriers.

Demographic trends that everybody seems to be concerned about don't, in my perception, seem to be happening fast enough to have a lot of impact. The aging of society is happening at a quarter of a year's worth of age per year. So, it's going to take a couple of decades for the things to start really impacting us. We generally deal in shorter time frames.

Consumerism is the new fad. Some elements of it seem to work and some do not. Most of it seems to be elements that people are afraid might work. So you don't want to be left behind. The tiered networks and the network development, which I view as an element of consumerism, do seem to work sometimes. It's a strategy that has to be done right and in the right place.

Product development. There seems to be a lot of discussion about it. Everybody seems to want the products, which is great for consulting actuaries like me. I love to help my clients develop them, but nobody seems to be selling much of it. And there seems to be a lot of information development on the Web, and people are viewing the Web as the new way to educate and interact with recipients. It's my perception that there are people who readily adapt to the Web, and there are people who don't readily adapt to the Web. For those who do, you can communicate that way, and for those who don't, you can't. So, visions of transforming the universe, I think, have to wait until some of those people who aren't communicating that way get old enough that they're not involved anymore.

Underwriting and profitability. It seems like underwriting has largely stabilized. There is some movement forward in the predictive modeling area. So far it looks like most of the movement has been that people have learned to call their models predictive models. Risk adjusters are the beginning, but I do believe that's where we're going to see movement, better predictors and more sensible and sound uses of predictive modeling over time.

There are some regulatory issues that have to be addressed if we're going to have an impact on the future. I think Jerry's going to talk a little bit about the association

health plan issue. If the individual market was constructed in a way such that a regulation wasn't a problem, it could have been the answer to many of the issues that regulators have tried to deal with, such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It wouldn't have had to come if people had their own policies. They're automatically transportable. You go from place to place, and you just have a policy.

Anyway, one major impediment to solving that has been what the Academy's Rate Filing Task Force (RFTF) has tried to address. We've called it the closed-block problem. It's not just limited to closed blocks, but that sort of typifies what it is. The problem is having carriers who will issue a policy form for a couple of years, close it off, rate the heck out of it as the experience goes up and then open up a new block and rate it at a select level. Once somebody does that, everybody else has to do it, at least to some extent, because you can't afford not to. The only alternative is to subsidize older risk with the newer risks, and you can't afford to do that and be competitive at the same time. So that was the problem behind the small group regulatory problem that led to small group reform in the first place, and now it's starting to be addressed on the individual piece.

So, this task force was formed at the request of the NAIC originally to update and rewrite the model rate filing guidelines, which is an NAIC model that's available to the states to use to regulate individual A&H rates for major medical type coverages. The group's focus quickly changed to solving the closed-block problem and that stopped the rewrite in its tracks. We've spent three-and-a-half years now defining, modeling and trying to address the closed-block problem. I've gotten to know both of our other speakers a lot better along the way, and they're both involved in the same effort.

In doing that, we spent some time talking about everybody's favorite: the many solutions, of which there were many on how to solve for the closed-block problem. Then we tried to start categorizing them. Ultimately we've ended up with four categories of solution sets, and we have subgroups that are defining each of those four. This supermodel of a model takes consistent assumptions, methods and populations across and will model all of these solutions going forward. Here's how each of these models address or fail to address the public policy goals of the NAIC. For instance, the NAIC says rate increases shouldn't be too high. So, which of these methods produces rate increases that are not so high?

There are four models. Interblock subsidy consists of durational pooling and rate compression. With durational pooling, once you get beyond year n as an individual policyholder, you are thrown into a pool that is rated together. Rate compression, à la small group, says the highest rates and lowest rates can't differ from each other by more than some percentage after you've accounted for benefit differences. The third is prefunding. The fourth is called individual medical pool, which is a cross-company pooling mechanism. But within the individual market, once the rates get above a certain trigger level, people are thrown into a pool.

So we've all gone through a learning curve on this Excel. First it started taking longer and longer to go through e-mails, and then we zipped it. Then it took longer and longer to send the .zip file. Now we have a dedicated Web site on the Academy's server so that everybody on the committee can get it or deal with it on the server. So, it's pulling us by the neck and making us pay attention to that stuff.

The NAIC is supposed to take the results of this and make a decision. As the chairman of that group, I see my job as doing this in a way that makes the NAIC be accountable for some decisions. This rate filing guideline project was the first thing that I ever worked on for the Academy about 20 years ago, and it's now probably going to be the last thing I ever work on for the Academy. It never was adopted because they give it to the Academy, and the Academy does its stuff and gives it back. Then the NAIC says it doesn't like this or that, and the group doesn't have a group decision.

