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FLEXIBLE BENEFITS

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Recorder: MICHAEL W. HUDSON

- *Current developments affecting flexible-benefit plans*
- Pricing and underwriting considerations in a flexible-benefits environment
- Managed care options in a flexible plan
- Employer challenges in managing flexible programs
- Have they met employer cost targets? What are the pitfalls?

MR. ALFRED A. BINGHAM, JR.: I'm a senior manager with Ernst & Young in Atlanta in the actuarial benefits and compensation group.

Steve Eschbach is a partner with Ernst & Young in Los Angeles. He directs the health and welfare services for Ernst & Young's west region. He's consulted on a number of flexible plans with both large and small clients, and primarily is involved in helping clients use flexible plans to truly manage their benefits. Gary Brantz is a principal with Towers Perrin and has been with them for 10 years. He has experience with a myriad of group health actuarial issues; he's worked in health care for 17 years. Prior to joining Towers Perrin, Gary was with the Blue Cross/Blue Shield system. Wayne Page was in corporate human resources, and had experience in the insurance industry prior to coming to the consulting field. He was vice president of human resources for Transamerica Insurance Company. He was the project director on its first flexible plan there, so he has experience on the corporate side of this issue. Most of the flexible implementations that Wayne works on average around 1,000-2,000 employees.

Benefits is an important topic for us as actuaries. The flexible-benefit environment has been around for a while, but it continues to evolve. I think you've all read in magazines and industry literature about the prevalence of flexible benefits, particularly among middle-sized and large employers. There are a number of reasons why employers have them; I believe Wayne will talk about that soon. He will give the employer's perspective and will give a general background on flexible benefits. Gary will go through an example of renewal pricing in a flexible plan. Steve will present a case study of a large employer whose objective was to use flexible as a transition into managed care. We're seeing more and more of this type of use of flexible, both as transition to managed care, and primarily as a tool or framework for a number of objectives to manage benefit programs.

MR. WAYNE E. PAGE: I'm going to run through some of the reasons why employers implement flexible-benefit plans. Some of this is going to come from database surveys, opinions, and things that I have observed, both from my corporate experience in human resources and from my consulting experience when actually working

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with clients and implementing flexible-benefit plans. When I talk about flexible-benefit plans, I'm not referring to salary conversion arrangements, premium only plans, premium conversion arrangements, pretax, or spending only. I'm basically going to be referring to full flexible-benefit plans or cafeteria plans, where employees have the opportunity to choose from a full range of eligible benefits, whether that be medical, dental, life, vision, or disability, including spending accounts; and the full range of pretax and after-tax benefits that are offered in flexible plans.

Why do employers implement flexible-benefit plans? Primarily it has been to shift costs. Employers have been on the receiving end of cost shifting, and it is an opportunity for the employer to shift cost to the employees. Look at some of the initial implementations in the late 1970s, early 1980s. One of the first objectives was to introduce employee contributions. Employers could shift some of the costs to the employees, with the convenience of a pretax arrangement. As flexible-benefit plans have matured, we have tried to shift cost to employees, not only by raising the employee contributions on a pretax basis, but we have also tried to shift costs by raising deductibles or by motivating employees to participate in flexible-benefit arrangements that have more managed care elements.

Another reason employers want to adopt flexible plans is to be competitive. That was not a reason in the late 1970s or early 1980s. But because flexible plans are now much more prevalent, applicants are asking employers about choices in benefit plans during the interviewing process. More applicants are asking about flexibility and choices in the benefit plan, because they are already participating in an employer's plan. To be competitive, employers have to have more choices, because employees like choice and they like flexible-benefit arrangements.

Employers adopt flexible plans to permit additional flexibility within a multidivisional organization. If you look at organizations that have branches, or nationwide divisions, one set of benefits is not going to work in the Northeast and in the South and in the Southwest and on the West Coast. They are different markets. Employers need to compete in those markets, and employers introduce flexible-benefit plans so that they can be flexible across divisional lines or geographical lines. With a credit-driven flexible plan, it is possible for an employer to have one established set of benefits nationwide, with different employee contribution levels or different credit or subsidy levels within that design. Or, they can have multiple designs nationwide.

Another reason these plans have been adopted is that it's fashionable. Human resources executives are just like every other executive group. They get together in meetings just like this, and they don't want to be the last ones on the street to have a flexible-benefit plan. It is state-of-the-art.

One of the more recent and popular reasons to implement a flexible plan is to motivate behavior. We try to motivate employees to enroll in lower cost options or to enroll in options that have more managed care elements. One of the first flexible plans I was involved with had a lot of cost shifting and raised deductibles, but the flexible methodology was used to help sugarcoat the entire process so that the employees could swallow the pain and not have as much trouble with the election process. They were given something in return for some of what was taken away; they were given additional choices.

Another reason is to educate and inform employees about benefit costs. A flexible-benefits approach, particularly one that uses personalized fact sheets, or computerized enrollment forms, or uses allocation of credits, is an excellent way for an employer to inform employees about how much money they are receiving in the hidden paycheck. A credit-driven flexible plan generally allocates credits to employees equal to the employer's subsidy and, in many instances, it shows up on the pay stub as another earning's field, so every paycheck becomes a benefit statement.

An informed employee is an educated employee and, hopefully, will make more intelligent decisions about how to spend the company's money or the employee's credit. Flexible credit can be spent on the array of available benefits. By employing this kind of methodology, employers hope to create a partnership. They hope that employees will buy into the problem. It's not the employee's problem. It's not the employer's problem. It is society's problem, and the problem we're talking about here is escalating health care costs. If we can create an employee-employer partnership, then the employer isn't in this game alone. The employee is educated and can make better decisions about how to allocate the employer's subsidy or credit in a benefit package.

Another reason employers implement flexible plans is to gain control over administrative systems. I'm working with a client that has spending accounts and has a pretax arrangement for existing premiums, but there is not a full flexible plan. We're doing a benefit study, and I asked for all kinds of demographic data. I asked for claims information. I asked for participation information, and was told they'll have to get back to me later. They went into the payroll system to try to create reports, but the information just isn't available. This organization is spending $2.5-3 million a year for employee health and welfare plans, and no one know's where the money is going. Many times an organization will implement a flexible plan to gain access or control over administrative systems data and information, because the systems that are required to implement and manage a full flexible plan are excellent ad hoc reporting vehicles to receive data and to manage the plans. I don't think I've ever seen flexible actually implemented to achieve this objective as a single objective, but it is an important objective.

Another objective might be to lower employee and employer tax obligations. That's obviously a reason to implement a pretax arrangement. And in the studies that Peat Marwick Thorne Actuarial & Benefits Inc. has done, it's very interesting that we find there are still maybe 25-30% of the employees in certain markets in this country who are paying eligible employee contributions on an after-tax basis. They don't even have a pretax arrangement. There are pretax savings available to employees. Federal Insurance Contributions Act (FICA) savings are also available to employers through flexible methodology.

One of the more popular reasons to implement a flexible plan is to meet the dual income needs that we have in our society and to provide better coordination between two employer plans. If you have the richest plan in town, you will end up, as an employer, subsidizing all of the other employers. Many employers are interested in adopting a flexible-benefits approach, so that they can better compete with the other employers in town. What we're really trying to accomplish here is to have the husband and wife sit down at the kitchen table with two sets of employee

handbooks and summary plan descriptions. The objective is to better coordinate benefits when there is a dual-income situation in a family.

