

## Americas: Managed Care

### A frontline perspective on 2011 pricing and product trends

#### A national perspective on the middle-market

On Nov. 10, 2010 we hosted our 8th annual conference call with middle-market employee benefit consultant Ken Ambos, featuring his frontline view of 2011 pricing and product trends. As background, Ken is a national employee benefit practice leader for Equity Risk Partners, a San Francisco-headquartered risk management and employee benefits consulting firm with a national scope of practice and a focus on the high-end of small group and middle-market employer segments, which we continue to see as the key bellwether for health insurance industry trends.

A transcript of the conference call is provided in the body of this report.

#### Strong price discipline following the 2006-2009 industry downcycle

Over the years, Ken and his colleagues have provided a quite valuable perspective to us in terms of spotting key inflection points, including major carrier service disruptions as well as turning points in the health insurance industry underwriting cycle (in particular, the shift from multi-year periods of intense price competition and margin erosion to recovery of price discipline and margin expansion).

With that backdrop, our call this year highlighted a strong bias to price discipline across most carriers and markets, consistent with what we expect given our view that 2010 marks the first year of recovery from the 4-year industry down-cycle (2006-9), with – for example – the Blue Cross plan margins hitting a 20-year low in 2009.

#### Higher pricing for 2011 partly reflects new health reform mandates

Conservatism in underwriting moving into 2011 is widespread. On average, carriers appear to be incorporating an additional 100-300 bp in pricing to reflect the expected impact from health reform mandates (e.g., preventive care, adult dependent coverage). With regard to the pending minimum medical loss ratio (MLR) thresholds, most carriers appear to be positioned for rebating surpluses as opposed to pricing lower to proactively achieve compliance with MLR floors. In this context, it appears that Coventry's recent public comments about pricing proactively below trend for books below the MLR threshold is an outlier. However, carriers are citing the MLR rules as a rationale to compress producer / broker commissions.

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## Overview: Summary of key takeaways from the call

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### Summary of key takeaways from our call

We have summarized our view of key takeaways from the conference call

**Is the health care reform legislation (ACA) impacting the behavior of buyers and/or sellers in the mid-sized employer health care plan space?**

Among buyers:

- No evidence of health reform being a catalyst for uptick in employers dropping coverage.
- Grandfathering provisions are being considered in plan design adjustment process, but ultimately net cost of coverage is trumping concerns over ACA compliance.

Among sellers / carriers:

- Pricing loads for new ACA mandates (e.g., preventive care, adult dependent coverage) are 1% - 3% on average.
- With regard to the pending minimum medical loss ratio (MLR) thresholds, most carriers appear to be pricing without regard to the MLR thresholds, apparently preferring to position for rebating surpluses versus pricing lower to proactively achieve compliance with MLR floors. In this context, it appears that Coventry's recent public comments about pricing proactively below trend for books below the MLR threshold is an outlier. However, carriers are citing the MLR rules as a rationale to compress producer / broker commissions.

**What is the overall level / intensity of price competition in the market?**

Generally, not very competitive. No evidence of carriers consistently favoring a market share-growth-oriented pricing strategy, despite a clear opportunity to do so.

**Are you seeing differences in new business vs. renewal underwriting?**

Not measurably so, beyond typical market dynamic of (initial) renewal underwriting being marginally more conservative than new business.

**How wide a range of price points between carriers? Have gaps narrowed?**

About the same as a year ago or perhaps a bit more narrow (when we observed competitive price points narrowing at that time). We see about a 7% to 10% spread between low and high quotes for comparable coverage.

**Any regional / geographic variances of note?**

Generally not. We see fairly consistent behaviors coast to coast. One outlier is Texas, where employers appear to be "getting hit harder" with rate increases reflecting a 3% to 5% excess variance to averages elsewhere.

**What are the ranges of health plan price increases you're seeing for late 2010 / early 2011 renewals? How do these compare with last year?**

Price increases on average are significantly higher relative to this time last year. Last year, we were seeing initial renewals in the +15% to +18% range that were negotiated and/or brought down to +9% to +13%.

