The Underwriting Cycle: The Rule of Six

Alice Rosenblatt
EVP, Integration, Information Management & Chief Actuary

*Views and opinions expressed by WellPoint, Inc., are not necessarily shared by The Ronald Reagan Presidential Library and Foundation.*
The statements made during this presentation that are not historical facts are forward-looking statements within the meaning for the Federal securities laws, and may involve a number of risks and uncertainties.

Factors that could cause actual results to differ materially from expectations include, but are not limited to, the risks discussed in the Company’s most recent filings with the SEC, including its Annual Report on Form 10-K for the year ended December 31, 2005, and its Quarterly Reports on Form 10-Q for the reporting periods of 2006.
Agenda

• Six-Year Underwriting Cycle Pattern
• Six Contributors to the Underwriting Cycle
• Why the Cycle is Six Years
• Action Steps
• Conclusion
Six Year Underwriting Cycle Pattern

Underwriting gain (loss) as a percent of revenue*

Data represents all Blues plans 1960 - 2005

Source: Blue Cross Blue Shield Association, 2005.

* Underwriting gain (loss) is calculated as revenue minus claims expense and administrative expense. Beginning in 2004, revenues and claims expense are reported gross of administrative services only amounts, however prior periods have not been reclassified to conform to this reporting change.
Six Contributors to the Underwriting Cycle

- Claims payment cycle time
- Renewal dates and process
- Growth versus profit objectives
- Role of the actuary
- Rate regulations
- Reimbursement methods
Claims Payment Cycle Time

- Historical cycle times: 90-120 days
- Current cycle times: 40-60 days
Days in Claims Payable

Days In Claims Payable*

* Includes the operations of the former WellChoice, Inc. and the former WellPoint Health Networks Inc. in all periods. Refer to “GAAP Reconciliation” section in back of book for further details regarding comparable basis information.
Renewal Dates and Process

Experience Period

9/1/05 to 8/31/06

Midpoint: 3/1/06

Rating Period

1/1/07 to 12/31/07

Midpoint: 7/1/07

16 Months of Trend
## Renewal Dates and Process

<table>
<thead>
<tr>
<th>Trend Assumption</th>
<th>Factor</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>7%</td>
<td>1.094</td>
<td></td>
</tr>
<tr>
<td>8%</td>
<td>1.108</td>
<td>1.4%</td>
</tr>
<tr>
<td>9%</td>
<td>1.122</td>
<td>2.8%</td>
</tr>
<tr>
<td>10%</td>
<td>1.136</td>
<td>4.2%</td>
</tr>
</tbody>
</table>
Growth versus Profit Objectives

Growth

Profitability

Sales

Underwriters and Actuaries
Role of the Actuary

Number of Credentialed Actuaries in BCBS Plans

Total: 429

Number of BCBS Plans: 140 65 37

Reimbursement Methods

MORE CONTROL
- DRG
- Per Diem

LESS CONTROL
- FFS
- Discount from billed charges
Why the Cycle is Six Years

Profit (Loss)

Year 1
Year 2
Year 3
Year 4
Year 5
Year 6
Action Steps – Claims Payment Cycle Time

- EDI
- Data warehouses
- Auto-adjudication
Action Steps – Renewal Dates and Process

• Small Group and Individual
• Government Programs
• Self-funded business
• Focal renewals
Action Steps – Growth Versus Profit Objectives

• And not or

• Profitable membership growth

• Pricing discipline

• Value not cost
Action Steps – Role of the Actuary

• Actuaries part of teams, including executive team

• Adequate actuarial staffing
Action Steps – Rate Regulation

• Lower the number of uninsured
• High risk rating pools
• Relationship building
Action Steps – Reimbursement Methods

• Actuarial models
• Use of data
• Pay for performance
Conclusion

From:
Conclusion

To:

% of NSR
The Underwriting Cycle: The Rule Of Six

Six factors have historically influenced a six-year health insurance underwriting cycle.

by Alice Rosenblatt

ABSTRACT: The underwriting cycle is a thing of the past for most health insurance companies. There were six primary factors that caused the six-year pattern of the underwriting cycle for 1965–1991. These factors were claims payment cycle time, renewal dates and process, growth versus profit objectives, role of the actuary, rate regulation, and reimbursement methods. Most companies have made major changes to influence these factors, which will prevent a recurrence of the underwriting cycles of the past.

