RECORD OF SOCIETY OF ACTUARIES
1983 VOL. 9 NO. 4

HEALTH CARE ISSUES AND STRATEGIES FOR THE 1980's

Moderator: ROBERT H. DOBSON. Panelists: MEMBERS OF HEALTH SECTION COUNCIL. Recorder: DONALD G. HAMM, JR.

MR. ROBERT H. DOBSON: I know we are glad to be at this session because this is a very exciting time. It is the first Health Section day at a Society meeting. The Health Section was the first special interest section formed, and the first section, as far as I know, to produce a newsletter and sponsor a day at a meeting.

We're trying some different and innovative things. Health actuaries tend to think of themselves as innovators. It already started this morning with a networking breakfast. I thought that was a success. I see some of the people are slow getting over from that room, so they must have been in interesting discussions.

It's a real honor for me to be here with the people that are on this panel. They are all either current members of the Health Section Council or former members and I think these people are some of the best health actuaries. I know they will provide a lot of valuable information on their interesting topics.

We are going to start off by hearing from Paul Barnhart. Paul is a past president of the Society of Actuaries and Chairman of the Health Section Council. He will be talking about the state of the Health Section and taking care of a few business matters.

Then we will move into presentations on topics of current interest. The first report will be in the individual area by Spence Koppel from Combined Insurance. He will be followed in the group area by Ray McCaskey from Blue Cross and Blue Shield of Illinois, who will report on the group area. After these presentations, we will have somewhat longer presentations leading into two sessions that will take place later in the day. I'll say more about those later.

I want to briefly read one thing from the Society of Actuaries Yearbook about what sections are supposed to do, it will help to remind everyone about our purpose and help in the soliciting of comments. "The key to the sections concept is bottom up or coming from the members interest. This means that sections will be stuctured, but flexible, so they are responsive both to the needs of the profession and to the specific needs of the members. Society members can discuss their special interests at the section level with other members and still be served professionally through the Society structure." Since we are trying some innovative approaches to some of the sessions today, some of them are going to be more successful then others. We really can't do a good job of serving the members of the section without hearing from you about both what you like and what you don't like. I certainly hope that you will be responsive and let us know, either through the Health Section Council or through the Education Commit-

tee, which sessions you like and don't like.

MR. E. PAUL BARNHART: My main purpose this morning is to conduct the shortest business session on record, because we don't want to interfer with the program. We do want to have a short business session since we think you do want to know what's going on.

We are going to begin by calling on Ed Wojcik to present a report on the election.

MR. EDWARD J. WOJCIK: Here is just a short report on the recent election for the Health Council Members. The 309 valid ballots returned from 760 eligible voters created a return rate of about 41%. This compares with last year's return of 331 from 600 eligible voters or 55% return. Some of our eligible voters aren't really showing enough interest in the Health Council elections.

The result of the election was that there are three new members, each having a three year term of office expiring in 1986. The members are as follows: Bob Dobson, Don Peterson and Charles Kraushaar. If these gentlemen are here, please stand up and be recognized.

The outgoing members of the Council are Steve Carter, Allen Ferguson and Tony Houghton. I would like for them to rise because they have done a wonderful job on this Council in the past couple years.

MR. BARNHART: I do not know what to think about the voter turnout for this election. We had 55% last year and 41% this year. I don't know what this says, but I know that in the Society elections, the percentage of Fellows voting has been slipping. Maybe that is just a measure of the growth of the Society and the difficulty of knowing who people are and who the nominees are. We hope that the other 59% of the Fellows will give this some consideration and cast your ballots, because you really do have some input regarding the Council membership.

We had an intentionally short response time which we thought was better. There was supposed to have been about a three week response time. If some people did not get their ballots, we will have to mail earlier in the future.

You have all been paying $5 dues to belong to this organization. We thought you might have some interest in what has been happening to that $5; therefore, Pete Thexton will give you a brief treasurer's report.

MR. PETER M. THEXTON: We started with a fund balance of about $3,700. We received dues of $5,200 and received $500 of interest. Our expenses were nearly $3,000, most of which went for printing of the newsletter. The ending fund balance was $6,400.

MR. BARNHART: The primary expense for most of the sections is expected to be for printing. Since we will be putting out a quarterly newsletter, it appears that most of our expenditures will be in the area of membership communication primarily through the newsletter. We hope to eventually become involved in some seminars and organize more meeting activity. Although we expect some additional expense, we will not consider raising dues.

I would like to ask for a show of hands on how many in the room are Associates. (Approximately 25% of those in the room raised their hand). That is good representation. Let me ask another question? Assuming you could vote in this section, would you exercise that franchise and do better than these fellows who had a 41% turnout for the last election? Can we now see a show of hands as to how many of you would vote given the privilege and opportunity of doing that? (Nearly all of the Associates raised their hand). I'm happy to announce that as of right now Associates have that privilege and opportunity. Let me explain what has happened. There is a new pension section that is being formally organized at this meeting. In their petition for organization they very strongly urged the Board to allow Associates to vote and hold office, because they felt they had so many practicing pension actuaries. Many of them, who have been practicing for years, are Associates but not Fellows of the Society. The board agreed with it so strongly that they adopted a rule that all new sections, including the new Pension Section, must allow Associates to vote and hold office. For the five existing sections, of which we are one, the Board's decision was to make it optional with the section. Your Council decided that we might have submitted it to a vote and let the Fellows decide whether or not to let Associates vote. We really decided that it was a foregone conclusion that the existing sections would most surely make this change. By vote of the Council, we petitioned the Board to allow change of the bylaws permitting that voting, holding office, and all the rights and privileges of membership in the section, are simply stated in terms of 'members of the Society'. There will be no distinction between Fellows and Associates in the bylaws.

We hope that you enjoyed the first issue of the newsletter. I felt it was packed with information about what is happening with the section. I am going to let the first issue of the newsletter serve to cover the status of the section.

I was also assigned by Bob to say a few words about the status of regulation. Certainly the hottest issue is Unisex. Let me ask again for a show of hands. How many of you were in that session yesterday on the Unisex problem? (Approximately 20% of those in the room raised their hand.) I assumed that many of you were there. It certainly appears that our hottest regulatory problem lies in that area, in spite of the fact that no Unisex legislation has been passed by Congress. It appears that companies dealing with Group conversions or even companies with payroll deduction plans involving individual disability policies may have to recognize this problem. There is a definite implication that any kind of health coverage, even though it is individual policies on a group conversion basis or a payroll deduction basis, may have to respond to the implications of the Norris decision of the Supreme Court. That remains to be seen. Obviously our most pressing problem is whatever needs to be done to accommodate some of these issues, particulary the recent Norris decision of the court.