Now, a year later, we are seeing initial renewals closer to the +17% to +22% range, with less movement off these numbers on negotiation, resulting in +14% to +18% net outcomes on average.

If we remove the high rate increase outliers (those groups getting 30-40% range renewals), then the average rate increases approximate the level of last year. However, there are a material number of these high rate "outliers" this year.

In general, we would characterize underwriting "discipline" as strong, consistent, and persistent. It seems only minor negotiated rate changes can be secured in most cases. Competitive alternative quotes are the main way to get relief, but in most cases the alternative price ranges from competitors are narrow.

We also observe that plan design buy-downs are not being afforded the same price decrement value as in prior recent years (as a hypothetical example, where an x% increase in co-pays might have cut the rate increase by 100 basis points last year, this year the same change produces a 50 bp cut in the rate increase).

**Has there been any notable change in the nature of buy-downs between plan design changes that increase employee expense when using the plan (e.g., higher employee cost-sharing for inpatient hospital admissions) versus employee premium contribution increases that impacts all covered employees?**

In general, we are seeing more movement on the employee contribution side, both due to near-exhaustion of typical coverage buy-down options and "grandfathering" considerations (but, again, net cost is trumping grandfathering concern for almost all employers in this segment).

**Are employee premium contribution changes tracking employers' cost escalation?**

Not uniformly; in many cases employers are absorbing a proportionally higher share of the increased premium costs (it was noted during the call that this observation is somewhat contrary to survey results pointing to more of the share being shouldered by employees).

**Have "consumer directed health" (CDH) plan designs continued to gain greater market share?**

Yes. CDH considerations factor into the fabric of every plan design discussion at all client size levels.

Whether it's high-deductible health plans (HDHPs) alone, or conjoined to a savings account vehicle (HRA/HSA), most employers either have one or are moving toward inclusion of one as an option.

CDH penetration has now reached over 30% of our clients and well over 10% of total covered lives (membership). Critical mass has been achieved!

However, a side point here is that we are seeing CDH plan renewal increases in excess of the rate increases on 'traditional' plan designs, which is the opposite of what we had observed until this year.

A factor appears to be employer funding of employee HRA/HSAs, which in effect appears to blunt the inhibition of utilization demand that would otherwise occur in a CDH plan (by fully funding employee HRA/HSAs, employers are turning CDH plans into virtual first-dollar coverage, or at least some carriers appear to be perceiving it that way).

**Besides price, what other criteria are employers using to choose between carriers?**

Price remains paramount. But after that, it is service (CDH capabilities as a component) and network.

Meanwhile, health and wellness is emerging as a bigger differentiating factor relative to prior years for carriers. There is growing sentiment that health and wellness may be “the last battleground” for viability of employer-sponsored health plans given that plan design/cost share changes can only do so much. Therefore, taking a more active role in impacting employee health remains a possible positive direction. Meanwhile, expansion of health engagement and wellness appears to be aided by the health reform legislation incentives for investment in wellness activities.

That said, some clients are increasingly looking to contract directly with independent specialty vendors versus using the ‘passive’ wellness tools baked into carrier offerings as employers seek to: (i) own their own health status data regardless of health plan in use, (ii) have a direct stake in the cost/outcomes ROI measurement, (iii) hold vendors accountable to measurable group health improvement standards, and (iv) facilitate greater acceptance by the workforce versus the inherently more cynical view of wellness programs sponsored by an insurance carrier.

**Have clients shown a greater willingness to move from carrier to carrier in 2010/2011 given the continuing difficult economy?**

No. The lack of compelling alternatives is more responsible for the dearth of carrier changes than a client’s reluctance to do so.

**Transcript of conference call (November 10, 2010)**

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**Matthew Borsch, Goldman Sachs:** Good afternoon everyone and thanks for joining us. I would like to introduce our guest expert for the call. This will be our eighth annual conference call with Ken Ambos for his frontline view of 2011 health plan pricing and product trends.

