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GROUP DEVELOPMENTS IN THE 1980's— VARIOUS PERSPECTIVES

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1. The consultant's point of view.

2. The corporate employer's needs and concerns.

3. The group insurance underwriter's outlook.

MR. ROBERT A. HALL: It would seem that the group insurance market, or more generally the use of the employee benefits mechanism, is still and will continue expanding in the 1980's. By way of comparison, if, as Ashby Bladen indicated during the General Session yesterday morning, individual insurance products are now really out of their time frame, the group mechanism may be at its peak or still coming into it. In any case, there is no question but that at present the purchase of insurance benefits and the function of benefit design is very largely influenced by employers.

This session is going to approach the 1980's group insurance employee benefits market from three different perspectives: the employer purchaser, the consultant adviser and the insurance company provider. Probably most of us here relate closely to just one of these three groups. Each group takes a position colored by its responsibilities and objectives. These positions, although certainly far from identical, are not altogether different. The differences, however, are what we should be cognizant of. In the employee benefits market we must, of necessity, work with and, in turn, be concerned about the problems of the other two related areas in order to satisfactorily and effectively solve our own problems. In listening to these panelists' remarks, we might try to gain some insight or possibly acquire a different understanding of the concerns or needs of these other areas.

MR. CARSON E. BEADLE:

The Consultant's Point of View

In examining the impact of group insurance and other benefit changes on corporations, we might begin with those issues which actuaries and statisticians, such as those of you in this room, have brought to the attention of the rest of us. For example,

1. You tell us that in 1980, the stereotypical male, principal wage earner with wife and children at home represents only 20% of the work force.

   That raises the question: "For whom were our contemporary benefit plans and Social Security programs designed?" Was it not for this most recent of our minority groups?

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2. You tell us that fringe benefits now represent 30%, 40%, and even 50% of our direct compensation costs.

   How recently was it only 5% to 10%? What are the consequences of such a rapid growth in benefit costs, and what should we be doing in anticipation of the day the Chief Executive Officer says, "Stop. I've spent too much already." Should we still be adding yet another layer of group life insurance, or some other benefit?

3. You identify for us the cost implications of early or delayed retirement. You make sure that the ramifications of the Age Discrimination in Employment Act (ADEA) are understood in the United States and you implore us to understand that future benefit costs may rise to the point where extended employment becomes the only adequate "financing" method available to us.

   But, are you aware of how that message impacts on the corporate decision makers, or how the corporate structure can frustrate the making of decisions that effectively capitalize on your knowledge and facts?

4. Some of you might tell us, as has the U.S. Chamber of Commerce, that 1980 benefits costs in the U.S. will reach 400 billion dollars.

   But what aggressive steps are being taken by your profession to halt runaway costs rather than just identifying, analyzing, and processing such statistics? And if unfamiliar steps are to be taken, what are they and how should they be done?

5. You have told us that in 1900 there were 102 males for each 100 females age 65 or over, and that by 1975 there were only 69 males per 100 females.

   What is the impact on costs of these statistics as women enter the work force in growing numbers and their earnings escalate relative to males due to the lower wage relationships of the past?

6. As the baby boom group passes through our system what will be the interests of these people for benefits and how well will our programs meet their demands for change and the significant impact their numbers will have on their views being heard and acted upon?

7. The combination of increasing numbers of women entering the work force and the impact of the much larger numbers of people entering the work force may bring about major changes in how the job market is structured.

   More part time jobs, job sharing, pay reduction in exchange for larger vacation, and the shorter work week are some of the signs.

   Neither we nor our clients may subscribe to some of these innovations, but those of us in the benefits field must be sure our plans can relate to a company's emerging policies. These plans should not be an impediment to achieving corporate objectives, and we must understand the corporate structure in which these changes occur.

What is the relevance of all these statistics and changes to today's group insurance benefits planners?

Most benefits practitioners today work in an environment where the ability to be flexible is complicated by conflicting jurisdictions and goals. This constraint applies equally to employers who buy benefits, insurers who sell benefits, and most of us who design benefits plans.

Major changes in design are frequently out of reach so we settle for what we can get - at best a compromise, at worst another layer of immovable commitment ill suited to the needs of the future.

Let's consider for a moment the major areas affected by benefits. These are employee relations, collective bargaining, short-term costs, long range funding, manpower planning, compliance with legislation, taxation for the company and for the employee, corporate image in the community, competitiveness for staff, communications and understanding by employees, administration, and claims cost containment.

Who in most firms makes the decisions in these many areas?

Who makes the manpower planning decision to encourage early retirement in response to the ADEA?

Who makes the key decision on improving early retirement provisions under the pension plan?

Let us also examine the functions that have an impact on or are themselves influenced by benefits decisions.

1. Finance - The Treasurer or Vice President of Finance often has the last word on pension expenditures, actuarial assumptions, and investments.

2. Personnel - The Vice President of Personnel and Labor Relations may have the last word on personnel policy and salary related issues such as compensation and sick leave but may or may not make the final decision on pensions or insured benefits.

3. Benefits - The Benefits Manager may be responsible for group insurance, pensions, collective bargaining, the placing of insurance, and the establishment of trust funds.

4. Insurance - The Insurance Manager with his knowledge of the insurance marketplace may make the final decision on some insurance products or he may have to approve rates and placement.

There are other areas which affect benefit plan design, or are influenced by benefit plans. Some of these are frequently overlooked.

1. Manpower Planning - Benefits plan design is seldom influenced by these people and yet they are responsible to lay out a course for the future, including encouraging or postponing retirement, increasing part time activity, and competing in the work force for certain skills.

2. Data Management - Probably no single issue has confounded the implementation of new benefits or the conducting of an annual valuation more than the current status of our data and our inability to manage it.

