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GROUP LIFE AND HEALTH PRODUCTS UNDER CONDITIONS OF INFLATION

Moderator: PAUL R. FLEISCHACKER. Panelists: TED L. DUNN, RICHARD B. SIEBEN, NEAL N. STANLEY

1. The development of alternative delivery systems such as Health Maintenance Organizations

2. The potential for further computerization of claim, issue and recordkeeping systems

3. Viability of new areas of coverage, such as vision care and legal benefits, particularly in view of increasing employer costs

4. The future traditional insurance mechanisms as compared to "Administrative Services Only" and similar approaches

5. The varying effect of inflation on different segments of the health insurance market, and the resulting impact on product design and pricing

MR. PAUL R. FLEISCHACKER:
"Cost of Employee Benefits Soars 763% Over 30 Years"
"Health Insurance Has Unhappy 1981"
"The Battering Will Continue, Majority of Health Executives Say"
"Employers May Inherit Health Costs"
"Sharing Medical Costs With Workers May Not Curb Health Care Inflation"
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"Stop-Loss Buyers Find Eager Sellers, Low Price"
"Small Employers Switch Health Insurers"
"Benefit Cuts on Horizon? Recently Negotiated Pacts Contain Health Concessions"

These are but a few of the headlines of articles in our trade journals dealing directly or indirectly with the subject we are going to discuss today - group products under conditions of inflation.

In January, 1982, the Department of Labor reported that the average consumer price had risen by 10.4% and the average cost of medical care by 10.8% in 1981. A closer look at the medical component indicates that the hospital costs still continue to climb at an accelerating rate - 14.8% for room and board and 13.9% for other hospital charges.

A survey of hospital room rates and physicians' fees per visit conducted by Towers, Perrin, Forster & Crosby's (TPF&C's) research department in the fall of 1981 showed hospital room and board costs increasing at a rate of 5% to 28% depending upon the geographical location. Physician fees per visit increased at a lower rate, ranging from 5% to 15%.

The 1980 Chamber of Commerce Study indicates that total employee benefit costs expresses as a percentage of payroll has been relatively stable at approximately 37% over the three year period 1978-80. During this period, benefit cost per employee in dollars increased 8.2% in 1978-79 and 9.4% 1979-80. At the same time, the increase in total payroll dollars per full-time employee dropped from a 9.1% increase in 1978-79 to 8.0% in 1979-80.

What are the consumers doing in the way of health care cost containment practices? Recently, TPF&C's Employee Benefit Information Center conducted a survey of health care cost containment practices adopted by 213 major corporations located throughout the country. The following is a brief summary of some of the highlights of this survey:

Second surgical opinions covered by 84% of the responding companies; of those companies, only 2% made a second opinion mandatory and 22% encouraged the use of this option by providing financial incentives.

Majority of companies provided coverage for
- pre-admission testing - 94%
- surgi-centers - 87%
- extended care facilities following hospitalization - 74%
- home health programs 53%

Less than 20% of respondents covered employee expense for
- hospice care at home
- extended care facilities not following a hospital stay

Only 3% of the respondents required pre-authorization of non-emergency hospital confinement.

81% offered coverage by federally qualified HMO's. Employee participation, however, was relatively low. In nearly 75% of those companies offering HMO option(s), less than 8% of the eligible employees joined.

What are the insurance industry and Blue Cross-Blue Shield organizations doing to control costs? What alternative products and services are available from companies including third party administrators?

The program lists five topics. We will discuss the fourth topic first: The future of traditional insurance mechanisms as compared to "Administrative Services Only" and similar approaches. Our first speaker will be Neal Stanley. Until May, 1981, Neal was Chief Actuary for Republic National Life. At that time, he decided to consult in group insurance for self-funded plans. Neal is now associated with Group and Pension Administrators, Inc., specializing in group insurance benefits.

MR. NEAL N. STANLEY: Some years ago, probably in the late 1950's, we had occasion to prepare a pension plan for a hospital in the South. We were asked to determine the amount of pension that could be provided by a contribution of 5 cents per hour. I still remember being amazed and appalled at the level of salaries which were paid to the employees of that hospital. They were unbelievably low.

As a result of that experience, for years I viewed the increase in hospital costs as thoroughly justifiable and indeed necessary in order to enable the hospitals to pay a decent wage. A recent experience, however, has caused me to wonder if perhaps the catch-up has not been overdone. A one day stay for out-patient surgery of a minor nature produced a hospital bill of $1,133.80. This was the charge for a day room, operating room, anesthesia, recovery room, and a few drugs. No overnight stay was involved.

If hospital costs were too low in the 1950's, and they were, are costs too high in the 1980's? Or do present costs reflect the same level of inflation as other areas of the economy?

