



National Health Care Reform and Predicting Risk

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Change is coming! Are you making the correct decisions for individual and small group business?

The year 2009 has brought significant change and activity in health care reform. Much of this activity has been directed around enhancing access and the use of underwriting risk activities in the individual and small group markets. While final details of this reform are still open to debate and ongoing dialog, health plan's reactions have ranged from more intensive examination and use of predictive modeling tools and approaches in individual and small group markets on one hand, to a wait-and-see attitude concerning the use of risk evaluation and pricing tools on the other.

Until the reform direction is clear and put into law, the benefits of proactive action today far outweigh the risks of waiting.

Why Act Now?

New policy requirements, new restrictions, and new regulations will require health plans to be flexible and adaptable, and fully understand their current and future risk. A change to the health care system can translate into more opportunities for well-prepared health plans to dominate the market. In order to secure financial success in the changing environment, health plans need to be prepared—and maintaining the status quo may not be enough.

To set the foundation for future discussion, we must distinguish between a health plan's understanding of an individual's or group's risk level versus the use of that risk knowledge in rating (i.e., accepting or rejecting an individual application or small group for coverage or the setting of differentiated prices/rates). While all or some aspects of the latter may be restricted in the future, the need for the former will *never* be eliminated. As such, several key considerations arise:

- **Who** in the company is involved in the evaluation of risk for rating purposes? Multiple areas besides underwriting may be involved and changes in rating may affect the ability to discover risk. In the future, multiple areas can benefit from risk knowledge, even if they do not today.
- **What** will the restrictions be and how will the change address the anti-selection issues? If we assume a future state eliminates the use of preexisting condition exclusions

or other rating variations, will a risk pool apply to spread the costs of potential anti-selection? Risk identification may be critical in using any cost-sharing pools.

- **When** will any restrictions on pricing or underwriting apply? While no definitive timeline can be pointed to for certain, transition periods of 12–18 months seem likely. A health plan that opts to make no changes in its approach and/or process by maintaining the status quo until the effective date of any change is, by definition, making a choice. However, this lack of action during the interim period is not necessarily an action based upon the best financial and competitive positioning assumptions.
- **Where** does the company store existing risk evaluations currently used in the rating process? If other functional areas within the company lack access, valuable risk information may not be considered when making broader financial, clinical, and marketing decisions.
- **Why** act now in a period of uncertainty? Best practice approaches are proactive and directed. Bypassing rationally priced growth opportunity or maintaining inefficient cost and risk identification processes and approaches does not help a plan position itself to compete in a changing market.

Sample Considerations

The sluggish economy and related unemployment rates, coupled with an increase in potential applications generated by most reform proposals, are likely to create more growth opportunity in individual products than ever before. As such, health plans must compete in the current and future regulatory environments for these members. Let us consider the impact of the five points listed above with two scenarios from different points of view for the individual market:

Scenario A: Minimal to no existing individual business

Faced with exploding growth, many health plans look to the individual market as both a boon and a bane. If they fail to enter the market, they may lose market share even as their competitors gain. Entering the market under existing rules may prove cumbersome. In an effort to grow membership, plans may decide to reduce or lessen the rigor associated with typical successful individual product lines.

In order to develop a building block now that can be a cornerstone of growth in the future, the company must have a strong unified vision of how to position the product in the marketplace, and then ensure all departments work together to support its success. This unified vision forms the basis of best practice individual underwriting, with a keen focus on the underlying predictive risk tools that will be or are already in use.

Broadly, these risk predictive tools¹ can be classified as Rx or pharmacy profiling-based and debit point-based approaches. Understanding which tool(s) to use and how to use them effectively requires deliberate examination and consideration of future changes.

A health plan in this situation is in an ideal position to readily focus on the who, what, where, when, and why issues because a new activity can readily minimize the slow, manual, and costly administrative processes that are prevalent in programs that do not use automated tools. More importantly, both risk evaluation approaches noted above are relatively inexpensive to use and require minimal capital start up, returning positive ROI almost immediately under existing individual accept/reject or rate change regulations. And in the event of emergent regulation changes, such processes could still provide valuable information to the risk of the individual or group members for clinical management and financial evaluation and projection purposes.

Scenario B: Existing individual business—heavily focused manual risk evaluation processes

Just like a new plan entering the market, a health plan using manual processes and risk evaluation approaches can immediately gain administrative efficiencies and create a stable platform for growth under current and future rules with even a moderate introduction of more streamlined approaches and automated risk evaluation tools.

Automated tools focus on the entire process flow to clearly delineate the steps and transition from pure risk identification knowledge to final acceptance and pricing.

