RECORD OF SOCIETY OF ACTUARIES
1991 VOL. 17 NO. 3A

FLEXIBLE BENEFITS UPDATE

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Panelists: RICHARD C. DREYFUSS
PAUL R. FLEISCHACKER
ALLAN GOLD
Recorder: HUGH LARSON*

- Potential impacts of recent and prospective legislation on flexible benefit programs
- Pricing and underwriting considerations in a flexible benefits environment
- Managed care and flexible benefits
- Meeting the challenges that confront employers with flexible benefit programs

MR. THOMAS J. PARCIAK: There will be three speakers who are going to address various aspects of flexible benefits. Paul Fleischacker is a vice president and principal with Tillinghast in New York and consults with insurance carriers and HMOs about a variety of issues. He will lay the foundation for this meeting by discussing flex benefits design and pricing issues.

Paul will be followed by Allan Gold, an associate actuary at Aetna Life and Casualty. Allan is responsible for pricing, managed care, and HMO service fees at Aetna. Allan will be describing the "marriage" of flex and managed care and assessing the benefits and drawbacks of this "marriage."

The final speaker is Rick Dreyfuss who is director of executive compensation and employee benefits at Hershey Foods Corporation. Rick also is an Associate of the Society of Actuaries. Rick will describe an example of Hershey Foods' flexible benefits plan, implemented several years ago, and Hershey Foods' process of pulling managed care into their benefit plans.

I am going to start the discussion with a background on flexible benefits. Two years ago, Section 89 was introduced. Many people thought Section 89 was going to be the death of flexible benefits. At the time we were worrying about a variety of things, but the death of flexible benefits certainly wasn't one of them. As you know, Section 89 is now dead, and flexible benefits are definitely alive. Recent surveys have shown that 27% of all employers who have 1,000 employees or more have a flexible benefits program of some form. Twenty-three percent of firms with 150 employees or more are making some use of Section 125. My own firm, TRC, has 26 employees, and we use Section 125 to minimize employee contributions for medical benefits. Paul Fleishacker will now explain flexible benefits.

MR. PAUL R. FLEISCHACKER: I'm going to be covering four topics in my presentation. Each topic could itself be a presentation. Given our time constraints, I am going to discuss the major points of each of these topics. The topics include: a

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definition of flex, historic and recent legal considerations surrounding flex benefit plans, design issues, and underwriting and pricing issues.

What is flex? A Section 125 flex program permits employees to adjust elements of pay and benefits to suit their particular needs within certain constraints. It allows pretax choices (usually only once a year). The choices with fixed benefit expenditures may include cash, nontaxable benefits, and certain limited taxable benefits. These plans also have distinctive tax advantages for both the employer and employee over the traditional benefit programs.

The nontaxable benefits that can be included in a flex program are: health care (medical, dental, vision and hearing); life and accident insurance; disability insurance (long-term and short-term); vacations (buying and selling vacation days); dependent day care; a 401(k) plan; and flexible spending accounts.

Taxable benefits include: cash; life insurance and accident insurance (taxable benefit if the amount of life insurance on an employee exceeds the limitation under Section 79 of $50,000); group auto; long-term care; and other benefits that are permitted by regulation.

There are certain tax savings under a flex program. Employees can use pretax employee contributions to pay for some benefits such as medical and dental. As a result, employers save on the Federal Insurance Contributions Act (FICA) taxes and employees save on both the FICA and federal taxes.

There are also special rules that apply to flex programs. Employees must select their options before the beginning of the plan year. These elections must be irrevocable once the period of benefit coverage begins, but the IRS does allow option changes if the employee has a family status change, such as marriage, divorce, death of a spouse, or birth or death of a child, as well as several other conditions. The IRS also allows changes if there are significant changes in either cost or levels of benefits during the course of a plan year.

Finally there's the "use it or lose it" rule. Contributions to flexible spending accounts unused by year end for specific benefits elected cannot be refunded to the participant in cash or in the form of any other benefit. There are some exceptions to this rule regarding vacation days.

Next, I am going to review legal implications of implemented flex plans, but first, I am going to briefly review some of the history of the regulations as they apply to flex plans.

Under the Revenue Act of 1978, Section 125 and 401(k) became law. Section 125 provides that a cafeteria plan participant would not be subject to income tax solely because a participant may choose among the plan benefits as well as foregoing benefits for cash. Thus a cafeteria plan provides protection from the doctrine of constructive receipt. Although the 401(k) plans became law under this act, it was unclear whether or not a 401(k) plan could be included as a benefit in cafeteria plans. This became possible under the Miscellaneous Revenue Act of 1980. In 1984, the IRS came out with an information release in which they cracked down on many of

the early versions of flexible spending accounts which violated the "use it or lose it" rule. This release also described operational rules for cafeteria plans.

In May 1984, the IRS issued proposed regulations for Section 125 plans, which were in the form of 21 questions and answers.

In 1984, the Deficit Reduction Act, Section 531, contained a series of changes in Section 125 and transitional rules to provide employers with some relief on nonconforming flexible spending accounts.

Finally, the Tax Reform Act of 1986 contained several changes that impacted cafeteria plans: a modification to the nondiscrimination rules applicable to benefits offered through cafeteria plans, and as Tom mentioned, Section 89 was enacted (which was subsequently repealed in 1989). Also, the definition of cafeteria plans was expanded to include arrangements with no taxable options. This was also repealed in 1989.