Using 1967 as a base year, the consumer price index for all items in 1950 was 72.1 while the index for the medical care component was 53.7. Therefore, in the 17 year period 1950 to 1967, the medical care component of the consumer price index increased 86%, while overall prices increased 39%. During this period, the number of physicians was a fairly stable 150 physicians for 100,000 population, while the number of nurses increased from less than 250 per 100,000 population to a little over 300 per 100,000 population.

During the next 10 years, 1967 to 1977, consumer prices increased 81.5% while the costs of medical care increased 102.4%. During this period, the number of doctors increased to 198 per 100,000 population and the number of nurses increased to 465 per 100,000. Also during this period, the portion of medical costs paid by the third party intermediaries increased from 48% of medical care services to 80% of medical care services.

From 1977 to January 1982, the consumer price index increased from 181.5 to 282.5, and increase of 56%, while the medical care component increased from 202.4 to 313.4, an increase of 55%. The number of physicians and nurses per 100,000 population continues to grow.

The figures suggest that the catch-up period for medical care costs was the period ending in 1967 where health care costs increased at twice the rate of costs in general. Since 1967, health care costs have increased pretty much in line with costs in general. However, a closer look at the medical care index reveals that such costs have been held down because prescription drugs and dental services, particularly prescription drugs, have increased less than the cost of living index, while physicians services have increased slightly more than the cost of living index and the cost of a hospital room has increased far more than the cost of living index. Using 1967 as a base, the hospital room index stood at 363.9 in May 1979, while the prescription drug index stood at 104.6 and the general consumer price index stood at 214.1.

Hospital care accounts for 40% of total health costs, physicians and dentists 25%, and drugs 8%. It is clear that the component of health care cost that most directly affects the cost of health insurance, namely the cost of hospital care, has gone up much faster than the other components of medical costs and much faster than other costs in general.

The cost of a hospital room increased 90% between 1965 and 1970, 62% between 1970 and 1975, and 54% between 1975 and May of 1979. These costs are continuing to increase. Any attempt to lower the cost of medical care must focus on this component of medical costs.

The U. S. Chamber of Commerce does a survey of fringe benefits of 983 large companies. In 1980, for the first time the cost of life and health insurance exceeded the cost of pension plans - $950 per year per worker for life and health insurance compared to $888 for pensions. Only Social Security at $954 per worker entails a greater cost for the employer. One would suppose that employers would begin to show the same attention to the cost of health insurance benefits that they have shown in the past to the cost of pension plans. Indeed, there does seem to be increased recognition of possible cost savings in the health benefit area.

In the renewal underwriting of group health insurance, there is a strong trend to giving increased credibility at a lower and lower case size. It is even argued that groups as small as 10 or 15 lives should have variance in renewal premium based on that group's own experience. The argument goes that a group with claims the past year is willing to pay a rate increase while the group with no claims will not accept a rate increase but will shop for the better rate.

Such underwriting practice gives the impression that every group will eventually pay its own claims. If that is the case, why not self-insure? The insurance carriers have effective methods to compete with self-funding on large groups. Minimum premium plans give most of the benefits of self-funding to the employer and at the same time give employees the comfort of knowing that the plan is guaranteed by an insurance carrier. Also, the insured plans have conversion features.

At least some carriers are attempting to hold minimum premium plans to groups of 500 lives or more. This practive leaves a large market for self-funded plans in the smaller case area. With both specific and aggregate stop loss coverage readily available to groups of 100 lives or even less, an effective proposal can be made to an employer of 100 employees. It would seem likely that minimum premium plans will have to be offered on much smaller groups if the life carriers are to compete with self-funded cases.

Another method of funding smaller cases is the high deductible plan. In this case, the employee will have the normal one hundred dollar deductible coverage; however, the employer buys a $1000 deductible policy from an insurance carrier. In the event of a claim, the employer pays up to $900 on a self-insured basis. A variation of this plan was recently introduced at a seminar in Las Vegas by a well known excess loss carrier. This plan features a $2500 deductible for employees and a $5000 deductible for families. In addition to the specific coverage, the plan also provides aggregate coverage. The plan is designed for cases as small as 15 lives. The plan is the standard comprehensive plan with $100 deductible, 80% coinsurance on the first $2000 and 100% payments on amounts in excess of $2000.

On a 15 life group with 8 employees and 7 employees with dependents, the aggregate attachment point is $7,150 and as stated previously the deductible is $2500 for single employees and $5000 for families. The policy provides for conversion to individual policies at a cost of 30 cents per month per employee. The rate, including conversion cost, surplus lines tax and filing fees is $34.76 per month per family coverage and $17.18 for single coverage. I do not know the age or sex composition of the group.

The rates include a brokerage commission of 15% the first year and 5% renewals. The rates also include a service fee to an approved third party administrator of $2.50 per month for a single employee and $4.50 per month for a family. Billing will be done by the excess carrier, not the third party administrator.