   If we introduce new flexible plans without first having simplified our existing plans, we could blow a fuse and fail at the most important point in benefits, that of delivering income security dollars to the consumer when needed.

3. Corporate Planning - Though not as involved in routine personnel and finance related activities, this group is developing policies that could dramatically alter the future shape and structure of the company.

4. Legal - Though seldom responsible for the final decision, the position of the legal people and their sphere of influence can hasten or retard many benefits decisions.

In reviewing these several jurisdictions it is vital that we as practitioners, and that corporations as the users of our products and skills, understand that benefits have very important implications in each of these key areas.

We should know that any structure which blocks or distorts information or discourages the analysis of all implications by those in these affected spheres of influence can create damaging results. At the very least, it can unnecessarily complicate planning for others. For example, to ignore the pension spouse benefit when redesigning a group life plan, or to ignore the influence of the ultimate plan on early retirement, is to do an incomplete job of planning.

Each function needs the opportunity to influence benefit plan decisions, but the structure must still allow decisions to be reached.

The process for achieving this should include:

1. The opportunity for each body affected by benefits to identify implications of greatest concern to them.

2. Time to take their concerns seriously and recommend warranted modifications.

3. A final decision maker to ensure decisions are made quickly and with the authority to proceed in spite of some unresolved differences.

With these thoughts in mind and with one eye on the significant plan design changes that will be needed to cope with the many changing influences we have already discussed, it may be useful to examine how we might approach the subject of effective plan design in a period of change.

We should first recall that our present benefits have evolved in response to a number of isolated stimuli ranging from legislation such as Employee Retirement Income Security Act, Equal Employment Opportunity, and ADEA, to union demands and their influence on salaried plans, to Social Security changes, and many other influences I am sure you could list. As such, it would be quite surprising if today's benefits plans met today's objectives properly.

In dealing with this challenging thought, I find it most useful to meet with those people who influence decisions in the areas of personnel, finance, insurance, and manpower planning and go back with them to some very fundamental questions.

The first question is, "Why have benefits plans at all?" When this question is answered frankly and in depth and when the various responses are organized in priority order, the list makes a very useful base against which to measure existing benefits.

For example, if a priority is to meet employees' financial needs at time of loss, it is unlikely that a plan designed to reward length of service will meet that priority.

Or, if a priority is to communicate to employees the real worth of their plans, it is unlikely that this can be achieved if the plans contain a number of complicating grandperson clauses.

Other questions worth asking include:

1. How do employees perceive their benefits?

2. Are benefits plans designed with the employee in mind as the end customer?

3. What growth is expected in government benefits? Are our plans designed to readily adjust or integrate, thereby preserving spendable income?

4. Have plans been explained so that employees will accept downward adjustments in our private sector plans?

5. Has the tax impact of benefits and costs been taken fully into account?

6. Have benefits at retirement been properly rationalized with manpower planning objectives?

In examining why there are benefit plans at all, several possibilities emerge.

1. To attract and hold employees.

2. To maintain a specified competitive position.

3. To be a good employer.

4. To be a good corporate citizen.

5. To meet union demands, and assess their impact on non-unionized employees.

6. To encourage or at least not impede early or late retirement, to meet personal income security needs, or to reward long service.

Next, we should ask, "Which of these reasons are still relevant?" Then, "How well do existing plans meet the current reasons for having a plan, in your view and in the view of employees?"

In considering these questions it is useful to think of the employee as the end customer for employee benefits plans. Few plans are designed with this in mind. For many companies, it is very difficult to do. As we reviewed earlier, different jurisdictions control various benefits. Sometimes those responsible speak with each other, and sometimes they don't. They often live in a win/lose environment where they are not free to be as objective as they would like to be. If they allow life insurance to be replaced by a spouse's benefit under the pension plan, or if they replace the pension spouse's benefit with an insured survivor income benefit, someone is seen to be a loser.

Those of you in the insurance industry have precisely the same problem. Many of you are structurally handcuffed to consider "pushing" only the product in your jurisdiction, be it group life insurance or pension, and not to consider which approach will best help your client achieve his personnel objectives.

Yet, events are descending upon us so rapidly that artificial impediments to viewing benefits in their totality with the employee as end customer need to be removed. Benefit plans should be designed without regard to the vehicle used or narrow departmental interests. Plans should be simple, cohesive, and above all relevant to employees.

The bottom line is this:

1. Employers are likely spending more money on benefit plans than they need.

2. They are likely getting less credit for their benefit plans than they deserve.

3. They have likely set themselves up to absorb the increasing costs of their own plans, of Social Security, and of Social Security benefit increases.

4. They and their insurers are likely operating in an environment where major and fundamental changes in plan design are difficult to achieve.

5. They are likely confronted with increasing chief executive interest in the costs and human resource implications of benefits plans.

To address these issues, I believe we need to do the following:

1. We need to step back from the forest of legislation, compliance, demands, etc. and look at the end result of our combined benefits upon the occurrence of a covered event to an employee.

2. We need to take the broad look.

3. We should know why we have these particular plans in today's terms.

We need to understand employees' perceptions of the benefits and their real value. We need to recondition their thinking to understand that in the benefits area more is not necessarily good and that benefits can absorb an unwarranted amount of today's spendable income.

Plans should be designed with the employee as the end customer and with ease of communication or virtual self-communication as primary goals. If we cannot explain it easily and relate it to employee perception of need, we should discard it and start again.

Finally, plans should permit a ready flow from active service to retirement, without serious disruption of income security.

The ultimate challenges to actuaries are to understand the nature of this change that is about us, and to understand the importance of flexibility in arriving at a final design that achieves personnel or people objectives. The challenge is to be ready to press for those changes in your structures that will permit you to deliver the right service or the right product to meet the challenge of the future, for it is already upon us.