What kind of hurdles are there that an employer needs to clear? Well, one is very poorly defined objectives. I find that a number of clients want to implement a flexible-benefits plan, but they don't know why. They get two or three months into the project, and they still don't know why they want to do it. Plan designs start changing and communication objectives start changing because no one sat down on the front end and asked, "what the objectives are that are trying to be achieved."

Another hurdle is payroll and systems limitations. A complex credit-driven flexible arrangement generally needs freestanding software of some kind, because the payroll system cannot implement credit-driven flexible plans. Payroll systems can manage and implement net payroll deductions and may be an implicit design, but the allocation of credits is something that creates difficulties with company internal administrative systems.

Another hurdle is the status quo. We always have grandfathered situations and employee relations issues and, well, we sometimes can't change that because it's been that way for 10 years. It's difficult in a defined-contribution approach to reallocate costs and allocate credit if there is a lot of status quo, grandfathering, or arrangements that the employer is not willing to touch. Too many "sacred cows" get in the way of achieving the primary objective. However, preserving the status quo might be an objective.

Budget is a hurdle. Flexible plans are expensive to implement. You may have to pay an actuary to do an effective job of pricing the plan. You need to pay communication consultants. You need to find administrative systems. It is not at all unusual for an employer of 1,000 employees to spend $50,000, $75,000 or $100,000 plus in implementing the kind of plan that we're talking about. Budget considerations and restraints are definite considerations and hurdles that need to be cleared.

Another hurdle is the uninformed or overly cautious underwriter. We might create new designs or even designs that aren't that creative, and then find an underwriter who has little experience with flexible plans. I've dealt with some of the largest insurance companies in the country in different regions. In one region the insurance company might be very cooperative. It understands what you're doing. The rating is very supportive. There are very few underwriting hurdles, and it has seen many flexible designs. With that same insurance company in a different region of the United States, this might be the first flexible plan that an account representative or an underwriter has seen, and we need to train that underwriter. So it is not at all unusual, when you're dealing with an insurance company that has a lot of flexible implementations under its belt, to be working with a new underwriter or an account representative that is in new territory.

Executives can sometimes have narrow vision. Everyone is an expert. Everyone with the client company, and everyone with the employer, is a human resources expert. They know how to hire people, they know how to fire people, and they know how to rate LTD plans. I sat in a corporate lunchroom once and watched an operations vice president rate an LTD plan. And he said, "Well, if one of the options is 40% and

one of the options is 60%, the 40% option should be x% of the other cost; it's all ratios." We started moving around table napkins and spoons, and he had it all priced right there in the lunchroom. So everybody is a human resources executive and can make these kind of decisions. And, frankly, some of these people are the ones who end up on your steering committee and are the ones who you need to spend the most time with in managing these kinds of relationships.

One of the additional hurdles is employee skepticism. "There must be a reason that the employer is spending a couple hundred thousand dollars to implement this plan and to turn all of my benefits upside down. There must be a catch here somewhere." It is very important in employee communications to recognize the natural employee skepticism that you are going to face when trying to change their very comfortable employee benefits.

What kind of challenges does an employer face as it manages a flexible plan? An initial challenge is determining how much change to introduce in the first implementation. With many of the flexible plans that I have seen in the last couple of years, the employer has had an objective to have a budget-neutral implementation so that the employer's costs don't go up, without changing the net employee contribution required by the employees. They want to get the methodology in place and then tweak it from year to year to year.

On the other end of the spectrum, an employer might say, "I need to cut my benefit costs 20%. How am I going to do that? How much change am I going to implement initially and do I want to do all of that in the first year?" So, one of the first things that an employer needs to do is determine how much change it wants to introduce and how quickly.

Another issue is how to adjust the plan from year to year. If you adjust the plan radically every year, employee skepticism starts to creep back in; there is never any stability. The employees start to wonder what they can rely upon and what you are trying to do to them now. They start to think two or three plan years ahead of you. Well, if you're doing this now, what are you going to do next year or two years from now?

Another challenge is the continual changes that we see in the tax code and regulations. Perpetual changes in the tax code cause havoc. Anticipated changes in the tax code can cause havoc with the plan design. We don't have to remember too far back to remember the Tax Reform Act of 1986 which included Section 89. Flexible plans just absolutely dried up. Employers were scared to death of implementing lots of changes and choices in their designs because of compliance requirements of Section 89. So an employer is continually challenged in trying to keep up with changes in the code and in the regulations.

Additionally, we have ongoing and continuing employee relations issues. A flexible plan needs tender loving care to maintain the employees' trust. If we're not truly creating an employer-employee partnership, if it's only a one-way street in favor of the employer, then employees will recognize that very quickly. We need to have a continued eye on positive employee relations issues.

Then there is the ever-present pressure that health care inflation puts on plan designs and pricing. Flexible plans are very difficult to price when health care inflation is in the double-digit (15%, 20%, 25%) area. If these kinds of health care escalation realities cause you to change plan design and implement more managed care issues, it's almost like reimplementing and communicating all over again with employees.

The last thing I want to comment on concerns implementation. It may be very easy to get into the corner office, talk to the CEO, and get board approval. You spend a lot of time in the ivory tower talking with all the executives about this great new plan and what it's going to do. Then after the implementation is over, it's like a marriage. As the years go on, it's difficult to keep management's, particularly senior management's, attention focused on this issue. When you walk up and say you need another $50,000 or $100,000 in consulting fees to manage this issue that is $3 or $4 million a year in expenditure of health-care costs, the CEO looks at you and says, "Well, did you fix that back in 1985?" Then you have to remember that you sold this flexible plan in 1985 on a whim and a prayer that this was going to fix the health care issues. So as executives, we need to keep our peers' attention and senior management's attention focused on this issue and keep it focused over a long period of time.

MR. GARY SCOTT BRANTZ: I'm going to go through a renewal pricing exercise for multiple medical options. Obviously, as Wayne talked about, health care is one of the key issues in addressing, or in terms of, the objectives for a lot of employers in their flexible plans. I'm going to attempt to take you through an exercise here. We're going to go through an actual case study, with actual numbers showing the process that we go through in assessing repricing of multiple medical options.

The first step is to analyze the claims experience. That consists of looking at both claims and enrollment and then looking at some of the selection factors that come out of the experience. That is then compared to a selection model that you may or may not feel more comfortable with in terms of the actual experience.

The second thing is to look at the company budget. A lot of companies struggle with their objectives and what I try to do in this situation is pin the client down to an actual cost objective. The typical question I get is, "What are the prices?" My response generally is, "Well, how much money do you have to spend?" That's going to dictate a lot in terms of what the employees are going to have to come up with. Looking at the company budget is a critical task.

