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FLEXIBLE BENEFITS UPDATE

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- Plan design
- Pricing considerations
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MR. HARVEY SOBEL: Our three speakers are Tom Boldt from TPF&C, Al Masciocchi from Aetna and Janet McCullough from Wilson Sporting Goods. Tom will begin the session by looking at flexible benefits from the consultant's perspective.

MR. THOMAS R. BOLDT: Clients sponsor flexible benefit programs for a lot of reasons. In some cases, they need to combine benefit programs because of a merger or acquisition. Others do it because of employee dissatisfaction; they want to increase the visibility and appreciation of their benefits program. However, the most common reason for implementing flexible benefits is to gain control over the rising cost of welfare benefit programs, especially medical benefits. When cost control is the number one goal of a company that is putting in flex, it provides the sponsor with a specific, measurable goal. Therefore, one of the key issues in looking at flexible benefits from a consulting standpoint is pricing.

The first thing I want to discuss is the "magic" flex pricing formula. The cost of flex can be calculated as: paid claims, plus administrative expense, plus flex credits, minus the price employees pay to get into the plans. Once a sponsor has selected the deductibles and co-pays for the plan, the paid claims are pretty much cast in stone. We can't do much to lower them.

Therefore we have to do a careful job of setting plan prices and credits to make sure that the flex plan can meet the financial goals of the employer. So, here's a basic approach to flex pricing during the plan's first year. First, you take the company's current claims as a basis and project them to the first year of the flex plan. Then you adjust the paid claims from the nonflex plan based on whether or not you're making a plan reduction. For example, if your current plan is a base plus major medical, and you're changing to a comprehensive plan (which would be your high option in flex), you adjust the claims as if everyone were going to get the high-option flex plan. Next, you identify any changes in demographics caused by the introduction of flex. For example, if you've got retirees in your old claim basis, and retirees aren't going to be part of the flex plan, you need to adjust the claims projection for that. And, if you're going to take a more aggressive pricing strategy towards HMOs, you need to adjust the claims for the fact that you may get more people back in the plan because of the HMO penetration. Next, you calculate the actuarial value of the options you're going to offer in the flex plan. You estimate the enrollment patterns for each of those options and simply allocate the paid claims you projected from the prior plan to the first plan year for the flex options.

For example, let's say our 1988 medical claims were $1,500,000. Projecting them to 1990, we have $2,000,000 of total claims with a thousand employees covered by the program. The actuarial or relative values of our three options are as follows: the high option is 1.0; the middle option is 0.85;

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and the low option or core plan is 0.7. Next are the assumed enrollments for the programs: 85% staying in the high option; 5% electing the middle option; and 10% electing the catastrophic program. These are standard enrollment assumptions for a flex plan for which the high option is similar to the prior, nonflex plan. By just multiplying the actuarial value times the assumed enrollment for each of those options, then adjusting the employees by that weighted average and dividing by the claims, you can determine the price tag for each plan: $2,078 for Option 1; $1,766 for Option 2; and $1,455 for Option 3. Not exactly rocket science, but this entire pricing example assumes that paid claims are a random variable and will not be affected by the introduction of flex. This approach adds a conservative element to the price tags, but a little conservatism probably isn't bad in the first year of flex.

Now let's get an idea of how this pricing method has worked for some actual flex clients. Our first example is a company with three flex plans. Plan 1 is the high option choice: $150 to $300 deductible, 80%/20% co-insurance, relative value of 1.0, assumed enrollment of 85%. This is the plan everyone had prior to flex. Plan 2 is the middle option: $500 individual deductible, $1,000 deductible for families and so on. The relative or actuarial value of this plan is 0.82 compared to the high-option plan, and assumed enrollment is about 5%. Plan 3 is the core option, or catastrophic coverage: $1,000 deductible, a relative or actuarial value of 0.69, and an assumed enrollment of 10%.

Here is the actual plan experience for the first year: Actual enrollment was 87% for the high option, 5% for the middle and 8% for the catastrophic plan. This is typical when you have a flex program where the high-option choice is similar to the nonflex plan -- most employees stay in the old plan. People who are healthy or have coverage elsewhere go to the catastrophic plan so they can free up flex dollars to spend on other choices. Finally, a small group of people pick the middle option for reasons I haven't been able to figure out yet. This particular client was subsidizing dependent coverage for medical care and wanted to do that in a discreet fashion, so we didn't reflect the true cost of dependent care in the price tags. Nevertheless, there was an acceptable loss ratio across all the plans. The high-option plan had a loss ratio of just slightly greater than one. Plan 2 had a loss ratio of less than one and Plan 3, the catastrophic option, had a loss ratio of much, much less than one. The overall ratio for the entire program was 0.98, producing a plan that worked just the way it was supposed to. In general, we're collecting just enough from employees to cover expenses, and the charges are actuarially fair. By this I mean that if a person changes from Plan 1 to Plan 2, the difference in price is the actuarial value of the additional risk that person is assuming based on the entire employee group.