MR. MICHAEL J. GULOTTA:

The Corporate Employer's Needs and Concerns

The cost of employee benefit programs impacts directly on corporate management's ability to meet its responsibilities to its stockholders, to its employees, and to the consumers of its products. No one is more aware of the increasing cost of providing fringe benefits than the corporate employer. After all, it is the employer who usually provides for these costs. For AT&T and its principal telephone subsidiaries, the employer cost of providing medical care has more than tripled over the last 15 years. It has tripled not in dollars but astoundingly as a percentage of payroll to nearly six percent of payroll currently. This is both a very significant increase and a significant level of expense. AT&T's experience is not unique! GM's expense rose from 3% to 9% of payroll over the same period while another very large corporation's medical care costs rose nearly four times to over 6% of payroll.

Underlying these increases are improvements in plan benefits and the effects of inflation and utilization increases as well as other factors. Management cannot sit by and permit benefit costs to be uncontrolled in the 1980's. I expect management will take definitive steps to effectively gain control of benefit plan costs.

One very good reason for this is that both foreign and domestic competitive pressures will require increased future productivity. To survive as a business, management must respond to the competition by being more efficient and by shedding excessive expense. How will this be accomplished?

Benefit plan structures will be reviewed and certain cost-effective proposals to change those structures will be made. During recently completed contract negotiations with unions representing approximately 3/4 million employees of the Bell System, AT&T offered a proposal to amend its basic and major medical benefit plans. Among the elements of the proposal were a dollar limit hospital room and board benefit and a dollar maximum on hospital extras. The current contract provides service benefits. Basic surgical benefits were to be provided on a reasonable and customary basis but not in excess of a scheduled benefit. The benefit plans would be designed not to be retrogressive but, given expected inflationary conditions, dollar limits would be expected to affect benefit payments near the end of the contract period. Dollar limits and scheduled amounts would be

subject to negotiation rather than increasing benefits automatically to keep pace with medical care inflation. Thus, management would have the opportunity to control the increase in benefits and benefit costs.

Employees and their dependents would become more involved in the financial aspects of health care delivery, hopefully as prudent consumers rather than simply as patients. This, we believe, is an essential feature of any cost containment program which would ultimately be beneficial to employees and their dependents.

Further, a greater portion of any increase in the total compensation package would be explicitly recognized in the bargaining process.

Lastly, unions would be able to claim credit for increases in plan benefit levels which, under a service contract, are not considered any gain at all.

As I mentioned, this management control oriented benefit structure was introduced by AT&T management in recently concluded labor negotiations. Unfortunately, agreement was not reached on a changed benefit structure in the medical care area. However, agreement was reached giving management similar control with respect to pension benefits as a change from a final 5 year average pension plan to a flat dollar per year of service plan was negotiated for non-management employees. This is proof that it is indeed possible to negotiate structural changes which will enable management to gain control of the increases in plan benefits and, therefore, contain increases in plan costs. In 1983, when our current union contract expires, we may reintroduce similar changes in the medical care plan.

There is another possible change which, while not related to coverage developments, will impact the way carriers and group policyholders will interact in the 1980's. Again, one reason for this change is the rapidly increasing level of health care costs which employers have had to bear. To some extent, group policyholders have simply been paying the bill for medical care coverage without very much questioning in regard to how the premium dollar was being utilized. I can assure you that these days will soon be gone. Certain corporations' managements have already commenced asking for specific utilization data from insurers for purposes of reviewing just how the premium dollar is being spent. We can expect more quality control on management's part in the delivery of the insurer's service. At AT&T a system which will provide management with a tool for determining among other things whether the carrier is operating an efficient claims administration program has been put into place. We expect to start experiencing the returns on investment in that system very shortly.

Relating to the cost of group insurance programs then, and especially in the area of medical care, the 1980's will witness a new management attitude toward employee benefit programs - a seriously concerned attitude which will change both the benefit structure of currently existing plans and the usual insurer-policyholder working relationship.

Another major concern of corporations will be the manner in which the costs of post-retirement group insurance benefits will have to be accounted for beginning in the 1980's. The prudence of advance recognition of post-retirement group insurance benefit costs on an actuarial basis has not yet been fully realized. An analogous situation existed in the pension area for about half a century until finally in 1966 the American Institute of

Certified Public Accountants completed and published an Accounting Research Study which formed the basis for Opinion No. 8 of the Accounting Principles Board. Opinion No. 8 was much more specific than prior accounting research bulletins by defining parameters for determining minimum and maximum accounting charges for pension costs. Pay-as-you-go and terminal funding approaches were deemed unacceptable.

The Financial Accounting Standards Board (FASB) has undertaken a review of accounting by employers for pensions and for other post-employment benefits. The Board has already indicated that post-employment benefits (such as life insurance, medicare supplements, and payment of Part B Medicare premiums) may be similar to pension benefits in many respects since future disbursements may be estimated based on appropriate actuarial assumptions and calculations. The Board also notes that there is a fairly wide range of practice in accounting for these other post-employment benefits and that there is no authoritative generally accepted method of accounting for the costs of these benefits. However, it is important to note that the Board has not made any final decision either with respect to the perceived nature of other post-employment benefits or with respect to how such benefits should be accounted for. Some would argue that the nature of these post-employment benefits are sufficiently different from pensions and that there is little rationale for similar accounting practices to be applied. For example, in some cases it may be argued that no legal commitment has been made to continue the provision of these other post-employment benefits. Thus, the nature of the employer's promise is considered to be a qualified promise. Of course, in the pension area, on plan termination, the plan sponsor is faced with some liability. Others would argue that other post-employment benefits do not represent a form of deferred compensation, but instead are gratuities and thus the logic would follow that gratuities need not be accounted for over the active working lifetime of employees but are chargeable to expense on a pay-as-you-go basis. Another argument might be that prospective benefits under post-employment benefit plans may not be amenable to accurate forecasting since, for example, possible external developments like a comprehensive national health insurance arrangement could eliminate the need for post-employment medical care programs. Unfortunately for the supporters of this view, the same argument can be made in the area of pensions - for example, that Social Security will be expanded and eliminate the need for providing certain pension benefits. Yet, this possibility has not preempted advance accrual accounting for pension benefits.