The next step is projecting the cost and going through an exercise that I refer to as incremental pricing. Finally, look at the prices and the objectives and determine the balance between the company subsidy, in the various medical options versus the credits that the company is going to put in the hands of the employees for making decisions, and determine whether that's going to have an impact on the enrollment. This is a recursive process. You set some prices on some distribution of employees and then look at the outcome of those prices and determine whether or not you're comfortable that the input, in terms of the distribution, is going to be affected by the outcome of the prices. Obviously, you could go through that circular path an infinite number of times, but generally, after about two passes and discussions with the clients, you can reach a consensus on what the distribution is going to be.

Table 1 shows a case study for a company that has 10,000 employees. There are four medical options. These options are all self-insured or minimum premium arrangements, where basically the company is covering the cost of the plan. There's not an HMO. I've ignored the dependent portion of the cost. The process is exactly the same for the spouses and children, in terms of the pricing approach.

TABLE 1
Case Study – Renewal Year Pricing of Medical Options

Current situation	Plan A	Plan B	Plan C	Plan D	None
Average number of employees	6,000	1,500	500	500	1,500
Current prices	$1,000	$900	$750	$550	$0
Current company-provided credits	$1,250	$1,250	$1,250	$1,250	$1,250
Net cost to employee	($250)	($350)	($500)	($700)	($1,250)

In terms of value, plan A is the best plan; plan D has a fairly high deductible. This particular company allows employees to opt completely out of the medical plan. Plan A costs an employee $1,000. Plan B is $900. Plan C is $750, and so forth. These are annual prices.

The current company-provided credits are a flat $1,250 per employee. So in terms of the plan design, all employees get $1,250, they have four medical choices or options (those are the price tags), or they can just take the $1,250 and walk. So the net cost to employees is the bottom line here. The net cost would be credits, meaning employees are going to walk away with some money, no matter what they pick. The philosophy this particular company intended is for the employees to be able to have some money left over to help offset some of the prices for the dependent coverage.

Table 2 is what we looked at or encountered when we got the claims information for the experience period. Again, we have the top line being the distribution of the employees by option. The second line is the actual claims, and these would be annual incurred claims. So you go through whatever processes you need to convert paid to incurred and project to get an experience period. And in this particular setting, the client had annual claims of $14,725,000. Now you can see there's quite a disparity from one category to another. I always point out that it's very important to recognize that these are not a result of plan differences as much as they are of who's electing those coverages. An employer sees something like the cost and automatically says, for example, "We want everybody in plan C, because these (plan A) people are costing us $2,000. If we could get them into plan C, they would only cost us $1,100." But the fact is, those people in plan A who are costing $2,000 wouldn't cost $1,100 had they been in plan C. There's always education that needs to take place in terms of the client understanding these numbers. (The net cost to the employee came from Table 1.)

TABLE 2
Case Study – Claims and Enrollment

	Plan A	Plan B	Plan C	Plan D	None	Total
Average number of employees	6,000	1,500	500	500	1,500	10,000
Annualized claims	$12,000,000	$1,725,000	$550,000	$450,000	$0	$14,725,000
Average cost per employee	$2,000	$1,150	$1,100	$900	$0	$1,473
Net cost to employee	($250)	($350)	($500)	($750)	($1,250)	N/A
Current company cost per employee	$2,250	$1,500	$1,600	$1,650	$1,250	$1,923
Current company cost	$13,500,000	$2,250,000	$800,000	$825,000	$1,875,000	$19,225,000

If you look at the current company costs for these various options, there is the actual amount that the company is expending and the net cost to the employees. You combine those to get the current company costs. On average, because all categories of employees are taking cash home with them, in addition to whatever medical option they choose, the average cost for the company is more than the medical plan. What we're basically doing initially is figuring out how much the company is currently spending. The company is currently spending $19,225,000 on the flexible plan as it relates to the health care program, $14,725,000 on the medical benefits, and the remaining $4,500,000 on the credits.

Now we get to review the company objectives for the program in this particular case. The company is trying to balance what it is going to do with the employees, how much cost it is going to shift to employees, and what it can afford to absorb. In this particular situation, the company said, "We're in tough economic times. We can't afford any more money than we're currently spending. Our cost objective for the new year is no increase. Our cost objective is $19,250,000. That's what it was last year. On an average basis, we need to design the pricing structure for this program such that we won't spend more than $1,923 per employee." Our charge as actuaries is to develop a pricing structure that will meet that goal.

Administrative expenses are going to be covered separately, so we're not going to fold those into the pricing. Only pure claims will be considered from a pricing standpoint. You certainly could load the administrative expenses into the cost structure in whatever makes sense or supports the distribution by the client or that the client wants.

Another critical element of the cost objective is to determine what the company's goal is in terms of a targeted subsidy. And in this situation, the company's target plan is plan D. It's basic philosophy is to pay for plan D or provide a subsidy that's equivalent to plan D. If employees want to buy up from there, they can. But we want them to pay the full cost, taking into account any adverse selection loads. Now

they also have a little bit of extra money that I'll soon show you, because that target is really well below the average $1,900 that they're spending. Finally, the employer said if costs can't go up, it want's to hold fast on the credit formula in the new year. Another of our goals is going to be to hold that credit static.

The top line of Table 3 is basically taking the actual experience by plan and inflating with 15% trend. Presumably, there might be a different trend based on some of these different options. But again, in the interest of simplicity, all I did was basically take the average cost for the experience period and increase it by 15%. And $2,300 is the expected average cost for Plan A in the new year for everybody who is in plan A and, likewise, $1,323 is the average cost for plan B for people who are currently in plan B, etc.

TABLE 3
Case Study -- Incremental Prices

	Plan A	Plan B	Plan C	Plan D	None
Projected average cost (15% trend)	$ 2,300	$1,323	$1,265	$1,035	$0
	Employees in Plan A	Employees in Plan B	Employees in Plan C	Employees in Plan D	Employees with No Coverage
Cost:					
No coverage	$ 0	$ 0	$ 0	$ 0	$0
Plan D	1,725	1,033	1,091	1,035	
Plan C	2,001	1,199	1,265		
Plan B	2,208	1,323			
Plan A	2,300				
	Employees Electing Plan A	Employees Electing A or B	Employees Electing A, B, or C	Employees Electing Plan D	Employees Electing No Coverage
Cost:					
No coverage					$ 0
Plan D			$1,556	$1,035	701
Plan C		$1,841	1,805		
Plan B	$2,208	2,031			
Plan A	2,300				
Incremental price	92	190	249	0	(701)
Accumulated incremental price	531	439	249	0	(701)

Next is the calculation of incremental prices. What we're going to do in this incremental pricing exercise is set plan D, and then figure out how much employees are going to have to pay to buy from plan D to plan A, B, or C. Then we will look at people who are in plan C and see their cost for the various options.

Take this actual $2,300 for plan A and determine what the cost would be for those people if they had been in plan B. You more or less readjudicate the claims for those people and come up with an average cost. For the people who are in plan A, their average cost, had they been in plan B would have been $2,208. Their average cost had they been in plan C would have been $2,001, and had they been in plan D it would have been $1,725. Now we take those individual plan average costs and come up with the incremental costs for people who are going to make those elections to buy up. The people in plan D cost us $1,035. The people who are in plan A, B, or C have to first make an election from plan D up to plan C and their average cost for plan D is $1,556. Their average cost for plan C is $1,805. So the difference in these plans is $249. Basically if we charge all of those people $249, we'll have enough money for them to buy up from plan D to plan C.