MR. SPENCER KOPPEL: I was asked to talk about trends in Individual A & H. As I was thinking about these trends, I realized that I really must distinguish between those things that are actually being developed or are developments that are around, those things that might be trends, or in the third category, those things which are just wishful thinking. Trends are driven by the various conditions existing in the marketplace or the operating environment. Clearly one of those trends still is the old bug-a-boo

of inflation as it affects medical care costs, and the Medicare and the State of New Jersey's approach to inflation by the use of the DRG (The Diagnostic Related Groupings) of various care categories. I presume many companies are considering putting similar types of provisions in their policies, and it might also be used in a group situation. I think that on the individual side, companies might be considering putting a similar type of provision into their policies with the specific benefit amount varying by the area in which the policyholder resides.

In general I think because of inflation, indemnity types of benefits and surgical schedules are being considered. I don't know whether they will return, but limits on the amounts paid as opposed to reasonable and customary seem to be talked about a great deal more.

Similarly, cost containment provisions like second opinion surgeries, outpatient benefits, and outpatient surgeries are also being talked about more in the medical care types of coverages.

In the area of inflation, companies have to deal with rate increase situations. Companies are realizing that a rate increase does not always or rarely has the results that are intended. Clearly, the more you raise the rates, the more policyholders who are in good health are going to go to another company where, if they can qualify for new insurance, they can get coverage at the select rates. Companies and regulators are realizing that something has to be done to deal with the issue of closed blocks of policyholders where there are no healthy lives to keep the rates down. In the regulation area, Washington and Florida have offered regulations which consider the closing off of a block of policyholders having such adverse selection which causes their rates to increase. These policyholders that can not get coverage anywhere else have to keep paying the higher and higher premiums or else dropping their coverage entirely.

Inflation also affects your administrative costs and companies are looking for ways to reduce their costs in the underwriting area by greater use of pre-existing condition exclusions as opposed to full underwriting. Direct response marketing is one of the marketing areas that is being considered as a hopefully cheaper way of marketing as compared to an agency force. Time will tell which one is actually cheaper.

Regulation has an impact on policy design. Certainly minimum loss ratio standards will eliminate policies which cannot meet these minimum loss ratio standards. This may or may not be a good situation. Companies will be deciding whether or not to offer policies that have lower loss ratios. If they offer these policies, they must find a way to raise the loss ratios. This might include the elimination of heavy underwriting or paying of claims more liberally. If a particular loss ratio must be achieved, why pay a significant amount of claims administration expense when you must increase the loss ratio through other means. Obviously, you do not want to pay an inequitable claim, but to the degree that you are going to have to achieve a particular loss ratio, companies are probably going to be considering ways to accomplish that at the lowest possible cost.

Unisex is obviously going to have an impact on the policy design and the rates. The available technology may provide companies the opportunity to change from packaged policies towards individualized benefits.

Administrative technology will probably affect the way health insurance policies are designed in the future.

There has been talk at other meetings concerning individually experienced rated policies. Just as with auto insurance, a policyholder's own claim experience can affect their rate.

Trends in aging are that a greater proportion of the population in the United States is becoming over age 65. This has been the trend over the last several years. It is projected to continue but eventually level off. This group of policyholders has clear needs for certain types of benefits and I would think that the trends will be to design better benefits for this group of policyholders.

Trends in the workforce are the existence of more women wage earners and two income families. These might bring about loss-of-time types of products that are designed more specifically for these situations, either through joint policies or through benefits that are specifically designed for a two income family.

And the last item that I would like to comment on is that investment yields in the last several years are significantly higher. This appears to have created a trend away from the pre-funding of future benefits both in the life and health insurance areas. This comes about naturally by virtue of the fact that it is more expensive in opportunity dollars for a policyholder to fund his future benefits with current dollars. The policyholder would choose to lower the amount of premium paid and fund the additional amount by other means to achieve a higher investment yield. I would raise the question whether or not true level premium guaranteed renewable health insurance that is inflation related, or even aging and selection rated, is a viable product in today's environment.

MR. RAYMOND F. MCCASKEY: When I was asked to stand here before you this morning, they wanted me to spend 10 or 15 minutes talking about all of the current issues of the day or at least everything I know about them. And about 10 or 15 minutes should just about do it. But when I really thought about it, there is actually quite a bit of material to cover. There is a series of things that people in the group business, or at least in the group health business, really have to consider.

Most of these things, which I'll call new developments, in one way or another relate to what all of us probably consider to be a very old problem. That is the problem of medical care costs taking quantum leaps every year and having to explain why it is our premiums are going up 40% when the CPI is 15%. Now much of this is not really new. These things have been around for a long time, such as the new evolution of medical technology and increases and shifts in utilization and so on.

To the health actuary, maybe all that has changed is the pace of change. Things seem to be happening faster or maybe I'm just reacting slower. But I think things do seem to be happening out there. And another twist is that we are seeing some different reactions coming from government, at various levels, from the providers of health care--the hospitals and doctors, and so on. There are things happening out here that are really making it a different job for the group health actuary than it has been in the past.

I heard several of these things discussed around at the breakfast this morning. Cat scanners, for example, is one topic that probably is overdone and just when I thought we could stop talking about it, my medical people in the last couple of months started talking about NMR's (Neucleomagnetic resignators). These are going to replace CAT scanners. All I know about them so far is that our medical director told me each time they flip on the switch, it's going to cost about $500 more than a cat scan did. I've also found out that in my state of Illinois, in addition to all the hospitals, at least seven new independent specialty groups are going to begin business with the NMR's. Five or six years ago I never would have taken this into consideration in managing a health care portfolio, but all of a sudden it is something to consider.

On a broader scale, another thing discussed at some length this morning is the whole subject of cost shifting. This was discussed in at least a couple of different contexts. The hottest topic today is probably the federal and state government's approach to holding down their portion of the escalation of health care costs. The cost shifting may be viewed as a large balloon where they have their hands firmly on their half of the balloon, and as they squeeze, it seems that our half of the balloon is getting bigger at a pace even more rapid than it would otherwise.

Spence mentioned DRG's in New Jersey and elsewhere. I have nothing too much enlightening to say about it except to mention it has baffled our analysis so far in terms of the impact on hositals and how it is going to cause hopitals to change their remaining pricing and costing structures. The best that I can determine at this particular point is that there is no one single answer. We find in our analysis that the DRG system in some hospitals will be a windfall and others will be hurt badly. I am not sure that the individual hospitals will know until it actually starts to happen.

The other major thing is the fact that there are a variety of states in the country that have decided to take matters .into their own hands and put a regulatory cap on the hopsital cost situation. At least a dozen states have had varying degrees of success with various approaches. We've got some people that are trying to regulate hospital costs, otherS trying to put a cap on rates and still others that are putting caps on hospital revenues. Quite clearly all of these things are going to affect the needed levels of group health insurance premiums in the coming years.

One of the big questions that the health actuary has to consider is whether our traditional methods of doing things in projecting health care costs are appropriate methods given these external factors of government action, cost shifting and technology. Can we count on the future to have some relationship with the past? I will leave this issue for Mr. Berry to deal with later in this session.