Let's look at what happened in the second plan year. First, as people became more comfortable with flex, more of them changed from Plan 1 to Plan 2. Second, we cut back on the amount of credits we were giving employees to spend. As a result, Plan 1, which used to provide employee-only coverage, started costing money, producing the shift from Plan 1 to Plans 2 and 3. The loss ratios for the plans were as follows: 1.07 for the high-option plan; 0.7 for Plan 2; and 0.43 for Plan 3. Overall, the loss ratio was 1.01 . . . bad, but still in the ballpark. Again, overall, the flex plan is working. We're getting enough income to cover our expenses and everyone who picks a plan is paying a fair value.

Our next example is slightly different because it was the result of the merger of two companies. The high-option plan is a $100/$200 deductible arrangement; the middle option plan is a 1%/2% of pay deductible arrangement; and the core plan being a 5%/10% arrangement. All three plans have an 80%/20% co-payment provision. The actual enrollments were: 25% staying in the high option, 65% in Plan 2, and 10% in Plan 3. Under this arrangement, there was no hidden dependent subsidy. Instead, the flex credits increase as the number of family members increases, as do the prices charged to get into those programs. The credits are based on Plan 2 prices, so an employee with no dependents can get into Plan 2, employee-only, at no cost. Buying into Plan 1 requires an out-of-pocket expense, while selecting Plan 3 frees up a few dollars every month. Some small contributions are required for dependent coverage under Plan 2; these are more substantial for Plan 1, but are still low enough under Plan 3 to free up some credits.

Now, we can look at the renewal year experience for this plan. Option 1, because it had an enrollment of only 25% of the employees, had a very high loss ratio: 1.57. Plan 2, which most of the employees elected, had a loss ratio of 0.76. Plan 3, the catastrophic plan, had a very low loss ratio: 0.24. This is a good distribution of loss ratios for that kind of enrollment pattern and once

again, the loss ratio of 0.96 for the overall program means the sponsor is able to cover the plan's expenses and costs of administration.

As I said at the beginning, this is a very straightforward way to price flex. I think it has several advantages. First, because it is straightforward, it's easy to program into a computer. Second, it's very easy to duplicate results from year to year.

MS. NEELA RANADE: When you do the first year pricing, what kind of provision do you build in for antiselection? What kind of measure of conservatism do you have?

MR. BOLDT: Well, by assuming that paid claims are a random variable, we build in the antiselection factor because what's going to happen is this: if we anticipate that the claims paid out of the high-option plan will be paid during the first year of the flex program, we're assuming the people who elect the lower option plans will not have any claims, and we know that's not the case. We also know that the people who do elect the lower option plans -- the actual claim incurral being random enough -- will incur claims under those plans. So, by assuming that the claims paid won't change by introducing flex, we aren't taking into account the fact that those people who are "opting down" are going to have bigger deductibles and bigger out-of-pocket limits applied to their claims.

MS. RANADE: So your employer's starting plan was your high-option plan? Is that what you're saying?

MR. BOLDT: Yes.

MS. RANADE: What happens if the starting plan is the middle option?

MR. BOLDT: By charging the actuarial value of the plans and assuming the paid claims are a random variable -- and I mean paid claims, not incurred claims -- you've already adjusted for antiselection.

MR. SOBEL: Are you saying that the difference between paid and incurred is your margin? If it's 2%, then you have a 2% margin built in?

MR. BOLDT: Yes, exactly. In pricing the plan, we're assuming that the people who elect the lower options won't affect our paid claims. But we know they will; we know they'll lower our paid claim totals.

MR. STEPHEN M. MAHER: I'd like to ask about the differential in the loss ratios of the various options. You said you thought each of the groups was being treated equitably. However, in some cases, the loss ratios for the highest group were six times what they were for the lowest group.

MR. BOLDT: Well, in our approach to flex pricing, we don't try to make all the options self-supporting, which would produce a loss ratio of 1.0 for each program. When you do that, you get widely divergent prices. Over time, the high option, which will have all the sick people, will produce a loss ratio of greater than one, so this plan will need bigger rate increases every year. The people who elect the lower options tend to be healthier. For these plans, you must adjust the 0.24 or 0.4 loss ratio to get it back to one. As a result, if the high-option plan has a $200 deductible and the low-option has a $1,000 deductible, you end up giving people too many flexible credits to move from the high plan to the low one. When people elect a bigger deductible, they should only get the actuarial value of the extra risk they're accepting and that value has to be less than the difference in the plan deductibles. The approach I described keeps that actuarial value at a reasonable number.

MR. MAHER: Well, I agree that you don't want to price the plans so the loss ratios are exactly the same, but I was still very surprised at the magnitude of difference. In one of the examples you gave, I think there was a differential of six-to-one or more in the loss ratio that would be experienced.