Look at the next category over. It includes people who are going to buy up to plan B and those are both the people who end up in plan A or plan B. And so $2,001 is the average cost for people electing plan A or plan B for plan C and $1,199 is the average cost for people in plan A or plan B for plan B. The weighted average of those numbers is $1,841. The weighted average of $2,208 and $1,323 is $2,031. So the incremental cost to buy up from plan C to plan B is $190. So it costs $249 to buy from plan D to plan C, and an additional $190 to buy from plan C to plan B. And buying up from plan B to plan A comes out to $92. Now the accumulation of those really gives you your price tags, because people are going to buy from plan D to plan A. They do it in stages, but that's what they're going to pay. People are going to buy up from plan D to plan B, etc.

Now what is interesting is the cost for the people who aren't in any plan. There is not a lot of claims experience typically on the people who have opted out. So, the exercise basically is to come up with a selection model that would produce an expected cost for those people, had they been in plan D. The model that I used came up with an expected cost of $701 for those folks. Now let me stop here. This line is probably the key line in terms of what goes into this process for incremental pricing. That line in this example is based on actual experience, so I didn't adjust any of those numbers to obtain a more graduated smooth selection model. What we typically find, (actually, I think I've found in every single case that I've looked at), is that the highest plan almost always attracts the highest cost individuals. But we don't always see that as we move down. You might get some inconsistencies there. You would think that, the lower the plan, the more healthy the individuals. Since people don't select medical benefits with full knowledge of what their real needs are going to be next year, you just don't see that in terms of analyzing the claims experience.

Now I haven't adjusted for that, but typically I would develop some kind of a model that would smooth that selection basis. So that in total, there is an average selection for the group, but each particular portion of the group, the 6,000 people who are in plan A, are going to have a higher than average utilization of the program than the average group of 10,000, and so that's where this $701 comes in. Basically, the question is how healthy or how much lower than average in terms of utilization those people are who have opted out. In terms of actuarial theory, people are not going to opt out unless they're very confident about their health, and so they're probably the lowest cost people. However, I think in reality, more people opt out

because they have other coverage and that could be almost any kind of employee. For example, they're married and they have spouses covered elsewhere. In terms of what we're going to give away from the employer perspective, if you assume that they're the healthiest group, then you're going to be giving away less than their actual costs. So there's a little bit of a margin or a cushion in that calculation.

The top line of Table 4 comes directly from Table 3. It's simply the incremental prices or the accumulated prices for each of these programs. The projected cost also comes from the top line of Table 3. Line one is the price tag that we are planning on charging employees, and line two is the expected cost for the people who are in the various plan.

TABLE 4
Case Study – Subsidy vs. Credits

	Plan A	Plan B	Plan C	Plan D	None	Average Total
Alternative I						
1. Prices	$ 531	$ 439	$ 249	$ 0	($ 701)	N/A
2. Projected total cost	2,300	1,323	1,265	1,035	0	$1,693
3. Net company cost	1,769	882	1,016	1,035	701	1,401
4. Additional available credit	522	522	522	522	522	522
5. Available company cost	2,291	1,404	1,538	1,557	1,223	1,923
6. Company-provided credits	1,250	1,250	1,250	1,250	1,250	1,250
7. Employee price (2+6−5)	1,259	1,169	977	728	27	1,021
8. Adjusted employee price	1,264	1,174	982	733	0	1,021
Alternative II						
Company-provided credits	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000
Employee price	1,009	919	727	478	(223)	770
Adjusted employee price	971	879	689	440	0	770

Line three is simply the difference between line 2 and line 1. This produces an average cost of $1,400 for the company. Remember that our cost objective is $1,923. Basically, we've got more money to spend on these employees than the plans are going to cost, once we net out what we're going to charge people. We're going to charge the top line. It's going to cost us line two. That leaves the employer with the third line, and there is more money available than that. Well, how much more? We have on average $522. So we add the $522 to the $1,401, and we get our average cost. Line five is the available company cost. That's the total amount that the company can afford to put into this benefit program and still meet its cost objectives (line 3 plus line 4).

We now have another category of company costs, which is the credits. Remember the company cost objective was to freeze credits. So the company is going to provide $1,250 of credits. Now we have to calculate the final employee cost, taking into account how much in credits we're going to provide. Basically, if the company's cost objective is line five, we have to cover the total projected cost plus the credits, minus what the company's going to pay to give you what the employee has got to come up with. There are two sources of funding in this situation: the employer and

the employee. And the employer is going to provide the benefits out of the plan (line two) and the credits (line six). So that's what the company is going to come up with. Line five is all that the company can afford. So if you add the total benefits together, lines two and six, and subtract what the company can pay, you're left with what it has to charge the employees to make this all work out, and that's line seven. Now, interestingly, when I looked at that, I came up with an amount of $27 to charge people who are opting out. This would be a very difficult employee relations issue to communicate to people: pay $27 to get absolutely nothing from the health plan. So I basically just spread that $27 into the other prices. It still comes out the same in total, and we end up with a final pricing schedule (line 8). The price tag for plan A would be $1,264. So employees would receive $1,250 in credits. If they want plan A, they have to pay $1,264.

I came up with another alternative (see Table 5) because the employer didn't want to give those kinds of rate increases to people in the health plan. Either the employer is going to have to come up with more money, or it is going to have to redistribute the money in the program as it exists. I've created alternative II, which cuts the credits back to $1,000. If you go through the same calculation, taking line two, plus line nine, this credit line, and subtract off what the company can afford, you get a new price line. We get a credit for those people who are opting out, but we don't really want to give them any more than $1,000. So we've spread the $223 back across the people who have opted into the health plan. Basically, all this does is redistribute the money. It's taking money from people who are not in the health plan and giving it to people who are staying in the health plan. That's actually the reverse of what a lot of companies are intending to do, which is to equalize things whether you're in the program or not. In this particular case, I don't think this would be where the company would move, but it's certainly an alternative to look at. I think they understand that there aren't a lot of sources here for the company. They either have to come up with more money, or they have to charge the employees.

To summarize, Table 5 is a comparison for alternative one of the actual price tags. Remember that the top line here was the current situation. That's what the company price tags were last year or are in the current year. And line two is the price tags we just came up with. So the difference is line three: an increase for plan A of $264 and plan B of $274. Now this is interesting because plan B is getting a larger dollar cost increase than plan A. That's because I didn't adjust this at all for smoothing the selection pattern or selection model. Typically, you wouldn't find that. Generally, I would smooth things out, so that the highest cost plan would be getting the largest dollar increase. But they're all getting about the same amount of increase. The most important thing, though, is to look at what the net cost is to the employees, because that's what they're going to typically look at. They're going to look at how much the bottom line is impacting them, and so they're looking at the price minus the credits. And in this situation, because the credits were frozen, the actual increase to the employee is the same as the price increase. That's all alternative I.

If you move down to alternative II now, the price tags all go down from what they currently are, so there's some good news there. You go out to the employees and say, "Guess what, we're going to reduce the prices for everybody for our entire health-care program, but we can't give you $1,250 in credits any longer, we can only give you $1,000." So the net impact is still a cost increase to everybody, and you'll

notice that the hardest hit group are the people who are opting out. Instead of getting $1,250 for opting out, they're only getting $1,000.