The latest set of proposed regulations were issued in March 1989. Again, the IRS regulations were given in a question and answer format. These regulations provide guidance on many cafeteria plan issues. The regulations defined where desired benefits constitute "qualified" benefits under a cafeteria plan (which may include cash, nontaxable benefits, and taxable benefits), and they also define prohibited benefits (such as education and scholarships). The regulations also discuss the prohibition of benefits which defer the receipt of compensation (this includes deferred compensation plans, other than 401(k), and the carry-over of the unused benefits into a subsequent plan year, such as unused dollars under a flexible spending account). The regulations also discuss the circumstances under which a participant may revoke and change existing choices (for example, the family status changes that I discussed previously). Finally, the regulations discussed the special rules governing flexible spending arrangements (including the imposition of a risk-shifting obligation onto employer plan sponsors).

My next topic is design issues. We generally look at four phases of flexibility. The first plan is the pretax plan contributions. This is the simplest flex program. It is used primarily with health insurance plans and can increase take home pay for employees and decrease employer taxes because it decreases taxable income. Finally, this program has little administration requirements. Generally, the administration solely requires that the employer have the capabilities for a payroll reduction.

The second phase is flexible spending accounts. This is the next step towards full flexibility. Flexible spending accounts provide for tax-free reimbursements of certain eligible expenses which can include health care expenditures, (such as deductibles and coinsurance), medical, dental and vision care services, which are not covered under the health plan. It also can include the cost of dependent care while a person is working. Flexible spending accounts require an annual election of pretax contribution levels and an authorization for the employer for the deduction to decrease the taxable income. The employees are required to submit receipts or bills to claim the tax-free reimbursement. The final point under the flexible spending account, as I've mentioned before, is that the "use it or lose it" rule applies.

A third phase of flexibility is expanded health options. These types of programs typically include choices for basic medical coverages, such as basic plus major medical, comprehensive major medical, an HMO, a PPO, and in some cases, a waiver of coverage. They often include other optional coverages such as dental, vision and prescription drugs. Obviously, this provides more flexibility for employees through the use of choices and the use of pretax contributions. Selection of a low-cost option may result in excess credits which can be used for purchasing other benefits. There's also the potential for employer cost reduction by shifting employees to more cost-effective coverages using the incentives that are built into the program.

The fourth and final phase of flexibility is total flexibility. This is a modular approach in which an employee elects "core" benefits and uses flex dollars and employee contributions to purchase "noncore" benefits.

A modular plan is a set of prepackaged benefit coverages in which the participant selects the package of benefits he or she wants. A core-plus-options plan is one in which there is a basic core package of benefits for all employees, with a set of options available to the employee for changing the core benefits.

The coreless plan is one in which the employees elect what coverages they want. That is, there is not an underlying core plan.

Under a core plan, that is, a core-plan-with-options, the core plan itself is set with a benefit level that is the same for all employees and is based on an assumed uniform level of needs for all employees for medical, retirement, disability, group life etc. The core benefits are financed with employer's dollars only; that is, there are no employee contributions to the core benefits financing. The core benefits finally are set to take into consideration the employers budget constraints.

The obvious questions are: how many options should we have and how many is enough? Some employers and consultants believe that more is better. This is not always the case. An optimal number of options can be determined using the following criteria. First, employees should be able to select benefit levels that approximately meet their individual needs. Second, the pricing of the plan should allow the employer to meet its short-term financial objectives. Third, both the benefits and the pricing structure should allow the employer to satisfy its long-term financial and employee relations objectives. Fourth, the employees should be able to understand the choices with a reasonable degree of effort.

In designing the options, it is desirable to define the target market for each choice and to estimate the number of participants within each option. If it is anticipated that few employees are going to elect an option, it's probably better to eliminate it from the program. This not only makes it easier for the employee to make a choice, but also eases the administrative burden for the employer.

In general, employees are often satisfied if they have choices in the types of benefits they want (for example, medical, life, dental, and LTD). The number of options within each benefit may be less important.

To see how a flex plan can work and solve an employer's problems, let's take a look at a case study. In this particular program, the employer problems included geometrically escalating medical costs and strong demand for a dental plan by the employees. The employer resides in a state with both high state income taxes, and a very strong competitive employment market. The current medical plan provides for first dollar coverage with dental, vision and prescription drug coverage: it is a base plan with supplemental major medical. There are no other medical options available under the program.

How can flex help solve these problems? First of all, to address the escalating costs, the employer can adopt high- and low-option medical programs with the high option being the same as the current program and the low option being a comprehensive major medical with a deductible and coinsurance. The employer can also increase the internal controls. For example, the employer can incorporate a strong utilization review program under both medical options. In fact, the employer can promote employee consumerism through pretax costs and incentives to switch to the lower option. One way it has done that is to add the dental plan to the low-cost option which encourages the employees to switch to the low-cost medical plan.

To address the high state tax rates, the employer can add a pretax contribution and a flexible spending account. These will reduce the impact of increased cost sharing by converting after-tax expenses to pretax expenses. It also reduces the employer and employee FICA taxes.

Finally, to address employment competition, the employer can structure an attractive package for recruitment and retention.

My last topic is underwriting and pricing issues. There are several key issues to be addressed in underwriting and pricing flexible benefit programs. The first is the determination of the amount of dollars the employer wants to spend and how the credits are to be allocated to the employees. Should credits be based on dependent marital status, length of service, payment levels, location, or some other variables?

In determining the allocation formula and the benefit package to be offered, the employer must assess their impact on employee relations. The pricing, credits, and program design must be set to meet the employer's short-term and long-term cost strategies. Finally, and perhaps most importantly, the impact of adverse selection must be evaluated and factored into the plan design and pricing.