It would be my view that as less and less pooling is involved in renewal underwriting, the employers are going to determine to self-insure more of the risk themselves. This may be accomplished either through product innovations by the insurance carriers or by the continued growth of third party administrators.

One aspect of the health insurance business continues to intrigue me. In the middle 1970's, we were able to market as much guaranteed renewable individual

health insurance as we wanted with a commission of 12.5%. We were able to do full underwriting, and the products contained limits in the neighborhood of $7500. Yet we lost money and withdrew from the market. Now Multiple Employer Trusts (MET's) issue policies on two and three lives, pay 20% commission, do limited underwriting, issue virtually unlimited coverage, and expect to make money. Is it possible that individual coverage could be underwritten profitably today? If not, is it possible that small groups can be underwritten profitably? If neither individual nor small groups can be underwritten profitably, who is going to provide for the health insurance needs of the millions of individual proprietors, partnerships and small businesses in this country?

MR. FLEISCHACKER: Thank you, Neal. Our next speaker is Ted Dunn. Ted is a graduate from the University of Texas (BBA) and University of Michigan (MA). He joined Provident Life and Accident Insurance Company in 1951 as Actuarial Trainee and is currently the Vice President, Actuarial and Underwriting, Group Department. Ted will discuss the same topic as it relates to the Provident's experience.

MR. TED L. DUNN: As recently as ten years ago, all of the group business of the Provident Life and Accident was conventionally insured. In 1981, however, 74% of the group health benefit payments of $1.3 billion were made either under minimum premium or ASO plans and only 26% were made under conventionally insured plans.

There is an upper limit on the percentage of health benefit payments under minimum premium and ASO plans since many employers want some conventionally insured portion to remain in their plan. This could be the entire plan for small policyholders who want the insurance carrier to carry all of the risk for a pre-determined premium. Other policyholders would prefer to have an insured arrangement only for excess medical coverage on either an individual or aggregate basis, or both, and certain coverages may continue to be fully pooled such as high amount AD & D.

It should be noted again that the proliferation of uninsured and partially insured arrangements tends to dissipate some of the regulatory safeguards provided by conventionally.insured plans.

MR. FLEISCHACKER: Thank you, Ted. From what I have seen, the underwriting limits concerning minimum sizes for self-funded plans have been on a downward trend for the last two or three years. Would anyone care to comment on this trend and what limits it may reach?

MR. STANLEY: One hundred should be the very minimum. As I understand it in the industry, it is around 200 now for minimal funding. Some companies are even going as high as 500.

MR. DUNN: At the Provident, we started off doing ASO just for groups with one million and over annual premium, and then dropped it down to half a million for minimum premium with some exceptions. Right now, we are providing coverage on a minimum premium and ASO basis down to about 200 lives. When we announced this to our field force, we thought we were really letting the bars down, but we haven't noticed any great upsurge of interest among this size case, although I think it is inevitable that it is going to keep going down in size. One of the things that does concern me about doing these uninsured benefit arrangements on smaller groups is the lack of regulatory control. Somebody is going to get hurt, and it is going to be the insured employee. I would hate for the life insurance industry to get a black eye out of this

kind of thing. We need to be very mindful of this.

MR. FLEISCHACKER: As compared with minimum size groups for ASO, do the same underwriting rules apply for the offering of stop-loss coverages? I have seen some companies offer this coverage to groups with as few as 50 employees.

MR. STANLEY: I know that it is done, but, considering the costs involved, I don't see how you can have as effective a proposal at 50 lives as compared to a fully insured plan.

MR. DUNN: If you are going to get into the market place under 200 lives, you have to provide this type of coverage because these groups cannot bear the shock loss of a large claim. It is just not feasible for a company that size to attempt to fund some of the large claims that we routinely see now, as contrasted to a few years ago when a claim above $50,000 was very rare.

MR. FLEISCHACKER: Our next topic will be item five in the program: The varying effect of inflation on different segments of the health insurance market and the resulting impact on product design and pricing. Richard Sieben will address topic. Dick is the President of R. B. Sieben and Associates. Prior to that, he was the chief financial officer for Blue Cross and Blue Shield of Illinois.

MR. RICHARD B. SIEBEN: I assume most of you attended the excellent session yesterday afternoon as a warm up to today's topics. It featured analyses measuring both the magnitude and internal characteristics of the inflation we've been experiencing in health care. That session ended with a gentleman posing a philosophical question about the concern expressed about health care representing 9.8% of the Gross National Product (G.N.P.). He noted the implied premise that this is too high and questioned whether thoughtful consideration might make the case that the appropriate level should be even higher and that we're worrying about the wrong problem.