The one major change I have seen is interacting with the customers. Through the 1960's and the 1970's we found all the ways to squeeze the last drop of blood out of the administrative and the cash flow aspects of group health premiums. I think finally the world has discovered the other 90%. We now hear everybody, both the consulting and the insurance company side, as well as coalitions of employers talking about cost containment.

The real key for doing anything about health care costs is having the data--good sound numbers. A lot of companies and employers are coming

together. These coalitions, insured with a number of different carriers, all have a little bit of data, none of which is the right data. This is all in different forms and formats with different definitions. One of the real needs for group health actuaries is this demand for data and how it is packaged. It must be in some sort of consistent format so that it can be used in the marketplace. This is one issue that will have to be addressed - the whole subject of management reporting at the customer level.

Within the cost containment area there are numerous companies, employers, and insurers struggling with the issue of how to contain costs. There has been a lot of housekeeping. These are benefit design modifications and hospital audits. I really think that the major cost containment developments have yet to be seen. The employer would actually begin to get involved in the delivery of the health care. These are the things which have not yet appeared, but I see coming. The employer role is going to get larger and larger and they are going to take a much more direct part in the purchase of this very expensive commodity.

I see new things on the horizon in the emergence of new competitive forms. We have been through an era of the emergence of self-insurance, third party administrators, and HMO's as alternatives to the traditional insurance programs. There are new things on the market. The insurance dentists of America is a preferred provider approach that the health insurance industry is working on to get at the issue of lower costs on dental care. In Illinois, our corporation has formed a dental capitation plan. Occasionally I call it a dental HMO and get quickly corrected. I think probably the hottest topic is these preferred provider programs or preferred provider organizations, and exactly what impact they are going to have on the whole health care business. We have a strong contingent of people in our shop who feel that in five to ten years from now these are going to be the dominant form for the delivery of employer sponsored group health benefits in the country. These are going to bring a whole new set of actuarial issues and problems. Since we have seen this emerge in a nice conservative state like Illinois, I am sure it's well advanced on the coasts in some form or another.

These new forces are emerging and coming together. Within the group insurance setting, we are starting to see instances where individual employees within a group have more choices about how they are going to obtain their coverage. I think that we are actually to the point where perhaps in the group health business we are starting to see flexible benefits. It used to be something just to talk about at meetings, but now employers are trying to save some money by putting a new deductible in the health care program. The money is then put in a 401K, as the incentives seem to be there. Some of the lines between the group and individual business may start to get fuzzier as we really start to think about individual selection even in the largest group setting.

With a more complex environment and new forms of delivery emerging, it still is to be seen what will happen in the group environment.

MR. DOBSON: There are a lot of things going on in the area of health insurance. Ray, what you just said is a very good lead into what George is going to talk to us about.

George Berry, a consulting actuary with Milliman & Robertson, Inc. is going to talk about the art and science of anticipation. I might add that George is my former boss and taught me all that I know about anticipation. He practices what he preaches, because he anticipates excellent performance from his staff all the time. I know that from experience. George, I am going to be anticipating a lot from you. I am anticipating an excellent presentation and a captivating follow-up workshop in session 43 this afternoon.

MR. GEORGE L. BERRY: Well, that puts us even for a whole lot, Bob. As a matter of fact, I think I owe you one now.

I was probably the one who suggested this topic--the art and science of anticipation. I think when most people hear about this topic they think that this probably means a lot more art and a lot less science. But in fact, the way I am going to describe it, it means a lot more science and a lot less guessing.

I want to talk about what it is, why we should think about doing it, and give you some applications that I have used to follow the process. It really is a process. It's a process or a method or a way of thinking to try to make some sense out of what's going on. You've heard people say that as each day goes by we suddenly find another tree in this health care forest and pretty soon we are spending all our time looking at the new trees. It becomes increasingly difficult to make any sense out of the forest.

Anticipation, the way I've used it, is really an effort to try to learn and understand what is really going on and, what kind of a response we should be making to it. I use a classic scientific method which is to develop a hypothesis in order to explain what I see. I then gather evidence and test that hypothesis recognizing that I probably will be changing that hypothesis several times a year to improve it, alter it, or find places where it was just wrong.

I looked up "anticipation" in the dictionary, and the definitions included prior recognition, to consider in advance, give advance thought, discussion or treatment to, to deal with in advance to counter, guard against or forestall by prior action, to act before often with the intent or effect of checking or countering.

Anticipation is something that was probably invented by an actuary or at least somebody that wanted to be an actuary, and it is something that each one of you in this room has used. The process I want to talk about is a way of using it a little more scientifically, perhaps, than we have in the past. The reason for doing it is that the world, in my judgment, has become too difficult a place to live in, or certainly to be a health actuary in, without using it.

If we don't have some idea or hypothesis about what we think is happening, we are making too many guesses too often with no way of knowing whether or not we're consistent, and with no way of knowing whether or not other people in our organization have the same ideas. We run the risk that what we try to do will end up being counter productive because, for example, I may be trying to increase profits and my marketing man may be trying to increase market share. We may be doing it in a way where only one of us can succeed.

One of the things that falls out of this approach is communication. We need to tell more people more often what we know and we need to tell them in English. Actuaries do not have the best reputation for speaking in English. People even refer to our language as actuarialese, which is a polite way of saying they do not understand what we are saying. I think we have important things to tell them. I have spoken with several thousand non-actuaries over the last several years. They had one characteristic in common. These were public employee groups, industrial groups and manufacturing groups. The one characteristic they had in common about health care financing and delivery was ignorance. I was absolutely astounded at their misperceptions, their nonperceptions, their dissatisfaction and their anger at the insurance industry and actuaries for not informing them. One of the things I would like to do this morning is show you some slides which I have used to develop, observe, measure, and validate the hypothesis that I use.

The elements or qualities that are useful in this kind of process include information, experience, ingenuity, imagination and logic. Logic plays a very great role in developing this kind of process. The major reason why is that the past is no longer a reliable guide to the future. In many respects, many of our techniques assume the past will be a reliable guide to the future. When that stops being true, when in fact, the past may bear no relationship at all to the future, we need to think through that premise and find other ways of doing what we do.

Another premise, whose validity is to be questioned at this stage of the game, is the use of averages. I think what we will see over the next couple of years is a greater movement to the use of underlying frequency distributions. A number of actuaries are starting to look at probability distributions, to look at claim frequency distributions, and even to look at income distributions by group in order to draw rate conclusions.

The major response of the health insurance industry over the last 15 years has logically been--if you lost money, raise rates; and if you lost market share, lower rates. We are now moving into an interesting environment whereyou can both lose money and market shares simultaneously, but logic says you cannot both raise and lower your rates simultaneously. A lot of companies find themselves in this embarassing position.

I would like to show you a number of things. I'm not asking you to agree with my conclusions, but these are the conclusions that I deduced in a number of different areas.

