RECORD OF SOCIETY OF ACTUARIES
1992 VOL. 18 NO. 4B

EMPLOYEE BENEFITS FROM AN EMPLOYER'S PERSPECTIVE

Moderator: THOMAS P. BLEAKNEY
Panelists: ROMAYNE P. BERRY*
WILLIAM R. BREEN, JR.†
ALAN V. CHRISTENSON‡
Recorder: THOMAS P. BLEAKNEY

Employers present their views on critical issues that relate to providing benefits to their employees. Included will be discussion of:

- Cost-containment arrangements
- Role of managed-care plans
- Flexible-benefit plans
- Post-retirement benefits
- Cost-sharing arrangements with employees

MR. THOMAS P. BLEAKNEY: The problems in providing employee benefits, particularly in the health-care area, are exceedingly challenging at the present time, and so now we're going to have a chance as actuaries to listen to those who are really in the trenches, while we are a little bit more remote.

Our panelists represent three major areas of employees: government employees, negotiated plans, and corporate employees. You'll have a chance to get different perspectives, although there is some crossover in the experience of our panelists.

Our first speaker represents government employees. Alan Christenson has been the personnel director of Arlington County, Virginia, since 1973. There are approximately 3,000 employees in the county whose benefits he's responsible for, various kinds of public employees, that include court systems and fire and police. He has taken on any number of special responsibilities with various organizations and held top offices in at least four organizations: the International Personnel Management Association, the Canadian Public Personnel Management Association, Metropolitan Washington, District of Columbia Council of Governments, Personnel Officers Technical Committee, and the Washington, District of Columbia Local Government Personnel Association.

MR. ALAN V. CHRISTENSON: My role is to share one employer's attempt to cope with the now familiar story of escalating health insurance costs. I will describe the process we used for reaching a set of recommendations on future health-care policies for our organization. Our final decisions have not been made, but it has been a

* Ms. Berry, not a member of the Society, is a Life and Health Insurance Program Manager in Washington, District of Columbia.

† Mr. Breen, not a member of the Society, is Director of Health Choice in Memphis, Tennessee.

‡ Mr. Christenson, not a member of the Society, is Personnel Director of Arlington County, Virginia Municipal Government in Arlington, Virginia.

torturous 18-month process so far, and I think we have another 18 months to go before we make fundamental changes in how we do business.

In April 1991, the county manager appointed a health-care task force to review the County's health insurance program. We want to achieve the maximum attractiveness of the health insurance program, maintain its fiscal soundness, and preserve high-quality health care. This required us to look at the short-term and the long-term issues. Background data on our health care will set the context.

Over a period of five years, we have gone from $4.4 million in claims cost on our indemnity to $10.3 million. Our health maintenance organization (HMO) premium costs have gone from $2.2 to $5.6 million, and you can see the percentage changes (Table 1). You can also see changes in the enrollment, where we have had in five years, a 14% increase in indemnity policies and a 155% increase for the HMOs. This year actually saw a 6% decline in indemnity plan enrollment.

TABLE 1
Indemnity and HMO Health Insurance Costs/Participation

	Indemnity				HMO			
Fiscal Year	Claims Cost*	% of Change	# of Policies	% of Change	Premium Cost*	% of Change	# of Policies	% of Change
FY 88	$4.4		1,813		$2.2		1,166	
FY 89	5.4	+23%	1,864	+3%	2.6	+18%	1,266	+ 9%
FY 90	6.8	26	1,955	+5	3.6	+38	1,373	+ 8
FY 91	8.1	19	2,050	+5	3.8	+ 6	1,311	−5
FY 92	9.2	14	2,074	+1	4.6	+21	1,431	+ 9
FY 93	10.3	12	1,943	−6	5.6	+22	1,576	+10
Increase from FY 88-93	+$5.9	+134%	+130	+14%	+$3.4	+155%	+410	+35%

* Numbers are in millions.

We have another way of displaying the health insurance costs. The solid bars are the HMO costs and the shaded ones are the indemnity plan (Chart 1). Looking at the distribution of our population, the Blue Cross/Blue Shield indemnity plan has 48% of the active employees and 92% of our retirees (Table 2).

Some information on Arlington County will help to understand the context in which the county manager had to make some changes in our health program. Arlington County is one of the highest per capita counties in the country. We have AAA bond ratings from both bond rating agencies in New York. Over half our school population is minority. We have a community of 13% Hispanic in 1990, 9% black, and 6% Asian. We needed to pay attention to the issues of our future work force, and an increasingly diverse one at all levels of the organization. So the manager, our chief executive, appointed a task force that included employees from throughout the organization, at all levels. It includes clerical employees, professionals, and a few management level, but not many. We believed that in order to get employees and retirees to buy into such a major change, we needed their input, their network into the organization in order to get that involvement.