All the above can directly or indirectly impact the design, underwriting and pricing of a cafeteria program.

First, what does adverse selection mean? Adverse selection is selection by the employee which benefits the employee. Specific characteristics of the employee are not recognized in the pricing. Examples of this can include selection by age for flat rate life insurance and selection by health for multiple option medical programs. The effects of adverse selection on cafeteria plans are many. At the individual plan cost level, cost can change significantly. The degree of selection is a function of participation with the biggest impact on plans with the lowest participation level. The total plan cost typically increases only slightly. At reenrollment, there is another element of

adverse selection because both the participation level and the selection levels are impacted, and this leads to impacts on the pricing of the options and the credits.

Maintaining a desired cost balance is extremely difficult because the contribution levels effect participation and participation effects the claim costs which determine the required contribution levels.

There are some techniques for controlling and managing adverse selection. These include plan design limitations and constraints (such as limiting the number of options, having evidence of insurability and the use of preexisting condition limitations). You can also control these through anticipatory pricing and the use of subsidies between the different benefit programs.

I think some of the key factors influencing selection are the relative benefit values of the options, the employee contribution levels, and employee perceptions of need, risk, and entitlement. We have seen on quite a few programs that, in general, employees are risk adverse (they elect in that manner).

Moving to a pricing model, I've seen a number of different pricing models for multiple options and cafeteria-type programs. They all fall in somewhat of a general mode. As a general guideline, the first step in the process is to calculate rates on a no-option basis. That is, the actuary assumes that all the employees elect that option. The next, and most difficult step, is estimating the participation level for each option and the degree of adverse selection.

Some type of selection factor analysis is critical in this phase. Quite often, a subjective analysis is done which accounts for adverse selection in the current and proposed programs, contribution levels and the credits. From there a subjective judgment is made as to what the participation levels and adverse selection levels are going to be.

Some tools that we use quite often are employee surveys and trade off analyses. These tools help us estimate what employees will elect, what programs at what price and from there we can get an idea of participation levels which lead to estimates of adverse selection.

Another method I've seen utilized is a claim distribution model. As you know approximately 25% or 30% of employees are not going to use the medical program in any one year. Obviously these employees are likely to select the low-option plan. At the other end of the spectrum, you have the high utilizers. They're going to pick the high-option plan. Between these extremes are employees who are relatively healthy risks and may select one or the other. That is where a lot of judgment enters.

Finally, some people use selection models. I have seen selection models which incorporate claim distribution tables together with rates and credits that are going to be charged for the various programs. These models try to schematically determine what the participation levels and the cost will be for the various options.

No matter what method you use, you combine the model results with the weighted premiums for each option and for the total program. The final step in the process is

to realign the rates and the credits to achieve the strategic goals that have been laid out by the employer.

In the April 1991 issue of *Health Section News*, Ed Mailander wrote an article called "A Multioption Pricing Model." In this article the author presented a generic pricing formula which in essence relates the cost of the multiple option plan to the cost of a single option plan modified to take into account enrollment, relative value of the other options and selection factors. This formula is geared toward two medical programs, but obviously it can be extended to more than two (and can also be extended to benefits other than medical). The key factors here are the enrollment percentages for both option A and B and the plan's relative values. These are typically taken as the actuarial, or manual, differences between the various options. The selection factor reflects the relationship between those expected to select the option and the experience of the total population.

A Generic Pricing Formula[1]

$S_{mo} = S_{so} (E_A \times RV_A \times SF_A + E_B \times RV_B \times SF_B)$

where S_{mo} = Claim cost for the multiple option plan

S_{so} = Claim cost for the single option plan

E_A = Enrollment in Option A (high option)

RV_A = Relative value of Option A with respect to benefit plan that generated S_{so}

SF_A = Selection factor for Option A

E_B, RV_B and SF_B are the equivalent values for Option B (low option)

The key factors in the formula are the enrollment and the selection factors. The article presents a couple of formulas for determining the selection factors and enrollments. In essence, the article says you can relate the selection factors and the enrollment factors. For example, under that first formula, the selection factor and the enrollment factors would equal one. The article provides a table which is based on claim distributions and percentage enrollments in the high-option plans as well as a table of factors for both the enrollment and the selection factors for both the high-option plan and the low-option plan.

A Generic Pricing Formula[2]

Formulas for selection factor:

- $SF_A \times E_A + SF_B \times E_B = 1$
- $SF_B = k \times E_B + j$

  where $0 < j < 1$

  $k = 1 - j$

[1] Edward M. Mailander, "A Multioption Pricing Model," *Health Section News,* April 1991.

[2] Edward M. Mailander, "A Multioption Pricing Model," *Health Section News*, April 1991.

The article states that the more realistic selection function is the second one, which requires an estimate of the selection factor for the first few individuals likely to elect the low-option plan. I think he makes a good point in the article that there is an advantage in doing it this way, since it's sometimes easier to estimate the selection characteristics of those electing down in coverage, rather than electing up in coverage.

To conclude my presentation, about two or three years ago our company adopted a flexible benefit program. At this time I will turn the meeting over to Allan Gold.

MR. ALLAN GOLD: I would like to talk about how the managed care component of an employers plan may interact with the flexible benefits care component. Depending upon the strategy, or the lack of a strategy that an employer has, the two components may compliment each other, or they may work against each other.

The first thing I will talk about are the goals of each of the two programs, flexible benefits and managed care. For flex there are two goals that are often associated with the program. The first one is converting a defined benefit plan into a defined contribution plan. In that way the employer can more systematically determine how much it wants to contribute to the plan.