The provision of post-employment fringe benefits should be considered a labor cost and, therefore, the cost should be recognized over the active working lifetime of employees. The requirement to accrue for the cost of all post-employment benefits over the working lifetime of employees so that the expense of labor may be matched against the revenues generated by that labor may well be a fact of our lives after FASB deliberations are completed in the 1980's. Certainly one of the corporation's responsibilities is to fully and fairly disclose to current and potential investors as accurate a picture of its financial fitness as possible. The argument can easily be made that recognizing post-employment benefit costs on an actuarial basis will be a positive step in helping the corporation meet this responsibility.

There is another interesting point on this subject. The Cost Accounting Standards Board (CASB), which is basically responsible for specifying criteria to be used in determining the measurement and allocability of costs under government contracts, issued regulations on accounting for

insurance costs approximately two years ago. Prior to the issuance of final regulations, the CASB expressed its preference for recognizing the cost of retired lives benefits over the active working lifetime of employees. The CASB noted that the cost of a retired lives program, like other fringe benefits, is a cost attributable to the use of labor and that it is properly allocable to the cost objectives which benefit from that labor. The CASB ultimately did not require that costs be recognized on an advance accrual basis. One reason for this action was that it was thought that if prefunding were to be required, many government contractors might discontinue their retired lives program. The point here is that there is support for the view that post-retirement costs are indeed a cost of labor and should be recognized as such.

In summary, the key word for the 1980's from the corporate employer's perspective is cost. The corporation's concern will be its level, how to reduce its rate of increase, and proper accounting recognition.

The actuary's role is to address the concerns of the corporation, to formulate innovative ideas in the areas of plan design and cost control which will assist the corporation in meeting its responsibilities, and to take an active part in discussions taking place in the accounting profession. These tasks are well suited for actuaries and indeed will require the expertise of the actuarial profession for their successful completion.

MR. STANLEY L. OLDS:

The Group Insurance Underwriter's Outlook

First I would like to bring a different but related picture into the discussion here. The American Council of Life Insurance has a Trend Analysis Program (TAP) which has led to the issue of 20 or so reports. In the spring of 1980, they published TAP No. 19, titled "Health Care", in which three scenarios of health care in the year 2030 AD, 50 years from now, are spelled out - all outrageous and unlikely to occur but all containing some elements and ideas that are reasonable and which are likely to occur in whatever health care setting and environment may exist in 2030.

The three scenarios are:

1. Routine utilization of high technology in medical care.

2. Individual responsibility for personal health and well being.

3. Governmental responsibility for all health problems.

The first scenario ties all health care advances in the next 50 years and the basis of health care programs in 2030 to the advancement of medical technology. The following types of statements appear in the report:

1. Food and energy shortages have been alleviated by genetic engineering in plants.

2. Screening for genetic markers in children is now routine.

3. Spare parts banks for humans are commonplace.

4. An anti-aging vaccine has been developed. Average life expectancy is 125 years!

5. Micro-processors worn like wristwatches monitor and analyze certain chemical processes of the body. Diabetes is fully controllable.

6. Remote telemedicine diagnostic equipment has made home diagnosis commonplace.

7. Society has not kept up with the hardware. Life and death ethical questions are solved more slowly than technical problems.

The second scenario takes the approach that good health is a personal thing. The important aspects of health care are the maintenance of good health and the prevention of disease.

1. Every component of society - the workplace, educational institutions, transportation networks, and urban environment in general - is considered part of the health care system.

2. The definition of health problems is expanded to include morbidity and mortality resulting from traffic accidents and crime as symptoms of the diseased community.

3. The public recognizes the ineffectiveness of National Health Insurance (NHI) programs and places great emphasis on individual responsibility.

4. Hospitals have been converted into crisis intervention centers, health education centers, and fitness centers.

5. Patients alter lifestyle to treat chronic cases.

6. The first generation of children educated in this manner reach adulthood. A significant percentage of them have gained control over their bodies equivalent to that exercised by Eastern mystics.

7. Energy wasting behavior, chemical pollution, and dehumanizing work (or the state of being out-of-work) are considered conditions of disease.

The third scenario states in effect that government is the sole provider and judgment maker for our health care.

1. Government assumes control of all medical schools in 1992.

2. Government gave up on attempts to control hospital costs and turned to controlling number of hospitals and number of beds.

3. Government directed that everyone involved in health care do whatever was necessary to find out which health care procedures really work.

4. New medical technologies have to be accompanied by statements of potential impact on society, the economy, and the environment, as well as health.

5. In the year 2007, government commences explicit rationing and intervention in individual health decisions. It is society versus the individual.

This scenario also states that voluntary controls simply don't work. Health care costs are determined by the way people live. To hold down costs and to promote public health, the government is forced to intervene in individual life decisions. In that context, people who pursue unwarranted health risks are considered as social criminals.

Some of the outrageous predictions described above will occur, or begin to occur, in the 1980's. Will we recognize them when they arrive? Better yet, will we anticipate them and prepare to weave them into the fabric of our products? Will we pay for screening for genetic markers, anti-aging vaccines, cancer preventive drugs, a routine visit to health education and fitness centers, or the wristwatch micro-processors to monitor the diabetics? It is fascinating to look into the future and speculate. My concerns are not that things will change, but that we in the health insurance industry will fail to anticipate and recognize these changes.