CHART 1
Average Age of Arlington Subscribers
Fiscal Year 1991

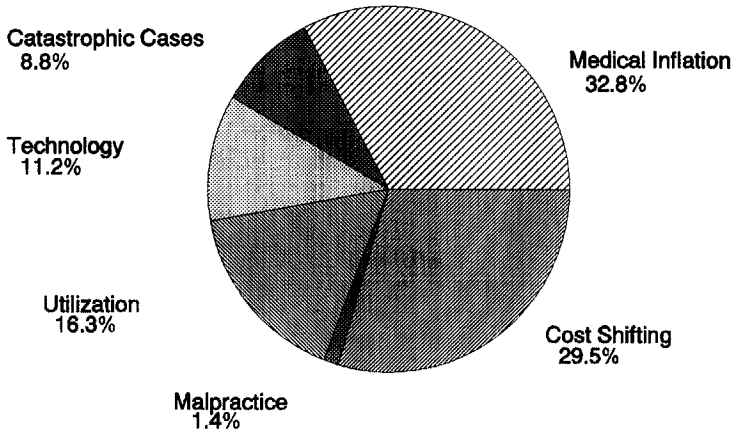
TABLE 2
Distribution of County Employee and Retirees by Plan Type*

Plan	Employees (%)	Retirees (%)
BC/BS	1,203 (48)	855 (92)
HMOs	1,293 (52)	72 (8)
TOTAL	2,496 (100)	927 (100)

* 87% of County employees are enrolled in a County health plan. Percentages in table refer only to those in a health plan.

I won't go into the national data other than to just highlight the main points that are in Chart 2, but we were aware of the major factors in terms of medical inflation, catastrophic cases, high technology, utilization and cost shifting, and the degree to which there are problems. We had to take a look at what our situation was, because what can one employer standing alone do to deal with the tough issues that are out there when the problem is national in scope. So we looked at our information and like many public-sector employers, we have a fairly high employer contribution to the premium for employees and retirees with a full career, 80% in our case. Retirees are all eligible for coverage if they retire with coverage and do not drop it at any time. At age 65 we pay 100% of the employer cost of a plan complementary plan to Medicare, and retiree health premium rates are prorated tied to length of service. We're self-insured on the indemnity program.

CHART 2
1989 Health-Care Inflation Averaged 20% Nationwide
Percentages for the Components of the 20% Rise in Health-Care Costs



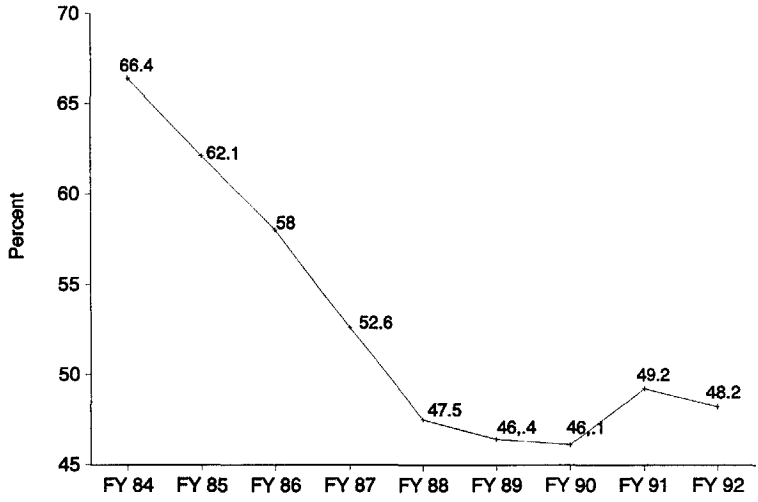
Our major problems were as follows: We did not have effective cost containment . . . we just were not working with our indemnity plan. We don't feel that they were effectively helping us in that arena. Second, we have adverse selection. As you can see, from 1984 when the indemnity plan had 66% plus of all employees, it's now dropped below the 50% point (Chart 3). We had another major problem, in terms of age. The average age of our HMO subscribers is 39, of our indemnity subscribers it is 51 years, and the third problem was the significant increase in large size claims from 1988 to 1991. It's almost doubled. Some of those costs are at $100,000, and $150,000, as you know, and those were all major problem areas.

Now the task force had to come up with a strategy to deal with this and they met once a week for 18 months, that group of employees and retirees. They got out into the organization, they talked with people, and there were major battles. There were employees who wanted to retain the existing HMO; employees who loved the Blue Cross/Blue Shield indemnity plan. The indemnity plan was creating havoc -- we had a 37% increase in premiums last year on the Blue Cross/Blue Shield indemnity plan. We reviewed nine different options. How do we make indemnity work better, modify coverage, increase out-of-pocket costs, restructure premiums, provide a clinic and/or pharmacy, use a preferred provider organization, negotiate an arrangement with a local hospital, use managed competition, implement an integrated health promotion program, and offer a choice plan (multiple option point-of-service).

The group agreed options one and two were musts -- making indemnity more efficient and cost-effective. The net savings, which would be one time, was in the range of 5-7%, which was nowhere near going to solve our problems. Some other

alternatives, either because of our size or other considerations, were really not options, and then we ultimately have gone, in terms of the committee's recommendation to the chief executive at this point, to the last two options, and that's to implement an integrated health promotion program and offer a choice plan.