I don't think we'll get an answer to his question. The sheer size and growth of the health care component will keep the debate biased in favor of "too much." The focus is on the fact that the growth of the health care component continues to exceed the growth rates and inflation in other critical components of G.N.P. When total G.N.P. growth rates have been low, or flat, one of the critical changes is that our post war experience of having health care consume an expanding piece of an expanding pie has been replaced with the pressures to recarve a pie of constant, or modestly expanding, size.

The demand from all segments for more, when there is no longer enough more to give everyone something, implies smaller slices for some segments. The size of the current health care slice makes it highly attractive as a target for either capping or reducing its share. Against this background, a thoughtful national policy debate to determine whether a larger share would be a proper objective won't occur.

Instead, we will continue to have policy skirmishes like the recent cost shifting strategy, and we are unlikely to reach a national policy decision in an orderly fashion. Short term reactions and responses will assume a problem, will shift dollars from one sector to the other and will create severe disjoints, increasing the unpredictability of our work. There are indications that the attack will continue and the discussions will be less than rational. That's the price that goes with the size of the segment we're participating in as health insurers.

For example, at the budget presentation last month, Secretary Schweiker of Health and Human Services referred to the current 19% rate of increase in the cost of hospitalization as "unacceptable," and the threat of caps was raised again.

The issue in Washington, of course, is the extraordinary growth in the portion funded by the government and the search for ways to withdraw some support. I find it interesting that five years ago, our industry was arguing against further government expansion into the private sector. Yet, when we come to count on a given level of government participation, the threat of cut back or withdrawal raises extreme concern about the short term impact.

The industry's response to shifting is correct in noting its severity and that it is hidden from clear public understanding of its impact. However, the industry also claims that it is unfair to shift some of the Medicare burden back to the private sector. Our thinking is muddled by the fact that so much of government participation is hidden.

The government subsidy of our business is hidden through the non-taxability to us as individuals of employer contributions for the cost of our health care. For example, assume your employer pays $1,000 for your health care and that you're in a 30% tax bracket. Your net cost is $700, and the government tax subsidy is $300. If the government overtly, or indirectly, forces a 10% increase into the cost borne by the private sector, then the cost of your benefit is $1,100, and the net cost to you is $770. They've increased the tax subsidy to $330, so that the net private sector subsidy is reduced from $300 to $230. That is a reduction in subsidy, not a $100 penalty.

I don't approve the cost shifting action. However, fairness is not the issue. We are very much involved with government participation, not only in what government funds directly, but through what it indirectly funds through the tax policies that have added to health care inflation.

It is only five years ago that I first heard any serious suggestion that some changes in tax policy would be necessary to get market place forces working on the health care cost decisions made by individuals and providers of care. The extent of third party payment has immunized those decisions from the forces of the market place.

Now, of course, that topic is hot in Washington, and the debate is public. The thrust is aimed at limitations on employer deductions combined with tax free incentives for individuals choosing a lower cost plan, rather than upon limiting the tax free income to individuals. However, we continue to respond to one piece of policy at a time, and we must expect that to continue and should anticipate that the decisions will not always be rational nor be without disjoint.

The impact of the historic inflation patterns of health care and the particularly severe inflation of the last two to three years has created the conditions where we should expect more disruption. We will not return to business as usual, because the pace of tampering and experimenting will increase. The conditions that have prevailed will undergo fundamental change. Tax deductibility was not an issue. We assumed that Medicare would pay relatively fairly for its patient load. Changes will occur, and they will be disruptive and difficult to deal with.

I'd like to make some observations about inflation in hospital costs to underline the difficulties. The behavior over the last three years has been abnormal. Trends for hospitalization have been exceeding medical surgical trends, and it's usually the other way around. Furthermore, the current combined cost and utilization hospital trends of 19% to 21% have been sustained at that rate for nine quarters. They leapt to that level after a cyclical bottom of 11% to 13% in 1979. 1979 was an aberation, with the health care component of Consumer Price Index (CPI) approximately equal to the aggregate CPI, a very unusual phenomenon during the past 25 years.

Again, indirect federal influence can be identified. There was tremendous heat applied with voluntary price controls, plus the threat of cost containment or capping legislation in Congress. This led to the voluntary effort, which was a political survival strategy of reducing one's visibility by making smaller than necessary increases in hospital charges.

When the Carter administration's programs appeared politically dead in late 1979 and early 1980, a surge in prices was unleashed to catch up. The artificial restraint through 1979 severely impaired hospital margins, and the 1980 price increases weren't sufficient to recover the losses incurred in 1978 and 1979.

Thus, we see inflation in hospital charges increasing dramatically after a period of severe restraint and then being sustained at those high levels for some nine quarters. At the same time, we have observed coincident straight line decline in inflation rates for many of the elements in a hospital's cost, such as food, energy, etc.