The phenomenon of the underwriting cycle has been well documented. The health insurance underwriting cycle demonstrated amazing regularity during 1965–1991—a six-year cycle of three years of gains followed by three years of losses. The years since 1991 have shown a different pattern, however, which has led some observers to question whether the underwriting cycle will continue into the future.

Based on my experience in the industry, the underwriting cycle will continue into the future for some insurers but not for most. This is attributable to the actions taken by insurers, both profit and not-for-profit, that will help them avoid the swings of the underwriting cycle in the future. Even for those companies that do experience underwriting cycles, the swings will not be as severe as they have been in the past.

There are six causes of past underwriting cycles that explain the cycle itself as well as the six-year pattern. These factors work in concert with each other. In this brief comment I outline these factors and what lies ahead for the health insurance industry.

Six Contributors To The Underwriting Cycle

- **Claims payment cycle time.** Before the recent improvements in electronic claims submission, auto-adjudication, and other technological advances, cycle time as measured from service date to payment date of a claim was often 90–120 days. This implied that at any point in time, the three or four most recent months of experience used in financial or pricing calculations were based primarily on projections of past claims data, generally per member per month claims projected forward with a trend assumption. This straight-line type of projection for the most recent months often led to a delay in recognizing that trend was turning upward or downward, causing pricing errors and earnings swings.

- **Renewal dates and process.** The majority of renewals for group health insurance occur on January 1; in the past, these rates were guaranteed for twelve months. For the customer, this ties in nicely with fiscal periods and with calendar-year deductibles. Renewals on any date are subject to a gap in time between the prior experience and the future pro-
jection period. For example, for a January 1 renewal, the underwriter needs to release the renewal to the salesperson by October 1, and the salesperson needs to release the renewal to the account by November 1. For larger accounts, this might occur several months earlier. Therefore, the underwriter would be using paid claim experience through the end of August and projecting this experience forward. Health care actuaries often refer to the “midpoint to midpoint” rule for trend, which means that a past twelve-month period (in this case, the twelve-month period from September 1 in year x through August 31 in year x+1) is being projected with sixteen months of trend to the renewal twelve-month period (in this case, January 1 in year x+2 to December 31 in year x+3). If one now combines this with the claims projection process mentioned above, the projection period increases from sixteen months to nineteen months, since the last three months of incurred claims are themselves based on a projection. That is a long period of projection for health care costs. If a 12 percent trend rate was used, and the trend rate should have been 15 percent, the difference on a compounded basis for nineteen months is worth 5.1 percent. That is a huge difference for an industry that usually runs pretax net gains of 3–7 percent. If most of the business renewed on January 1, then that 5 percent miss would apply to the majority of the business for a full twelve months.

■ Growth versus profit objectives. In the early years of for-profit managed care, investors rewarded growth over profitability. At the point of greatest gain in the cycle, management was faced with the daunting question of growth versus profitability. If enrollment had slowed down and if management was comfortable with surplus levels, there was an attempt to lower trend rates or to take other pricing actions to improve the competitive position. This started the cycle in the opposite direction.

■ Role of the actuary. The underwriting cycle has been studied primarily for Blue Cross and Blue Shield (BCBS) plans, since the data have been available through the Blue Cross and Blue Shield Association. Many Blues plans did not have actuaries on staff until fairly recently. An article published in the May 1996 issue of the Actuary reported that the number of actuaries at BCBS plans increased from 15 in 1970 to 245 in 1995.1 When health maintenance organizations (HMOs) relied on capitation, many companies did not think that actuaries were needed. As a member of the actuarial profession, I can easily point to the lack of actuaries as one of the causal agents of swings in the underwriting cycle. Actuaries are trained in using data to analyze trends and in building financial models. However, the most difficult part of a health care actuary’s job is predicting when trend rates are changing direction—either up or down; a delay in recognizing that inflection point is often the key driver of the underwriting cycle.