The second goal is to provide employees with the opportunity to customize their benefits. Employers recognize the diverse needs of their employees. And as employees are asked to share more and more of the cost of the benefit programs, flex allows employees to pay for only those things that they want. Before I talk about the goals of managed care, I'd like to talk about the managed care spectrum. On one end of the spectrum are the traditional, unmanaged, indemnity plans. And on the other end are the staff model HMOs.

Between these two extremes are managed care products such as phone based, precertification, concurrent review and provider networks. Further along the spectrum are the HMO point-of-service products where in-networks benefits are provided in an HMO setting but employees have the freedom to seek care outside of the network. At this end of the spectrum, the in-network care will generally be managed by primary care physicians. Next to staff model HMOs on this spectrum are individual practice association (IPA) model HMOs.

One of the goals of managed care is to decrease the cost of the benefit plan by decreasing both the utilization of care and the unit cost of care. To justify decreasing utilization, one upholds the premise that a significant portion of care is inappropriate. So, managed care also intends to increase the quality of care by decreasing the amount of inappropriate care.

Managed care is designed to give employers and employees more value for their health care dollar. Many employers have viewed their flex plan and the managed care component of their plan as independent programs. But it is important to recognize that employees only see one plan. They must understand that plan in order to use it effectively.

So, the first thing I want to say about the two plans, flex and managed care, is that together they make the employee benefit program extremely complex. This is especially true if the design of the options is not carefully considered. An employee might ask things like, Will each option have networks and the same types of managed care requirements? What's different about each plan? When do I have to call to precertify? When does the doctor have to call? What's covered and what's not covered? Is it the same in all the options?

Employees may also be confused by the implicit message of the two programs. Flex offers choice. Managed care takes choice away. In order to assure that employees understand and use the plan appropriately, the marriage of managed care and flex must be well designed and well communicated.

By controlling the use of inappropriate care, and by controlling the cost of that care, we are making the plan more affordable for both the company and the employee.

Now I'd like to talk about how the flex plan and the managed care program may be integrated. Remember that as long as an employer has an HMO option in its plan, it has a managed care component to the plan.

Integration of the two plans, or the two components of the plan, includes HMOs as part of a managed care strategy. Combined, an employer has one risk pool. Or we may consider the employees in the HMOs as not being in the employer's risk pool.

There are three ways that the components of the program may be combined. The first and perhaps easiest way is to merely overlay the managed care process onto each non-HMO option. All options can have the same managed care requirements that employees need to follow. These could include phone-based precertification and concurrent review and/or networks.

One important issue about this type of integration is the HMOs. Implementing managed care processes in the indemnity plan may make a plan resemble an HMO except that it has significantly more hassles. This resemblance could actually increase HMO penetration. Overlaying managed care on indemnity options must be carefully monitored to understand how it will impact the overall result for the plan including how it impacts the HMO penetration.

Another consideration with this type of integration is the feasibility of implementation at firms with multiple locations. Adequate provider networks may not be available at all locations. This may require different plan designs or pricing strategies for nonnetwork at locations. It may also complicate the access to care for those employees on assignment at locations with networks when they aren't used to dealing with networks.

The second way that the components of the plan may be combined is to offer an additional managed care option. In this case the option will be a PPO or network option and is added to the current selection of the indemnity option and the HMO option. All of the non-HMO options could have some form of phone-based precertification. A major drawback with this strategy is the proliferation of options and the possibility of antiselection. Also, unless the HMOs are integrated as part of the

managed care strategy, the complexity and confusion resulting from the proliferation of options could defeat the goals of the new options by inadvertently increasing HMO penetration.

Finally, managed care as an option can be used as an interim step towards the third scenario, managed care. This is consistent with the one risk pool view of an employer's plan. The one plan would be the HMO point-of-service product.

The big question is how to get all the employees into that plan? One good answer is flex. By strategically managing the design and annual pricing of the available options, employers can move their employees into the managed care option during the course of a few years.

This final strategy will become increasingly important over the next few years. This is because the lines between managed indemnity plans, network-based managed care and HMOs are becoming very fuzzy. They will become even more fuzzy after the expiration of the HMO law.

As this fuzziness spreads, the spectrum of managed care will continue to evolve. Employers are struggling to determine just where on that spectrum they want to be. Flex can be used to manage the transition to a particular spot on that spectrum, or it can be used to offer employees the opportunity to choose where on that spectrum they want to be.

As employers manage their transition to managed care, there are several things to consider which will be helpful regarding the development of their managed care strategy. Should the employer view its plan as a single risk pool, or should it consider employees at HMOs as being outside of its risk pool?

The concept of the single risk pool is the foundation of experience-rated group insurance. The employer bears the full risk of the experience of the plan. And in this case the employer also gets the full benefits of the savings associated with managed care, including the savings from the HMOs.

With just one pool the employer can more easily manage the pricing of the options to steer employees towards certain plans. Or the employer can give employees options that are more related to the actuarial value of the plans as long as the total revenue into the plan is equivalent to expected plan experience.

Single-risk pools require experience-rated HMOs. One way to acquire experience-rated HMOs is to contract with a vendor that offers an integrated multiple-option plan that combines the experience of the indemnity, PPO, and HMO employees.

If an employer cannot get a multiple-option plan, or some other form of experience-rated HMO, it may want to design its plan such that HMOs that don't experience rate are relatively unattractive.