The first slide is our old friend, actuarial balance, which probably you haven't seen since the examination days.* (Slide #1). I've identified eight things which are necessary to achieve actuarial balance and as an actuary, that is what I'm trying to achieve. What I've observed in the past work is that people do not try to achieve actuarial balance. What people try to do is maximize one or more of those objectives. They may try to maximize adequacy, they may try to maximize competitiveness, and so on. My conclusion is that in order to achieve balance you must optimize these eight factors. You cannot maximize any one of them, and that means simply that an organization will end up making less money than they would like and selling, less business than they would like. The idea of optimizing or balancing rather than maximizing may sound like an obvious idea. Most managements I've dealt with maximize. They approach the

* All slides immediately follow Mr. Berry's presentation.

problem by trying to maximize the result. They say to the actuary, we want as much profit as we can get, then they will say to the marketing man we want as much business as we can get. This often guarantees that they will get neither. I think that's an idea you should think about in the context of your own organization.What we will have if we do not attempt this is a continuing conflict where some members of your organization will win and some members will lose.

This is a picture that I have used quite a bit. (Slide #2) It is a picture of a premium rate and its components. By manipulating those components we can develop any kind of cash flow or risk mechanism that exists today in the marketplace.

What I have found in talking to people is that there are several things that they think actuaries can do and can't do. One in particular relates to the expected claim estimation. If we estimate expected claims to be $1,000,000, you would not believe how many people think that in fact those claims are honest to gosh going to be $1,000,000. If they are not, they feel it is not due to risk or random fluctuations but due rather to incompetence. I have talked to about 10,000 customers who think that's true. I have talked to several thousand marketing people who thought that was true. They never took advanced calculus and all this magic math that we took and they thought we could use a computer and figure it out to the nearest penny. I think because we haven't made that clear, we've created the impression in the marketplace that there is no risk involved in this business. The only risk that really occurs in group insurance is due to the fact that risk exists in the marketplace. What we really need to do is begin to say to people what the outcome could possibly be. For example, we are reasonably confident that claims might fall between $750,000 and $1,400,000. That will quickly identify the amount of risk that is involved. I would say that is the single most misunderstood thing that I have seen in talking to non-actuaries.

The second most misunderstood thing relates to the claim reserve, even among those people who understand the difference between cash and accrual accounting. They are not able to understand the difference between cash and accrual accounting in health care financing. One of the directions health care financing has taken over the last eight years is to move from accrual accounting to cash accounting, particularly with public employee groups where you can just kind of forget that you have that liability if you are operating on a cash basis. We use the word claim reserve and most people can't figure out what that means. I think we need to find better ways to explain cash and accrual accounting. Because they do not understand the risks and the limitations on the estimates we make, they don't have a good understanding of that thing on the top called margin.

The reason I show you that is because part of my hypothesis must now reflect the fact that the public in general does not really understand how health care financing works. Therefore, the solutions that they see as solutions may not be correct.

On May 9, 1983, Newsweek dusted off its article that it publishes about every five years, about the new war on health costs. It says that we are spending too much money and we have to do something about that. This is an indication that somebody is concerned that a lot of people are concerned about this.

One of the reasons they are concerned about health care costs relates to the consumer price index. That is an extrapolation of the consumer price index using a senario that I call the 1974-81 senario. This says if that period repeats itself, the rate of inflation will be at a certain level. This has been an important part of the research that I have done and the science that I have pursued to try to understand the health care field and to form the hypothesis that I formed. One of the things we've discovered is the delay between the behavior of medical care claims trends and the consumer price index or the rate of inflation. There tends to be a lag in the sense that when the consumer price index goes up, the medical care rate of inflation tends to go up about 8 to 18 months later, and simularly tends to go down 8 to 18 months after the CPI has come down. That is significant now, because the general rate of inflation is low single digit and the rate of medical care inflation is not. People have suddenly noticed that the difference is larger than they can afford. I think people have discovered two things: 1) they have to make up deficiencies that they see in their programs today, and 2) somehow they have to break the medical care trend. I have seen more people come to that conclusion in the last six months than in the last ten years.

I think the reason they came to that conclusion is the unemployment rate. The way we got the rate of inflation down was by driving the rate of unemployment up and we managed to hit double digit unemployment. One of the things I have observed is it creates a new definition of competition in the economy, a new definition of performance and a new emphasis on results. The new definition of competition is if you win you stay in business, and if you lose you do not. The only definition in the past was if you lose you make 10% instead of 20%. Business is still adjusting to the kind of competition which drives you out if you don't win. We are squeezing the economy to drop people who cannot perform. This doesn't just include automobile companies and steel companies, but also includes health insurance companies, hospitals, and physicians. It really includes everybody. The medical care part of our economy is being dragged into that kind of competitive environment. To a great degree what we are beginning to see are the forces of competition operating on the medical care system. It will change dramatically and quickly.

We hear that health care benefits are changing. We hear that traditional benefits were designed for the average employee defined as age 40, male with a non-working spouse and two children. Today he is only 15% of the workforce. Demographics are changing. We have more working married women, fewer two spouse households and fewer one wage earner two spouse households. (Slides #3 and #4). Logic says that employee benefits should change.

As a result of this process one must ask himself why is that happening, as well as what will happen if that happens. One of the things that you can begin to conclude from statistics or ideas like this is there will probably be dramatic changes in coordination of benefits provisions. We will probably also see dramatic changes in underwriting guidelines. Most underwriting manuals still have remnants of the 1950's, i.e. the old 75% participation requirement. They were written for a different world. In terms of drawing conclusions from this process my expectation is to see substantial changes in COB and substantial changes in risk selection or underwriting. We need underwriting manuals that reflect those slides that have just been shown.

I identify three elements to medical care: cost, quantity and quality. These are out of equilibrium but they are trying to move towards equilibrium. My conclusion is that in fact they will achieve equilibrium whether we want them to or not. They will do that by some of them going up and some of them going down, but ultimately they will work toward equilibrium.

This leads me to what has been talked about for the last 12 to 15 months by everyone, as opposed to the prior time when just some of the people were talking about it, health care management. There are three key elements of health care management: one is information, one is expertise, and one is medical provider impact. My hypothesis includes the idea that people have become much more interested in health care management because they have become much more interested in saving money. The reason they have become much more interested in saving money is they can no longer raise their prices to cover the cost of health care, so they will have to lower the cost of health care either by cutting their benefits or cutting their costs. This creates opportunity because the people who can do that best will be the people who will have the greatest opportunity to increase their market share. The people who cannot do that will have the greatest opportunity to lose their market share. This will separate the winners and the losers on the third party payor side.

Information on the claims side includes the hospital, physician, other facilities and other programs. This is the kind of hospital information that some people are interested in seeing (Slide #5). They want to know what is causing their experience to go up and they want to know how they compare to somebody else. Part of the process of anticipation involves writing things down. I am showing you some lists that I have made.