¹ Refer to the Ingenix Solution Overview—“Predictive Modeling for New Business Underwriting Solutions” for a specific discussion of the tools that can be used for such risk identification. Also, refer to the Ingenix White Paper—“Five Essentials for Evaluating Predictive Modeling Solutions” for a more comprehensive discussion around predictive modeling issues.

For example, under today’s rating approaches, risk evaluation may stop after a health plan identifies a currently unacceptable condition (and therefore rejects the application, if permitted by state rules) or reaches the maximum rate up value. Significant critical risk quantification values may be missed as a result.

How to Act Now

As health plans attract new enrollees and groups from the masses of uninsured or from the consumers who will be switching health plans due to the health care reform, it is important they fully understand the risks involved. Reviewing a company’s risk assessment tools and updating them appropriately is critical to managing the risk.

Ingenix Consulting recommends health plans consider a series of questions to help refine their decision to enter the individual market and stay competitive. These questions should be examined twice: First in terms of current rules, regulation, and opportunities, and second, in light of potential regulatory changes in the future.

While these questions are primarily directed to companies who are considering entering the individual market for the first time, they apply equally as well to existing operations where periodically restating the underlying assumptions of the strategic direction drives continued improvement activities.

General Market Questions

- Why are you adding the individual line of business? Is it to gain market competitiveness, regulatory compliance, or to supplement top/bottom line growth?
- What is your growth strategy? Are you expecting this new individual line of business to add substantial short- or long-term growth?
- What are your margin requirements? Are you expecting this new individual line of business to add significant short- or long-term margins?
- What are the growth and margin targets? Consider business rules and how much risk you are willing to take.

- What are your competitors doing with this line of business (Jet issue, average turn around times (TAT), web capabilities, predictive risk approach, etc.)? Do you need to follow suit or leapfrog?
- Does your state apply creditable coverage on individual?
- Do you know if your state allows Pharmacy Profiling?

Potential Underwriting Practices

- Do you plan to jet underwrite (manually or systematically)? What are the criteria? Individual—Jet approve and reject? Is it based on age? Does the application include answers to medical questions? Prior claims and/or prior submitted applications?
- Will you require medical records or other requirements for certain pre-determined medical conditions (such as high blood pressure or high cholesterol)?
- Will you require a tele-interview to underwrite an applicant? Or to obtain missing information or details? Do you need scripted or underwriter's questions? Or applicant and/or producer/broker assistance?
- Will you require different underwriting rules for certain age bands?
- Do you have a reinstatement policy? Will you allow someone cancelled for non-payment to reapply? Is there a time limit he or she must satisfy before reapplying?
- Have you developed preexisting procedures (with claims and underwriting participating)?
- Have you developed misrepresentation and fraud procedures?
- Do you apply a preexisting waiver for certain conditions?
- Will you re-underwrite an existing group member applying for individual coverage and require a pharmacy profile?
- Will you require re-underwriting a member on an individual policy when upgrading his or her policy (e.g., less out-of-pocket limit)? Will you require a pharmacy profile?
- Will you require re-underwriting a member on an individual policy when downgrading benefits?
- Will you allow someone rescinded a policy to reapply due to fraud?

- Will you require a five-year historical pharmacy profile or less (less is less conservative)?
- What is your rating approach—preferred, standard, rate ups (if so, how much), decline, rider, smoker/non-smoker, etc.
- How do you expect to assess risk? Rx profiling? Debit manual? Both? If so, how will the debit system tie in with the Rx profiling approach?
- Do you plan to use an automated online quoting tool? Will it be integrated with your claims and membership system?

The Future

- How will a change affect me?
- Does the risk identification process stop at a logical point to permit me to use the same processes and approaches without re-engineering for new restrictions?

Conclusion

Health plans that proactively examine opportunities to grow individual business, anticipating change, will not only see increased enrollment and financial potential but also position themselves for profitable growth in the future.

Change is imminent and essential. The health reform will bring big changes to the way health plans conduct business. Therefore, the best way to prepare is to put measures and tools in place that are both flexible and strong enough to handle anything that comes one's way.

Why Ingenix

Tremendous opportunities exist to reduce inefficiencies and inaccuracies, accelerate time to market, and improve the relationships between underwriting and other departments. To make the most of those opportunities, Ingenix offers unique solutions that leverage market-leading approaches to measuring risk and process automation, as well as vast experience with the practical implementation of health plan technologies.

Ingenix utilizes the largest industry normative database in the country to analyze variations and identify improvement opportunities. Our diverse portfolio of products and services converts data into actionable, fact-based intelligence for nearly every U.S. health care organization and more than 250,000 clients worldwide.



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