CHART 3
Arlington County
Percent of Health Subscribers in BC/BS (Employees Only)



Retirees in BCBS declined only from 96% to 92% during the same period

Now I'd like to talk about the task force recommendation to do two things. One was to offer a choice plan with a double option or triple option and the other was to retain our center-based HMOs but with a common premium so that premiums would not be a factor in the choice. That was a political decision of the committee, in my opinion, to be able to get the political buy-in between the two groups within the county.

The HMO people didn't want to give up the HMOs. The Blue Cross/Blue Shield people didn't want to give up their access to doctors. That's my perception of the situation, and the bottom line, the essence of the proposal, is that we want a choice plan which will provide an HMO component where we need to have at least 70% of the people using it in order to keep the cost to the level we need. The high end of that is if you want the indemnity component, you have to pay for it with large deductibles, both hospital and major medical. If we want to keep our HMOs, we're going to keep them for two reasons, because we want competition with the choice plan, but we want to make sure that we do not drive the indemnity plan out with adverse selection. Our choice was everybody in a choice plan and no HMOs, or if you want to retain your HMOs, you're going to have to pay the higher premiums that include the premiums of the choice plan.

The task force has now held over 100 meetings with the work force. We have reached 2,600 employees. We've met with them at night shifts and weekends. We've reached 250 or about a quarter of our retirees in face-to-face meetings. We believe that we've come up with a plan that will meet our needs for the near future and to the degree that we can help control health-care costs.

MR. BLEAKNEY: We will discuss this topic from the perspective of three types of employees, public employees, which Alan just discussed; negotiated plans; and then corporate plans. Our second speaker is Bill Breen, director of Health Choice, Inc., a managed-care company in Memphis, which is owned by the Methodist Health Systems and related to 13 hospitals in a not-for-profit health-care system. Before he joined Health Choice last year, he was the director of health planning & development at the Central States Health and Welfare Fund, which is the largest Taft-Hartley fund representing Teamster Union members. That fund began developing its managed care program in 1987 under Bill's direction, and that program grew to cover over 50,000 employees last year.

MR. WILLIAM R. BREEN, JR.: As Tom said, I used to work for the Central State's Health and Welfare Fund, which is one of the largest Taft-Hartley funds in the country, and it is the largest union trust fund serving Teamster members. I'd like to explain why I left there with a little story about one of the many meetings that I spent in front of a large group of Teamsters, rank-and-file members, having them listen to this young hot shot from Chicago flying into Omaha, Nebraska or Cleveland, Ohio, having to explain why they can't use the hospital of their choice, which is just down the street from their home, or that their physician of choice, whom they've visited and utilized for 35 years, and now have to utilize a managed-care network. It was during one of those meetings that I basically saw a vision and asked myself, could there be anything more challenging than this. There has to be something more difficult than taking one's life into one's hands in front of a group of rank-and-file Teamsters. The answer is yes, there is something more life threatening and that is standing in front of a group of physicians and hospital administrators and telling them why they can't charge whatever they want and medical care has to change.

I must say I do work for probably one of the most progressive health care, not-for-profit hospital systems in the southeast. I'm really proud of what Methodist Health Systems has been able to do. I'll get into a little bit about Methodist in a minute, but hopefully we'll be able to review what the front-line, in-the-trenches, managers have to keep in mind and deal with when they're out there speaking with the rank and file about the problem of escalating health-care costs.

As I said, I now work for Methodist Health Systems, which operates and owns 13 hospitals in what we call down in Memphis the mid south. This is basically a four-state area, including western Kentucky, western Tennessee, part of Arkansas and part of Mississippi, plus a little bit of Missouri. Methodist is a not-for-profit chain, it's been in the managed care business since 1985. I got to know the folks at Methodist very well, because they were the managed-care network that we at Central States chose for our roughly 5,000 employees who live in the service area of this managed-care company.

To give you a bit of perspective about collective bargaining, and I'm sure these are statistics of which you are quite aware, in 1992, 3.7 million employees are affected by 679 major bargaining agreements that will have to be negotiated this year. The interesting thing is that those numbers really don't change from year to year, because as you know, bargaining agreements are generally cyclical; they cover *x* number of years. At the Teamster fund, we generally dealt with a negotiating cycle that lasted three years, and after a little bit of time the negotiations for a new agreement would start upon signing on the dotted line for the last one. So we were always in the negotiation mode, but this year 679 major bargaining agreements will be hammered out, and it comes as no surprise to any of us that of all the many problems, one of the major issues that comes up in any negotiating session these days is health care.

To define the goals of labor, I base my thoughts on countless meetings with local union officials and the Teamsters, and from attending a few AFL/CIO meetings in certain communities where the Central States Fund had participation of employees. Labor generally wants comprehensive benefits and has achieved that. Union plans generally have, as you know, the most comprehensive benefits available out there. They generally, in most cases, have not caught up with what's going on in the rest of the payor community, whether it be municipal employees or company-sponsored plans. They want broad access to providers and they've had it. For years and years (using the Central States Fund as a good example) up until 1985, we had absolutely no managed-care agreements in place, aside from one HMO in Minneapolis that included most every hospital in the Twin Cities. These Teamsters were able to go anywhere they wanted and basically with first dollar coverage. They want high-quality care. The average rank-and-file member is as most of us, unable to define it like we would. We would like to at least, but the average rank-and-file members will tell you the physician is nice to me, explains things to me, I get in quickly, and they always treat me well, and last but certainly not least, they want little or no cost sharing. In fact, regarding the Teamsters fund that I used to work for, there still is no cost sharing from the standpoint that the employers who participate in that fund still pay 100% of the contribution that funds the benefits for those union employees.