The biggest savings are often associated with catastrophic claims. Efforts should be made to get all large claims into the network where they can be managed.

The development of a center of excellence component of the network for transplants or other big ticket items could also be useful, and of course, individual case management should be a part of all options.

Keep well run and popular HMOs as part of the plan. This keeps employees happy. HMOs are often the ones that are most able to provide the kind of service and information that an employer needs to manage its one risk pool.

And finally remember that the marketplace is evolving. The managed care and flex strategy should be viewed as a multiyear process. Set long-range goals and move towards them each year. Monitor the results and make corrections and adjustments to the plan and strategy as required.

To wrap up I'd like to reiterate that there is no one right answer as to how flex and managed care should be integrated. Just like any other plan it depends on each employer's current situation with respect to costs, demographics, human resource goals, and company culture.

However, these goals should be integrated. Each company must have clear goals with respect to their benefit plan and must understand how each goal impacts the plans and how employees use the plans. This is critical in order to assure that the long-range goals of the company are being met and that the employees are understanding the plan so they can make appropriate decisions about their choices.

MR. RICHARD C. DREYFUSS: I'm pleased to be able to contribute to this discussion of flexible benefits by addressing the employers perspective, and in particular, describing the experiences of Hershey Foods Corporation since it implemented flexible benefits in 1987.

Let me say at the onset that what I'm about to describe could best be categorized as a case study. It is by no means meant to indicate that we view flex benefits as our way versus the wrong way. Rather, within any organization, it is incumbent upon those responsible for the design of the benefit program to manage the environment that is supportive of the business needs and culture, and obviously optimizes the traditional conflicting priorities which exist between shareholders, customers and employees.

Before proceeding further, let me take a moment to introduce my employer, Hershey Foods Corporation, a $2.7 billion company headquartered in Hershey, Pennsylvania. Our main business is manufacturing confectionery products such as Reese's Peanut Butter Cups, Hershey's Kisses, and more recently, Kisses with Almonds. This segment of our business represents approximately 85% of our sales. Our second largest division, Hershey Pasta Group, produces many brands of spaghetti and other pasta products throughout the country under a variety of regional brand names.

The remaining business segments are derived from our international business in an area where we expect to grow substantially in the 1990s. However, this currently represents less than 5% of our sales. Therefore, in spite of our worldwide presence, we are essentially a domestic food company with the need to be

competitive in our production. A key supporting strategy of this is our ability to be competitive in all segments of our labor costs.

Since I am dealing with an actuarial audience here, I thought it appropriate to identify some important statistics about our work force. First, we are a company with approximately 12,700 employees and 2,700 retirees. Ten thousand of the employees are located in the United States, and approximately 6,000 of this group are located in central Pennsylvania within a 50-mile radius of Hershey, Pennsylvania. Our work force is approximately 40% unionized. Our average employee age is 41. Our average length of service is approximately 11 years.

In 1991 our benefit cost budgets for our group insurance, which includes medical, pension and savings, is estimated to be approximately $53 million of which approximately half is for health care.

In 1987, Hershey's objective for implementing flex was to provide flexibility to the company by decoupling the level of benefits from the cost of benefits themselves. Equally important, however, was the objective to allow employees greater choice in their benefit coverage due to a more diverse and changing work force.

As we look at health care and flexible benefits, the vast majority of our flex credits are related to health care. Someone once said the rest of it gets lost in rounding. Our principal insurer in central Pennsylvania is Capital Blue Cross. For you who are not familiar with the Blue Cross organizations in Pennsylvania, there are five Blue Cross organizations within Pennsylvania. But there is one statewide Blue Shield program.

Capital Blue Cross has the largest market share in central Pennsylvania with over 50% of the Pennsylvania market, and Pennsylvania Blue Shield represents an equivalent proportion on their side of the house. One thing that drives these market shares is that Capital Blue Cross has very favorable hospital discounts with their participating hospitals. They reimburse roughly 65 cents on every dollar of charges and all the hospitals in central Pennsylvania participate with Blue Cross.

On the Blue Shield side, approximately 82% of doctors participate. That includes primary care physicians as well as specialty care physicians. Their average payment is roughly 70 cents on every dollar of charges.

We use a variety of carriers outside of Pennsylvania, supporting our general notion that health care is best considered a local issue. Therefore, wherever feasible, we intend to work with insurers and providers as a strategy to better manage the health care system.

Our current medical benefit offerings include a traditional first dollar major/medical indemnity plan, which includes 120 days of room and board, 100% reasonable customary physician's allowance for surgery, and a major medical component with a $250 deductible and 80% coinsurance.

This, in essence, was our medical plan that we had in force prior to 1987, prior to going into flexible benefits. At that time, we provided the coverage to both employees as well as dependents on a noncontributory basis.

In 1987, as part of flex, we allowed employees to participate in one of three HMOs, and introduced two comprehensive options with a $250 and a $600 deductible respectively with the family deductible being twice that amount. After the deductible, there is 80% coinsurance up to the stop loss.

Our feeling at Hershey at that time was that employee security is very important. Therefore, as we transitioned into flexible benefits, we wanted to dispel the notion that flex was a complicated cost-shifting scheme. We gave employees sufficient credits to purchase the cost of the indemnity plan with the exception of a very minor $3 per month employee contribution which was the same across all family coverage categories. So, an employee would pay $3 for employee only, employee plus one, or an employee plus two coverage.

Very clearly, our primary motivation going into flexible benefits was not cost shifting, but to give the company more flexibility with respect to managing the health care of our employees. To compliment this program, the corporation also provided enough credits to buy the high level of dental, vision, and long-term disability in addition to enough credits to purchase one times your pay of group-term life insurance.