TABLE 5
Case Study – Impact on Enrollment

	Plan A	Plan B	Plan C	Plan D	None
Alternative I					
1. Employee prices					
• Current	$1,000	$900	$750	$550	$0
• New	1,264	1,174	982	733	0
• Increase	264	274	232	183	0
2. Net employee cost					
• Current	(250)	(350)	(500)	(700)	(1,250)
• New	14	(76)	(268)	(517)	(1,250)
• Increase	264	274	232	183	0
Alternative II					
1. Employee prices					
• New	$971	$879	$689	$440	$0
• Increase	(29)	(21)	(61)	(110)	0
2. Net employee cost					
• New	(29)	(121)	(311)	(560)	(1,000)
• Increase	221	229	189	140	250

MR. STEVE A. ESCHBACH: How many of you have actually been involved with rating a health-care plan? How many of you have been involved with rating a health-care option in a multiple-option environment? In California, anyone who would have answered the first should have answered the second. There are few plans that are not in the multiple-option environment. I will discuss a case study that is an example of a multiple-option program: 250 options. It's also a flexible-benefits program with 240 of those options being managed care in the form of HMOs. I thought it would be of interest to you, because this is an example of a controlled case. We can make one change and watch the impact in 150 different locations. We can analyze how different groups of employees react to common communications, pricing, and plan design. They all see a similar program, but they react very differently.

I'd like to discuss the background analysis that we went through, the recommendations we came up with, and a very brief overview of some of the results, and then our conclusions.

As general background, there are 20,000 employees in 150 different locations, with a significant turnover – 30% per year. There is a flexible-benefits program with three indemnity options that are the same everywhere. HMOs are intended to be very similar, to the extent that's possible (with the same copayments, etc.). HMOs are offered wherever available. This is a full flexible plan with credits and price tags. I'll be talking only about the health care options.

Also of interest is the organization's philosophy. In terms of presenting health care to its employees, it wanted to pay 70% of the second option (a $500-deductible plan). This was an important issue, because historically, this practice allowed some employees free HMOs, and in other geographic areas the same HMO might cost two or three times that of the richest indemnity plan. It's practice did not suggest its philosophy, it created an environment where employees weren't being equitably treated with respect to the value of the benefit or the level of employee contribution. When it was an indemnity plan only, the 70% rule worked quite well. But as HMOs were added in different geographic areas, simplified administration eliminated consistent application of benefits cost-sharing with the employees.

In general, this organization believes that HMOs are the way to manage health-care costs, and so one of its objectives was to increase managed-care penetration. To the extent we can allow choice, and we can allow employees to choose the plans that meet their needs, everyone is going to be better off.

We first reviewed enrollment results. About 11% of the population was waiving, 54% of the population was in an indemnity plan, and about 36% of the population was covered through the managed-care entity, the HMOs.

We further analyzed the actual rate increases by the separate managed-care entities. We found that the indemnity plans were increasing at over 20% a year. There was no PPO. The individual practice association (IPA) model HMOs were coming in at 15% average, again, throughout the nation. The network model HMOs had an 11% rate of increase; the group model had 12%, and the staff model HMOs were at 11%. That information helped management see to the extent they can encourage employees to use the managed-care environment, they will ultimately be better able to control their health-care costs.

We also looked at the number of options by location (see Chart 1). They had intended to leave the number of options open to local management. We prefer that the options be limited to two or three HMOs. I think it eases the communications to the employees. But in this particular case, in phase two, we'll try to restrict the number of options offered to an employee.

Chart 2 presents an interesting issue: management was proud of the fact that they had about 36% of their population in managed care. The first bar shows that in about 10% of locations, there were no HMOs. The second bar shows that an HMO was offered, but less than 10% of the population in that location chose to be covered by an HMO. Management had no idea. They kept on saying, "Managed care penetration is 36%." It was a surprise to them to see that, in fact, a number of the locations had very close to a 100% HMO penetration, and in those areas, employees liked it. They did not feel as if there was undue pressure to choose the HMO, and it shows through their election results. Chart 2 helped management appreciate that in order to look at their program, they no longer could look at one aspect, but instead had to shift their thinking to deal with each location as a separate entity. Then the options that were being offered began merging to those geographic entities.

CHART 1
Number of Options by Location

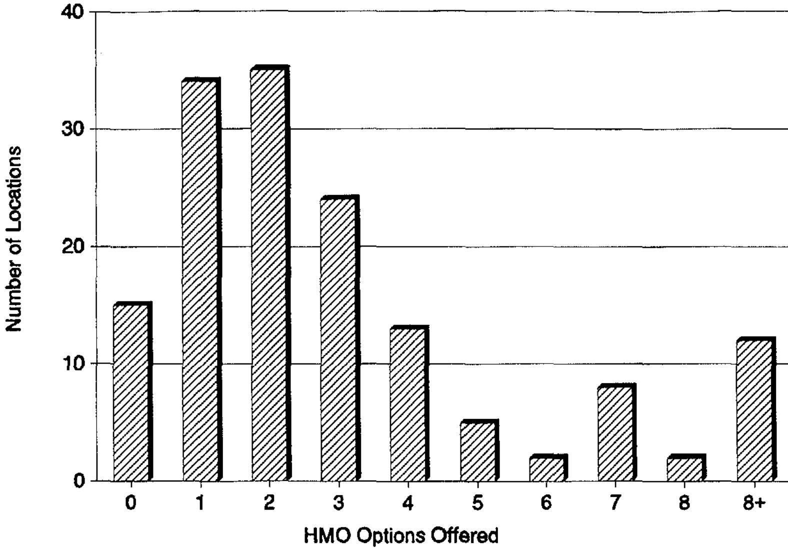
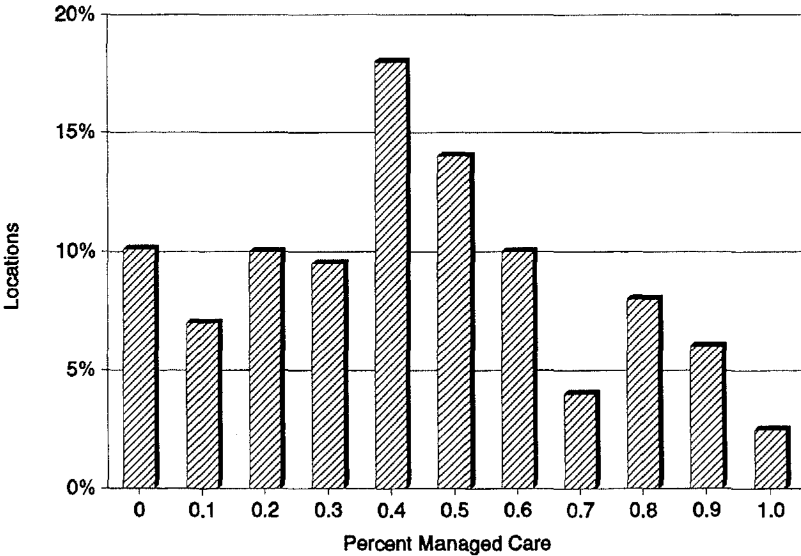
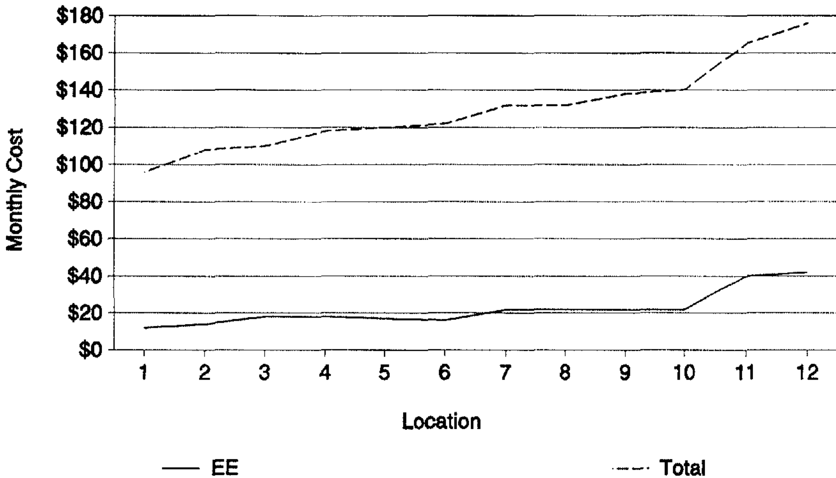