There isn't a process in place for them to agree as a group to go this way, so I viewed my job as trying to force that to happen. Fortunately, the NAIC conceptually agrees with that and is going to try to do that. So we're going to give our report on the results of the modeling. They're going to pick the model they want, and then they're going to give it back to us. Then we're going to take the one of those four that they've decided upon and try to draft a regulation around it that will implement it.

We're viewing this as an opportunity to try to make the mechanism work better and to try to build something into the regulation that will cause it to work better. One of those was a file-and-use rate for new products where the market is competitive. We have a philosophical agreement with the NAIC. The NAIC is OK with the concept that if the marketplace is competitive, and if we can give them a measure of that, they are willing to have it built into the regulation so they don't have to approve rates for new products that we thought might help solve the problem.

MR. JAMES E. OATMAN: I'm going to peer into the crystal ball and see what the future of individual medical insurance is going to look like. In fact, I think if you look at what I say, it's probably more like going inside the crystal ball and looking out. I believe that the fundamental changes that will occur in the individual and medical marketplace are largely going to be driven by changes that companies are going to put in place in terms of new capabilities they're going to bring to play in the individual market. That is because we've gone through a period of a fairly significant consolidation. A number of companies have been exiting over the last five years, and now I believe we're going to see an era of larger competitors that are much more capable than what we have seen in the past. They will bring a lot more to play. I'm going to walk you through the different kinds of skills that are required to be an individual medical player.

There are three different areas that I want to talk about. The first one is risk management. Data warehouses are the first area of risk management that I want to talk about. Risk management is important, of course, because individual medical is a very risky business. The second thing that I'd like to talk about is the whole area of consumer retail marketing. It is a retail product to consumers and has a lot of the aspects of what retailers would do in terms of developing their products. Thinking about it from that perspective is helpful. The third thing I'd like to talk a little bit about is distribution management. It is another key thing, partly because it's so hard to find the customers. About 7 percent of the population is buyers of individual medical. Therefore, having a lot of breadth to your distribution is a key element of being successful in the marketplace. Finally, I'm going to wrap up with a little bit of an overview of what those competitive dynamics are going to look like in the future.

First of all, in describing these skills I'm going to talk about them in terms of basic skills that I think are important if you want to survive. Then the next risk management skills that I think are important are what I call advanced skills. These are ones that more or less most of the leaders in the marketplace have today. And thirdly I will talk about expert skills that are very much evolutionary. Some of the leaders may have a few pieces of them they're beginning to develop, and I think this is where most of the action is going to take place in the future in terms of where the marketplace is going to end up going. Data, of course, is at the core of managing this business. Being able to have a lot of data captured, having it well organized and being able to deal with it is the key.

In terms of the basic skills that you need to have, I believe, first of all, that you have to have data around what's going on with sales. This includes everything from the time a piece of business is written to the time it is placed and put on the books. You're really examining what's happening with your producers and what's happening with your overall placement of new business. Are you attracting the right business? Are you getting it placed in force?

The next big database you need to have is one around product attributes, customer attributes, some of your intermediary attributes and premiums and claims. You must have a baseline database that allows you to manage and price your product portfolio. And then, finally, you need to have a fair amount of premium detail by each product feature and claims detail by service line so you can understand exactly where the claim's coming from. And I think that's a baseline opener.

Then, when you get into more advanced skills, you need to have the ability to track from a billed charge all the way through to a paid claim. That's mainly to help give you a good idea if you are purchasing health care at the right price, doing cost containment appropriately and adjudicating your claims properly. It will also help you understand if those items are being done consistently and in a way that you would expect.

The next advanced skill would be customized data marts for specific applications. Typically the organization of data for managing this business requires a fairly large data warehouse that is often too big to work with directly. So, you tend to want to create very specified data marts that are organized in a way that will allow you to manage each one of the functions of the business. So, you would have one for pricing; one to design products; one for renewals; one for underwriting risk management; one for claims risk management; one for provider relations, so you can understand what's going on with providers; and one by distributors, so you can look at your distribution-channel management. Having focused databases like this gives you much more flexibility in terms of drilling in and understanding what you're doing with the business.

There is also the expert skill, and this is getting into the leading edge of appending data from external sources. Often it is purchasing data, such as that you can get from MicroVision where you can segment the markets. You can go out and purchase other data on customers and append that to your database, capturing a lot of underwriting detail and getting more and more automated in your underwriting area. Being able to capture all of that detail allows you to do feedback loops on the effectiveness of your underwriting, capturing in your call center the details of each customer transaction. When they call in, if you have a good system that allows your customer service representatives to point and click, you can capture all that data.