But where do I think we really go from here? What are the factors that an insurance company must recognize in its portfolio and in its planning for the 1980's? Some of my thoughts are answers. Even more are questions.

1. Inflation - What are the implications when inflation on the health benefits the policyholder pays for is higher than inflation on the items which he produces? Will he continue to allocate an ever larger share of his resources to fringe benefits? I doubt it. Will we see higher deductibles payable by the employees, or will tax-sheltered fringe benefit "compensation" be at the expense of cash wages?

2. A Changing Work Force - Will the requirements of employees as consumers change as women become an ever increasing proportion of employed people? What ages are they? What is their family status? Are they still bearing children? Do they prefer life insurance, income insurance, medical/dental insurance, higher pensions, or a better parking space? Do they want to have their own employer provide insurance for them or do they want to be covered under their spouse's plans? And, who gets the kids?

3. National Health Insurance - Will NHI become a fact? What form will it take? What will be left for the insurance industry? Will the fear of having the continuing inflating cost of medical care paid by taxpayers keep NHI small?

4. Legal Environment - Will there be any significant change in the tax laws regarding contributions for fringe benefits? Will anti-discrimination laws force employers to contribute a like, identifiable amount on behalf of each worker regardless of sex, age, marital status, or dependent obligations? And what might the implications of that be?

5. Cost Containment - How important a factor will insurance industry participation in cost containment become? We've done a pretty good job of avoiding responsibility for the high medical care costs, but there is a voice which says, "You pay most of the bills, and you should have

the clout with the providers, so you dig in and help keep costs down! And by the way," the big voice continues, "you have all the statistics on what we're paying for and the ailments that our dollars are curing, so you get us better health for our insurance dollar." This is a major challenge to the insurance industry. Furthermore, this is a political problem which means it isn't going to go away, and we're going to be highly visible in our efforts to address it.

Some Predictions

1. Cafeteria Plans - The most significant change we will see in the 1980's is the increasing development in the use of cafeteria plans. To a greater and greater degree, the characteristics of the so-called work force seem to be dispersing. People who work are different, they are more aware of their different needs, and they need different solutions to solve their medical, dental, and life insurance needs, not to mention income continuation, pensions, and vacation benefits.

   The administrative support needed for cafeteria plans can be most complex. Not all insurers will be able to handle it, nor will all employers be able to manage it. But it will come as part of the progress of fringe benefit programs.

2. Cost Containment - The insurance industry provides large amounts of money to the medical provider industry, and we will probably be forced into a posture of helping control costs to a much greater extent than we now do. That will come from working with the provider industries as well as from designing plans which include those services which provide more health coverage for the premium dollar. We may also force the insureds to participate with us in recognizing that we all have a stake in controlling medical costs. This will take the form of more selective deductibles and coinsurance factors. And plans will tend to reduce abuse, not encourage it. The insurance industry will also find itself more active in dealing with Health Systems Agencies, Health Maintenance Organizations, Professional Standards Review Organizations, rate setting commissions, and other medical-interest organizations. Keep one thing in mind. If we spend as much time on containing claims cost, which is 80% of the premium, as we have on containing expense costs, which is only 20% of the premium, we will do well.

   The "wellness" thrust of health care, as described in the TAP scenario, will be led by HMO's in the 1980's, and the insurance industry could find itself in the interesting position of being involved on both sides of the fence as competitors to the HMO's and perhaps investors or operators of HMO's.

3. Coverages

   A. Dental - The number of people covered under dental plans will approximately double in the 1980's in accordance with the prediction of some experts. In addition, the buyers as well as the insurers will come to recognize the differences in the risks between medical and dental insurance. Plan design will help control over-utilization of dental procedures that are more expensive than the basic, yet adequate, procedures.

B. Vision and Hearing Care - This coverage is more of a budgetable item than a high risk insurance item. If fringe benefit dollars remain as precious as they are now, this type of coverage may be slow in growing.

C. Group Auto - How many of us would like to be in a position to pay for our automobile insurance with pre-tax dollars? (Admittedly, I might be making an erroneous assumption here.) We might even be willing to trade wage dollars for fringe dollars for this one. In addition, true group auto will raise expected claim ratios from the 60% level to between 70% and 80% depending upon the size of the case, a significant improvement in the effective use of premium dollars. Group auto isn't all plus. Coverage flexibility in any given group may be less than individuals desire. The traditional agent/policyholder relationship will be further eroded, and that will be a bone of contention.

Group Homeowners may well fall into the same pattern as group auto.

D. Prescription Drugs - The appeal here, of course, is convenience to the insured. There are no claim forms, and no significant outlay by the insured. This is a real consumer oriented coverage which can't miss. Just don't leave the plastic card at home.

E. Survivor Income Insurance - This coverage will make it, but only at the expense of traditional group life approaches which relate only to earnings or occupational class. A great deal of education will be needed to convert the employees' perception of group life insurance from entitlement to need. Voluntary Group Life will also make it, but at some expense to the smaller case individual life insurance market.

4. Blue Sky - An important aspect of our business is the funding of our insured plans. The funding patterns of insured plans in the future may not resemble the funding of plans in the past. We are not going to receive all of the premium we have seen in the past. The insured will keep much of it, and we will pay claims from his bank account. He will often keep claim reserves and maybe even the liability. It won't be Administrative Services Only (ASO), because we will keep the high and extended risk as well as perform administrative functions. As long as interest rates stay so high that our interest credits on reserves seem low to the policyholder, he will give us as little money as possible to administer his fringe benefit plans. The Health Insurance Association of America recently reported that medical care claim dollars paid by ASO/MPP (minimum premium plan) increased 44% in 1978, 31% in 1979 and 72% from the first quarter of 1979 to the first quarter of 1980!