The challenges facing labor really constitute a much longer list, but I tried to put a few of them down from my perspective, including increasing medical care costs, and as Alan said, very few ways to really deal with it effectively. Even being one of the largest payers in the country, spending approximately $600 million a year on health benefits, the Central States Fund found it very difficult (even in several large midwest communities where we had approximately 7,000, 8,000, 10,000 employees) to really effectively deal with the issues that are far more widespread than one union fund can deal with. Demographic changes that generally exist across all lines are affecting union and company-sponsored negotiated plans these days, including increasing retiree populations and statistically declining active employee populations, which are producing a higher average age for the active employee and an increasing percent of retirees as a percent of all covered lives.

Particularly facing the Teamsters, competitive pressure on those employers from non-union carriers in the trucking industry has played a critical role in making it far more difficult to stomach increasing contribution rates, from negotiating cycle to negotiating cycle, and what I would call, for lack of a better term, the decline of a "common good philosophy." While I am not old enough to remember those times, most

Teamsters would say Jimmy Hoffa stood at the podium and said, "We're going to take care of our members from womb to tomb," and "All for one and one for all, we're all in this thing together." The thing that I found most striking in my brief tenure at Central States was the fact that even in the few short years that I was there, this "common good philosophy" seemed to be waning. What was happening was that, with retiree costs increasing, once the active member started to understand that he was footing the bill, the active members started to ask themselves, once they were more educated about it, "Why don't you just make sure that I have better benefits and find some other way to take care of that retiree?" So that "common good philosophy" started to wane, and continues to do so, which is a real problem for labor, as I see it to treat everybody, including retirees, equitably.

One statistic that points out the competitive pressures facing union funds these days is the higher level of expenses for health benefits for the union firm versus the nonunion firm. The difference is remarkable and is also evident on a geographic basis, with lower expenses in various regions of the country where union firms are far less present (such as in the Memphis area).

Regarding negotiated plans, I wanted to basically break them into a couple of categories, or for lack of a better way to deal with it . . . one being plans where negotiated benefit dollars are on the table and plans where the union basically says I want these benefits, you company, find a way to provide it.

In relationship to the Central States Fund, we like to think of it as one of the very first flexible plans, in that when the fund was formed back in 1946, it was done so through what is called the National Master Freight Agreement, which is that agreement that once every three years you hear about for a brief period of time (and maybe longer if a strike looms with the major trucking firms) that basically created the fund in 1946. The union basically told employers to give the premium dollars. The union will decide how they are spent, where they are spent and what the benefits will look like, which as I conclude my brief speech, I will say probably it will end up being part of a demise, or certainly the reason that I'm very downbeat about the future of the union Taft-Hartley trust funds where there's union representation.

The Teamsters recognized early on that having the control over that money meant having the ability to greatly affect the lives and the welfare of those union members, and if there was more to be gotten, it would be the local union leadership who would get it, not the company, and it would be only through the hard-fought battles of the union that union members would have comprehensive benefits.

In addition to other Taft-Hartley union trust funds related to other types of unions, steel workers and other trained unions, there is another category being that of negotiated benefit plans, such as the big three auto makers, AT&T and the Baby Bells, steel industry, who basically negotiate with the union how and what the benefits will be. And it is up to the company to fund them and find a way to do it.

In the long run, the fact that when benefit dollars are negotiated for the Teamsters, and it's the Teamsters themselves through the fund who decide where those dollars are going to be spent and what kind of benefits they can buy with the help of

actuarial professionals, it's going to be that past glory that brings about what I believe is an extreme political problem for a union trust fund.

My tenure at union trust funds was spent at the Central States Southeast and Southwest Areas Health and Welfare Fund, which was formed in 1946. Our problems with increasing costs mirrored those of other union trust funds with respect to retiree populations, trends for active and retiree groups, and made it increasingly difficult to provide comprehensive benefits without cost sharing or managed-care strategies. I would say that the fund was one of the last to get into the managed-care marketplace, and certainly had not done an awful lot in the way of educating employees and union members as to the problems that it faced, or how the individual employee or union member could be a better health-care consumer. I think that we found ourselves behind the curve compared to many company-sponsored plans, with respect to educating members and making sure they understood how the benefits were planned and paid for.

The fund has 125,000 active members and 24,000 pre-Medicare retirees, and a total covered live population of approximately 0.5 million. Those are scattered about approximately a 33-state region. It's important to note that not all Teamster members in this region were covered by the Central State's Health and Welfare Fund. Many local unions have their own funds. Those might consist of a 2,000-member group for a particular local union in Toledo or Youngstown or Omaha, but generally the largest group of Teamster members in this region were covered under the Central State's Health and Welfare Fund.