On the physician's side, the same kind of information is becoming increasingly valuable to people (Slide #6). When they get the information they are finding that they really don't know what to do with it. Analysis and expertise have become increasingly important as has the ability to deal with and negotiate with providers. Unless you consider this information, you probably will find out that you are one of the ones that gets to pay more because someone else has figured out how to pay less.

One of the reasons I made a list of Health Care Cost Containment (Plan Design, Administration, Financing, Delivery System Management, and Health Management) was to understand the different kinds of things that will probably change.

In plan design there are three things that I think will happen. Cost sharing, incentives and choice are the only three things that will happen. I have tried to anticipate as an actuary what the consequences of those things happening are in terms of employee satisfaction, adverse selection, and response to adverse selection. I have made other lists to try and understand what I think will happen if people follow any one of these alternatives.

In administration there will be substantial changes over the next 12 to 36 months. Simply because people are discovering that we do not know enough about this business. We have to know more in order to get the costs down.

In financing, I think the three areas of insurance arrangement, self-funding and employee contribution will be affected over the next 12 to 36

months. I pursued the whole idea why we are out selling self-funding in the first place. I think one of the two major reasons is a transfer of the economic risks to someone else, and the other is a misperception on the part of some people concerning the risks involved as well as a desire for cash flow. The hot potato that is being thrown up in the air is who is going to take the economic risk. The economic risk is the uncertainty in the magnitude of the medical claim trend. This risk is now to a great degree the responsibility of the employer and he does not like it. The employer is looking for someone else to take it and will try to pass some of that economic risk to the employee. Some employers will try to pass it back to the providers. No employer that I talked to wants to take it himself. What we are really trying to find out will be who is going to take that economic risk.

With delivery system management, (Slide #7) there is a long list of things people think can be done to save money on the claims side. Some of those things save a lot of money and some of them actually cost money if not done well. As actuaries, we should be learning how to price, identify the major assumptions involved, find the key factors that will determine whether you make money, and we should be communicating, for example, that concurrent utilization review or preauthorization might save you five or six points. That is where I think we can perform an extremely valuable service as actuaries. One of the conclusions that you will come to is that it is difficult with some of those methods to save a lot of money and that, in fact, you may get more aggravation and spend more in administrative costs then you can save by lowering the claims. As actuaries we should be using our ability and science and information to learn how to price similar things. People are looking desperately to find solutions to this problem. I have not seen a lot of this done.

Next is health management which looks at individual people and considers what we need to do to control the claims (Slide #8). People need to manage their own health better, which has been happening for the last ten years and will continue to a larger extent.

I put together this chart to try to understand the dynamics of the hypothesis I have made (Slide #9). It moves through time and tries to identify the key issues and the response. Where we are today is looking at the cost and utilization of benefits, and our response is cost containment and delivery system management.

These are some of the things I have considered. Some of the measurements involve art and some of them involve science.

The techniques that I use will be used more often because we can't rely on the past as much. These include measurement systems in a way that we have not used them before. If I cannot rely on the past, the next best thing is to measure the present immediately. For example, to change the pricing system, one must have the ability to measure the impact of that month by using a computer to determine whether or not it is having the result that you expected. This is a superior method instead of waiting for a year and seeing whether or not the organization made or lost money.

The whole idea of monitoring experience rating systems is to understand rate increase distributions in order to understand deficit or recovery distributions which identify a strategy maximizing the number of acceptable

groups. This requires putting data into a computer and then sorting it. A lot of the analysis is simply sorting. Without that, I think we will not know enough. With that, I think the next movement is towards multiple financial forecasting where we address questions of what will happen if we sell more business, what will happen if we sell less business, what will happen if the trend is higher and what will happen if the trend is lower.

If you have not formed a hypothesis about the dynamics of the health care system, it is incredibly difficult to formulate a forecasting system that bears any relationship to reality.

You probably have found that the need to clearly communicate internally and externally in english will increase, in order to present people with facts, information, and alternatives. Actuaries are supposed to dispel the myth that somehow we know exactly what is going to happen in the future. We have got to make sure that the public and the people we deal with understand.

One of the things in the hypothesis that I developed is the significance of timing. When should decisions be made? What is the impact of waiting three months to change your trends? What is the impact of changing your trends today? If you observe a declining trend, which is what we have seen nationally for the last year, at what point do you begin to modify your own trends. How willing are you to recognize that trends follow a curve and do not follow a straight line? If the trend is 15 today it is highly unlikely that next year it will be 15. That kind of thinking led me into trend behavior to try and understand whether it would be more than 15 or less than 15.

Logic is a very valuable tool in looking at these things. For example, in 1979 when the rate of inflation was increasing, a logical conclusion could be drawn that if the rate of inflation continued to increase, we would have difficult times in the early 1980's because we would again have high double digit inflation. If the rate of inflation declined, we would have difficult times because the only way we could probably achieve that would be with high unemployment. The conclusion that could have been drawn in 1979 was that we would have difficult times in the early 1980's regardless of what happened and that we were not sailing into smooth waters. People who understood that could prepare to live through this period by having three or four years before the difficult times occurred to prepare themselves. This is the essence of the value of anticipation.

A major conclusion is that I believe we have crossed a threshold this year. The threshold is the point at which the cost of medical care exceeds the money we have to pay for it. For example, we think it will cost $350 billion and we have only $320 billion. If that's true, we have started a one year race and the winners of the race are the people who do not pay the $30 billion which is missing. The losers are the people who get to pay it. The winners and the losers include the entire system. They will be hospitals, doctors, third party payors, employees and employers. Ray commented that the pace of our work and the work environment has increased. The pace of the environment has increased significantly. I spoke with one large company who had just assigned seven people in that organization to lower their health care costs. That was their job. The officer that they selected to do this told me that he thought this would put him in the

limelight because the CEO was the one who said that this should be done. He said to his boss, "I will clean off my desk and in a couple of weeks, I'll be ready to go." His boss said, "well you don't understand, you're starting this afternoon." By the time I talked with him, he was scared to death because he didn't know how to do it.

My hypothesis is still valid as a result of this and other similar situations. Something is speeding things up and the conclusion I drew was that we would cross that threshold. What I see happening is a great acceleration in all of the things that we will talk about today in the Health Section.

The risk for third party payors on the income side is the selection spiral. The carrier may get into a selection spiral and not be able to get out. As actuaries, what we are really trying to do over the next 12 to 36 months is to avoid that. I think that will require a look at pricing on the basis of frequency distributions. It will require us to look at underwriting. It will require us to look at COB and to understand the good things and the bad things about cafeteria benefits.

Our work will become much more action oriented. If you've read the book, "In Search Of Excellence," you have probably found it extremely relevant to the way in which we will have to work in the future.