One thing is certain. History has taught us that for better or worse the future will be different. If you don't agree with me - either the questions or the answers - I have accomplished my mission to stimulate ideas on the subject. If any one thought I have expressed deserves repetition it is that is is imperative that the insurance industry anticipate changes and recognize them when they arrive.

MR. WILLIAM V. HAUKE: What percentages of all non-government health insurance dollars do self-insurance and ASO dollars currently represent?

MR. OLDS: The recent HIAA Statistical Information Bulletin dated September 22, 1980, indicated that about 15% of all non-government medical insurance claim dollars are paid under ASO and minimum premium plans. This does not include ASO cases administered by non-HIAA companies. The percentage is high because so many of the larger cases are in these categories.

MR. D. B. DIXON: What are your views on cafeteria plans?

MR. BEADLE: We have to start by defining what is meant by a cafeteria plan. I take an extreme view of a plan where each benefit is assigned a unit value, and employees have an ultimate flexibility to pick and choose what they wish.

We are currently undergoing a change in that the employer is moving to the center of our society. We have become disenchanted with government. Unions are certainly going to continue to be strong but there is a lot of concern about power in their hands and the fact that they deal with an isolated group of people. The employer is going to be taking on added responsibility.

If this is the case, the employer cannot be seen as having abdicated any particular area of fundamental income security. This should increase the importance of core plans that provide a fundamental or basic element of income security for all employees regardless of their marital status, dependents, age, and so on.

Having said that, let us look at the other side of the coin, flexibility. The demographic changes in the structure of our employee populations are tremendous. Examples such as a single parent supporting a child and having to pay a full family rate for medical coverage reveal that there are many problems to be solved. Above the core plan we need a very high degree of flexibility in the benefits that will be available to employees. We should carefully think out the manner in which employer dollars will be used to encourage added protection in those areas where the employer thinks it would serve the best purpose. My simple answer is that cafeteria plans are a frightening proposition, but flexible benefits are a must.

MR. HALL: It is important to consider one other aspect when you think in terms of cafeteria plans. There has to be a very extensive commitment on the part of the employer to counsel and advise his employees if he gives them the myriad of choices that cafeteria plans are generally thought to involve. The employer has to commit not only to a much more extensive administrative apparatus but also to the very detailed explanation and counseling that will be necessary if a large number of choices is going to be made available.

MR. OLDS: My interpretation of cafeteria plans is that there is a significant core of benefits that is provided for all employees. Optional benefits on top of the core plan provide flexibility.

MR. BEADLE: There is an issue that applies to both the employer and the insurance company which is absolutely vital. The insurance company must have the facility to pay the claims, and the employer must have the

facility to administer the plans. We are already involved with a recently acquired major client who installed a mini cafeteria plan. They took one portion of their plan and unitized it and made many options available. That took effect in June, and now there are approximately 4000 claims backed up waiting to be processed because the system is not adequately in place to handle them. Management's credibility is suffering because they introduced this with great fanfare.

MR. BURNESS R. EILER: Stan, in Scenario III you mentioned that the government was going to stop trying to control health care costs and begin trying to control the number of hospital beds.

MR. OLDS: That was the way they were going to control the costs.

MR. EILER: In the Minneapolis St. Paul metropolitan area they are already doing that. Fairview Hospital is trying to close unused rooms in downtown Minneapolis and build a health care center in a suburb that is unserved, but they can't get a license to do it.

MR. OLDS: What the scenario says is going to happen by 2030 has been happening in recent years through certificate of need laws. Many states have these laws, and the states are in their own ways trying to control overbedding, which is just too many hospital beds being available. It is interesting to watch the legislators try to backtrack and make exceptions after passing such laws. They put in special bills for certain hospitals in their own constituencies so that these hospitals can do things which the law specifically intends they not do.

MR. BEADLE: Hospitalization is totally socialized in Canada, and an early development when the government hospital plans began was the reallocation of hospital resources. Since there was only one owner of all hospitals, the intensive care hospitals and the cottage type convalescent hospitals could be deployed to ensure a balance of these different types of accommodation in each community. The idea was that an intensive care hospital with a very high per room per day cost wasn't needed for convalescent care. I mention that only because if the private sector is going to retain control of hospital resources in the United States, it may have to do some voluntary reallocation of those resources.

MR. BENJAMIN R. WHITELEY: I am aware of some communities in which employers and union leaders are getting together in cost containment organizations. The Greater Philadelphia area is one example. Are any of you familiar with these organizations, and can you tell us if they are being effective?

MR. GULOTTA: Pen-Jer-Del is the name of one group in the greater Philadelphia area that has been meeting, collecting data, and trying to influence the delivery of medical care. However, the jury is still out on the effectiveness of employers and unions getting together.

I have a question for Stan Olds and for the actuaries in the audience. Stan alleged that the insurance companies were avoiding the responsibilities in the area of cost containment. These responsibilities are to promote better health care, keep the cost down, and pay the claims. Of course, the impetus is from the employers and the unions who are tired of increases in health care costs. Have any of the companies which are represented in the audience attempted to develop a program of provider education? The insurance

companies are the focal point, and the employers can put pressure to bear on them. Have you instituted any programs of provider education with a goal of showing them what the norms are and what the abnormal behaviors are with respect to treatment and with respect to charges? If the answer is no, you can see why the employers are trying to do it on their own.

MR. HALL: A number of insurance companies have met with representatives of dental societies to go over these particular points, but much less has been done in the medical area. It is much easier to deal with this type of provider education in the dental insurance area, because there are significantly fewer procedures, and they are more clearly defined.