As a percentage of total participants in 1978, only 3% of the total participants were retirees. By 1987, 16% of those were retirees, and that number has not changed dramatically, because retiree eligibility rules have been altered, and the population has been somewhat static in the active groups, such that retiree percentage has not increased. Several other benefit changes and contribution requirements have lessened the desire of the retiree population to opt into the plan, while still the largest majority of eligible retirees do choose to participate.

Our goal with the fund was very "mom and apple pie" -- to provide the highest attainable health benefits to fund participants. Our objective was to contain benefit cost increases which ran approximately 14% through 1991 with a greater annual trend for our active retired population, approximately 20% for our retirees, and to contain those cost increases through a managed health-care program, without compromising broad access to providers or the quality of care. Now broad access is, I guess, in the eyes of the beholder. To the fund, that meant a large managed-care network in a given town that provided reasonable geographic coverage for union members. To the average rank-and-file Teamster, broad access is "I can go anywhere I want without any encumbrance or cost sharing based on the program that I choose."

There was a basic difference in the way that we dealt with retiree benefits that's inherent because of the fact that we were a Taft-Hartley fund. Until 1989, we did not have cost sharing for our retirees where they paid a percentage of their benefit cost when retirees began to contribute a modest (what we would call a modest) percentage of the total retiree benefit cost. We, too, at the fund found it necessary

to revamp our eligibility rules, such that the employee who had ten years of service could not retire with full retiree benefits. It would take a higher level of contributions and service to qualify for that, and because of the innate fact that we're a Taft-Hartley fund, did not have to prefund retiree benefits, and affect the bottom line in the way that the company-sponsored plan did. At one point we felt that this might be a draw in that the trucking companies participating in the fund, who comprised the vast majority of the employees, were covered under the Teamster fund and would not have to post those retiree costs as would many other firms. We generally found that this was not the case. They've dealt with Financial Accounting Standards Board and it did not impact whether we were going to be able to recruit additional fund participants to any degree. Retiree benefits from the company-sponsored plans have generally been greatly affected by Financial Accounting Standards Board rules and guidelines. Most of those companies have had to choose some sort of cost-sharing strategy with retirees, and have done what we had to do also and that is tighten eligibility rules, and in many cases, far more dramatically than what the union trust funds have done. Union trust funds were generally, at least from the Fund's perspective, still far more generous and liberal than many of the company plans that are being sponsored by airlines, the big three automakers, and other company-sponsored plans that have made such changes.

One of the things that, by virtue of the way that the fund accounts for retiree benefits, or perhaps one of the newest challenges facing the fund, is the fact that many of the employers have no "withdraw liability" on the health fund side, and have seen fit to basically withdraw from the health fund. They will provide coverage for their younger employees by putting those union members under the company-sponsored plan that's always covered the management employees, and leave the fund with the retiree component of their former employees. The fund has done some things with eligibility rules and contribution requirements to try to stem that tide, but it's becoming an increasing problem. Outside that one big national master freight agreement, only about 65% of the fund's participants participate in the fund through that trucking agreement. The rest of those participants come from numerous small agreements with mostly small employers, and that's a coming trend, but I'm not sure any union fund has found an effective way to deal with that.

Our change in demographics has been such that we had 200,000 active participants in 1978 and 2,000 retirees, and by 1991 that number had been altered to 125,000 actives and 23,000 retirees. Compared with company-sponsored plans this is not as major a problem as Chrysler or some of the steel companies had to deal with. But it is a problem given the fact that drop from 200,000 to 125,000 occurred in an environment that is from a union's perspective, very anti-union, very difficult with respect to competition, and in a basically totally employer-funded environment, aside from that small contribution the retiree now makes.

The fund still faces tremendous challenges with regard to being in business three, four, or five years from now. The present value of future retiree expenses for the Central State's Health and Welfare Fund is $436 million, compared to an average annual payout in 1992 of $618 million. With an industry that is teetering on the edge with respect to many union employers and especially trucking companies, we find it increasingly difficult in the era of competition to pay those contribution rights.

A far more dramatic illustration of the problem that retiree demographic changes can have would be Bethlehem Steel, which in 1975 had 35,000 retirees and 120,000 active employees, today has 25,000 active employees and 75,000 retirees. We've all seen these numbers before, the effects of Financial Accounting Standards Board rules on the bottom line for representative sample number of companies. At an hourly rate, the Teamster employers were the highest benefit plan which covers the highest percentage of active employees; they now pay $2.82 an hour for just the health benefits portion of that Teamster package, not including the pension. Contrasting that with the nonunion fund, you can see why those employers are under tremendous pressure.

Cost-sharing arrangements include deductibles and coinsurance modifications, premium differentials and plan maximums. Basically, in 1985 the Central States had none of these. It was a first-dollar plan with no premium differentials. The employer paid everything. He paid one wage regardless of single family, managed care, nonmanaged care, which was basically nonexistent, and the plan had virtually no maximums.