My hypothesis says that we need to talk less and act more. If we make mistakes, or if it does not turn out the way we thought it would through our monitoring and measuring systems, we should quickly change what we have done rather than spend six months trying to anticipate what we should do and find it obsolete when we are ready to do it.

I hope that you will communicate effectively the assumptions, the uncertainty, and the risks in terms that people can understand. As I said, I think it involves some art and some science. If I'm right, this race I have been talking about is on.

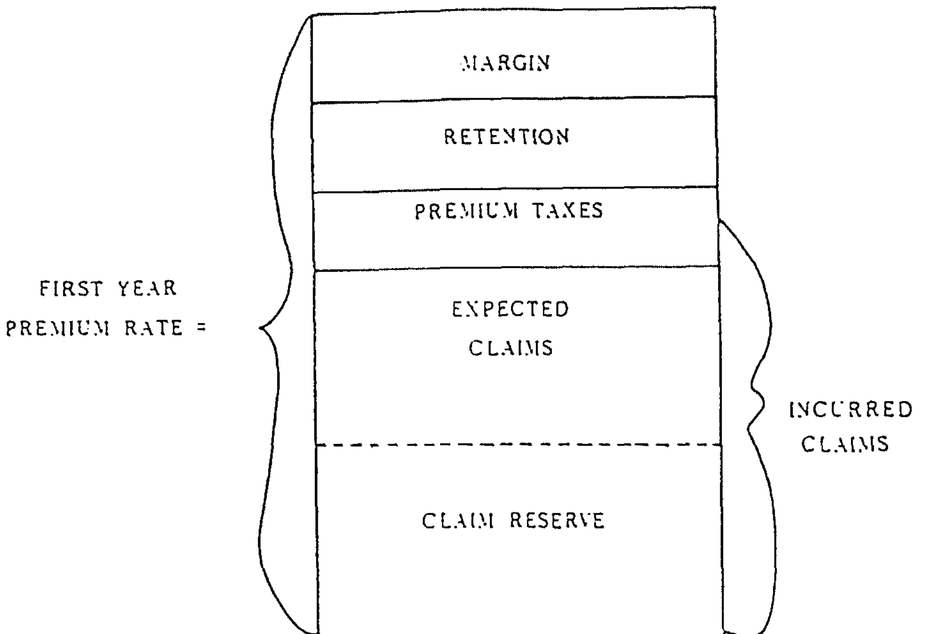
SLIDE #1

ACTUARIAL BALANCE

1. Adequacy
2. Competitiveness
3. Consistency
4. Equity
5. Resources
6. Simplicity
7. Timing
8. Understanding

SLIDE #2

FIRST POLICY YEAR



SLIDE #3

DEMOGRAPHICS ARE CHANGING. . .

	1950	1976
WORKING MARRIED WOMEN	24%	45%
TWO SPOUSE HOUSEHOLDS	79	61
ONE WAGE EARNER, TWO SPOUSE HOUSEHOLDS	43	25

SLIDE #4

ATTITUDES ARE CHANGING . . .

- ABOUT WOMEN WORKING
- ABOUT COMPANY PATERNALISM
- ABOUT EMPLOYEE INVOLVEMENT

SLIDE #5

HOSPITAL INFORMATION

INPATIENT

- ADMISSIONS/1,000 MEMBERS
- DAYS/1,000 MEMBERS
- AVERAGE LENGHT OF STAY
- CHARGES/ADMISSION

OUTPATIENT

- VISITS/1,000 MEMBERS
- CHARGES/VISITS
- SHORT PROCEDURE UNIT VISITS

CATEGORIES

- BY DIAGNOSIS
- BY HOSPITAL TYPE
- BY DAY OF WORK

SLIDE #6

PHYSICIAN INFORMATION

- SURGERY
- MEDICAL
- ANESTHESIOLOGY
- RADIOLOGY
- PATHOLOGY

SLIDE #7

DELIVERY SYSTEM MANAGEMENT

- UTILIZATION REVIEW
- HOSPITAL CHARGE AUDITS
- USUAL AND CUSTOMARY
- CASE MANAGEMENT
- MODEL TREATMENT PROGRAM
- PROVIDER REIMBURSEMENT
- HEALTH MAINTENANCE ORGANIZATIONS
- PREFERRED PROVIDER ORGANIZATIONS

SLIDE #8

HEALTH MANAGEMENT

- EDUCATION
- COUNSELING PROGRAMS
- HEALTH EVALUATION
- LIFESTYLE ENGINEERING

SLIDE #9

HEALTH CARE PRIORITIES

	DEMAND	RESPONSE
PRE-1940	BENEFITS	NONE
1940-70	BENEFIT	HEALTH INSURANCE
1970-83	COST OF BENEFITS	ALTERNATE FINANCING
NOW	COST AND UTILIZATION OF BENEFITS	• COST CONTAINMENT • DELIVERY SYSTEM MANAGEMENT
FUTURE	APPROPRIATE HEALTH CARE	HEALTH MANAGEMENT

MR. DOBSON: Our final speaker this morning is Harry Sutton. Harry has worked for many years in the area of alternate delivery systems, first with Prudential and now with TPF&C. He is certainly one of the most knowledgeable actuaries on this subject. I happen to be treasurer of the only HMO in the state of Alabama. The HMO happens to be in a negative surplus situation, so Harry asked me not to say that he taught me everything I know about HMO's. My boss is hoping that by being here I will learn something from Harry.

Harry is also kicking off a session that will be presented later this morning, Session 34. He has lined up a couple of non-actuaries to be on that panel and talk about alternate delivery systems. One of the things George says is that we need to communicate more with non-actuaries. I think that panel will give you a good chance to do that. I'm sure it will be provocative and hope it will be well attended.

MR. HARRY L. SUTTON, JR.: I would like to cover a couple of things to bring you up to date on the generalized status of the HMO, or prepaid health care industry. We will look at the movements towards other alternative systems and discuss some of the changes that both insurers and employers are trying to make to their health care programs. Finally, we will look at some of the external factors that are going to make it very difficult for actuaries and insurers to live in the very confused environment that I see occurring in the next couple of years.

I am reminded of a meeting of the Society of Actuaries ten or fifteen years ago in which I used a simile. We talked about the fact that the railroads back in the 1920's were one of the major industries in the United States but they went under as a major functioning industry because they did not realize they were part of the transportation industry instead of the railroad industry. I raised the question of whether the health insurance industry was going the same way because they did not recognize that we are part of the health delivery system, as opposed to merely reimbursing medical costs.

George talked about something that I have been pushing in the HMO area which is essentially getting involved in the management of the delivery of health care. The HMO industry is not a single system but they are generally assumed to be four models: the prepaid group practice model, the staff model which has salaried physicians, the network models which typically are of groups of fee-for-service clinics, and the IPA which are reconstructed groups of fee-for-service physicians who practice anywhere but are linked together by risk carrying prepayment.