■ Rate regulation. In states where rates for individuals, small groups, or seniors required approval from regulators, it was easier to get approval for higher rates when the plan’s surplus position was low than when it was high. It was also difficult to convince regulators that trend was accelerating when this could not be statistically demonstrated from prior experience. Depending on the size of these blocks of business, this might compound the effect, so that when the surplus position is at its highest and the plan starts trying to raise enrollment in response to competitive pressures, it is also not getting sufficient rate increase approvals from regulators; this drives earnings toward the downward part of the cycle. The rate approval process also introduces an even larger time gap between the experience period and the rate projection period, because of the time needed for regulatory review.

■ Reimbursement methods. BCBS plans have historically used network models, even
before the rise of managed care. However, if the reimbursement mechanism was a discount from billed charges, the projection of future trend rates was just as uncertain as a projection of fee-for-service trend rates. For commercial carriers, payments were generally made on a “usual and customary” fee basis, so once again they were inherently uncertain. This resulted in misses on setting trend rates in pricing, which caused the earnings swings.

**How The Six Factors Work Together**

If one has a majority of renewals on January 1, and the trend factor used for pricing is too high or too low, pricing itself will be too high or too low, causing the underwriting cycle. The six years can be characterized as follows:

1. **Year 1:** Trend starts to increase above the projection. Because of the nineteen-month lag for renewal rating, this inflection point is missed, and actuaries hold the trend constant. There is a minor loss, or earnings are close to break-even for the year.

2. **Year 2:** The company has missed the trend for January renewals on the low side. The majority of cases have been underpriced for a full twelve months, leading to heavy losses. The error would normally be corrected by the middle of the year.

3. **Year 3:** Trend is correct for the January renewals, but there are still some inadequacies in the early months, because of underpriced renewals from the months of year 2 prior to the correction (such as underpriced results for January, since the correction cannot be made until the February renewal). Financial results are closer to break-even.

4. **Year 4:** Trend and pricing are correct for all renewal months, and the profitability picture improves, and is better than break-even.

5. **Year 5:** Rates are correct for all renewal months, and trend may have started to decrease. The gains are highest. Market pressure starts to build, and discounts are built into rates.

6. **Year 6:** Rates have been discounted too much, so the gains are lower than they were in year 5, but there are still gains.

In Exhibit 1 in the paper by Joy Grossman and Paul Ginsburg, the pattern described above is not entirely consistent. This is because the six-year timing may affect companies at different times, so that when one looks at the entire system of Blues plans, the pattern is not exactly as described above. However, it does follow three years of underwriting margin losses followed by three years of gains.

Companies within the BCBS system as well as HMOs and commercial carriers will continue to experience the underwriting cycle. However, since many companies have taken steps to avoid the downward part of the cycle, since 1991 the pattern has been different than the earlier pattern; the cycle has evolved from a pattern of gains and losses to a pattern of greater and lesser gains.

**Steps Insurers Have Taken To Avoid The Cycle**

The steps that most health insurers have taken to avoid the down side of the underwriting cycle fall into the six categories described above. (1) Claims payment cycle time: Through technology enhancements, more claims are now received electronically (some carriers have even given computers to providers to assist in this goal). Many companies have decreased cycle times to fifty to sixty days on a dollar-weighted basis. They also have invested in data warehouses that allow actuaries to retrieve claims data shortly after month’s end, so that actuaries are always working with current data.