In 1987, we developed a managed-care strategy, which was not all-encompassing, but certainly formed the basis of what we tried to do mostly through preferred provider organization (PPO) arrangements, and that was to, first of all, change patient expectations. One of the things that we would find when we would speak to the rank-and-file is maybe somewhat anecdotal, but you would get out there and speak to the Teamsters, and find out how they handled the major decisions about where they shopped for the cheapest tires for the car or the cheapest food prices. The best place to buy any given item was far different for other goods than it was for health care. Basically, they would drive 40 miles out of their way to utilize a factory outlet to purchase those other items much cheaper than they would have otherwise paid. They wouldn't, however, drive two more miles out of the way than they normally would to use a preferred provider. Well, they didn't want to. We found that to be a real interesting phenomenon and one that we had to deal with on virtually a weekly basis when we were dealing with those rank-and-file employees.

To change patient expectations and education is something we had to do, along with benefit design changes, concentrating our market share, leveraging our purchasing power among payers, but also participating with managed-care networks that had multiemployer participation. Avoid selection bias when negotiating with HMOs and PPOs for risk arrangements that we were seeking, and try to negotiate based on data that let us know where we were spending our dollars, who is providing services most efficiently, and where some level of quality indicator could be measured. Lastly, our strategy relied on risk sharing with providers through PPO risk arrangements that generally involved withholds with physicians and hospitals.

By the time that I left Central States, we had approximately 50,000 employees residing in the service area and participating in a managed care (mostly PPO programs) in the central and southern part of the United States, in 16 metropolitan marketplaces.

Our program is called Team Care, hence the Teamster logo. We tried to utilize the "one for all, all for one" philosophy the best we could by describing the managed-care

program as something we had to do to maintain the fund's viability in the future, and by placing the providers at risk.

The enrollment program, as far as we knew, was one of the first out there to involve PPOs and utilize a formula that placed the providers at risk for the cost for the folks who enrolled and remained enrolled in the plan.

With regard to the future from labor's perspective, I have participated in a number of Teamster planning sessions with regard to the fund, and local unions that participate in the fund. Basically they're looking for a government solution to the problem. It's interesting, and sort of ironic, that a union that disdained government involved in virtually every aspect of its operation looks to the government to solve the problem that it knows it can't solve itself, and basically sees the government as the only solution to the health-care cost crisis that can rescue many of the folks who have to make those hard decisions to cut benefits or increase cost-share responsibility on the part of the employee. They see the government as the only answer to that, while at the same time, they disdain government involvement in every other aspect of their operation.

In any government solution that's generally discussed among these labor unions, they want to maintain access. They don't want to have to utilize a network, as is being talked about by both the administration and the challengers' advisors when it comes to health policy in the next administration, and they basically want someone to keep those promises that they've made to their retirees and their active members. They can't do it. They can't accept not being able to strike like they used to, and face heavy competitive pressures of nonunion employers. They can't bring about and weild the kind of force that they could bring about in the 1940s and 1950s and 1960s, and force the employer to provide the dollars to keep those promises. That problem is finally coming home to roost for many union trust funds out there, particularly the Teamsters where you have the local union leader in leadership and international leadership that also sit on the board of trustees of these Taft-Hartley funds that they helped create. It puts them in an extremely precarious position to every three years run for political office within their union, and yet every three years also have to come back and find some way to hit the union employee with an additional coinsurance requirement or premium differential or restriction of access to providers in order to maintain a solvent fund.

That brings me to my summation. Having spent time in that industry, I can't help but be very down beat about the future of a fund like Central States, given the retiree commitments that it's made. It cannot survive without having to drastically alter retiree benefits, and take away or not meet those promises that either were inherently made or were inherently understood by the local union membership who joined in the 1950s or 1960s.

MR. BLEAKNEY: Our third speaker is with Woodward & Lothrop, a $1 billion per year department store network with 12,000 employees located in seven mid-Atlantic states. Romayne Berry is vice president, currently responsible for salary administration, benefits, and the information services programs related to that. Her duties also include executive compensation and payroll, labor contract negotiation support, and property and casualty risk management. She has 18 years of benefits experience,

including five years in an actuarial consultant firm. She is also the most recent past chairman of the National Capitol Area Health Coalition here in Washington, D.C.

MS. ROMAYNE P. BERRY: In this economic environment, health-industry reform is increasingly an urgent matter for employers. However, with the exception of a handful of national business leaders, the employer voice has generally been inaudible. The problem stems from the fact that there are so many interest groups, that at best, all any of us are doing is stymieing the efforts of each other. Not only has this inhibited rational solutions to the problems, but the long-term fear is that the interest groups with the loudest voices will out-maneuver the party with the most to lose, and that is corporate America.

But this wouldn't be Washington if I didn't start my remarks (a bit tongue in cheek) with a disclaimer. That is, my comments do not necessarily represent a single philosophical approach endorsed by my company. Actually, I'm not sure a consensus on a single approach could be achieved in most organizations. My thoughts are a synthesis of my corporate responsibilities, benefit industry organization participation, and experience as an officer for the past several years in the National Capitol Area Health Care Coalition. As a health-care coalition, we have represented many of the largest employers in the Washington, D.C., area and have tried to address the difficult task of health-care cost containment.