To compliment the flexible benefit program, spending accounts for both employee and dependent health care were implemented to allow employees to purchase noncovered items on a pretax basis.

To summarize, Hershey's objectives were to respond to our changing work force and to give the company the tools to better manage its benefit levels and costs in the future.

This is in contrast to other companies' experience where, because of other business reasons, flexible benefits have been the alternative with a completely redesigned benefit plan very likely confronting the employee with benefit options and contribution schedules that they had never seen before in their careers with their employers.

The question that this presumably raises in your mind is what has happened to Hershey since 1987? Clearly we have seen health care increases at what we consider to be unacceptable levels. Looking at this from a long-term business strategy with the real growth of our business being approximately 4-5% each year, and inflation being close to 4-5% a year, one could expect sales from our continuing operations to grow in the neighborhood of 9-10% per year.

Our health care costs since 1987 have increased approximately 14% per year in central Pennsylvania, which may be considered very good. However, in the context of our business, when your expenses are increasing faster than your revenues, this portends problems no matter what business you're in. Therefore, it became incumbent on the corporation to properly manage its benefit program. I raise this issue because in 1989 we successfully negotiated flexible benefits with our largest union in Hershey. In doing so, union benefits continued to parallel the salaried benefit strategy

because we have an egalitarian philosophy towards employee benefits. Therefore, we wanted to treat all union and nonunion employees the same. We extended the $3 increment as a means of participating in the indemnity plan to all employees. But at that time, 1988, we increased the $3 up to a raging $5.50. And now the employee cost is $7.99 per month.

More important though is that going forward we negotiated with the union that all future cost increases in our flexible benefit programs will be shared 70/30 with the company absorbing 70% and the employees 30%.

We feel this is the appropriate strategy for long-term management of our flexible benefit program. As a result of the 1989 negotiations, the corporation also tightened its case management and chiropractic benefits in addition to better managing in-patient psychiatric benefits, an item which has been in the forefront of many company's agendas in the last few years.

However, an important feature introduced in 1990 is the concept of age-based wellness. Employees are eligible to receive a physical, with the physician of their choice, which is reimbursed at a 100% of reasonable and customary guidelines.

We also offer a prescription drug card. This program is somewhat unusual in that generic drugs are entirely company paid and brand name drugs receive a 10% differential. Employees are allowed to submit those balances under the particular health care plan in which they've enrolled. To date we're satisfied with the results of this particular program.

The majority of my talk is not to be focussed on the macro issue of health care management. Many of us have read about and been overwhelmed by this complex problem. This issue is larger than we are, yet one which we are considering very reasonable and prudent initiatives on a local basis in order to better manage our costs.

Let me briefly describe some of the strategies that we have in place for central Pennsylvania in the area of managed care to show you how flexible benefits and managed care come together. As mentioned earlier, our cost continued to grow at an unacceptably high rate. Through a utilization review study conducted last year, we learned that approximately 14% of our costs can be attributed to services which add no value to the health care system. That is, we are dealing with redundancies and questionable practice patterns; we have unmanaged care.

Currently, we are undertaking a managed care project applicable to all salaried and hourly employees, which we fully expect our largest union to successfully negotiate with us. Frankly, it will be substantially involved in the overall strategy. Our viewpoint is that organized labor shares with management the objectives of an improved health care system. It realizes health care costs are often affecting wage settlements because a disproportionate share of total compensation is consumed by health care. Its issue as they work with management is very clear: who will get the savings? We feel this is a reasonable and legitimate issue to be discussed through the collective bargaining process. This is not to say that every single line item that we or they are considering will be acceptable to both parties. But rather, managing health care is a shared objective.

Our fundamental strategy in central Pennsylvania is to try to work with the existing Blue Cross and Blue Shield established provider discounts. Unfortunately, our health care system in America currently rewards processes as opposed to outcomes. Our strategy is to address managed care through better managing quality of health care and comparing the outcomes measurement within our health care system.

We intend to do that in part by utilizing a resource which has been a law in Pennsylvania for approximately five years. In 1986, the Pennsylvania Health Care Cost Containment Council, otherwise known as HC4, was established by the general assembly of Pennsylvania through an act supported by Hershey Foods Corporation.

Assuming medical outcomes can be quantified, when one goes through a quality health care process, better health should result and be measurable. Every quarter the HC4 produces hospital effectiveness reports for each acute care hospital with more than 100 beds, on a diagnostic related group (DRG) basis (that is by hospital, by DRG). The reports provide data for public review: the number of patients, the average length of stay, the average patient's severity, healthiness after your hospital experience, proportion of admissions over age 65, mortality, readmissions and the average cost of services that were provided.

This information enables all purchasers of health care to understand that there are substantial differences in quality among and even within hospitals and in the very cost of services themselves. Therefore, our strategy is to integrate this key concept of quality into managed care. We look at this data, in conjunction with other data relating to doctor's practice patterns, in both primary and specialty, because of the interdependencies between hospitals and doctors. Therefore, we need practitioner data as well as hospital data in order to pull together an effective health care network. This data is also within the public domain.

Our intent is to work with hospitals and doctors who buy into quality standards. There has been strong opposition in Pennsylvania to the Health Care Cost Containment Council from many Pennsylvania-based provider groups. Their opposition is not to the integrity of the outcomes that have been reported, but rather that data are in the public domain. This, in essence, represents a public report card on hospitals.