2. **Renewal dates and process:** Companies have diversified the customer segments they serve. Large-group business is heavily January-dominated; small-group business is less so; individual business is not at all. Government programs generally have July 1 or October 1 renewal dates. Large-group business can be written on a self-funded basis. Ancillary lines of business not subject to medical price trends can help moderate the financial impact of the renewal distribution. Some companies have changed their contracts to allow off-anniversary rate actions and will take this step if there has been a big miss in pricing. Also,
some companies may have blocs of business, such as individual or small group, for which focal renewals are done—meaning that all of the business in a bloc is given a rate increase on the same date, instead of having each piece of business renewed on an anniversary date.

(3) Growth versus profit objectives: Some companies view this as an “and,” not an “or,” and have set goals that use words such as “profitable membership growth.” These companies have also developed pricing discipline and will not discount adequate rates to the point of inadequacy, in spite of market pressures. Companies have also learned the importance of focusing on value instead of cost. The value comes from network quality, information, pricing stability, financial stability, product innovation, disease management and other medical management programs, and customer service. Many companies realize that this is not an industry in which discounting works, with pretax margins of 3–7 percent, not a 30 percent margin business in which a company would be satisfied with a 20 percent margin.

(4) Role of the actuary: In companies that have taken steps to avoid the cycle, not only are there an adequate number of professional actuaries, but the actuaries hold positions at the executive team level. Actuaries are integrated into the entire operation of the company—not just valuation and pricing, but underwriting, network contracting, medical management, and product design.

(5) Rate regulation: Some companies can obtain adequate rates in spite of rate regulation. They have developed good working relationships with their regulators and have assisted in efforts to lower the number of uninsured people in key markets, participated in high-risk rating pools, and worked to keep claims costs and administrative expenses as low as possible.

(6) Reimbursement methods: Many companies have developed provider reimbursement mechanisms that do not make them dependent on changes to billed charges. Actuaries at these companies have developed models that allow them to predict contractual rates for future periods fairly accurately. These companies also review utilization patterns and look for ways to improve quality by eliminating inappropriate use of health care services.

In my opinion, the underwriting cycle pattern seen from 1965 to 1991 is a thing of the past. However, it will probably continue for some companies and still swing earnings up and down slightly for others. As companies continue to make the changes described previously, the swings will continue to moderate. It is in consumers’ best interest for the underwriting cycle pattern to mitigate, since the result will be more stable premiums.

The author thanks Dave Colby, WellPoint chief financial officer, and the senior actuaries at WellPoint for their review of this paper and helpful comments.

NOTES
1. R.J. Myers, “The Blues Sing Praises for Actuaries,” Actuary (May 1996): 8. The article also reported that the number of Society of Actuaries members increased from four in 1970 to 206 in 1995.
WellPoint, Inc.
GAAP RECONCILIATIONS
Investor Conference Dinner
December 11, 2006

WellPoint, Inc. (the “Company”) has referenced certain non-GAAP financial measures throughout this presentation book. Included below and on the following page are descriptions of those measures, including reconciliations to the most directly comparable measures calculated in accordance with GAAP.

Comparable Basis Days in Claims Payable Statistics

On November 30, 2004, Anthem, Inc. acquired WellPoint Health Networks Inc. and Anthem, Inc. changed its name to WellPoint, Inc. On December 28, 2005, WellPoint, Inc. acquired WellChoice, Inc. For accounting purposes, the WellChoice transaction was assumed to have closed on December 31, 2005. Accordingly, operations of the former WellPoint Health Networks Inc. and the former WellChoice, Inc. are only included from the respective transaction closing dates forward.