MR. JOHN K. KITTREDGE: Perhaps the most extensive current attempt to educate providers is in the Milwaukee area. This is primarily under the auspices of the HIAA, but a number of insureds with significant amounts of business in that area are involved. An attempt is being made to see exactly what results can come from this type of arrangement.

At the Prudential, we have had varying success in demonstrating to providers, physicians, and hospitals that the patterns of care that they have been following are not efficient and are not necessarily the best in terms of being able to meet competition and yet provide a high quality of care.

One of the best things we are doing which is closely related to provider education is second opinion surgical programs. The jury is still definitely out as to the ultimate effectiveness of second opinion surgery, although the experimental data has been quite encouraging. We now have over one hundred policyholders who have plans under which a lower percentage of the physicians' or surgeons' charge is paid if there is no confirmed second opinion. This is something else we would like to watch a little longer.

MR. BEADLE: Jack, have you had any measurable feedback yet on the effectiveness of your employee health education films program?

MR. KITTREDGE: I have not had any feedback in a form that would give me confidence in saying that employee behavior has been changed. Health education accomplishes nothing if it doesn't change the behavior of the participants.

MR. HAUKE: There has been tremendous development in the group insurance field in extending group insurance or pseudo-group insurance to people that were formerly buying individual insurance. These are the very small employee groups, often with less than five lives. Much of what we have been discussing doesn't really apply to these groups. Could anyone comment on the expansion of group insurance in this area?

MR. OLDS: This is a marketing problem more than an actuarial problem. This type of business is currently in place, and our marketing people and those of other companies are not going to let us get out of it because we all have a stake in it.

MR. HALL: Group insurance should be offered to a group with a minimum amount of individual underwriting. Medical evidence should not be necessary because you can rely on the ability to obtain a reasonable cross section of exposure. This begins to break down when you go below ten lives. It isn't really a group insurance product that is being offered to

these very small groups. A market does exist here, but it really is a different product than group insurance.

MR. BEADLE: Bill is right to draw attention to the fact that we are focused on groups of a different size, but he also raises a fundamental point concerning the survival of the private sector in this field. Every involvement of government in the benefits area has essentially been driven by lack of adequate coverage for the self-insured or the very small employer group. All of the political support for progress in this area comes from that group, and if as an industry we are not giving it adequate attention, we are probably sowing the seeds of our own destruction. It is a terribly important point.

MR. OLDS: Aren't there also tax and compensation considerations for an employee who happens to work for an employer with only two other employees? That individual feels entitled to the compensation, including some fringe benefits, equivalent to a person who works for AT&T. There should be some kind of an employer sponsored plan. The insurance industry has come up with a vehicle for that which they call group insurance rather than individual insurance. However, I agree that in a sense if you require individual evidence of insurability it really isn't group insurance. It is a vehicle which serves a purpose, though.

MR. ALEXANDER D. BRUNINI: It seems that insurance companies and a number of large purchasers should have a sufficient amount of leverage over providers to exercise cost control. This is precisely what is happening with the vision coverages. In this area, insurers don't have the long history of relations with providers that exists in the medical area, and results have been most gratifying in large vision plans in terms of price negotiations. Hopefully we can learn from this and perhaps apply it to the other coverages.

MR. HALL: I assume you are referring to a vision care plan that has participating providers. These providers have to agree to the terms of the plan to become involved, and through that device some control can be exercised. This is a little bit different from the normal group medical arrangement other than Blue Cross.

MR. BRUNINI: In the medical area, even if it can be demonstrated that $150 is the reasonable and customary fee for a procedure for which a physician in a certain case charged $200, there is still an obstacle. The employee has bargained for a fully paid up plan, and has presumably given up some wages. He doesn't want to have to pay that extra $50. The insurer is trying to hold the claim to $150 in order to protect both its interests and those of the customers. Both are right, but there is no reduction in medical care costs.

MR. BEADLE: To the extent that the Blues have been successful in the area of cost control, it has been tied back to participation by the deliverers of the service.

MR. WHITELEY: Education of employers and union leaders is vital, because in any community they have the power. These people are hospital board trustees. They know the physicians. They should be able to exert much more influence than insurers.

MR. GULOTTA: We have been trying to accomplish that recently, and we did accomplish it in the pension area with the 1980 bargaining. We also bargained a scheduled vision care benefit. It isn't likely that we'll bargain a usual, customary, and reasonable (UCR) type plan again, in spite of what Lex said with respect to the success that you've had in the vision care area. It is extremely critical in the cost control process to try to get to the point where the employer can exercise some control over benefits. To use the $200 claim as an example, the employee feels he is eligible to collect $200, and the doctor feels he has the right to ask for the $200, but the employer doesn't think that it should have to pay $200. If the employer cannot get around this any other way, it will be done through plan design. It is an important ingredient in the cost containment process.

MR. BEADLE: I am curious to learn how a company with a high profile like AT&T can get their pension plan from a final earnings to a career average earnings basis.

MR. GULOTTA: That was a management plan, not a bargained plan. There was a potential employee relations problem, but this was handled directly by explaining the plan to the managers. However, as I mentioned, the management plan is not a bargained plan, and it didn't have to be sold except from the public relations point of view.

With regard to the non-management plan that had to be agreed upon with the unions, there were a couple of selling points. One of these was that the unions would now be able to claim credit for the benefit increases under a flat dollar per month per year service plan. Under a final five year average plan the benefit increased as the salary increased, and this was at most implicitly recognized as a benefit increase. Unions really didn't get any credit for a bargained up benefit. Also, a new vision care benefit, as well as other benefit improvements, was bargained. Furthermore, the accrued pension benefit was actually increased so there was an appeal for those who are going to retire within the near future. This was also appealing to the unions.

Changing the design of the medical care benefits was harder to sell. There was less appeal because if inflation went unchecked, there would be a decrease in benefits in the short term, probably even as early as the end of the three year bargaining period.