By way of introduction, Ken is the national employee benefit practice leader for Equity Risk Partners, a San Francisco headquartered risk management and employee benefits consulting firm with a national scope of practice and a focus on the middle market (and high-end of small group) employer segment.

I would also say that Equity Risk Partners consults on the placement, management and on-going administration of health plans across a diversified array of private equity investments that are geographically distributed.

This is a big reason why Equity Risk Partners has a national scope of practice and valuable related perspective they bring to their observations on trends here. So what we’ll do as we’ve done in prior years is I will walk Ken through a series of topical questions. I’m going to start on what is perhaps front of mind, health care reform.

Ken, what is the extent to which you’ve observed indications of health reform directly impacting the behavior of buyers and/or sellers in the middle market healthcare plan space?

**Ken Ambos, Equity Risk Partners:** Thanks Matt, and good afternoon everyone. We have seen impact of healthcare reform on the positioning of buyers and sellers in the mid-size market health space.

From a buyer’s standpoint (the employer group), we haven’t seen any evidence yet of this being a catalyst for employers dropping coverage.

That’s a general consideration Matt’s asked me about in the past, but again there hasn’t been observable connectivity of reform to groups cancelling coverage. However, it

certainly bears watching the closer we get to 2014, when some of the bigger reform elements such as state-level insurance exchanges and the like come to bear.

As a second element on the buyer side, grandfathering provisions in the reform regulations are being considered in many employers' go-forward health plan design decision process.

Whether or not to make plan design changes they might otherwise have absolutely gone for previously is being looked at relative to grandfathering trade-offs - is conserving the current plan design more sensible in the longer term than making near-term changes to save costs?

In the ultimate analysis, the mid-sized employer will almost invariably opt to curtail near-term cost of coverage vs. avoiding certain mandates associated with maintaining a grandfathered plan.

So, switching over to the seller's side (the insurance carrier market), pricing loads have been the most obvious manifestation of behavior change due to reform's advent. Generally, a 1% to 3% range of rate increment is being added to renewals explicitly for the new mandates that are included in the reform regulations. That's very tangible and clearly observable - the industry has not made any attempt to conceal this.

On a next level, the medical loss ratio (MLR) element insurers will be subject to in 2011 is a little more subtle, yet is likely to have significant impact on the carrier side that will manifest in pricing trends going forward.

Our overall observation is that almost all carriers are pricing without regard to MLR concerns to the extent that their positioning seems to be more "we'll worry about how to distribute surpluses if they occur", as opposed to pricing down to a tighter loss ratio in anticipation of avoiding that hassle.

Matt and I discussed Coventry's recent indication that in some instances they would consider target pricing below trend to avoid the buildup of surplus. From our vantage point that is clearly an outlier stance. The rest of the market has not shown any evidence of thinking that way.

A final observation relative to the MLR issue - it's a relative certainty at this point that the carrier community will begin to cite the MLR regs as a rationale to compress commissions that are built into the health plan products they offer.

I'll try to be as objective here as I can, given this could have significant potential impact on the revenue model for many businesses in our space...

Carriers taking this path could strain relationships with the current primary distribution system for the insurance industry's products - agents, brokers, consultants - that directly bring carrier products to the end buyer.

Will that ultimately enable a disintermediation of this function? Will it facilitate a shift toward a more direct distribution channel, such as state-level insurance exchanges? Could it erode the industry investment in benefits consulting, given margin shrinkage that may drain talent from this field?

These are all possible ramifications that should be assessed at this point in the grander scheme of things because it would appear such commission compression is coming relatively soon.

Just a quick anecdote along those lines: the idea of a broker dis-intermediated process brings to light a recent example where a client had not used an intermediary to help manage their health plan for a number of years.

We had opportunity to review their situation and found significant evidence of misalignment of the financial arrangements in place. The most vivid example of that was the client's reliance on the carrier's development of equivalency rates in a self-funded environment that ultimately proved to be considerably off the mark.

This triggered under-projection of the client's ultimate health plan costs vs. budget, with their employee contributions being lower than intended and their COBRA rates being insufficient.