Whatever ratcheting down we have seen in the cost component in hospital trends over the past nine quarters has been partially offset by the impact of two recessions on utilization. Although very recent experience would permit the conclusion that the annual trends may have fallen off to 16½% from a 19% to 20% base, it is very difficult for health underwriters to assume that the recent levels won't continue to obtain after experiencing the extraordinary shock of seeing trends leap from 12% to 18% across two calendar quarters. There are always cyclical spikes in trends when utilization surges prior to cost inflation relief. However, a sudden 50% increase in trend, an absolute increase of 6% to 9%, and the holding at that new high level for nine quarters, certainly does violence to a business that has margins of 2% to 3% in good years.

After such an experience, it is difficult to adopt trend assumptions recognizing that a real and significant drop was overdue, that all the catch-up has probably occurred, and that utilization increases will soften if the economy merely stops declining, much less recovers.

It's particularly difficult to risk such an assumption when the system may experience an aggregate one time surge in hospital charges of 4% or more to compensate for federal cost shifting. The figures can vary a good deal nationally, when the state by state responses to Medicaid cut backs are considered.

How and when will this occur? If it is immediate, our twelve month trends could exceed recent levels. If it is factored in at the rate of 1% per quarter, will the rates of general decline in trends reasonably anticipated be sufficient to offset it? Insufficient? More than sufficient?

The safe assumption is that 1982 will be just like 1981 and 1980, and that you can't predict things will get better until you can prove that they have. Thus, at the end of 1982, we could be looking back at three years of hospital inflation at the 18% to 20% level, with single digit inflation in other areas of the economy lowering general societal measurements of reasonableness. That will stick out like a sore thumb and build pressure for even more intervention with the consequent disruption to predictability. Talk of caps and public statements about unacceptable rates of increase tend to cause some price increase merely to position oneself better in the event the talk turns to action.

To survive in this environment, we have to broaden our definition of the product. We usually think of the benefit design and scope of coverage, concentrating on deductibles, co-payment levels, stop loss features, the insuring formulas for reimbursement. Product also includes the lateral expansion of coverage to dental, vision, home health care, etc.

We must consider the product as the entire health care delivery system and understand the economic forces of change in that system. That product is provided by someone else, and our insuring mechanisms are terribly susceptible to the pricing disjoints and the experimentation and innovation that is forced by federal consideration of pro-competition and tax reform, particularly with the modest margin structure we have usually built into our business.

When you so define the product, you must consider your exposure to hospital responses to these changes. The withdrawal of three to four billion dollars of Medicare and Medicaid patient support has to be picked up in their billings to the private sector. The 4% aggregate cost doesn't apply to individual hospitals. Access to federal funds has created hospitals that specialize in care to such patients, and it can be argued that such magnet hospitals have delivered better and more efficient care. However, if 50%, or more, of a specific hospital's beds are directed to such care and it is suddenly faced with receiving less than what that care costs, it has to reduce its dependency and market many of those beds to the private sector. Yes, many hospitals have marketing departments today.

Some hospitals are faced with insolvency, absent relief from local taxing authorities. I recall hearing claims of unfairness in a Florida County faced with the impact on the County Hospital of the Medicare cut back. The main industry of that county is attracting and servicing the elderly. Withdrawal of full support of Medicare now faces that industry with a new cost. If the local tax structure won't respond, insured groups in that county will have a shocking jolt to their cost patterns. Thus, the policy shift fall out impacts a local economy, and the restructuring decisions between federal, local, and private industry shares get made one at a time in the absence of a national policy debate setting broad restructuting objectives.

Responses to this turbulence in the business of running hospitals include quickening the momentum for consolidation. Hospital management companies, religious orders, and others will find cause for consolidating and centralizing services.

The realities of the market place will reduce the number of totally independent hospital units, and the delivery system has more centralized power.

We've seen similar market place responses in the delivery of professional care. The formation of the group practices that are necessary to HMO growth has the strong economic incentive of permitting doctors to share capital and administrative overhead, rather than one doctor risking that overhead alone.

Again, we've been designing insured group dental programs for twenty years, yet the market forces have evolved dental capitation programs, not as dental HMO's, but as opportunities to buy wholesale. Given an excess supply of dentists and the heavy capital equipment costs to start up a dental practice, individual dentists are hurting, and it is possible to attract a group of dentists and to negotiate a capitation that is considerably lower than traditional fee for service structures would cost. Through sharing of overhead and the marketing ability to keep the dental chairs full, the market place economics permit wholesale competition delivering more care for less than our traditional reimbursement programs.

In the design of our products, we need to understand the survival strategies of hospitals, doctors, and dentists, as they cope with what may be an oversupply of providers competing for less relative income.

When these strategies force groupings of providers, the opportunity to negotiate directly is enhanced for those who have the marketing power to deliver patients. The Aetna's new program, Choice, where the patient chooses the primary care physician, but has powerful incentives to select from a limited group of specialists with a specific hospital affiliation, is an example of providers hooking up with carrier distribution capacity.