MR. BOLDT: Yes, and I think when you get a lot of movement toward the middle option, with small enrollments in the high and low options, you're going to see a wide divergence in loss ratios because the low-option plan will have the very healthy participants, the high-option will have the

very sick, and the others will probably elect the middle plan. As long as the loss ratio for the overall program is close to 1.0, I think the financial goals of the program are being met.

MR. MAHER: I agree, but you said you thought each of the groups was being treated equitably. I thought one group was clearly subsidizing the others.

MR. BOLDT: Well, it depends on what you think is equitable. I've defined "equitable" to mean that everyone is paying the actuarial value of the program based on the experience of the total group.

MR. SOBEL: Isn't the employer's objective another consideration here? The employer may have certain goals, and as long as those goals are being satisfied, then the fact that options are not self-supporting could be irrelevant.

MR. MAHER: Right. The employer may want a level of cross-subsidization between the different plans. I agree with that.

MR. SOBEL: Now that we've heard the consultant's perspective, let's see how a large employer views flex. Our next speaker is Janet McCullough, the Vice President of Human Resources for Wilson Sporting Goods. She is currently responsible for all of the human resource activities for Wilson's 4,700 employees worldwide.

MS. JANET MCCULLOUGH: I'm not an actuary and I hope you're not going to grill me the way you did Tom. I've been asked to compare how things change for a corporation when it installs a flex program and when it has been in operation for a number of years.

Wilson currently has 3,000 employees in the United States and 2,300 in its flex program. Most of our locations are in rural communities, which was probably good strategy many years ago, when we were looking for low-cost labor. However, it has created a number of problems for us in terms of finding low-cost medical services such as HMOs. In addition, the culture at Wilson is fairly dynamic. I came from a PepsiCo organization. I had been there for a number of years, and I was used to a fairly high turnover of young employees. At Wilson, I was dealing with a much older population. I think the average age, when I arrived, was about 43 or 44 and the average length of service was around 20 years. In fact, we have one employee who will have 50 years of service with us before he retires. When I arrived at Wilson, the company was very paternalistic and one of PepsiCo's objectives was to change that culture dramatically. PepsiCo owned Wilson for about 15 years, until a leveraged buy-out in late 1985. In 1985, my job was to spin out of PepsiCo's corporate programs and form stand-alone plans for Wilson. The company that owned Wilson in those days did not intend to manage us. It was interested in profits, and last week, we were sold to Amer Group, a Finnish conglomerate based in Helsinki. It owns about 80% of MacGregor Golf and this group wants a long-term relationship. This will undoubtedly have an impact on what the corporate human resource objectives will be.

When I arrived at Wilson seven years ago, the paternalism extended to the benefit plans. Ours was a one-plan-fits-all mentality. The medical coverage was noncontributory for basic and major medical, with first dollar coverage on inpatient services. Obviously, this approach encouraged our employees to use hospital services, and as a result the costs were spiraling out of control. In addition, we had a very cleverly negotiated dental plan in all of our union locations, but had neglected to offer dental coverage to our salaried and nonunion employees. That was a major problem for us -- one we had to rectify. We also had an in-house claims processing operation and, again, a little more paternalism. Employees didn't have to fill out claim forms. Instead, they sent their receipts in and three or four employees in my department were responsible for making sense out of the bills and paying them. And when employees wanted to query their bill, they could phone and know they were talking to a friendly coworker, not a big, ugly insurance company.

This was the mentality that I faced when I came to Wilson to introduce a flex plan and help PepsiCo change the existing culture. In introducing flexible benefits, we had several definite objectives. The most important was to contain costs and give the company some flexibility in managing its benefits for the future; in short, change the culture, as I've mentioned. Second, we were beginning to see a greater variety in the types of people we were hiring -- younger employees, two-income families, single parents -- and we needed to address a growing diversity of benefit needs. We also wanted to align Wilson with the other PepsiCo divisions, which were

already in flex programs. In fact, those plans had been in operation for four or five years at that point. And, finally, we wanted to add the dental coverage for those employees whom we'd neglected, and move to outside, more professional claims processing. The original cost projection done by PepsiCo took the plan out five years. The estimates assumed an annual inflation rate of 20% and showed us that at the end of five years we would have some savings, due primarily to a reduction in costs in the first year.