I believe employers must approach solutions to this issue with a two-front campaign. Clearly, benefit plans must undertake tactical initiatives, and I will share with you our cost-containment efforts over the years. But I also believe that employer actions must be strategic. Within the employer interest group, we must recognize that there is a role for us to play in seeking solutions to the national health-care crisis. Employers cannot continue to simply reject the efforts of the various interest groups as simply being "too expensive" – or this national problem will linger, causing billions of wasted dollars. More importantly, corporate America may likely find itself at odds with the key players, and ultimately, not a significant factor in the solutions.

First, we must build a broad-base employer consensus – and the starting point is within individual companies. Interestingly, surveys are beginning to demonstrate that HR executives support at least incremental changes. This was a finding last spring of a William M. Mercer survey which reported that among 406 HR executives in major companies, there was a willingness to make certain concessions to achieve financial goals. Although drastic changes, such as increasing taxes, received less positive support, there was a sense that some tradeoffs were reasonable in order to create health-care reform. This is a good start – but the question comes as to how quickly employers will recognize that reform is headed our way regardless of our individual corporate preference. With U.S. health-care spending approaching $1 trillion a year, at 13-14% of GNP, the future is now. If our federal legislators and/or the administration can't find a way, state governments will continue to make inroads, resulting in inconsistencies in multistate benefit programs. Although state and regional participation is critical, the control must be at the federal level.

As employers, we know we're paying too much for health care. For most of us, no single component of our business has as much dramatic change each year as the percent increase in health-care costs. But we also need to recognize that we're

supporting a medical welfare system. As corporate taxpayers, the legislative intent seems to demand an increasing share of the expense. The key will be not just to finance universal access, but to ration services and resources effectively. In part, this will require changes to provider compensation systems.

Essentially, there are three primary problems: access, quality, and affordability. I believe the core problem is quality management. I assure you, from a social perspective, I'm very concerned with the 35 million plus Americans who are underinsured or noninsured. Clearly, we can't wait years to cure that problem. But I also believe that by improving and controlling quality, we, as a nation, will reduce long-term health expenditures, generating sufficient financial resources to adequately provide health care for most Americans.

But as I previously stated, employers must reach a consensus first within their organization -- and the more severe their financial exposure, the more critically the issue will be reviewed. In my company, we're looking beyond our benefit programs to seek solutions. We're interested in health-industry reform -- because despite ten years of vigorous cost-containment initiatives, we have not sustained permanent and predictable cost control. Our efforts at times have been remarkable, and we've achieved significant percent savings to total expenditure. But as a benefit manager I can say -- the bag of tricks is almost empty.

To start, the scene is the late 1970s -- early 1980s. We're in an expanding business environment and like many employers -- we're delighted with corporate profits and willing to share them with our employees. As a result, we expanded our benefits program. We improved our medical plan, added vision care, dental, orthodontic, and prescription benefits, as well as enhanced many other plans. But by 1982-83, we began to understand the expense impact of our expanded benefits program, and although we were not unduly concerned, we looked to optimize our cash flow and expense recognition. The obvious choice for immediate impact was self-insurance, the first year with aggregate stop-loss coverage.

Despite our momentary pause -- we were still "dressing" those yuppies and business was wonderful. So wonderful that it occurred to us that by improving the communication of our benefits program, employees might better understand how to use their benefits and appreciate them. So we created what turned out to be a national award-winning communication program called "Benefits By Design," and while we were at it, we also wanted to enhance our health program administration. We wanted the most efficient and effective on-line claim processing TPA/carrier in the country. This was to ensure prompt reimbursement of employee claim expense and as a result, we bid the coverage and ultimately changed administrators.

However, by 1984-85, the reality of our cost increases -- albeit by "design" -- was becoming a little breathtaking, and we began to carefully project long-term health expense. This was the start of our cost-management program, and we made certain cost-containment design changes. We improved the utilization/concurrent review guidelines and procedures, required hospital precertifications, established a mandatory second surgical opinion program, initiated case management and created cost incentives such as 100% reimbursement for outpatient surgery, home health, and hospice -- as well as provided greater reimbursement for use of a hospital PPO that

we had established with the National Health Care Coalition. We also expanded our HMO options and tried to financially channel their selection. For a short while, all seemed well. We were healthy as a company, our employees enjoyed their benefits, despite the cost-containment initiatives -- and costs had become relatively predictable again.

However, by the mid to late 1980s, several things happened. Despite our high turnover industry, our demographics began to shift and our employment base became more stable. As a result of less employee turnover, we began to statistically age quite rapidly. Also, we doubled in size from the Woodies Department Store chain in Maryland, District of Columbia, and Virginia, to include John Wanamakers in Pennsylvania, New York, New Jersey, and Delaware. Subsequent layoffs in the past few years as a result of the economy has also meant that younger employees have turned because they tend to be the ones with shorter service. We aged almost four years during the 1980s, from an average of 34-35 to 39 and pushing 40. Not only did we begin to see more severe illnesses and injuries, but, as is predictable in our predominantly female industry, our maternity rate skyrocketed as a result of our mid to late age 30s population. Increased utilization throughout all of the health plans severely impacted our costs, and the incurred but not reported (claims) effect relating to self-insured plans became erratic from an expense recognition standpoint.