Learn what your customers are asking for, what they're telling you about themselves, and then use that data to get a much deeper understanding of what their future behavior might be. Also, you should get detailed information from targeted outbound customer interactions. Ultimately, if you want to do a good job of managing this business, you need to be calling out to your customers, getting a deeper understanding of who they are, and then using that information to better manage the business.

All of this costs a lot of money, and I've seen people spend $10 to $25 million from start to finish on databases and building this kind of data capability, and sometimes quite a bit more than that. By the time you build all of this data capability to manage the business, there is more scale to the business than there used to be.

Data analytic capability. Now that you've got all the data, what are you going to do with it? The baseline skills are to be able to scrub it, validate it and make sure it's accurate before you use it. There's a set of baseline transformational adjustments you have to do to make sure you're not making mistakes about the way you're managing the business. That would be things like pooling of large claims, doing seasonal adjustments, adjusting your monthly data for working days, unleveling your premium adjustments so you've got a consistent view of loss ratios, coming up with expected values for claims and expenses and building those into your databases. And that gives you a baseline tracking mechanism for your business.

Then, as you get more advanced with your skills, you start looking for things that are early warning indicators. The individual marketplace is rampant with anti-selection problems, fraud and abuse, and very early on you want to be able to have detection systems in place to catch those problems. To the extent that you've got them automated, you're in much better shape, and automated detection tools are now being developed by a lot of people. Instead of having to look through numerous reports and find key variances, you have an automated system of searching at different levels of variables. Sometimes you'll do a one-variable analysis, a two-variable analysis or a three-variable analysis to get a detailed picture of where things are going awry.

Expert skills involve using more advanced statistical analysis to identify the leading indicators. This is done by using systems of credibility analysis and different types of multiple progression analysis to identify the key drivers of behavior. Often too many of the actuaries either don't have these skills or have long forgotten them, and we have to hire a lot of people with Ph.D.s in statistics and mathematics. –It would be nice if actuaries retained or had those kinds of skills, but often we have to go outside the actuarial realm for those skill sets.

Risk prediction. The first baseline skill is obviously with loss ratios, which most people use. Diagnosis typically comes next, and often some form of diagnosis grouping. Then, as you get more advanced, you put things into episode groups and bring in the pharmaceutical data to use as your risk prediction. And as you get more and more expert, you start looking at longitudinal data. Longitudinal data is the kinds of changes that are taking place over time in somebody's health, such as changes in prescription patterns over time. If a person had a certain disease many years ago, you can look at the cycle of that disease and see how it operates over time. Some are more consistent, and some go into cyclical patterns, depending on the disease. So if you take a longitudinal approach, you can do a much better job of predicting at an individual level where claims are going. This approach will also help in developing models that will predict your lapsation, help you understand the drivers of that lapsation and help you understand what you can do to improve it.

Crafting offers. This is a very important skill set. Part of it is underwriting, but it's a little broader than that. Continually re-evaluate projected cost of pre-existing conditions and risk behaviors based on changing medical paradigms. Keep your underwriting manual up to date. Keep your underwriting guidelines current with current medical practices. You also want to introduce new risk variables and refine the calibration of your existing variables. You have to make clear decisions about what particular variables are important to price on, what ones you're going to change in underwriting and what ones you're going to do up front at point of sale.

To be more advanced in crafting offers, you have to take a much more holistic view of health, looking at all the different variables and how they integrate. What are the covariances among all the different risk factors? And then you integrate the

risk evaluation you've done into the different product offerings. In terms of individual medical we have a very broad product portfolio, so the correct underwriting decision often is contingent on the product that's being purchased. Matching the right offer with the right risk evaluation is very much a complicated science, especially if you've got a very broad product portfolio.

The expert skills get more into the area of renewal, although creating crafting offers at point of sale is a key piece. Moving your underwriting closer to the point of sale and crafting an offer there and not having to resell a counteroffer will considerably help you. Getting more and more automated with your underwriting and all of the analysis and data techniques that you've got, building that into a more automated tool and pushing it out closer to point of sale will significantly increase your placement rate. Getting the underwriting decision making out close to the point of sale is where, I think, a lot of the action is going to happen in the future.

At renewal I see more customization of renewal offers based on what the customers told you they want, and what you believe will be most acceptable to them at renewal. Instead of just offering one higher deductible, you put a lot of thought into the most appropriate thing for that customer at renewal in terms of the choices that they might make. You should also track their responses and develop a learning model around that. I also think some outbound renewal management things to hang onto your book of business are important to make sure it doesn't end up in a bad closed block.