We introduced our program in January 1984. We called it Benefits Plus because we felt that there were added benefits and flexibility. For example, we offered a 401(k) for the first time, and of course, there were other tax advantages. We conducted several enrollments across the country. All started with advance bulletins to the employees and included audio/visual presentations, booklets and meetings to describe the program. After an intensive six-week effort, we found our employees were absolutely frozen in horror. The reason flex produced such a thunderingly negative reaction was that, for the very first time, our employees were confronted with the need to make a decision about something they had never had to think about in the past: benefits and what those benefits meant to them. We found out we had some literacy problems. In a number of our locations, we had employees who could not read or write and the bulletins we were sending them were so technical they went completely over their heads. Probably the worst problem, from my point of view, was the poor support from the managers. In fact, a number of them referred to the new program as Benefits Minus. To salvage the situation, we had to scurry around the country and hold one-on-one meetings with employees: walk them through their enrollment form, discuss their family health situation, and help them make decisions. This was the communications task my department faced in the first year of our flex program. Looking back, some employees truly did welcome the ability to choose their benefits. These tended to be the younger ones, the new hires. The older employees, who had been used to the old, noncontributory plan, viewed flex as a definite take-away. Surprisingly, there was a lot of adverse reaction to the idea of having to fill out claim forms. In some locations, we went so far as to hire benefits administrators who are still responsible for filling out claim forms for our employees. Again, that's the literacy problem and managers did not support our actions. But despite the problems, we felt we had done a good job of trying to communicate to people that you shouldn't be totally risk averse. Instead you should figure out what your needs are likely to be and pick the plan that best suits your situation.

What happened in year three of the program was that Plan C, our rich plan, was in a death spiral. In fact, going into year four, the cost was expected to go up by 70%. So we had to redesign our plan. Our original plan was designed to offer three options. With the revised design, which we introduced in the beginning of 1987, Plan C was dropped. Under the new approach, we sort of shifted B to C and created a new low option, Plan A. We also changed our pricing strategy, creating high- and low-cost regions. As you might expect, we found that the health care services provided in the larger cities like Chicago, Los Angeles and New York were a lot more expensive than in rural Tennessee. So, we changed the pricing on the plan and created a high-cost/low-cost enrollment form. We also changed the company contribution, so we were contributing more to lower income earners; high-income employees had to pay a larger amount for their benefits. With these changes, we were able to achieve a much better enrollment distribution for years four, five and six.

Now, let's examine the company's costs for the medical plans. Although I may refer to some of the other benefits we added, I am really just talking about the company's contribution on a per-employee basis for medical care. In the initial years, 1984 and 1985, we had some price reductions, so we were very happy with our flex market program. But, by 1986, we began to see that death spiral on the old Plan C and we found that our cost was increasing faster than the medical inflation rate. At that point, we also found that a number of our younger, healthier employees had migrated to the HMOs. As a result, in 1987, we changed to a strategy whereby we eliminated the richest option and insisted on precertification. Then, in 1988, we changed our company contribution for HMOs and made it the richest plan. We called it Plan D and this strategy worked. Healthy people began coming back into the indemnity plan, so we had better experience to support it. Over the last two years, we have kept our costs way under the medical inflation rate for the country.

Now, I referred earlier to the five-year projection that PepsiCo had done for us. On a per-employee basis, the actual cost of the old plan in 1983 was $1,618. PepsiCo had projected that, using flex, this cost would increase 100% in five years. However, our cost has only increased 30%, so the flex approach really has helped us achieve that first objective of containing costs. In fact,

we have been able to meet all of our objectives except the one of aligning our plans with those in other PepsiCo divisions. Obviously, we're not really interested in that any more. One of the most important advantages of the flex plan was the way it allowed Wilson to meet the needs that we could see our employee population having over the next five years.

As an aside, we have been singularly unsuccessful in getting our unions to accept flex, so we're a company with flex and nonflex plans standing side by side. Depending on which union location you're looking at, we have two distinct nonflex plans, both noncontributory. The unions have been demanding HMOs and we'd be delighted to offer them, but there is still the problem of being situated in a rural community. Frankly, we have not been very successful in helping HMOs get into the communities. In fact, in one location in Tennessee, we worked very strenuously all last year with Health Master to get them set up with a panel of providers, but the providers in this town actually boycotted the HMO. As a result, we have not been able to offer HMOs to the unions to help us control this cost. And we have good information that this is going to be a strike issue next year with our unions. They feel that their plans, although they're noncontributory and richer than the ones we provide to our nonunion people, are not good enough. Instead, the unions insist we should go back to the old plan, which would have no deductibles, no co-insurance and no employee contributions. So, buy your golf clubs this year. I'm not sure that there will be a supply next year.

Just as a comparison between the flex and nonflex plans, over the last five years the cost of the union plans has increased almost 100%. Thus, in 1989, we pay almost 50% more in medical plan expenses for a union employee versus a nonunion employee. We have to find a way to overcome this rejection of the flex programs by the unions.

What are we going to do about the future? Well, a lot of employers are asking that question. I don't think we've come up with any magic answers. Some things we're already doing: We've eliminated second surgical opinion on those procedures where we were seeing automatic affirmative expenses. We've also reversed the 100% payment of outpatient expenses because of the cost shifting that hospitals have practiced over the last couple of years. We're tightening down on precertification. When we started this, we had such a backlash from our managers group that we had to relinquish a lot of the penalties we had set up in precertification. Now that it's been in place for a couple of years, we're tightening down again. In fact, we're being pretty hard-nosed about what does and does not get paid if somebody does not precertify. We're also going to look at penalties for emergency room use in nonemergency situations. This year, we will embark on a triple option plan in two of our locations. In Chicago and in Nashville, we have set up a PPO employer coalition in cooperation with other local employers. In Chicago, we've teamed up with companies like Navistar, Zenith and Amoco. In Nashville, we're working with Textron and Murray of Ohio, two big employers there. Naturally, we hope that the coalition will offer us some effective cost management techniques.