We have customers and can negotiate incentives to individuals enrolling in programs that will purchase care from specific providers.

I would hope to stimulate some discussion based on the premise that the real product is the health care delivery system. The impact of inflation on that system has been to foster tampering, intervention, experimentation and innovation. There is more to it today than selling a group policy covering 150 employees of a particular employer and paying claims.

Consider what happens when you put competition in that program, with high options, low options, HMO's, etc. The extreme example is the Federal Employee Program, where the Blue Cross and Blue Shield programs have had the high option insured program. Each federal employee has the choice of high and low option Blue Cross and Blue Shield, other traditional insurance programs, plus several HMO options. Over time, the high inflation rates force migration from the highest cost programs, and each program experiences anti-selective deterioration in addition to trend inflation. The people who leave the highest cost program are usually healthier than those that remain, but less healthy than those who initially opted for the lower cost programs. Thus, when you measure the price increases necessary to keep each separate pool healthy, the perception is that the savings aren't being realized and that more reform is necessary.

As most carriers are positioned to offer what will be considered the high cost program, the providers of the experimental or low option programs will benefit from selecting against them, and you will have problems in pricing for the risk of declining participation as well as in dealing with the perceptions that your program is increasing in cost at an unreasonable rate.

HMO's have benefitted from positive demographic selection, and traditional coverage has been hurt. It's natural for the public to conclude that they need more HMO's, since the increase in the cost of traditional coverage looks out of line in comparison.

A final impact of the sustained inflation we've suffered has been the result of the paralleled high cost of money. We have seen a tremendous increase in the number of self-funded and minimum premium programs. Carriers who might have had 5% of their total book on the cost plus or minimum premium basis five years ago may have 40% to 50% of this basis today. The cash flow problems and interest costs of many businesses have led to daily wire transfers to cover today's claim payments.

If we aren't functioning as insurers when a program is self-funded, and we're not participating in the financing by holding reserves and earning a little interest, all of the cost pressure is on our efficiency in processing the business. A cottage industry of mom and pop claims administrators have joined the larger third party administrators in competing to take over that function, promising to individualize service and save administrative dollars at the same time.

If we weren't handling the money or insuring the risk, and somebody else is paying the claims, are we still in the business? We've unbundled our functions drastically in response to inflation, and other parties than carriers can compete for the separate parts.

Thus, a carrier's base for competing may be reduced at a time when it requires a very large base to make the complex strategic innovations necessary to survive in the health care delivery market. How large will a national carrier have to be to carry it off successfully? Many may have to consciously down size and carefully select the points where they'll participate. It will be difficult to stay sharp with all of these potential changes in delivery, with each employer offering four or five choices, and with competition for each piece of our traditional services. It will be difficult to conduct our businesses successfully with the operations we've built over the past twenty years.

If the unbundling continues, there is still tremendous need for our forecasting and pricing services. The first thing to disappear in a self-funded program is the thing that employers can least afford to give up, and that is the cost certainty that is part of a premium transaction. They have added uncertainty and unpredictability to their own costs. We, as actuaries, have the opportunity to reinforce the value of carriers in a market that has probably over-reacted to this unbundling phenomenon

This is the environment inflation has wrought. It isn't the same product, and our role isn't the same. I don't think it is a time for despair. It's extremely exciting - but it ain't gonna be easy.

MR. FLEISCHACKER: I have a couple of observations regarding Dick's comments. First of all, dealing with dental programs, capitation programs and over supply of dentists, these are a couple of capitation programs in the Twin City area that I am aware of that are set up along the lines Dick talked about - to take care of the over supply of dentists and to provide for a reasonable level of income for them at an affordable cost to the employer groups. In addition, there is a program called Consumers' Association For Professional Services (CAPS). Essentially, it is individual dental insurance. It is similar to a capitation program in that the association has negotiated with certain dentists

to provide certain levels of preventive and major restorative type services, such as entodonics and periodontics, at a discount.

The second item pertains to the comments made on multiple choice health plans and the potential effect on the cost to employers. This has great carry over repercussions to cafeteria type plans where you have multiple health options including HMO's. How do you price these options and take into account the potential anti-selection?

MR. SIEBEN: If your cafeteria is like mine, the price has gone up and the quality has gone down.

I'd like to give you an example of a situation where HMO's might be hurt by the anti-selection created by multiple choices. Initial HMO offerings usually find rough price parity with traditional broad coverage plans, particularly when offered to governmental units where the age characteristics are higher than in most industries. Modest price differentials can be overcome by the broader coverage usually offered in an HMO.

About a year ago, the State of Illinois determined that it could not afford the increase in cost necessary to support its existing health care program and made a substantial decrease in its basic program benefits, with changes in deductibles, inside limits, coinsurance, etc.

The State pays 100% of the cost for employees and makes a very small contribution for family coverage. Several HMO programs are offered.