Perhaps as a “commercial” for the profession I represent, I relate this story to affirm there are real reasons to have a professional advisor act as “middle man” in aligning the carrier’s objectives and actions with the needs and expectations of the client.

**Borsch:** That’s great, Ken. Can you characterize using a baseball analogy - what inning do you think we’re in with regard to carriers taking action on whatever they’re going to do on broker commissions? Is it still early stage or are we sort of midway in that process?

**Ambos:** I would say we’re past the third inning, but not at the seventh inning stretch yet.

**Borsch:** Got it.

**Ambos:** Where it will have the biggest impact is in the smaller group market, which is generally driven by an agency system where health benefits are not always a primary focus.

To get lower margins out of doing business, where agents get kicked in the head, a lot would seem to be leading down a path where they will be less inclined to do that type of work going forward.

**Borsch:** Absolutely, and certainly unbundling tends to bring greater price sensitivity and fear of that would be understandable. I can say that from the standpoint of an equity research analyst.

Okay, moving along here, Ken. The question that I ask every year, which is important here: can you characterize the overall level of competition in the current market?

**Ambos:** Sure. It’s not very competitive. We’ve seen no evidence of any players consistently demonstrating a market share growth oriented price strategy, despite what might appear to be a fairly clear opportunity for a player to jump into that void.

The only sure-fire avenue (particularly in the smaller end of the market) to secure any kind of improved pricing outcomes is to provide evidence of competitive market alternatives, which, in light of what I just said, makes it kind of a catch-22 situation.

**Borsch:** Can you characterize any differences you might be seeing in new business versus renewal underwriting?

**Ambos:** Nothing material. Other than the typical market dynamic of initial renewal underwriting being more conservative than new business – but even on that front, it’s tightened up.

**Borsch:** What about the range of price points between carriers? Have you seen gaps narrow?

**Ambos:** We have seen gaps narrow marginally, relative to last year when we highlighted that the gap was already moving toward a tighter pack mentality.

In a typical bidding situation, we’ve seen a 7%-10% spread between high and low price points, with the occasional outlier; but it’s increasingly rare to see extraordinary outliers, certainly on the low end. You’ll get your outliers mainly on the high end of that range for sure.

**Borsch:** Just so I understand the 7%-10%, you mean that if the low carrier is bidding 100, that the high carrier might be 107 or 110?

**Ambos:** That’s right.

**Borsch:** Alright, can you talk about any regional or geographic variances that stand out?

**Ambos:** In general, we’re not really seeing significant variance. There’s been fairly consistent conservative behavior coast to coast, but our national purview allows us to see some pockets where developments are more extreme.

For example, Texas – I think we mentioned that territory last year as well – but Texas clients are getting hit harder by a factor of about 3%-5% in excess variance to averages we’re seeing elsewhere across the country.

**Borsch:** Very interesting. If I could just ask a sub-question on that: it seemed like for a few years there Texas was getting somewhat lower trends so maybe there’s a little catch up going on.

**Ambos:** Could be, but our sense is that it is more an extreme amount of conservatism being exhibited compared to other parts of the country; not so much a look back or a recapture scenario.

**Borsch:** Moving on to the level of health plan price increases, can you talk about the ranges that you're seeing for late 2010 and early 2011 renewals and how you think these compare with prior years?

**Ambos:** There's little question from our point of view that the averages are materially higher than they were this time last year, when we were experiencing initial renewals in the +15% to +18% range that were brought down to an average of +9% to +13% through negotiations and plan buy-downs.

What we're seeing in the current cycle is numbers closer to +17% to +22% increases on the initial go-round, then less movement off those numbers through negotiation and buy-downs, resulting in +14% to +18% net outcomes on average.

There have been some more extreme outliers on the high end that range. If we were to normalize for those, we might say that the average rate of increases is tracking relatively close to last year.

However, the number of those outliers where we've seen 'hard to rationalize' renewal increases of +30% to +40%, even over +50% for mid-sized companies, have dragged that average upward.