We've also done a fair share in the area of preventive health care costs. A number of years ago, we started trying to educate our employees with a program we called Health Sense. Basically, it was an effort to give employees enough confidence to question their doctor about excessive testing. Although we really backed that one with a lot of effort, we found that we still had to install the precertification program because they just couldn't overcome the mystique that their family doctor has. If the doctor said they needed to go for x-rays or other types of tests, they didn't want to question his judgment. Last year, we embarked on a national AIDS education program. This year, we're going into seat belt usage and we'll be providing statistics on accidents. Lowering cholesterol levels by offering more nutrionally balanced menus in our cafeteria is other item on our agenda. We're also looking at providing prenatal care. One year, we got hit with premature twins that cost us $200,000 and really made a significant blip on our annual premium statement. We've also installed some other programs: an employee assistance program to help people deal with personal problems, smoking cessation, weight reduction, aerobic classes in our work sites, health club memberships where there's one available, and health screening. Most recently, we introduced smoke-free buildings at some of our sites, and in another month or so, we're implementing drug testing policies throughout the country.

If I had to do all of this again, knowing what I do now, I would definitely spend a lot more money and time upfront on communication. I think we relied too heavily on PepsiCo's experience in introducing the flex program. We found we had an entirely different population and we should have spent the time and money to survey the employees before designing the plan. More to the

point, I would have educated the managers, who turned out to be our worst enemy. Even today, they complain about the lack of stability in a flex plan. They are still looking for a single plan that won't change every year, but those days, I think, are gone. In the future, we will probably set up employee task forces to address the rising costs of health care.

One final point: in sponsoring a flex program, you must recognize what it is and what it isn't. It is flexible and that means you will have to continually change it to meet the demands placed on you as a sponsor by your employees and the health care delivery system. It is not a cure-all, so you may have to supplement it with other techniques, like employer coalitions, to meet your specific objectives.

MR. JAMES M. MCCREADY: Did you have to tinker a lot with your prices? Because of actual plan experience and some of the things we were talking about earlier, did you find that you had to subsidize plans and did you have some of the problems of skewing that we talked about earlier?

MS. MCCULLOUGH: Yes. I'd say one thing that happens with flex is that the consultants get rich. We've spent a lot of money on actuarial projections and we tinker with the pricing every year. One of our big problems is that, as a company, we want to control our costs and pass on as much of the expense as we can to employees. Because we are dealing with some hourly employees whose average income is around $15,000 a year, this isn't really practical. We'd have a revolt on our hands. Instead, we've tried to come up with creative ways to tinker with the pricing.

MR. MCCREADY: Do you feel you've been able to divorce the price from the credit issue in order to control the credits you give to employees, so that the price is really driven by whatever the cost is?

MS. MCCULLOUGH: I guess I'd have to say yes. We've been fairly happy, particularly with only a 30% increase in 5.5 years. However, I wish there was a way to reduce the hue and cry that we hear from the employees.

MR. MCCREADY: I was curious about cost control. You said you had reduced the cost increases to 30%. Because flex by itself won't ensure cost control, was it HMO participation or some other factor that helped hold down your costs?

MS. MCCULLOUGH: I think the biggest factor was the change in design, getting rid of the very rich plan. We have tried to manipulate our population, if you will. One year, we found we had more chronically ill people in the indemnity plan. By changing the company contribution to HMO participants, we made it the most expensive plan. That brought healthy people back into the indemnity plan. That's typical of the ways we used to try to contain our costs.

MR. MCCREADY: What's your HMO participation overall?

MS. MCCULLOUGH: For the most recent year, it's down around 10%.

FROM THE FLOOR: I have a two-part question. One, do you have more than one carrier involved in your flex program? And two, do you think the flexible benefits environment is too difficult for a single-line carrier to compete in successfully? In other words, is it easier for you to go with just one carrier who can provide the dental, major medical, LTD, and whatever else you have in your flex program?

MS. MCCULLOUGH: We have two carriers. One has our accident and LTD; the other has all of the other coverage. We have not had any difficulty at all in terms of service or administration. I will say that we changed carriers midstream and the reason was not service or cost, but more planning for the future. We found that we were trying to educate ourselves to do more of the claims analysis in-house. We wanted to find out how much we were spending on chemical dependency and mental health treatment, how much on prescription drugs and the like. However, our first carrier was rather limited on the kinds of reports that it could give us. So we've made a change, and so far, we're fairly happy. However, when we did our carrier evaluation, we were very impressed with the candidates and felt that all of them have become very familiar with flex plans. They know what they're doing and we've not had any problems with carriers in that regard.