Thus, they down grade the basic program, minimizing the contribution increase, so the differentials for the several HMO programs increased substantially. So did HMO enrollment. One program had a 600% growth. When the big program became lower cost by reducing benefits, there was significant flight to the broader benefit HMO programs.

Given the increased cost differentials, we can guess who enrolled: people currently under care protecting their coverage.

Despite the talk about controlling price through higher deductibles and copayments, there has been limited employer response. There is potential for very adverse selection against HMO's if employers respond by reducing benefit programs where dual choice exists.

HMO's could become the clear high option. They have often been beneficiaries of positive selection in the initial period of their marketing, but will face real threats if they hold to broad community rating mechanisms and can't differentiate between risks when competing programs reduce benefit levels.

MR. MARTIN STAEHLIN: What does the panel see in the 3-250 life market in the next couple of years?

MR. SIEBEN: We must solve the problems of the 3 to 250 life market. Given our observations of what is happening in the 250 and over market, they may be the only problems that are really left to us to solve. If the larger employer is going to hold all the cash and transmit at the rate you pay claims, is self-insuring, and is going out to bid on administration, soliciting bids from third

administrators quoting on cost per claim or cost per head with promises of trouble free claim service, big coordination of benefit savings and twenty-four hour turn arounds, which part of the market will we be insuring, unless it's the one you call the current problem? Where else can the profit come from?

MR. STANLEY: It is a shame that there is no individual coverage available for the smaller groups, where people could get long term commitments to their insurance needs. Right now, for 3-25 lives, I would suggest a MET. This is still a problem because these groups are all having to shift from one MET to another for a year or two, and the agent has to spend all of his time rewriting the same groups. For 25-50 lives, I would suggest buying group coverage from a good company. Starting at 50-99 lives, I would recommend the high deductible approach as opposed to self-funding. At about 100 lives and up, you can begin to consider self-funding.

MR. FLEISCHACKER: I have one other observation in this area. Some smaller employers have been convinced that self-funding is the way to go and that this is really going to reduce their costs. If they sat down and added up all of the pieces of going self-funding, the cost for the stop loss coverage and administration, as well as the claim costs themselves, they would find out that the sum of these pieces would likely exceed an insured program. I'm talking basically in the size ranges that Neal was referring to, the 3-50 or 3-75 life group.

Our next topic will be item three in the program: Viability of new areas of coverage, such as vision care and legal benefits, particularly in view of increasing employer costs. Ted Dunn will address this issue.

MR. DUNN: Vision care has been provided in some benefit plans for 20 years or more, but this coverage, and others like it, have never caught on due to the continuing crunch on employer costs of funding medical care cost increases and adding other coverages such as dental to the employee benefit package. In the Southeastern part of the United States, for example, dental coverage is only now being added to many benefit plans.

This crunch on employer costs is going to continue for the foreseeable future, and new areas of coverage may more likely arise from the employee pay all payroll deduction area. Coverages in this area currently include mass-marketed automobile and home owners insurance and life insurance plans providing additional coverage through some combination of term life insurance and an accumulation of permanent values.

MR. SIEBEN: What is the economic value of the products we're discussing? Vision care is certainly more questionable than group legal, and group auto is a creature of tax policy. You know it is cheaper for me to add $100 to your income through some insured benefit mechanism than it is to pay you $100 in wages. That's the only reason for the dollar trading of vision care. We can talk about promoting good vision, but the economic loss to the vast majority of the people you know without vision care is trivial. This is true for most dental plans, as well. These coverages are just part of your compensation package.

Broad catastrophic health coverage is really casualty insurance, protecting your assets, directly, or through protecting against the creation of substantial debt. It's the same as fire insurance, protecting you from being wiped out if

your assets aren't covered. You could walk out of this hotel, be hit by a car and have $75,000 of medical expenses before you regain consciousness; so you protect against that risk.

But why do you need insurance to cover something that is easier to budget than a new refrigerator? Gosh, I didn't plan on new glasses, and I'm really hurting.

Other than the tax incentive, there are provider forces at work as well. They will get together and offer a discount for vision care to capture a market. Group legal care will compete with pre-paid legal plans, because there is a lawyer glut, as well. If the government dumps accountants as well as lawyers back into the private market, we'll have pre-paid accounting care as well.

MR. FLEISCHACKER: The next subject is: The potential for further computerization of claim, issue and recordkeeping systems. Ted will address this topic.

MR. DUNN: A number of computer systems were devised in the 1960's and 1970's to handle the claim and administrative functions associated with group insurance coverages. An important impetus for such systems was the desire to obtain productivity gains among the work force performing the functions.