CHART 2
Local Managed Care Penetration



Another interesting point that came up during the analysis was historical information. One HMO was offered in 12 different locations. That HMO ranged from a single employee rate of $98 in the lowest cost area to a single employee rate of almost $172 in a different location with the same benefits. Again, that helped management to appreciate that there's a significant difference in the cost to their program and how they needed to, again, revise their thinking (Chart 3).

CHART 3
Option Cost in Locations



From another perspective, we tried to see if there was any pattern in terms of enrollment (see Chart 4). None jumped out here. We split those different numbers (see Chart 5). Instead of just looking at cost by HMO, we looked at the low-cost (to the employee) HMO and the high-cost HMO. We plotted those. We see what we call risk segmentation. Election patterns vary significantly, depending upon whether it's perceived by an employee to be a low-cost option or a high-cost option. The dark squares are the low-cost managed-care alternative in an area, and the open squares are the high-cost managed-care alternative. From one perspective, results are skewed, because not all of the locations have the same number of employees. So, when we look at percentage of enrollment on the left-hand side, that's with the whole company. It might be that with the very highest dark square there is a low percentage, but it is of a very large office, and so we can't take this too literally, but I think a pattern is coming in place. Certainly, those squares that come to the right are high cost. That was tough. And the darker squares are low cost, so that shows that we didn't make too many mistakes in the programming. But the enrollment percentage is higher for those of the low-cost HMOs. That is something that we believe is very significant in terms of looking at rates and looking at employee selection information in developing enrollment pattern analysis.

FLEXIBLE BENEFITS

CHART 4

National Enrollment

CHART 5

National Enrollment

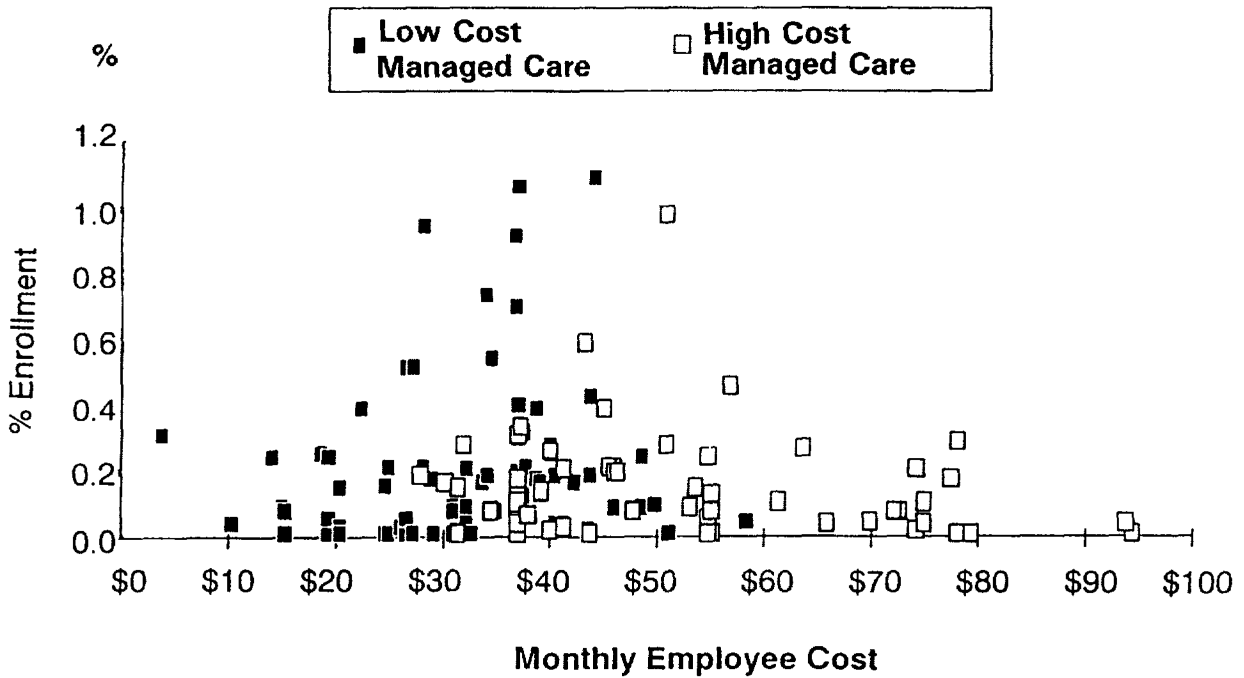
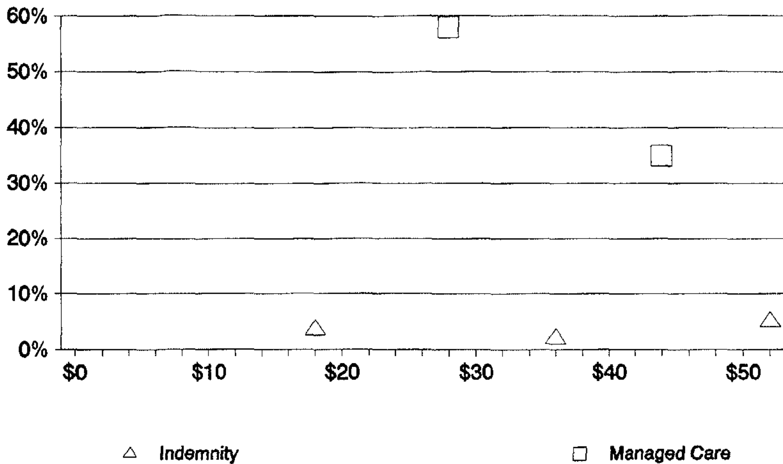


Chart 6 illustrates one city. The $1,000-deductible indemnity plan is there at $19. The high-option plan, which is like a $200-deductible plan, is there at $51. We can see that in this particular case, employees really like their HMO alternatives.