MR. GARY L. LAUGHARN: Do you extend any of this coverage to retirees?

MS. MCCULLOUGH: We have a retiree medical plan. Actually, it's Plan A, the lowest cost option. Probably the smartest thing we ever did during the sale by PepsiCo was to negotiate a deal to leave all of our retirees in its retiree medical plan. As a result, we started fresh in 1985 and only have about 70 retirees at the moment.

MR. SOBEL: We're going to move on now to our last speaker, Al Masciocchi. An associate actuary at Aetna, Al will give us the final piece in the flex picture, the carrier perspective.

MR. ALFRED J. MASCIOCCHI: What I'd like to discuss is where I see things moving: starting with three or four years ago, moving into the flex market, and maybe making some predictions about where I think we'll be in a year or two.

First, one of the things that has almost disappeared when you compare flex plans with those of three and four years ago is the confusion of choices and the confusion of credits. I think "confusion" is a good collective noun for the type of plan design we used to see as recently as three years ago. At that time, a lot of plans had as many as five options, not including an HMO. Participants might have had four or five different credit levels, depending on what plan they took. To an insurance company employee, it looked like a great way for people selling administrative services to make a lot of money. Now, many plans offer a maximum of three options, with an HMO, and there is a trend toward one level of noncash credits. We've also seen a broadening in the market. Approximately 50% of the Fortune 100 companies have flex plans. Flex is still most prevalent in two industries: banking and finance, and manufacturing. But it's begun to spread to smaller companies. Employers with fewer than 500 lives can easily get into flex now. Flex is also being offered more frequently to hourly and part-time workers, and we're starting to see more coordination with retiree coverage. With regard to the latter, retirees will either get the richest plan or the cheapest one. At Pillsbury, for example, retirees just get credits based on their years of service and basically must purchase a retiree-pay-all plan. This approach ties into the whole question of retiree medical liability.

As regards the future, spending accounts are the fastest growing thing we see in flexible plans. We're also seeing more age-graded rating, both in life insurance and contributions to HMOs. More emphasis is being placed on the idea of benefits as compensation and this leads to the last two items we're seeing: equal credits and less of a subsidy for dependent coverage. Under this approach, you would get the same number of credits, regardless of your dependency status. We're also seeing more multiple coverage categories: breakdowns into employee only, employee plus spouse, employee plus child, employee plus family. Again, the idea is that each employee is equal as far as compensation goes and they should purchase the benefits they need for their own situation.

We see a number of different employer goals. I just wish all of them were as clear-cut as Wilson's objectives. Three years ago, employers moved to flex because they read it was a nice thing to have or because it was considered the new wave of employee benefits. However, they really didn't know what it was supposed to accomplish, what it could accomplish, or what it could not accomplish. And some of the goals employers set for their plans proved to be mutually exclusive. Recruiting and retaining employees has always been a popular goal, especially in the health care and financial industries where there are problems in that regard. Sponsors want to increase the employees' appreciation of the value of benefit plans. But this could be a double-edged sword if you convince employees that their plans are valuable by showing them how much it's going to cost them to buy it this year. There might be some backlash. However, properly presented, discussions about benefits can make employees more aware of just what they're getting -- all those benefits that they had taken for granted. The importance of a benefits package is much more obvious when the employee must make the financial decisions and select from an array of benefits.

Flex is also a way to maximize the tax effectiveness of compensation, which is a means to give something back to employees at very little cost. When you take with one hand by raising contributions and credits, you can give some of it back by using Section 125.

Flex is also an effective response to a more diverse work force. These days, all employers face the differing needs produced by greater numbers of workers, single parent families, and dual incomes. Flex plans enable an employer to respond to the various benefit needs more effectively. It's also a

way to combine benefit plans after a merger. You can subsume two or more plans under one flex umbrella and simplify your plan administration.

For many employers, the primary reason for moving to flex is to manage health care costs. However, this is something that must be dealt with cautiously because it's not as straightforward as it seems. Even with a flex plan, keeping up with health care costs basically means cost shifting. Employees don't like cost shifting. Insurance companies don't like cost shifting either when it's the government shifting Medicare costs onto private industry. But cost shifting is fine, it seems, if you're moving the expense from the employer to the employee and that's really where most of the savings occur. There are other sources of cost containment and you can identify most of them without any difficulty. The biggest one, as I said, is cost shifting. When they implement a flex plan, 44% of employers raise deductibles up to 25% and increase out-of-pocket maximums, even for the richest plan. You can also reduce costs by having your employer-funding level tied to things other than medical care inflation. Typically, medical care inflation is used for a single plan where you're not changing the contribution levels that much. As alternatives, you could tie the funding level to general inflation or wage inflation and pass the excess cost along to employees through a combination of the benefit prices and credits Tom spoke of earlier. Managing those credits in terms of dealing with people in different dependent categories or eliminating subsidies is another way to reduce costs. Again, this is something that one-fourth of employers will do when they implement a flex plan or when it matures. The advantage is that it allows you to transfer benefits and save money too. When you offer people the choice, some, rather than select unstable, risky medical benefits, will select a life benefit or disability benefit. That's a more stable cost for the sponsor and far less prone to out-of-control increases than medical plan options. There are also savings that can be realized on FICA taxes, salary reduction, spending account forfeitures and, as I said, better experience. The latter is a bit "iffy" and much harder to demonstrate -- that you're actually controlling health care costs rather than transferring them.