Financial forecasting. A story was always told about actuaries that said they were the people that sat in the back seat, looked out the back window and drew a map. I can guarantee you that that approach to actuarial work won't work with individual medical. You have to have your nose firmly pressed against the windshield and be looking as far into the future as you can. Developing as many tools as you can to be able to forecast where you're going with your business is absolutely vital. Managing your business with a view to where it's going as opposed to where it's been is the most fundamental skill that's required to be successful. I think the first model that people typically build tend to be extrapolation models of past experience, and that will help you pick up on early changes and forecast them into the future.

As you get more advanced, you need to start doing a detailed analysis of the variables that are driving that behavior. What's causing the variances? You must be sure to introduce them into your modeling. You also need to analyze the interdependencies between those variables to enhance your predictive capability. A lot of time is spent trying to understand the best kinds of predictive models to determine where your book of business is going. I think the leaders are identifying things in their books of business six months sooner than a lot of other people, or the people that didn't survive, because of the fact that they had better prediction models.

Expert skills involve looking at the external environment, introducing those variables into your forecasting and combining those exogenous variables with the endogenous variables into a forecast that does a much better kind of a holistic economic forecast of where your business is going. I think that will be the next level of business management model forecasting used in order to be successful in this business.

The final point on risk management is one around shaping the regulatory and legislative environment. This is very critical because many state jurisdictions take an attitude and a view much more toward socializing of risk. I think our last speaker believed in socializing it all under one single payer. To the extent that you want to have a viable private marketplace, you basically need to have the principles of free market operating. You need to be very active on the legislative front, and in terms of shaping that legislation and the rules, you also need to be able to develop models then that will optimize within these legislative and regulatory constraints.

Consumer retail goods marketing. This is another area in which the insurance industry lags far behind many other businesses when it comes to consumer marketing and dealing with retail products. Quite frankly, we often have had to go outside of the insurance industry to the consumer-goods industry to find people that have these particular skills. The base skill is, first of all, doing focus groups with your customers. You have to do a little bit of segmentation first to try to figure out exactly what customer segments you are going to be working with. That helps you identify the things that are the most important to consumers and what they value in the product. You can then utilize that to develop an analytic tool called conjoin analysis. Some of you may have used that when you develop all the different test packages of products at different price points, give people forced choices and take it out and survey. That gives you a pretty good idea of how much value customers place on different aspects of the benefits. Effectively, that allows you to start merging the demand curve in with your cost curve in terms of building and pricing products.

The next skill set is one of segmenting customers, looking for groups of customers that have unique needs or differentiated purchasing behavior patterns. You want to try to identify which customers are going to be buying in a different way and behave differently after they purchase. That will help you in terms of designing appropriate products that you can move quickly to market. Developing products that are targeted to each one of those segments becomes the next kind of skill set that you need to have. Also, consumer goods manufacturers are very good at packaging products. Being able to take all the data that you've gotten from your research and build it into a particular product package that the customer can understand and that you can move through your distribution channels to market is much more efficient than it would be if you simply let your actuaries do all of the design.

Market testing new concepts. I think we often develop products based on field input and put them out into marketplace. Sometimes they work, and sometimes our intuition was not all that good. As you start to do more and more consumer research, you'll find your logic and your intuition about the marketplace isn't represented by the way the customer thinks. They think very differently, and you get a lot of surprises. That alone says that you need to do the consumer research, but you also need to do a lot of market testing to make sure your concept works so you don't have failures. You should deploy new concepts into a test environment, have a control group, evaluate your test results and then roll out your successful tests. You should keep learning from those that are failures. As you're operating in different marketplaces you're doing an awful lot of testing. That has become a byword for the way we manage the business. We do an incredible amount of testing of new concepts before we roll them out nationally.

Expanding the segment. This is an important consumer issue in that right now three out of four people that could potentially be in the individual marketplace are nonbuyers, or the uninsured, and one person is a buyer. So, nonparticipants outnumber the participants by nearly three to one, and that produces a couple challenges. You should develop products to make sure that your book of business doesn't end up uninsured with the next year's rate increase, and you'll retain them at the margin in the marketplace, as well as to attract new people into the segment. I think if we truly believe in free market, we, as an industry, must step up to this issue of trying to develop more attractive consumer products that will attract more people so there are fewer uninsured.