MR. DIXON: Are there any benefits from employee fitness programs? Is this an area that insurance companies should be moving into?

MR. HALL: I have some reservations about providing group insurance benefits that reimburse the cost or part of the cost of an annual physical examination. This may not be a cost effective use of the employer's dollar. I do not know whether any insurance companies have any experience and are in a position to conclude that this is a cost effective benefit that should be put into a program. A number of companies have written this type of benefit, not necessarily on a large scale but for fairly extended periods of time.

MR. OLDS: Several years ago Kaiser Permanente published information regarding annual physicals or periodic physicals. Due to cost effectiveness, they recommended that so-called annual physicals be given less often than annually up to certain ages. They reduced the frequency by approximately

half until age 50 or even higher. The exams didn't discover as many medical problems as they anticipated. When they compared the cost and the medical problems uncovered, annual examinations did not appear to be cost effective. The reduced frequency of these examinations did not appear to lower the quality of medical care.

MR. BEADLE: We have been asked a few times about insuring someone who has a fitness program or is about to embark on a fitness program. We have even had correspondence from people who design fitness programs. They want to find an insurer who will help them promote it. We really have no basis beyond some pre-conceived notions.

MR. KITTREDGE: What I was talking about earlier was health education. This consists of educational programs designed to get people to stop smoking, lose weight, get exercise, or what have you. As opposed to that I interpret this question as referring to a fitness program where typically an organization has some organized mechanism of getting people to exercise the way they should. We have a number of fitness programs developing in different directions. One program in Houston has been monitored fairly closely to see what changes it has brought about in terms of the physical condition of the people participating. The jury is still very much out although there are some indications of changes. One of the things we do not know is who among the participants continues with the fitness plan. How many would be exercising anyway?

Physical fitness plans are an area where more experimentation would be worthwhile, and careful research is being done. It will probably be some years before I will be comfortable with any feeling as to the cost effectiveness of these plans.

MR. HALL: Are you looking at this from the standpoint of the Prudential as a corporate employer, or do you feel that there is a possible insurance benefit here?

MR. KITTREDGE: At the moment we are looking at it as an employer.

MR. HALL: Is there any provision for the employees' dependents to participate in this?

MR. KITTREDGE: No.

MR. OLDS: We have talked about a program to discourage people from smoking, an annual physical, and physical fitness programs, but there is one program that has been overlooked. This is nutrition. I do not know of any organized program sponsored by an employer. We know very little about nutrition relative to the potential, and yet I think it would have as much impact for some people as a physical fitness program.

MR. WHITELEY: There is a group in Portland, Oregon, called Health Works, Incorporated, that is doing this type of program. They employ a multifaceted approach that includes nutrition, exercise, weight loss, and stress reduction, among other things. The idea is to approach the employer and suggest that he pay the cost of medical care programs for all employees who participate, and not pay the cost for those who don't. Over time, this is supposed to work out to save the employer money. It might be on the bargaining table in the future.

MR. HALL: This kind of thinking is pretty far reaching. It shows that the employers, particularly the larger employers, have decisions to make as to just how deeply they should get involved in what heretofore were not considered to be employer concerns. They have to decide both in terms of what they would require of their employees and how much of their own money they wish to put into programs like these. We are just seeing the beginning of this.

MR. ALAN HOFFMAN: In what different areas of the group insurance plan are cost of living increases generally recognized?

MR. OLDS: The most common recognition of cost of living increases is in pensions. I don't think the increases are recognized specifically as such in group medical insurance other than the fact that companies frequently raise their group insurance rates to recognize the ever continuing increase in the medical provider charges. Of course, claim reimbursement based on reasonable and customary charges of medical providers is recognition of cost of living increases.

MR. HEADLE: There will probably be a little less attention to cost of living adjustments right now simply because of the very high rate of inflation. This creates a spread between what we can reasonably afford and what is needed to look like we are really doing something worthwhile. In other words, if you can afford an increase of 2% or 3% under a plan, and the current rate of inflation is 11%, there is not much incentive to make the 2% or 3% increase. This might incur the wrath of the employees by raising the subject and not appearing to deal with it effectively.

MR. HALL: Just the opposite point of view was expressed here a few minutes ago by Mike Gulotta concerning the change in their pension benefit formula. They went from a salary related plan to a plan that has some scheduled limits in it.

MR. GULOTTA: I agree with Carson's comments with respect to how corporations are meeting the problem of higher rates of inflation. Basically we have decided that we are not going to make any commitments whatsoever with respect to keeping employees whole relative to cost of living adjustments. For example, our last ad hoc adjustment in the pension plan was made in December, 1979. In passing the resolution increasing the pension benefits, the Board clearly stated that the employees were not to construe its action as any guarantees. This action and any further actions would be at the discretion of the Board. Looking prospectively, as a result of bargaining with the unions on the non-management pension plan this past August, there will be a 9% increase in benefits effective next July and a 7½% increase effective 18 months from that point. That will be it. There is no commitment to any other cost of living adjustments.

MR. EILER: AT&T has indicated that in some areas they are using cost containment to reduce the cost to the employers, shifting the burden for the claim from the customers to the employees. I wonder if other employers are going to do that. Does AT&T have a program for sharing an inflation reducing package with the employees?

MR. GULOTTA: We have gotten to the point where we do not think the employer should assume the entire risk of inflation. As a corporation, we are moving into a very competitive environment and we simply cannot afford to absorb

the entire risk of inflation. This does not mean that our employees will be neglected or allowed to suffer. We still have to be a good employer and we have to attract and keep our employees. These are very important objectives and without them we cannot run a business. At the same time we must strike a balance. One cannot accept the risk of inflation totally, and be competitive.