With the possible exception of a few sophisticated computer systems implemented in recent years, many companies and institutions are finding that their existing computer systems are rapidly becoming out of date and require more and more time and expense to maintain. Many current computer and manual administrative systems are not designed for the current methods being used to finance group insurance benefits and cannot be modified to accomodate them. In addition, it is not unusual for an entire group insurance systems staff to practically devote its entire effort to maintaining the existing systems with little or no time remaining for developing new systems.

Although the inflation levels during the middle 1970's did not unduly reduce group insurance profit margins, the double digit inflation rates on expenses in recent years significantly reduced profit margins on group business as well as contributing to adverse underwriting results. Group operations which are going to survive the 1980's must have low unit cost factors for paying claims and running administrative systems, while at the same time maintaining profitability and high service levels.

Claim computer systems are going to have to provide meaningful cost containment data demanded by our customers in addition to providing all of the other necessary records for maintaining the business. Companies with future low unit claim costs are going to be receiving a great deal of their claim information from the National Electronic Information Corporation and similar arrangements.

A current example of an application of further computerization in the issue area is the preparation of an employee booklet-certificate for a new or revised group benefit plan. Most of the wording for the booklet-certificate is stored in the Word Processing equipment. After any suitable changes are entered by a contract underwriter, the revised text is electronically transferred to a laser printer which prints the booklet-certificate.

MR. FLEISCHACKER: Our final topic is: The development of alternative delivery systems such as Health Maintenance Organizations. Dick Sieben will address this subject.

MR. SIEBEN: HMO growth has been dramatic during the past decade of inflation. In 1971 there were 3.4 million members enrolled. The annual increase for the next three years was 600,000 members, with 5.3 million members in 1974 when the HMO Act began to have an impact. The complications of that act may have been responsible for the annual growth slowing to 300,000 members per years through 1977. From 1977 through 1981, membership increased from 6.3 million to 10.3 million, with the largest absolute and percentage increase coming in the last year.

In recent years, the number of HMO's has been increasing about 10% per year, with a total of 254 in mid 1981.

The growth is uneven nationally, with 35% of the membership in California. The only areas where HMO's have more than 10% market penetration are the West Coast, Wisconsin, and Minnesota. There are many sections of the country where they haven't made a dent yet, so markets vary from mature to non-existent.

The era of federal funding caused some problems. Many HMO's weren't soundly conceived or managed, and the federal requirements for qualification led to ignoring sound underwriting principles. The disappearance of federal grant support would certainly lead to shock price catch-up if revenues were 10% short of expense.

Initially, the Act encouraged unsound underwriting and was oversensitive to HMO independence from traditional carriers. The regulators appeared to believe that close ties with carriers meant carriers would stifle HMO growth to preserve their traditional base.

The pendulum swung rapidly. Insolvency has been an issue. It is estimated that $2,000,000 or more of initial losses are incurred before most HMO's are large enough to break even. The size estimates for break even range from 25,000 to over 50,000 members.

Thus, strong financial sponsorship was permitted and eventually encouraged State regulators who will deny rate increases for traditional carriers to prod HMO's to increase their rates even more than they plan. The industry is thinly capitalized, and the solvency concerns are legitimate.

The capital requirements for start up, expansion and growth are large, and venture capital is appearing from private investors, business, and carriers. Acquisition will occur as it did earlier with the purchase of proprietary hospitals.

One of the largest infusions of private capital is, of course, Pru-Care. They recently purchased a major HMO in the Chicago area, and I understand they intend to open a new facility of that HMO every six months.

I'd like to relate this development to the remarks I made earlier about the opportunities for negotiating directly with the providers of care and finding mechanisms for controlling the cost of care on behalf of your customers.

Providers can organize locally. Thus, you have to have a concentrated customer base or marketing strategy to negotiate. Consider Prudential's withdrawal, temporarily I understand, of the products offered the three to fifty life market through their national agency force. At the same time, they pay a substantial premium for a financially weak HMO serving the northern suburbs of

Chicago and announce plans to spend large sums expanding Pru-Care throughout the metropolitan area.

That appears to be a concentration of marketing. Rather than have a million insureds in a national market, why not pick a few markets and seek some of the coverage of all employers rather than all of the coverage of some of the employers? Concentrate on Chicago market share and write 200,000 contracts and repeat that in several other markets, and you can gain a million insureds with much more control than through the traditional nationally distributed product. That's focusing your power where the power handles are available.

If down sizing your group health operation isn't attractive, then you have to consider whether you can concentrate your efforts in an area where you are strong and seek penetration large enough to get you into direct negotiating on behalf of the employers you serve, and you'll be the marketing partner for these alternative programs. I'm not sure that is the way to go, but there appears to be evidence that such strategies are developing. Rather than try to cope with the complexities of having a tiny share of a national market, it may make more sense to seek 10% of limited geographical markets. Does this strategy of market restructuring look like it's likely to occur? I've read a lot into a few events, and I'm curious as to whether others have reached the same conclusions.