Any consumer retailer will tell you that the purchasing side of the equation is one of the most important aspects of running their business, and this is certainly very true of individual medical. Sometimes tiered networks work, and sometimes they don't. I think the more fundamental issue with health care purchasing is to recognize that it's very different from purchasing cost of goods sold in any other business. It's different in the sense it's very local. It's also different in the sense it's totally or largely unknown, and that's obviously our job as actuaries at point of sale. You don't know for that particular customer at point of sale what their cost of goods is going to be specifically.

Distribution channel management. Building different distribution channels is a core skill. I think in the past most of us had traditional brokerage marketing. Now we're seeing the development of outbound lead generation. Affinity relationships are becoming increasingly important. Inbound e-commerce, selling directly on the Internet and outbound direct to consumers through different techniques of going out and reaching consumers is key.

So what are all the competitive imperatives behind all of this? What does all of this mean in terms of the marketplace? I think critical mass will become an increasing critical success factor. Size will be necessary to build all of these capabilities. And brand identity, I believe, will be powerful in a retail consumer-driven marketplace. If

you can differentiate yourself with a brand and stand out, that will certainly be a key success factor and something you're going to be seeing more of in the individual markets. Strong distribution outlets will be critical to retail market success. You will have to let customers choose how they want to do business with you. In the past we said this is the way we reach customers. Now I think you have to look at it much more from the perspective of how does the customer want to come to you? To the extent things are moving to be more consumer driven, you need to look at their needs. And competitors of the future will be larger and better known.

We've gone through a phase where we've seen a lot of consolidation. I believe we're going to see some new entrants among some larger players, and I think we'll see a number of the HMOs try the individual marketplace as they try to take a more comprehensive view of the world. That will certainly change the dynamics. I haven't given you, necessarily, a very big picture of exactly what the marketplace looks like, but I can tell you that if you develop these kinds of skills and capabilities, you wouldn't have to worry a whole lot about what the future marketplace would look like because you'd have a lot of the skills to adapt to whatever the future might be.

MR. JEROME WINKELSTEIN: I'm the head actuary at Blue Cross California, and one of our most profitable products is our small group business. I think, in general, the future is pretty good for the small group business with one big question mark, and that's concerning the recent legislation or pending legislation of association health plans. I'm going to speak more on that later.

The state of the marketplace. Currently, almost all states have some degree of small group reform, and it varies a lot by state. Small group reform was put in place to prevent the cannibalistic pricing and underwriting practices that were happening in the market.

In the early '80s I had just joined John Alden Life as their first small group actuary. John Alden had made money in small group for about the last 10 years and was very profitable. I came in and looked at their experience and found that even though we were very profitable, our rates were getting less and less competitive in certain parts of the country. At this point in time you could underwrite, turn down groups and rate up groups. There were no restrictions by the states. We did a study, and found that we could get the equivalent of an 8 percent rate action by just dealing with the sickest 5 percent of the groups, and by sickest 5 percent I mean we did a pseudo or a predictive modeling-like study in which we looked at future continuing claims. So it wasn't just the high loss ratio that made for a bad group, it was also future claims from those groups. So we went out with very high rate actions. We actually doubled the rates plus the normal rate action.

So we went a 100 percent plus trend on a segment of business. The idea, insidious enough, was not to have the business stay with us at the higher rates but actually to drive it to our beloved competitors as a double whammy. This worked very,

very well for John Alden. By dealing with the lowest or the worst risky 5 percent of the business, we were able to keep our rates competitive for several years thereafter. However, the marketplace saw what we were doing, and other companies in the marketplace were probably doing similar things at the same time. We got to a very cannibalistic state where the sick groups had virtually no place to go.

The definition of small group differs by state. In most states it's considered to be up to 50 lives, but I know that in at least one state it's at 25 lives, and I'm sure there are other variations. There's a great variety in the restriction on rate compression and allowing the rate to vary by underwriting, and that's the guts of small group reform. In some states the community rating or actually the rating band you're allowed is plus or minus 0 percent effectively, or a very minor rate compression. In other states it's up to plus or minus 35 percent or more. So there's very little rate compression.

This also changed the impact of underwriting versus other things you could do. When you gave a very large rate band like plus or minus 35 percent, looking to underwrite the best risks and put them in a tier above or below your 0 percent rate is a very good competitive technique in order to gain the best profit. In California we're at a plus or minus 10 percent. So we're a very compressed—almost community rated. When that happens, the impact of underwriting is lessened. And the resultant impact on small group reform, again in Blue Cross's case of California, we find right now that when you rank our claim per month per member (PMPM) by level, small group is our highest claim PMPM, followed by large group, and individual is the lowest because we did a lot of underwriting in individual. It is benefit-adjusted, so I'm talking benefit neutral.