In order to provide more meaningful comparisons between and among periods, the Company has included “Comparable Basis” calculations of the Days in Claims Payable statistic for periods prior to 2006. These Comparable Basis statistics have not been calculated in accordance with GAAP. The methodologies for calculating the Comparable Basis statistics are described in the footnotes to the tables where such information is reconciled to WellPoint, Inc.’s historical GAAP financial results.
<table>
<thead>
<tr>
<th></th>
<th>WLP As Reported (1)</th>
<th>WHN (2)</th>
<th>WC (3)</th>
<th>WLP Comparable Basis (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>December 31, 2005</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical claims payable</td>
<td>$4,853.4</td>
<td>–</td>
<td>–</td>
<td>$4,853.4</td>
</tr>
<tr>
<td>Benefit expense</td>
<td>$8,200.3</td>
<td>–</td>
<td>$1,305.9</td>
<td>$9,506.2</td>
</tr>
<tr>
<td>Days in period</td>
<td>92</td>
<td>–</td>
<td>–</td>
<td>92</td>
</tr>
<tr>
<td>Days in claims payable</td>
<td>54.5</td>
<td>–</td>
<td>–</td>
<td>47.0</td>
</tr>
<tr>
<td><strong>December 31, 2004</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical claims payable</td>
<td>$4,202.0</td>
<td>–</td>
<td>$678.8</td>
<td>$4,880.8</td>
</tr>
<tr>
<td>Benefit expense</td>
<td>$5,051.7</td>
<td>$2,961.1</td>
<td>$1,164.8</td>
<td>$9,177.6</td>
</tr>
<tr>
<td>Days in period</td>
<td>92</td>
<td>–</td>
<td>–</td>
<td>92</td>
</tr>
<tr>
<td>Days in claims payable</td>
<td>76.5</td>
<td>–</td>
<td>–</td>
<td>48.9</td>
</tr>
<tr>
<td><strong>December 31, 2003</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical claims payable</td>
<td>$1,841.7</td>
<td>$2,747.1</td>
<td>$609.5</td>
<td>$5,198.3</td>
</tr>
<tr>
<td>Benefit expense</td>
<td>$3,083.0</td>
<td>$4,149.5</td>
<td>$1,072.9</td>
<td>$8,305.4</td>
</tr>
<tr>
<td>Days in period</td>
<td>92</td>
<td>–</td>
<td>–</td>
<td>92</td>
</tr>
<tr>
<td>Days in claims payable</td>
<td>55.0</td>
<td>–</td>
<td>–</td>
<td>57.6</td>
</tr>
<tr>
<td><strong>December 31, 2002</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical claims payable</td>
<td>$1,826.0</td>
<td>$2,422.3</td>
<td>$559.9</td>
<td>$4,808.2</td>
</tr>
<tr>
<td>Benefit expense</td>
<td>$2,901.6</td>
<td>$3,526.2</td>
<td>$974.4</td>
<td>$7,402.2</td>
</tr>
<tr>
<td>Days in period</td>
<td>92</td>
<td>–</td>
<td>–</td>
<td>92</td>
</tr>
<tr>
<td>Days in claims payable</td>
<td>57.9</td>
<td>–</td>
<td>–</td>
<td>59.8</td>
</tr>
<tr>
<td><strong>December 31, 2001</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical claims payable</td>
<td>$1,360.3</td>
<td>$1,934.6</td>
<td>$634.1</td>
<td>$3,929.0</td>
</tr>
<tr>
<td>Benefit expense</td>
<td>$1,967.1</td>
<td>$2,611.4</td>
<td>$903.6</td>
<td>$5,482.1</td>
</tr>
<tr>
<td>Days in period</td>
<td>92</td>
<td>–</td>
<td>–</td>
<td>92</td>
</tr>
<tr>
<td>Days in claims payable</td>
<td>63.6</td>
<td>–</td>
<td>–</td>
<td>65.9</td>
</tr>
</tbody>
</table>

(1) Represents the historical, GAAP information of WellPoint, Inc. as of the date indicated and for the respective three month periods then ended.

(2) Represents the historical, GAAP information of the former WellPoint Health Networks Inc. as of the date indicated and for the respective three month periods then ended.

(3) Represents the historical, GAAP information of the former WellChoice, Inc. as of the date indicated and for the respective three month periods then ended.

(4) The "Comparable Basis" information was calculated by adding the historical, GAAP information of the former WellPoint Health Networks Inc. and the former WellChoice, Inc. to WellPoint, Inc.'s historical, GAAP information for the respective periods.