We now have one full year's worth of data which was produced on a quarterly basis. While one year of data does not make a health care system, we feel that over time these trends will be extremely important as a long-term strategy. Augmenting this process is a desire to work with primary care doctors and reward them through a financial mechanism which is yet to be developed but will probably be some type of withholding arrangement along with an incentive to have them perform the standards that we define using the health care cost containments data. Our physician reimbursement levels may increase due to this strategy because of more effective specialists and hospitals. Our target date for the implementation of this program is January 1, 1993.

Hershey Foods Corporation is committed to wellness. We introduced a fully paid, preventative health care program in 1990 and also sponsor a fitness center in Hershey, Pennsylvania which is free for employees to use on their own time. We

believe healthier people don't use the health care system as much, and controlling utilization is an integral ingredient in controlling overall health care costs.

Let me briefly share with you a pilot program which we are currently implementing for 600 corporate staff employees, like myself, in Central Pennsylvania. I'm sure all of you have heard statistics such as 1% of employees generate 50% of medical costs or 20% of employees generate 80% of medical costs. No matter what the exact relative portions are, clearly there is cross-subsidization in the health care system. Further, a Hershey Food study conducted last year revealed that approximately 35-40% of all health care claims are related to conditions that can be influenced by individuals' life styles.

In 1991, the corporation is instituting a wellness incentive plan which requires these 600 employees, on an employee-only basis, to go through an annual medical screening in which the corporation will assess your healthiness (smoking and exercise). In addition, the corporation will measure blood pressure, cholesterol and weight. This pilot program is structured so that employees with unfavorable lifestyles will have to pay surcharges to participate in the health care program.

For example, in 1992, smokers will pay an incremental $33 per month for the privilege of smoking. Employees with high blood pressure will pay an incremented $12 per month. These additional surcharges will go into a pool that rewards those who have positive lifestyles. For example, those who don't smoke will receive an extra $20 a month in flex credits. Those with favorable lifestyles will receive additional flex credits, based on the risk program that they're participating in. There's a different level of penalties and rewards for each of the five various risk categories.

This program is structured so that the corporation neither makes nor loses money in the flexible benefit program. While we have computed that someone who fails all five risk categories could have a risk charge of $117 per month, we have capped the incremented charge at $50 per employee per month.

Last week, we began employee meetings on this pilot program. No one at Hershey Foods is neutral on this topic. It's one that we feel directionally is appropriate, but obviously we could have a separate forum on this topic alone. We're convinced that directionally this is the right thing to do. And we're looking to extend this to other locations as well, possibly including the union employees in subsequent years.

Our strategy is twofold with regard to health care: the wellness incentive is intended to keep people out of the health care system and the managed care program is intended to better manage individuals once they get into the system.

Let me tie this all together under the flexible benefits banner. First, wellness incentives are an adjustment to your otherwise stated flex credits. Under managed care, we will obviously have to revisit the issue of how many options we provide. It is very clear that for managed care to work, we will have to get our high cost claimants under a managed care environment. Our objective is to make managed care the preferred option. Obviously we will have to offer some type of financial incentive to reinforce this point.

We see HMOs as an integral part of our managed care study. Fortunately, in Central Pennsylvania, HMOs are the highest cost option available to our employees at Hershey Foods. This phenomenon has held true since 1987.

Our intent is to work in cooperation with HMOs to develop experience-rated products. Currently, this is not permitted under Pennsylvania insurance law. We're also performing a quality review of the HMOs to ensure that the HMOs meet the same quality standards that we demand. While we currently offer four HMOs, the number in the future will be predicated upon their performance against these standards. We will likely have a coverage option available for those who don't want to participate in a managed care setting. This option will likely have a large deductible of $1,000, and we will carefully price this option to control adverse selection.

The adverse selection which we have encountered to date has been very modest. We believe we have proper risk segmentation of our health care offerings, such as HMOs that are the highest cost option. Our indemnity plan is second in terms of cost to the employee. The two company-provided comprehensive plans are third and fourth respectively.

This is a logical position for the benefits. We firmly believe that the most extensive coverage should have the highest price tag. This is our principle strategy when it comes to risk management. Fortunately, we have not had to artificially price any of our offerings either on an HMO or a company-provided basis at this point.

The mind-set of the HMOs in Pennsylvania is not aggressive but is cooperative. Shadow pricing does not exist in Central Pennsylvania. Approximately 15% of our employees are enrolled in four HMOs. Two-thirds of our employees are enrolled in Blue Cross/Blue Shield indemnity and comprehensive options with nearly all of those in the indemnity option. About 10% opted out of the medical program and receive approximately $1,000 to do so.

Some people have suggested this HMO penetration is too high. Some consultants have suggested to us that 10% penetration is the right level from a risk standpoint. So perhaps we are doing something correctly in the absence of a rigorous risk analysis.

The most important challenge facing us as a company is one of education. Not only educating our employees and providers as to the dynamics of the health care system, but getting them more involved and informed in every segment of the health care system.

We are trying to balance the role of the company in procuring cost-effective health care benefits. We definitely need more employee and provider involvement if we are to be successful in our endeavor. The communication vehicle is probably the most important element because we are trying to manage change. This change affects our business in an international way. As we are asking our employees to do more in less time, we are also attempting to provide greater value to our shareholders for their investment dollar.

Further, we are concerned about employee morale and productivity, which is why we take our employees as seriously as we do. This health care initiative and our flex benefit plan are helping our employees manage through our changing world.

MR. PARCIAK: Sounds like you've got some very interesting opportunities. I wish that many of my clients did not have HMO shadow pricing.