Strategies to win. What we do works for us in our environment in California. We carefully study our experience and plan and project. When we've acquired new companies, the actuaries would come to the old actuaries that are the California actuaries and ask when we do rating. It's like all of our time is taken up by planning and forecasting and comparing our actual results to the plan. We certainly emphasize forecasting and tracking against forecasts.

We do full-blown monthly financial and actuarial closes, and we study our business by plan. In small group we actually have, on purpose, limited our number of plan offerings to nine. We have seven PPOs and two HMOs. That way, when we do study one of the nine plans, we have a considerable amount of data, and it is statistically credible. We study it by geography. There are nine geographies mandated under California small group regulation. We study it in the employee versus dependent unit peers of dependent rating, age, gender, group size or risk-adjustment factor (RAF). The RAF is in the plus or minus 10 percent range. It probably wouldn't come as a surprise to you if I told you that a 1.1 is by far our highest loss ratio. Of course it is guaranteed issue, and we can't go any higher. I wish we had a 2 RAF. Maybe then it wouldn't be our highest anymore. We also

track our net income very, very carefully versus our target net income. We track it on a PMPM net income basis and on a percent of premium net income basis.

Projection model considerations. We spend a lot of time on modeling. We have our duration curve, so even though we are dealing with a guaranteed issue product, we find based on our own experience there is a duration curve on the claims PMPM cost. Business that's been with us one month, two months, three months, etc., has a rising duration. It's not as much as we see in our individual business, which we also track by duration, but there is durational consideration. It's probably because of groups coming to us that are willing to change their provider network. They're not quite sure how to use the system. And so they are somewhat healthier in the beginning, and that's something we do model. Anti-selective lapsation is important to model. Any time we give a rate action we see we get an uptick in lapses, and the groups that lapse are healthier than the groups that stay. We look at that and try to model it. We try to estimate what would happen to the anti-selective lapsation both in terms of lapses and claim cost increase of the remaining business, which are interlinked, at each rate action.

Rate guarantees. At times in some of our business lines we do give six-month and even 12-month rate guarantees. We usually do rate actions as of a point in time. So we'll raise the rates in August, but if a group that was written in March has a six-month rate guarantee, they're not going to come up for the rate action until September. That's something we want to model to see how the premium PMPM is going to flow in.

Leveraged claim trend. Leveraged claim trend is what it says. You have your claim trend, but you have deductibles and co-pays, so your actual rating trend will be somewhat above your contractual or baseline trend.

We have a philosophy, and this comes down from our president, Leonard Schaefer, that we're supposed to price right. This is a particularly important value in times when the underwriting cycle starts getting wild. At the top and the bottom of the underwriting cycle we have what is euphemistically called at WellPoint as the idiot of the month, and we have companies out there that underprice and overprice. They've made money, they've had a good quarter, so they try to buy business the next quarter because they think they're making money just because they're more intelligent than everybody else, and it's very, very difficult. The actuaries will typically say you have to have proper rate where the marketing force is saying, no, we're not going to sell any business.

I'm not saying we don't slip our rates a little bit, but we're careful that we're still making a profit. Even if we're making somewhat less profit, we try not to follow the marketplace and hope that our competitors get smart real fast. When people are underpricing, you want them to get smart and realize they are underpricing. When they're overpricing, you want them to stay stupid so you'll underprice them. But certainly having pricing discipline is a core function of what we do at WellPoint.

Develop competitor intelligence. We have a competitive unit within actuarial. I think a lot of companies do, and we track what our competitors do. We try to track after every rate increase or around every rate increase where we will be versus our competitors and when they're likely to increase based on past experience. We get market intelligence from the field. They give us information about what they think certain companies are doing out there. In California we really only have about three or four major competitors in both the individual and the small group side. So it's maybe a little easier to track the competition. When we do it we have a grid of rates by areas, competitor and product, and the marketing folks use this to change their marketing strategy.

So if they see the gray area, which is where we're more competitive, let's say in Health Net in a certain part of California, they will try to market that product in that region. They will alter their market strategy looking forward rather than just selling what they've always sold, which is easier said than done because people are creatures of habit. If they always sold the $2,500 deductible in Kern County, they may continue to sell it, but we're saying, no, you really want to sell the HMO there because that's where we're the most competitive.

Provider contracting. I think there are two key areas where I would attribute a lot of Blue Cross of California's success related to the actuaries. We have a lot of actuaries. My department consists of 54 associates, and that's one state. We have a lot of people. Several years ago there was a study done which positively correlated the profitability of insurance companies with their staff of actuaries. So, we have a lot of actuaries and, even better, the executives seem to listen to us most of the time.