We did a study of a number of our plans. I've taken the one on which we have the most experience as an example. This plan was installed before flex choices, with an employer goal of controlling costs. They were getting out of hand. As a result, the sponsor wanted to tie its cost increases to wage rather than medical care cost inflation. So in year two of the plan, when the flex choices were installed, the design was changed to three indemnity options, all comprehensive medical with 80%/20% co-insurance. The differences in the three options were in the deductibles and out-of-pocket limits. One thing you notice in the first year of flex is the huge increase in HMO penetration. This is a direct result of forcing employees to choose a plan. If employees don't fill out their enrollment form, they will have no benefits as opposed to simply being left in the $100 deductible plan. This is one of the things that this sponsor would do differently, because the company wasn't really interested in increasing HMO revenues. We did a cost study of this plan and demonstrated that the employees who shifted to the HMO in this year had claims equal to 57% of those for people who stayed in the indemnity plan. More to the point, when this change was made, the employer did not implement any accompanying change in its contribution strategies for HMOs.

Between year two and year three, the company began to address some of its other goals, which were to reduce the dependent subsidy and to increase the flex credits the program offered. In year two, the goal was for people to be able to buy back to the richest plan -- the $100 deductible plan from year one -- without any increase in cost. This was the benefits manager's way of avoiding a hue and cry, and it wasn't successful.

In year three, the company continued its strategy of reducing the subsidy, raising the flex credits, and presenting the idea of benefits as compensation. It also made a limited attempt to price HMOs more effectively, but we saw people starting to move out of the $100 plan. Unfortunately, they moved primarily to the HMO, which still was not being costed out properly.

In the fourth year of the plan -- the current year -- there was another increase in the flex levels and some gradual movement toward the indemnity plan. Nevertheless, we're still getting people who opt out entirely. From the insurance company's point of view, we don't want people opting out, but from the employer's point of view, it's a way to control costs, by shifting them to the other income in a dual-income family.

In talking with the benefits manager of this company, the key to making this plan work is communication. You can never have enough. This company ran into problems even though it had

meetings with all employees in groups of no more than ten. This was a large-scale undertaking for a company with more than 30,000 employees and still management doesn't feel there was enough communication to really implement this plan successfully. The other thing that the sponsor did not do that it wishes it had was integrate the HMO aspect of the flex plan more effectively into the overall program. By the time the flex program had been in operation for three years, there was very little movement among plans. People had settled in. Also, they don't have to continue to fill out forms after the first year, so there's a lot of built-in inertia. You have to force plan movement through higher credits and changes in benefit prices. I think where we're headed is a more integrated approach to the whole question of benefits. It's not enough to look at just flex or HMOs or retiree medical liabilities. All are parts of the same puzzle and some don't fit together very well, so there is a lot of juggling to be done each year, changing things here and there. HMOs really make all plans into flex programs. Many sponsors who think they don't have flex actually do because of their HMOs. You really have to integrate them into your overall benefits package. Retiree medical is a problem that only worsens when you implement flex because you must coordinate it with the flex plans.

The final topic I'd like to deal with briefly is Section 89 and flex. The good news about flex plans in Section 89 is that employers who have them are probably better able to deal with the new regulations because presumably they already have the more complex administrative systems necessary for Section 89 data collection and testing. The other advantage is that an annual enrollment process may make it easier to deal with the "sworn statement" aspects of Section 89. There's also some not-so-good news, as you might expect when you combine government interference with an already complicated employee benefits plan. Here are a few of the things, based on the latest regulations. Most should be taken with a very large grain of salt.

Under the 90%/50% eligibility test, the value of a benefits plan is net of any employer-provided credits. This is a problem or was seen as a problem for flex plans because the credits could not be taken into account as an employer-provided benefit. Fortunately, the regulations provide a way to include them. The unfortunate aspect is that you must pass a three-part test in order to count them. First, the percentage of highly compensated employees within the cafeteria plan -- as a percentage of the total population of highly compensated employees -- must be greater than the percentage for nonhighly compensated employees. Second, no benefit or plan within the cafeteria program can have any more than 25% of those eligible for the plan classified as highly compensated. Third, highly compensated employees cannot receive any benefits within or outside of the cafeteria plan that are not generally available to nonhighly compensated employees. As you may know, it has always been difficult to include executive medical exams or employee physicals as part of a flex program. Under Section 89, credits for those plans cannot be included in calculations of employer-provided benefits.