At the present time the enrollment in the HMO system is approximately 12 million people. There were about 11.5 million enrolled at the end of last year and the system has been growing rapidly. In 1982 the revenue of the HMO industry was approximately $6.1 billion. In 1981, all of the third party payors had revenue of about $84 billion. The prepayment industry at $6 billion of revenue is becoming an important factor. Many people have been disappointed that the growth has not been more rapid, but I feel the growth in the HMO or independent prepayment system is going to accelerate. I will discuss some of the reasons for this conclusion.

The financial structure of some newer HMO's has been studied. Forty of the largest HMO's produced a profit of $51 million on revenues of $2.1 billion. Since Kaiser is such a large organization they were excluded from the total. Ninety percent of these HMO's made a profit in 1982 in comparison to when only half of these made a profit in 1979 and 1980. The average rate of enrollment growth in HMO's over the last ten years has been approximately 11%. The number of HMO's, however, has grown yearly by 20% for the last ten years. A recent meeting with the federal regulatory agency revealed that they have federally qualified 38 HMO's in the last twelve months. This is 50% more than the prior year. The number of current applications for federal qualification is about 50% higher than it was a year ago. The introduction of HMO's is continuing and even accelerating despite the fact that the federal incentive grant program essentially will have been completed in the next year or two. This federal grant program functioned for ten years.

The government sponsored the introduction of a number of small programs. Very few of them have risen to independent viable size, which for a group practice is probably 30,000 to 50,000 enrollment. As a result, they may have gotten barely to a break-even operation but have no capital to expand. Most of these newer HMO's have a debt to equity ratio between two and three to one, which means that they have a fairly heavy debt load. Most of them did not have equity capital but had long term debt.

There are many larger organizations today that have purchased HMO through management contracts. Others are consolidating these smaller plans into a nationwide network of prepaid health care systems. Along with this, there is a major trend towards conversion from not-for-profit, which you had to be to get federal grants and loans, to for-profit with some discombobulation in terms of paying back to the federal government part of their seed money. During the past eight months three large HMO programs have sold equity: US Health Care, Health America, and Maxi Care. Maxi Care is owned predominately by Freemont General which is a casualty company in California. These stock offerings were modest by some standards at about $20 million each. Investors who bought stock in either US Health Care, or Health America have done very well. US Health Care has nearly tripled its price since February even though it is selling at 150 times earnings. Health America, which has only been on the market for three or four months, has already doubled in price even though it is also selling at 150 times earnings. Maxi Care, which was a minority stock offering, is below its original offering price.

A lot of private equity capital is being put into the market. The basics of the HMO's in terms of profit potentials still are not much different from the group health insurance industry of the past. It is a high volume of dollars but not very much profit left at the top. Half of that profit of $51 million out of revenues of $2.1 billion is from investment income on the claims reserves and other balances. It's kind of surprising that it is a gee whiz stock from that standpoint, unless they can grow rapidly in enrollment or expand their profit. My personal opinion is that it is hard to see why people pay 150 times earnings for the stock unless the HMO enrollment grows rapidly or the profits are expanded.

The other part of this consolidation trend is that there are major expansions of systems by the major organized HMO programs. Programs are expanding in new metropolitan locations, with perhaps ten new programs

expected within the next year. One of the speakers at the next session is Wayne Alberts who is the medical director of Kaiser Georgetown. He also manages the medical aspects of the Kaiser plan in Hartford. Kaiser has 4.2 million members. HMO's count members rather than employees. Insurance companies do not know how many people they have covered. Typically, the HMO's keep better track of people covered. Every time an HMO enrolls a million members, that is a million fewer people that the insurance industry will get. Kaiser had 2.4 billion of revenues in 1982. A study a couple of years ago showed that Kaiser would have been the 17th largest carrier in the United States, if you classify them in terms of revenue, even though at that time it only operated in six states.

Even though the status of HMO enrollment is only 5%, it is like walking through a stream that only averages six inches deep. There are four states in the United States where total HMO penetration is between 10% and 20%. Typically in most states the only carrier that would have that kind of a penetration would be Blue Cross. In four or five metropolitan areas, including Minneapolis, the HMO penetration is between 20% and 30% of the market. We think there will be a number of other metropolitan areas in the next couple of years where HMO penetration will get to this level. This is a potent marketforce in terms of selection, market potential, and other things.

I think one other aspect is that employers are concerned and have determined in these recessionary price increase resistant times that they can not afford to pay all the additional health care costs. I know from talking with some of our HMO clients, and talking with some of the large ones who do not need our services, that large corporations are calling HMO's to ask about establishing prepaid health plans in areas where they have major employee locations because they do not like the rapid increase in health care costs in those locations. Some of these will be in addition to HMO's that already may be there, but which may not have the capital to expand. These large national corporations have the advantage of a big insurer in that they have credibility and financial resources. The employers can be certain that they will not get into financial trouble.

In the first part of our following session, our speaker will be Wayne Alberts. Wayne will discuss the prepaid group practice as a means of controlling health care costs. Hopefully he will also discuss Kaiser's corporate philosophy regarding expansion in other areas of the United States. He is a key manager in their newest operations and will probably have a good insight into that.

I will now discuss some other developments. PPO's are a recognition that we are coming into a crowding of the available dollars to pay for health care. It is also a competitive mechanism to enable providers to get patients because of governmental pushes on all sides, a tremendous increase in the oversupply of hospital beds in most metropolitan areas, and a rapidly increasing supply of physicians. It may or may not reduce cost. A discount from a hospital does no good if they keep the patient a day longer. I do not know of any data proving that PPO's have ever saved the money they claim to.

One of the other interesting things in the PPO movement is that a large amount of the pressure for PPO's comes from hospital systems. We already

have proprietary hospital chains setting up their own PPO's or HMO's. If you look at the hospital as the center of the health care delivery system with their medical staff and their medical office buildings, prepaying what they already have is merely a vertical integration of their systems. These provider organizations are moving upward into the premium payment risk bearing segment. Why shouldn't they go out and compete for the same employers that you're going out for?

I see references to employer developed PPO's. These are where the employer goes out and negotiates contracts without real cooperation and a systemization of the delivery health care by the providers. It is hard to see how these could function effectively.

I find it very interesting that carriers who are talking about health care cost containment, employers, and others are trying to put management into the system through their group insurance contract or the employee benefit description. They are creating incentives to the employee to use the system properly by paying them better for doing one thing than for doing something else. It is an interesting and difficult communication problem to deal with the individual patient or employee to pursuade them to do something, rather than working with the providers. We are moving both ends towards the middle. George Berry is correct. The name of the game is management of health care delivery and we are pushing at it from both sides.