The other thing we do is to have 21 out of that 54 people involved in provider contracting. We also have the provider contracting people report up through the chief actuary. The function of these people is to plan. They're constantly putting out a three-year plan of what fees we expect to increase over the next three years by provider, by hospital system and physician group. We do a lot of planning.

There are also the twists and turns of the negotiating process, which is a very unusual process. We may plan to increase a hospital group's fees by 10 percent. Then, they send their first shot across the bow, and they say they want a 50 percent rate action. And we kind of laugh at them and say, no, we're offering 5 percent. And the president of Blue Cross is going crazy. He thinks we're going to miss our plan by a lot on this group. But, as it turns out, we usually come out pretty close to what we planned it at. It's not as easy as it sounds because they don't tell us what they want as an increase. They give us a charge master, and we give them a charge master in return.

So the people in this unit are analyzing the charge masters to get at what the real increases are likely to be. This includes not only the per diems but also the items

outside a per diem that we call stop loss in which a per diem's charges exceed a threshold, it flips from per diems to a percent of charges. So it's a very important modeling that they do there. They're constantly modeling based on what their offer is to us and our return offer. As we get close to the time the contract has to be decided, everything starts getting very frantic. We're getting close to the termination date, and that's when both sides really have to start negotiating. They are very busy constantly modeling each addition of the provider fee process or the contracting process.

These people are actually involved in negotiation and sometimes even the key negotiation. They almost play good cop/bad cop. The key person involved in this that reports to me, is kind of the bad cop. The provider contracting people are making nice to the hospital, and she's saying we still have to go down 3 percent or they won't sign and they will terminate us. It's not unusual for the last day of a meeting to run 30 hours straight. They get tired of the process, so they basically sign the agreement and go home. It's very arduous work, but it's kind of exciting.

The last major thing they do is actuarial pricing. To me, this is the closest to a crystal ball we have. We have people that are not only telling us what's recently been concluded in negotiation but what's likely coming down the road in terms of planning. They're telling us what our base trend is likely to be on our most important items, which are physician fees and hospital fees. So, it enables us to price and predict the trend very accurately out there. This is the Blue Cross trend, and our trend could be different than other people's trend simply because we have very steep discounts in California. These discounts are steeper than our competitors, and so to some extent we may have a jump in trend that's higher than the general level in trend.

At the end we're still lower than our competitors. Nevertheless, our trend or our change may be different from what's happening in the marketplace. Of course we also have to put on utilization and all that stuff, but this is on the cost side. Another thing that provider contracting does is capitation settlements on the HMO. I consider somewhat minor in terms of impact of rating, but it's important to the process. We have a provider quality program, an incentive program, for PPO providers that is based on quality, and they calculate all those payments.

Proposed accountable health plan (AHP) regulations. I am on the Academy Subcommittee on AHP, and the House passed the AHP, 262 to 162. This was not a big shock because we felt that it was going to be hard to defeat it in the House. We feel that a much better area to defeat it is in the Senate where sometimes you have strange bedfellows in this business. Senator Kennedy, of all people, basically said that if it ever came to his subcommittee, or to the floor, he would filibuster it until it died. So he's very much anti-AHP.

Let me just read a letter. We sent the letter at the end of April to the House of Representatives, and we said that this letter presents the comments of the American Academy of Actuaries' Association Health Plan Work Group regarding the

AHP Act. We said that even though we support efforts to increase the availability, affordability and access of health insurance, as currently written, the bill will likely have unintended negative consequences that would hinder the intent of the legislation. One of the biggest negative consequences is that, in our opinion, it would create an unlevel playing field. Basically, a multistate AHP can be governed by the small group rate regulation of any state it chooses that it's involved in. It could pick one of these plus or minus 35 percent states, or there may be states out there that don't even have small group reform, and do business in any state.

So they could compete in California against Blue Cross of California where it's a plus or minus 10 percent, but they could be rating on plus or minus 35 percent. And we felt that this would cause cherry picking. It would cause adverse selection. It would also increase the cost for the sicker individuals because the healthier groups would tend to get the good rates, and the sick individuals would not. This act is almost like the people had forgotten what happened when you let different people or companies rate the way they want to be rated. Also, there was a risk of insolvency. We felt the insolvency regulations in the AHP Act were very unclear and were not stringent enough to prevent some of these AHPs from going the way of the multiple employer trusts (METs) of the early '80s, when there were a lot of insolvencies.