As a follow on to those statistics, a couple of points I'd like to make, surrounding the fact that underwriting discipline has clearly been strong, consistent and persistent.

Minor negotiated rate changes are really all one can hope for in today's environment, unless we're able to point out some blatant calculation errors in the process of a client's experience rated renewal (which does happen, and we jump on that every time!).

Absent those types of errors, there's a pretty hard line out there. Competitive alternative quotes are the only things that have demonstrated a consistent ability to move an incumbent off their renewal terms.

The problem is, in light of the lack of competitive pressures out there, those types of opportunities are pretty hard to come by.

Lastly, relative to plan design buy-downs that employers have historically used to chip away at renewals that they had difficulty absorbing –we're finding that the decrement pricing in this year's renewal cycle is not up to the levels it has been in years past.

**Borsch:** Great. That leads right into the next question, which is on the topic of plan design vs. cost share adjustments.

Have you seen a notable change in the nature or scope of buy-downs between plan design changes that increase employee expense when using the plan versus employee contribution increases that impact the total?

**Ambos:** We're seeing a bit more movement on the employee cost share side of the spectrum, both due to the near exhaustion of typical coverage buy-down options and the grandfathering considerations we touched on earlier.

I'll again mention that the net cost issue trumps any concern about grandfathering at the end of the day for most employers in this segment.

Overall, the typical buy-downs, like increased deductibles, co-pays, et cetera are still out there for those employers that haven't gone to the well completely on that front.

However, they're getting lesser price reduction value for them.

I'll add, though, that the employee contribution changes aren't uniformly tracking with the employer's gross cost of increase. We're seeing that because of the size of these increases. Many smaller employers are almost by default absorbing a proportionally higher share of those increased costs.

**Borsch:** Well, that's an interesting observation. I must say, we're hearing inconsistent feedback on that front, with the New York Times article today talking about some employer segments, at least the larger employers, seeing the opposite, where employees appear to be bearing all of the brunt of rate increases.

You would say that for the employers that you're representing, it's more the employers who are bearing it?

**Ambos:** Well, at a minimum, Matt, I'm comfortable saying it's proportional. It's certainly not being foisted fully on the employees in our book of business.

Put in the context of the more price-sensitive smaller employer being hit hard by increases in prior years, which they have largely asked employees to bear the majority while essentially freezing wages, further piling on this year would simply not fly.

Many feel they're hitting a wall where employees just can't afford much more, to the point where they've got little to no disposable income left.

**Borsch:** Yes, absolutely. Have you seen the consumer directed health plan designs continue to gain greater market share?

**Ambos:** There's no question, Matt, that it's become the norm to have consumer-directed discussions in the fabric of every plan design and renewal conversation with clients.

Whether it's a high deductible health plan alone, or if it's conjoined to a savings account vehicle like an HRA or HSA, most employers either have such a plan in place or are moving toward the inclusion of one as an option to their more traditional PPO style plans.

To put it in perspective, year over year we've tried to track CDH uptake on our little sampling book of business. Conservatively, well over 30% of our clients have some form of a consumer directed plan and the membership in those plans is exceeding 10% by a considerable margin.

We've used those kinds of numbers as the signifier of critical mass. I think we can stop having that conversation.

**Borsch:** Yes.

**Ambos:** An observation, though, that bears watching relative to consumer plans: now that we've had several years of client experience with CDHPs, particularly those who have done it on a full replacement basis, we are generally seeing renewal rate increases in excess of trend and in excess of the more traditional PPO style plans that they replaced.

Needless to say, this is somewhat of a perplexing issue for the plan sponsor...

The carrier market is suggesting that the phenomenon is being driven by the employers who took a consumer directed approach to access the deep discounts on the high deductible plan versus typical PPO rates, but then went back and handed a good chunk of those saved dollars to the employee through seed money in the HSA or HRA.

This effectively thwarted the consumerism driving impact the products were designed to encourage. Individuals are not being held accountable for their consumer activities in the healthcare space because the health savings account is covering the balance that would have been out of pocket.