CHART 6
Local Enrollment



I don't think it's coincidence that the lowest cost HMO has a significantly greater penetration in this particular location, almost twice as much as the high-cost HMO. This city has close to 90% HMO penetration.

Another city, Chart 7, shows something similar, but not to the same extreme. The scale on the left changed, so we're at 35% and, again, we can see that none of these rules are hard and fast, because there are two HMOs with very similar costs. One HMO ended up with 35% of the location's exposure and the other is just barely on the chart. And the general trend is to not be the high-cost option if you're an HMO trying to enter the marketplace. I would want to watch how the employers are representing prices to the employees, because a change in price could have a significant impact on market penetration.

After going through this analysis, we have helped management understand that what they have been telling their executives could possibly be misconstrued, and it might leave them in a less than desirable position going forward. We suggested that they enhance their employee communications so that employees could better understand changes that would be coming and, in fact, help them understand that managed care is part of the future. And, as well, it would help them understand how to make effective decisions so that they could choose the plan that's most appropriate for them.

The second recommendation was to recognize regional differences. Regional pricing was implemented with minimal program design changes.

CHART 7
Local Enrollment

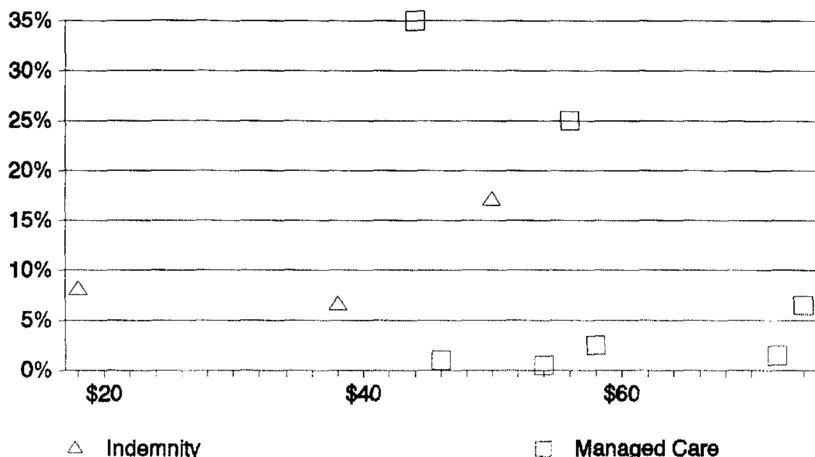


Table 6 shows the resulting enrollment shift in summary form. Waivers went up a little bit. The indemnity plan participation went up a little bit, and the mixed model HMO penetration went down a little bit.

TABLE 6
Results, Enrollment Shift

	1991	1992
Waive	10.5%	12.2%
Indemnity plans	53.8%	55.5%
PPO	N/A	N/A
Mixed model HMO	35.7%	32.3%

The striped bar in Chart 8 is 1992 and the darker bar is 1991. I don't think any common conclusions can be drawn. But upon looking at the individual locations, I drew some general conclusions. Again, the same sort of procedures were implemented or attempted to be implemented in each of the locations. When we have penetration, well, in about the 60%, 70%, 80% area, we typically saw about a 10% decline in HMO penetration. It wasn't across the board. In most of those locations, penetration dropped. However, one location had a 10% increase in HMO penetration. In the 30%, 40% ranges, there was very little change. For the less than 30%, we saw a market increase in HMO penetration.

Another issue of interest, because of the significant enrollment change from year to year, was election differences from 1991-92. In Chart 9, 1991 is a July number and 1992 represents January, so that shows about six months of turnover.

CHART 8
Enrollment Shift

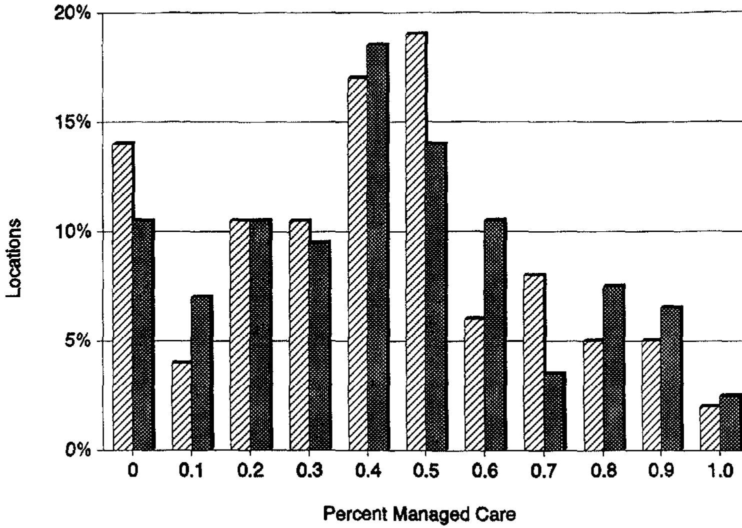
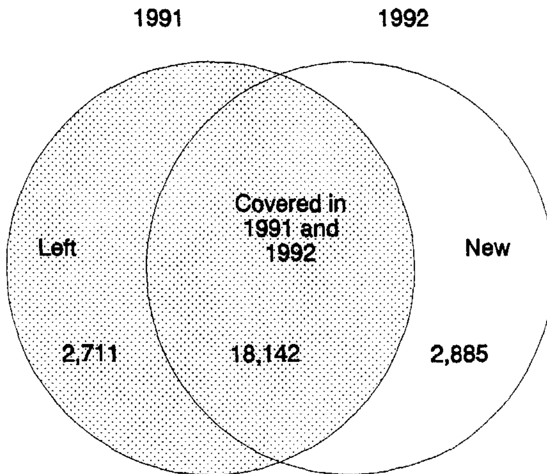


CHART 9
Population Changes



We studied covered employees, both in 1991 and 1992, and did a separate analysis of the new people coming in. The conclusion we'll draw from this is that new-hire communications are crucial to help employees choose programs that best fit their needs and help them understand and appreciate managed care.

For the old elections (see Chart 10 and Table 7), for the people who were in the program both in 1991 and in 1992, we end up with a waive of 12.1%. The managed-care alternatives have about 31.8% and the indemnity plans have 56% of the enrollment.

CHART 10
Old Election

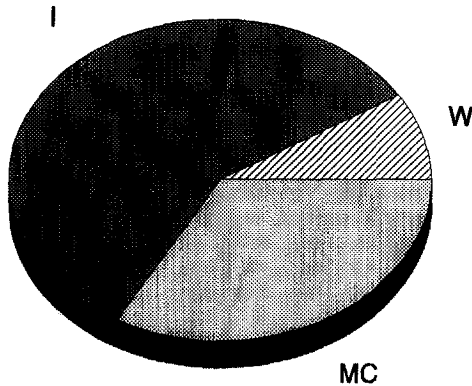


TABLE 7
Results, Old Elections - Details

	Waive	Indemnity	HMO	1991 Total
Waive	9.5%	1.1%	0.4%	11.0%
Indemnity	1.5	50.0	1.9	53.4
HMO	1.1	5.0	29.5	35.6
1992 Total	12.1%	56.1%	31.8%	100.0%

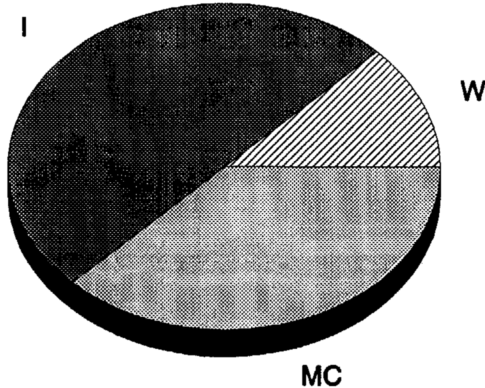
We looked at how that changed by group (see Chart 11). This chart is going to be much more useful on a location-by-location basis. But it was interesting to find that of the people who were in both years, 89% of the population elected not to change delivery systems, suggesting that once in a plan they're less likely to change.