MR. LAURENCE R. WEISSBROT: I have a question for Mr. Dreyfuss. Have you had any opinion on the legality of subsidizing the healthy lifestyle while penalizing the nonhealthy lifestyle, especially if it should turn out that more of your highly compensated executive types lead a healthy lifestyle and your low-paid people lead a nonhealthy lifestyle. I think you are going to have trouble passing discrimination tests. Have you considered that?

MR. DREYFUSS: Yes, we have very carefully. We've had our in-house council look at it a couple of times and also we solicited the opinion of a couple of outside firms. But, we would not be surprised if someone brought an action against us. We feel the action is defendable and it's one that we're comfortable with, because we feel we have good, solid data on which we're basing our decisions. But, there's not a lot of case study out there from which to glean experience. So, there is a risk, and we're aware of it and prepared to deal with it.

MR. JOHN SAARI: I have two questions for Mr. Dreyfuss. One is a clarification on the penalties for your wellness program. My first question is are the penalties real dollars or flex dollars? The second question, which is more complicated, is about the opt-out procedures and payments. What do you do in the case where an employee had coverage? Do you require coverage elsewhere? If they lose the coverage how do you handle that?

MR. DREYFUSS: With respect to your second question, we require employees who opt out to provide us with a statement that they have insurance elsewhere. We want our employees to make sure they have adequate medical care coverage. That is our position on opting out.

Your other question was about the amount of dollars that we provide? Those are flexible benefit dollars, but employees can convert those into real dollars if they're unused within the health care system. I don't differentiate between the two.

MR. JEFFREY L. SMITH: I have a couple of issues to which I would like to have some discussion or response. This might plant the seed for something in a future session.

I think there are two basic problems that confront flexible benefit plans that haven't been discussed. The first problem is that employers often have a traditional indemnity program which they underwrite aggressively and self fund. Then, they provide incentives for their substandard risks to go to managed care programs which by statute can neither underwrite nor have preexisting conditions. And then, neither support them in that end of the spectrum. They don't support the nonunderwritten plan because of experience rating the premium differentials far exceed what they're willing to endorse as differences in employee contributions based solely upon the

benefits. At the minimum, they just blame the program and dismiss them as an option. That is a very real problem.

We talked about family status changes which can result in changes from option to option. The second problem occurs if the plans offered are not underwritten or administered by the same carrier. The spouse terminates employment due to a pregnancy. Then, the families take the opportunity to opt into the highest benefit program to meet their needs. Then, they opt out at the next opportunity. The plan which has been selected against gets no support from the employer.

These are issues that have faced each and every one of us. I don't have a magic answer. Certainly, I have not seen very much employer support in this arena, nor have I seen much intelligence when we, as actuaries, try to work with employers and government entities to solve some of these problems.

Some of these problems are being reflected in the health care cost crisis which, until these basic problems exist, are not going to go away.

MR. PARCIAK: I agree with the majority of your points. I have seen employers who would like to have their worst risk moved to an HMO, or some form of managed care, but haven't figured out ways to do it.

We're convinced that the problem can't be solved unless all players become partners, where the players are the payers, the providers and the patients. Until all three recognize that they're all in the same game, and they all could lose the same game, we're not going to get a result that's satisfactory.

Hershey is an example of the partnership approach. They are working with their HMOs and the Blue Cross/Blue Shield programs to try to understand what the true costs are and to work out an equitable sharing of the costs.

MR. FLEISCHACKER: One solution would be to restrict the employees movement into the plan that the employee is currently in and not allow a higher option plan. That would mitigate some of the problems you're talking about. Looking at the overall cost impact on the total program due to this problem, it's probably relatively nominal because of the minuscule portion of employees for whom this situation arises.

MR. WEISSBROT: One of my pet peeves with the health care system is that we think of shadow pricing as a negative. I think Mr. Dreyfuss alluded that he was proud of the fact that he had no shadow pricing.

It seems to me that in any sort of a multiple choice program, there is one choice which is inherently better. I would say that it is the plan which has the most efficient way of allocating resources. In my favorite scenarios, there is a very high deductible medical plan.

I think one of the biggest problems with the health care system is that there's no incentive to the purchaser of health care, the patient, to minimize the cost of health care. The doctor tells him what he needs and someone else pays for it. A very high

deductible plan, such as $1,000, $1,500, even $2,000 does limit utilization. It does get people saying, "I can't pay that, doctor, is there another way of doing this that isn't going to cost me as much?" That's the question nobody ever asks.

If the high deductible plan is the best plan to have people in, or an IPA or HMO might be the best plan to have people in because of control, then you should use shadow pricing to drive people toward that plan. Make the cost for that plan less than its true cost and make the cost for the other plans more than their true cost. Any other comments on that?

MR. GOLD: I'd say that you want to strategically price your plans to get your employees into the plan that you would like to have them in – the most efficient one. The problem with shadow pricing is that the employer is not in control; the HMO is in control. The HMO is controlling what risks they attract. I agree with you that as long as the employer has control over the pricing, then it's a good idea.

MR. PARCIAK: I would like to address your question about which option is the best. I think the best option is different for each employee. The desire is to get employees into the best option for them. The low utilizer may find that the high deductible program is, in fact, the best program for him. The high user, who is going to incur a fair amount of medical costs, may need the most managed program, to most efficiently deliver health care.

You need to find ways of balancing those two in coming up with the end result. Effective pricing, related to the value of the program that somebody may enroll in, not necessarily related to the cost that you're going to incur, is one way to do that.