I have mixed views on this insolvency thing because if AHP regulation does pass and some of these AHPs go belly up, they might revise the act or make it stronger or repeal it. But it's a very important regulation from a small-group standpoint. It will really change the way Blue Cross of California would have to deal with small group. We have contingency plans in place, and we're creating other contingency plans. We're spending a lot of political capital. The Blue Cross/Blue Shield Association is spending political capital, and you typically only spend political capital on the stuff you really are concerned about. This is an issue we really, really are concerned about.

There are other regulatory issues in process or on the horizon. There are prompt-pay laws in several states, and this is something that will probably continue to expand rather than retract. These prompt-pay laws will probably cause fines and claims to increase. It also causes lag factors to get faster. So if you're a multistate company, and you have a prompt pay law in one of those states, you may find that the lag will be faster in that state. That's something actuaries have to recognize.

Predictive modeling. Like many other companies, we are looking at predictive modeling. We're looking at an encounter model a drug-only model. For HMOs you can only really use a drug-only model because we don't really capture the encounter data. And we're thinking strongly about using this to help with our RAF assignment. Much of it is between 0.9 and 1.1. Nevertheless, we want to do that as accurately as possible. One of the issues with predictive modeling, though, it is notoriously a poor predictor of really high claims. So it really can't tell if an individual

will get claims over 25,000 versus claims over 100,000. It would show the same risk for both individuals.

Composite rating. Blue Cross, California, does not composite rate. We list bill. We were getting a lot of pressure from our marketing people, particularly for larger accounts for which they say we need to composite rate. We need to have a rate that you're willing to guarantee for the whole group. If they add or subtract members, the rate can't change. We're investigating it. One of the issues is that most state regulation did not allow you to make any additional allowance for composite rating. Composite rating, even if everything works perfectly, misses an age change. So you are underrating somewhat with composite rating versus list bill, which will pick up on the rate change. We cannot load anything into our rates, and we're already restricted to a plus or minus 10 percent, so that's still something we're discussing and may or may not go ahead with.

The last thing I have is we're seeing mandate-free regulation. In order to keep insurance as affordable for some of the small groups that may forego insurance altogether or may have a much higher co-pay, it will allow them to do away with mandates. I think it has passed at least in a couple of states, according to my Unicare brethren who work in a lot more states than I do. This may be something else that's coming down, and, of course, that's hitting directly at the concern about the uninsured and underinsured people.

MR. CHARLES T. DOE: I'm with Aetna. I'm interested in your thoughts as to what you see as the best course of action to make sure that the AHP bill does not get enacted. One thought was attaching reserve requirements or other sorts of surplus requirements that might prohibit some of the AHPs from getting in, but I'd be interested in your thoughts.

MR. WINKELSTEIN: The Academy did issue the letter, and it was really not a wishy-washy letter. It said we are opposed to this. We didn't want to make it wishy-washy; they tend to pull comments out of context. So we are standing pretty firm on it. The legislative process in the United States is a very complex thing. Even if the AHP bill can't get passed, there's nothing to say that Congress won't append it to a completely unrelated bill that has a good chance of passing. So it's a difficult thing. WellPoint is doing a lot of lobbying. The Blue Cross Association is lobbying. There is a lot of concern, but at this point I've handed it over to our regulatory people at WellPoint, of which we have a major staff. The only thing that I am doing further on the actuarial side is developing contingency plans in case the worst comes to bear. We should develop a plan for what will we do to maintain market presence and a block of insurance.

MR. BLUHM: Does anybody here know who the players are? I don't. Who's behind it? Who's lining up on both sides of it?

MR. WINKELSTEIN: The Chamber of Commerce is very much for it. There's an agricultural association group in California called Western Growers that is very much a proponent of it. The bill says there will be caveats, or protections, placed into the bill that will prevent cherry picking, but they never say what they are. To pass a bill without those caveats in place, I think, is extremely dangerous.

MR. WILLIAM R. LANE: One of the big major players behind it is the National Federation of Independent Business (NFIB).

MS. JOAN P. OGDEN: I'm with Joan Ogden Actuaries in Salt Lake City, Utah. If I can continue the discussion on AHPs, there is a proposed change in the Internal Revenue Code, Section 419 and 419A, which for employer association groups where there are 10 or more employers participating would prohibit the deductibility of the health benefit costs as a business expense if any portion of the health cost or premium depended in any way on the actual or expected health claims experience of that particular employer. Now, the Internal Revenue Service has proposed this modification because of severe abuses in pools for life insurance, and when the issue with regard to health coverage was raised they said, tough, live with it. This would essentially invalidate not only AHPs across state lines, but also within a given state and employer associations where there is not a flat community rate. So you might take a look at that.