Our other speaker in the second program is Glen Wegner who was formerly medical director of Boise Cascade. He was involved in managing health care for a large corporation and is now a principal at Health Data Institute. He is establishing methods of analyzing data produced from carrier records, employer records, and hospital records, such that they can analyze items such as what is happening to a group of employees when providers are functioning in less than an efficient fashion, which hospitals are more expensive than others, and so on. Our discussion will start at the extreme of the closed panel group practice and then look at the types of data self-insured employers or insurance carriers can be analyzing along with some discussion of what do you do with the data you receive. What choices does the employer or the carrier have to correct or control the cost or manage the health care of a particular group of insured individuals that they are responsible for financially?

I will cover a couple of other items. There are problems not only with actuaries to try to figure out what's going to happen, but also for carriers to figure out how to market and set rates, and HMO's.

We are moving towards a more competitive system. Everything that we are talking about is going to limit the number of providers that may do business with a carrier, an HMO, or an employer. They will try to select effective or managed health care providers to provide services. Part of the problem insurance companies have is whether legally they can contract with a subset of providers rather than paying for health care costs no matter which provider a patient uses. The ability to spot what is happening and then the right legally to contract or penalize to limit the choices of people insured, are difficult questions. There are five or six states that are passing statutes which will permit carriers to differentiate either on reimbursement rates or selection of providers.

Some of the big industries that have been in trouble, such as auto and steel, with their big unions, have not made a lot of progress. I think they recognize that possibly some limitation could occur on the choice of providers or even exclusion of some providers from coverage on the basis of performance or non-performance. Some of the UAW plans even have a list of physicians who were determined to waste a lot of money who were excluded from coverage. This is a difficult question on restraint of trade.

I would like to talk briefly about four or five factors.

Changes in benefit plans and the selection aspects of where the employees go is based on which benefit plan option they have. There are two options even if you have an HMO versus an indemnity plan. Which employees tend to join an HMO? How much difference is there in the premium rate structure or the contribution that the employer makes to the HMO? What happens if the situation would reverse, where at one point the HMO was more expensive and later the HMO was less expensive than the indemnity for the employee?

We had some discussions at breakfast about the contributions made by employers for HMO options particularly in unusual situations. There are a slowly growing number of employers who have high and low option medical plan such as, Eastman Kodak, DuPont, Sun Company, and J. C. Penney. The nature of these two options creates a natural selection between the high option and the low option. The high cost employees, the older employees or employees with chronic problems stay in the higher benefit plan. Some of these plans may eventually shift a lot of cost in terms of contributions to the older or sicker employees. There is a social question as well as a question for the employer. This happens and we are trying to measure it. However, nobody knows how to predict it exactly or how the employer's contributions for any other type of options should be made. The same questions occur regarding flexible compensation.

I have a problem with COB in the way it is constructed today. I agree with George that it will have to change, if not be eliminated. I'm not sure it can be eliminated. The other major trend is to sharply reduce first dollar coverage. Quaker Oats' plan has a $300 family deductible to give the employee $300 to spend however they want on various medical services. How does that integrate with coordination of benefits? Does the other carrier, if they have double coverage, pay the $300 and put it in the employee's pocket? Xerox will be introducing on January 1 a similar kind of plan with a family deductible of 1% of payroll, a maximum of 80% of benefits, and a maximum of 4% of pay out-of-pocket. They are giving each employee $400 to sweeten the pot because it is cutting back from essentially a 100% benefit plan. The most extreme case I've seen is the utility in South Dakota which changed their benefit plan to a $1,000 deductible per person and gave each employee $800 in a health care expense account. That is a rather extreme change. The health benefits under the insured plan could drop 30% but that first $1,000 could be paid under coordination of benefits. When a person has that as an option and there is an HMO program available, the HMO is going to look expensive in comparison. They are going to have to put part of the $800 towards the HMO premium. What will happen to the selection if up to now the rates were matched and now a choice is available to receive $800 or spend it to join an HMO?

One of the things we want to ask Wayne is about the future of the HMO in an area with low cut back benefits plans, or multiple options. Before Xerox changed their plan, a meeting was called of their eight largest HMO's. They discussed the changes they were proposing in order to give their HMO's time to make a decision. The conclusion was that since the company benefit plan was dropping in structure, there would be a tremendous attraction of employees to join the HMO to keep full coverage. They seem to be happy thinking their enrollment would go up, but it remains to be seen which part of the employee group they will attract.

I mentioned the question of giving the carrier or the employer the right to subcontract directly with providers. In Minnesota, they just mandated in the last session that you cover various types of nurse practitioners under insurance contracts. All of these things will again force employers to become self-insured due to the state mandate of risks they are not affected by. HMO's have different benefit limits, therefore they do not have to hire chiropractors, or nurse practitioners, they can hire whomever they feel is effective to manage health care. The HMO's are organized systems which will eventually develop an even greater management advantage over a non-controllable or only partially controllable fee-for-service system.

All carriers have problems with catastrophic health care expenses. You probably have read about whether anyone should cover liver and heart transplants. All the employers I talked with ask if this is something we will have to pay for. I've got one client who had two $100,000 cases but at least they were aware of it ahead of time. The expensive claim is becoming a higher proportion of the total claim expense, at least in the fee for service system. It is amazing how little $1,000 would reduce the cost when you look at all the claims over $25,000, $50,000 and $100,000 today, particularly if you leverage with inflation on top of the deductible as the costs keep going up. I think that maybe a $1,000 deductible plan will not be considered very severe in a couple of years. It certainly is not this way in individual insurance today. The lower deductibles have certainly begun to disappear.

Employees are going to have more and more choices of where they opt to receive their health care services. It may be through multiple choices in indemnity with flexible benefits, HMO's, PPO's or whatever kind of options are available including some opting out completely in return for some money. The question is whether we must revert to individual underwriting or some other method of describing the health risk of almost everybody in a large employer in order to make some reasonable estimate of the prospective price of health care services for a subgroup of an employer population. In Minneapolis, some of the carriers have had to cancel large employers of 1,000 lives because only 100 employees were left in the indemnity plan. The carrier does not know how to establish a premium for those 100 people and tells the employer that they will write it as a cost plus plan because they could be in poor health. Carriers are not willing to establish a premium rate of $300 or $400 a month for a family in that group. It is really a very difficult situation.

Even with the feeling that there is much confusion in the health area, we have not seen much about national health insurance in the last four years.

At least one voice offered the opinion that there is confusion within the health care system because of the multiple options, the inability to project costs, and the fact that carriers might be losing money or going out of the medical aspect of the business or only willing to write high deductible plans. This confusion might cause changes in the marketplace where the only solution will be a simplified national health program. I can not see that far down the line, but I do know that within the next few years, the health care insurance marketplace is going to be very confused.

MR. DOBSON: We are out of time. There will be many opportunities during the rest of the day for discussion of these topics. I want to thank the panel for giving us a great lead-off. Remember that the topic for the day is Health Care Issues and Strategies for the 80's.

I would like to give special recognition to our recorder Don Hamm from Time Insurance Company, and also thank the Health Section Continuing Education subcommittee who did the work putting together today's program.