Table 7 shows that 12.1% of the people waived in 1992. Fifty-six percent were in the indemnity plan and 31.8% were in the HMO. And in 1991, we see that 11% waived, 53.4% were in the indemnity plan, etc. The people who didn't change are represented by the diagonal. In 1992, 1.9% of the indemnity participants moved into the HMO. Four and a half percent dropped out into the waive category. Of the HMO participants, 1.1% waived. Five percent actually went into the indemnity plan, and about 30% stayed where they were.

When we look at the people who were new hires, we find that more of those individuals are willing to go into managed care, again, helping us to improve the transition to managed care over the long term. We end up with 36% of the population in managed care, 11% waiving, and 53% joining the indemnity plan,

which is 4% greater from a managed-care perspective for new hires than the people who have already made an election and are staying in place.

CHART 11
New Elections



In conclusion, I believe health-care costs can best be managed locally. But in order to accomplish that the enrollment needs to be looked at, the enrollment needs to be understood, and the enrollment patterns should be watched locally to maximize their effectiveness. I believe that only by using the well-managed HMOs, are my clients and all of us going to have any opportunity to control health-care costs.

MR. CARL D. SMITH: One of the criticisms of the health care system in this country has often been that the people who are receiving the care have no particular attachment to the cost of care. In other words, there is this third-party system with the employer being involved, and it comes down to the employees making the decision as to which plan to get into on the basis of the employee contributions and the benefits. Could you comment on the theory of setting the employee contributions, or the price tags as they've been called, on the basis of the value of benefit and not the cost of the insurance? So, for example, an HMO plan providing 20% better benefits because the copays are lower, etc., has a 20% higher price tag.

MR. PAGE: You raise a number of interesting issues. One, in terms of employees making decisions based upon cost, in my experience with a number of employees over a number of years, I find that there are two types of employees making decisions like that. The low-cost employees will run very quickly. It doesn't take a lot of money and the low-cost employees will jump each year from option to option to the lowest cost option. Another group of employees have doctor affiliations and they don't even look at prices. It becomes a very emotional issue, and so emotional that we have seen people pay $600 more in annual price tags for a $50 difference in potential benefits.

MR. SMITH: On an indemnity-only approach as well?

MR. PAGE: On an indemnity-only approach. The out-of-pocket expense was the same. The copayments were a little bit different, and the deductibles were different by $50. Because the employer wanted to phase out that particular option, it had a $600 difference in price tags. There was still a significant number of people who took that option. One of the ways we try to help employers manage cost is to get away from enrollment decisions, because the high-cost people are very motivated by their relationship with their physician, and it takes a large difference in price tags to motivate them to change options.

MR. BRANTZ: Let me just expand on that a little bit and point out your example that an HMO might have first-dollar coverage. The assertion that it might be 20% more in terms of value, I think somewhat shortchanges the employee's perception of value. A lot of employees are going to perceive that the limitations in terms of provider network are less close in proximity of their providers and those kinds of issues. Those are value judgments that employees have, so I think comparing it just on a benefit-by-benefit basis is probably not the way to go. I would also just comment that in my experience, employees use inertia a lot in terms of their judgments and their selections, that they're risk adverse and tend to keep what they've got. So, I guess the concern that I have is that to the extent that the different options aren't priced on the same basis, namely, an HMO might be community rated, another HMO might be experience rated, the indemnity plan is experienced rated with a different population; if we continue to use the premiums as the guidelines for setting price tags, we could be encouraging employees into something like an arbitrage situation, where they're taking advantage of last year's experience in an inequity or, if you will, in the setting of the price tags.

MR. ESCHBACH: We've also had difficulty in pricing HMOs as an option within our employer programs. When an employer is self-insured there is one risk pool. When you introduce a community-rated HMO into this process, it's very difficult to calculate the cost of the people who are going to elect the HMO. If all options were experience rated, we would not have a problem. But, that is not the case and won't be the case. Employers should set the contributions for the options based on the expected cost assuming all participants were covered -- not the experience for those who chose the option. But because the information isn't there, that's been as difficult as the expected cost for the people opting out of the program. I think with some of the new changes in HMOs (experienced-based HMOs) and some of the managed-care developments (consolidated risk pools), we're getting away from some of the indemnity pricing here and HMO pricing here. A consolidated risk pool will go a long way in helping. I think we have a real opportunity to help people into the effective managed-care programs.

MR. PAGE: I think we've had a lot more experience over the past two or three years in working with HMOs. Because if you look back three years ago and longer, employers' hands were really tied on what they could contribute and what kind of price tags they could show for an HMO, and most employers would just take the price given to them by the HMO and display that for the employee. And because of federal regulations, they were required to have subsidies for HMOs equal to what they were doing on the indemnity side. But in the last couple of years, because of

changes in regulations, we have a lot more flexibility. We're seeing more experience rating and I think as we get more experience with these kinds of things, we'll find more flexibility in the pricing of HMOs.

MS. WENDY HARTMANN: Can anybody address what the bigger employers are doing just on an individual basis for the flexible spending accounts?

MR. BRANTZ: We found a lot of scare tactics when the advance reimbursement rates first came out and employers said they were going to eliminate the plans and some employers actually did. The advance reimbursement requirement under the proposed regulations has not really hurt the plans that much. We've seen some design characteristics and different kinds of maximums. But most of the clients I've had experience with have not changed the plan radically. It might have slowed down the adoption of these kinds of plans because of hesitancy on the employer's part. But I have found that the advance reimbursement is not scaring them away from keeping the plans that they already have.

MS. HARTMANN: How do average employers charge the employees for the spending portions? How do the employers charge to use the spending accounts?

MR. BRANTZ: I see very few employers charging the employee an administrative fee, if that's what you're referring to. They shoulder the third-party administration costs of running a plan, and I see a lot of clients using their own internal administration, so they consider it to be somewhat of a soft cost, unless they actually have had to add the staff. But I cannot point to a single client who passes administrative costs to the employee to participate in the plan. I would like to hear some of the other panelists.

MR. PAGE: I, too, know of no employers who charge employees for the administration. I think the issue is that most employers recognize that there are some FICA savings that can offset some of that, and they typically don't credit employees with interest on those funds. So, there are some cash-flow issues there, and it's typically not a very costly issue, so I wouldn't think that we'll see that either.