It's a bit of a chicken or the egg type of a scenario, since carriers offered such big decrements to move employers to take HDHPs and that freed up the cash flow to seed the accounts.

The most overt market impact of this that we're dealing with now is that many underwriters are requiring an indication of what the employer's savings account funding intentions are before they will issue a CDHP quote.

Then they can adjust price assumptions accordingly. I think the upshot of all this is the days of the big decrements going from a PPO to a consumer directed plan are largely behind us.

So the early adopters got a price advantage in the initial CDHP plan years, but it appears rates are escalating more rapidly now to make up for that.

**Borsch:** OK. That's going to be something interesting to watch going forward. Well, we're getting to the end of the list here but I want to make sure to ask about some of the other purchasing decision considerations that you're seeing.

I've asked this question in past years - specifically, besides price and I realize price is the big one, what other criteria are employers using today to choose between carriers?

**Ambos:** Alright, well, again, aside from price, which will forever be the primary driver, the next factors include service (usually the incumbent provider being the party held accountable for that), a subset of that being CDHP capabilities/expertise.

Provider network breadth is always a factor – the new carrier’s network needs to be at least on par with the outgoing.

Carrier brand image matters, but to a lesser extent than in prior cycles, partly because there are so few players out there and everyone’s brand is well known; and thankfully, there haven’t been any major scandals of recent vintage to steer public opinion one way or the other.

**Borsch:** Knock on wood!

**Ambos:** One additional point I’ll make on this front, Matt, is that we had health and wellness services and initiatives as part of our list of carrier differentiations in prior discussions.

We’re moving towards the belief that this needs to be move out of that category and into a factor that reflects the emerging health and wellness industry that’s becoming a category unto itself.

**Borsch:** Yes.

**Ambos:** I think we’ll see this evolve more rapidly now in the smaller end of the market, as wellness initiatives have been more of an accepted thing in the larger group area.

There’s growing sentiment that this could be the last battle ground for the viability of employer sponsored health plans.

There is only so much plan design and cost share changes can do. At some point, employers taking a more active role in guiding employee health behaviors can potentially tap an under-developed opportunity to see if there is a pot of gold at the end of that rainbow.

There are a couple of macro indicators that suggest things may need to or will be moving in the direction of greater direct employer wellness program investment.

One is the PPACA incentives for employers to do so. Tying this back to the discussion of whether this is a factor in carrier selection, our view is that we’re going to see an increase in employers looking to contract directly with independent specialty health and wellness vendors versus using passive wellness tools that have been and probably will continue to be baked into carrier plan offerings.

Employers should own their employee health profile data, so that regardless of the health plan carrier they are using at any given time, the group’s data travels with them.

Measuring a group’s overall health performance from the beginning of the process through intervals down the road would allow employers to have more of a direct stake in the cost versus outcomes ROI measurement of health and wellness programs.

This has been a hindrance to the uptake of these types of programs in the past. Corollary to that is the ability, when contracting directly, to hold the specialty vendor accountable for facilitating group health improvement.

It’s nice to have wellness tools built into carrier products, but there’s really no accountability for their enabling successful health status changes.

Then, finally, from a public relations stand point, there’s an inherently cynical, suspicious employee reaction to a program that’s pushed forth under the aegis of an insurance company as opposed to an independent specialty firm that might enable a higher level of uptake for the program’s go forward strategies.

The small to mid size market certainly lags the larger in pushing down this path but there appear to be some real indicators that this will be an area of growth going forward.

**Borsch:** My last question here, Ken, is relative to all of this, whether you’re seeing your employer clients show a greater willingness to move from carrier to carrier going into next year in the context of the continuing weak economy?

**Ambos:** Well, it's a bit glib, but I'd say "the buyer's flesh is willing but the seller's spirit is weak." There's a lack of compelling alternatives, which is more responsible for the dearth of carrier change than clients' reluctance to do so.

**Borsch:** That makes sense. We'll wrap it up then and Ken, thank you very much. Your insights are extremely valuable to us and thank you to all of the investor clients who dialed in. Have a great day.

**Ambos:** Thank you Matt.

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