The second area where Section 89 complicates a flex program is related to flexible spending accounts which, as I said, are the fastest growing aspect of these plans. The new regulations stipulate that, under the health care portion of a flexible spending account, each level of salary reduction must be considered a separate plan. This makes it virtually impossible to use the 80% test for determining whether you're being discriminatory under Section 89. This is the "safe harbor" test, so of necessity you have to move to a more complicated test for a flex plan or spending account. With a flex plan dependent care account, you don't have those troubles because it's governed by a different code.

MR. SOBEL: Al, could you touch on the types of underwriting you might go through at renewal on a flex case? Specifically, I was curious about whether you have to go through an intensive process of reanalyzing what the flex credits are, each year, or do you take a simpler approach once the plan is on the books?

MR. MASCIOCCHI: Generally, we take the simplest possible approach, which is that the analyst rarely bothers to consult with any of the underwriters or actuaries. Once it's on the books, it's on the books. I get called in when they're seeing rates increase 50%, 100% or 150% on the richest plans and they want some way to manage that. But, as a general rule, we rarely get into the reanalyses. The exceptions are when it's almost a new case because plans are being entered and dropped. Then, basically, you go through a new case analysis. But, for the most part, we don't do much on renewal plans.

MR. LAUGHARN: Al, do you see any dominant pattern of companies setting prices for HMOs or ultimately the employee contributions toward HMOs and flex plans?

MR. MASCIOCCHI: No, I don't. I've seen very few cases where people are trying to solve a problem by negotiating with HMOs or dealing with credits on the basis of looking at the experience of people going to an HMO. Of course, we would love for our plan sponsors to do that. As an insurance company, we have made an intensive effort to promote those services, but people don't seem that concerned. Either they don't realize the extent of the problem or they have bigger fish to fry. You're not proposing a simple solution when you ask an employer to experience-rate an HMO or negotiate pricing. The sponsor will have increased administrative work if it deals with its HMOs separately or tries to bargain with them. Also, some people are skittish about such negotiations from a legal point of view. For many companies, the HMO is the benefit that employees like, because it's as cheap as the indemnity plan and they get great coverage. So, while the benefit managers may be faced with a lot of flack about other things, they can always bring up the HMO plan. They certainly don't want to get rid of the one thing they can sell as a great benefit. A couple of large policyholders are trying to deal with their HMOs aggressively. However, as far as any trend, I can't say that I've seen anything but business as usual. Also, it's hard enough to just get information on what the prior plan was before flex was implemented or what the employee contributions were. Still, I haven't had any dealings with sponsors making contributions to an HMO based on age-graded rating. The only one I have any experience with was the case I discussed earlier. However, that study was not done from an age-rated point of view. We examined the expense levels of people who chose an HMO and compared them to their expenses under the indemnity plan. As I mentioned, the HMO expenses were 43% lower, split about one-third based on age and two-thirds based on health. Our findings were then used as a bargaining tool by the sponsor to say, "Hey, we don't want to deal with the equal contribution amendment." We don't think it really applies and we want some other kind of concessions or else we're going to press this, because we've got pretty substantial evidence that says you're getting the healthiest people.

MR. LAUGHARN: So they got price discounts from the HMO?

MR. MASCIOCCHI: Yes. And I haven't dealt with anybody who's approached it on any level except to use the information as a negotiating tool for a price discount. I think part of that is legal skittishness. They don't want to deal with a provider who may use the federal HMO Act to challenge their contributions. They'd rather go in beforehand, say here's what we have and here's what we want to do, then get an agreement that it's acceptable.

MR. LAUGHARN: Can anyone else on the panel comment on whether we can see the flex credits being adjusted for age rating for HMO participation? Is it possible? Or instead of taking the price quoted by the HMO, can the employer adjust the pricing to take into account HMO demographics?

MR. MASCIOCCHI: I would say that it's being done. I've seen it done in the aggregate, but not specifically age-rated on the flex ballot.

MR. LAUGHARN: You haven't seen it done in a flex situation though, have you?

MR. MASCIOCCHI: I can't say I've seen it done specifically in flex. Well, actually, Janet had mentioned that Wilson has adopted geographic rates and I've seen countrywide firms with national credits. In those cases, when the HMO comes in, the out-of-pocket expense for the employee picks up more than just the actuarial value of the benefit difference -- it also picks up the entire geographic difference. Basically, I think the whole area of flex credits for HMOs could use some pencil sharpening.

MR. CRAIG S. KALMAN: Janet, how did the unions view the use of flex benefits or were they not covered by the flex benefit changes?

MS. MCCULLOUGH: As I mentioned, we've been singularly unsuccessful in convincing our unions to accept flex at all, so they have a single nonflex plan. In 1985, we succeeded in negotiating deductibles and co-insurance, but they are still noncontributory single plans in each location. But we haven't given up. We're going to try again.