So we returned to the options that had given us hope earlier in the 1980s -- more cost-containment initiatives. We eliminated annual open enrollment periods and enforced stricter participation election rules. We increased what employees were charged for coverage, we increased deductibles and individual stop-loss levels, and we added a hospital admission deductible as well as one for outpatient surgery. The latter was to offset the increases in outpatient services being charged by hospitals. This occurred once hospitals got wise to the fact that benefit plans had created financial incentives for outpatient procedures. When the plan design incentives reduced inpatient income, hospitals responded by charging more for outpatient care. We also added mandatory generic substitution for prescriptions and shaved back a variety of health program benefits, such as limiting the number of treatments for substance abuse.

From a corporate philosophical standpoint, we believed that the primary users of health care should pay a greater proportional share of the expense than nonusers. Therefore, we tried to select cost-reduction initiatives which would achieve financial goals -- but affect the fewest number of employees. However, we discovered that 1% of the employees and their dependents were generating 70% of the expense. Therefore, there was no way to cost shift sufficient dollars to the primary users.

Our next steps were to anticipate establishing flexible benefits. Ultimately, we postponed doing so because of the administrative and employee communication expense. But, we had introduced the concept of "choice" in the mid-1980s by giving employees options with varying prices for life insurance and disability coverage. We extended the approach further by giving health participants additional HMO options and the choice of three comprehensive plans. We introduced Plans A, B, and C. Plan A was communicated as "basic catastrophic coverage," Plan B was called our "core plan," and Plan C was referenced as providing the "greatest repayment for

eligible costs." Each plan provided a different level of medical benefit reimbursement with corresponding gradations in vision care, dental, and prescription coverage.

For example, Plan A provided only medical coverage -- no ancillaries, with a $1,000 deductible and a $10,000 stop loss. Plan B was our target plan and we priced it to encourage its selection. Plan C provided the greatest level of benefit reimbursement, but even it was overall less than the singular plan previously offered. This total redesign achieved significant cost reduction, and our annual percent increases were less than health industry trends for our geographic region. However, between the uncontrollable nature of medical inflation and a declining business environment, we were still just holding our own.

Although we followed textbook cost containment, we believed we were still being dragged by the train. Up to this point we had simply been unloading freight -- throwing it from the speeding train -- and our health program needed effective long-term focus. This past August we moved to full-managed health care. Although our employees were initially worried about the "change," we benefitted greatly from the timing. There isn't a newspaper, national magazine, or political campaign that isn't discussing health-care issues. As a result, Americans, including our employees, understand the need for reform and our managed health-care arrangement has been accepted -- and we're receiving positive feedback.

We've tried to approach managed care in a comprehensive format. Although our long-term disability (LTD) claims have always been administered by TPA/carrier, this past March we also established a managed sick-leave program. We've linked the two to help early identification of potential disability claimants. This helped reduce administrative fees for LTD and will hopefully permit us to channel disability claimants to rehabilitation. However, our success has been in the control of sick-leave utilization. Although the data are still preliminary, the results have shown a 12% reduction in approved sick leave. Quite frankly, our in-house administration has historically been so poor, we ultimately expect a 20% reduction.

Since the bag of tricks seems depleted, we also anticipate expanding managed care and applying it to our dental program. I anticipate also making changes to our prescription drug plan to work more cohesively with managed health plans. I believe a future opportunity also lies in managed workers' compensation. Although some states currently restrict such an avenue, there is tremendous pressure on state legislatures for reform. Certainly, the pressure to curtail health industry expenditures shouldn't be limited to medical plans.

Nevertheless, the initiatives we've taken over the past 10-12 years are only tactical, and we still have the strategic to address. Health-industry reform has been severely hindered by the lack of consumer incentive to purchase cost-effective care. Most insured or covered individuals are able to submit claims without worry that the majority of their bills won't be paid.

With this as a backdrop to satisfy the increasing legislative intended mandate of providing universal access, the nation has two choices: either raise taxes for which employers will likely bear the burden or finance "access" by reducing the cost of care. The cost of care can be reduced by two methods: by either simply rationing care

based on dollars spent -- or rationing care based on cost-effective treatment, relative to success. In my opinion, the latter is the wiser of the two; however, this means that we need to identify the "best" care per condition.

I don't believe employers have a legal (as of yet) or more importantly, a moral, obligation to ensure that each and every employee and dependent is healthy and lives a long life. However, good business practice means we have a competitive desire to facilitate this. As a result, middle-size and large employers generally do provide health-care access with reasonable cost sharing. So, if as an individual employer I'm already taking care of my own employees, who's responsible for those without employer coverage -- or those without affordability? It's obvious from every survey on the subject that Americans believe universal access is the 11th Bill of Rights. But, I suggest that the more than 35 million underinsured and noninsured Americans are all of our responsibility -- not just the corporate community. The quick fix, to tax employers, is not a solution. It's simply an excuse to maintain the status quo, and it will only cause more business falter and create more underinsured and noninsured. It becomes a self-fulfilling prophecy. The cost shifting to the private sector from Medicare cutbacks has had and will have serious ramifications on employers, and that combined with the specter of *SFAS 106* has already started the employer process of redesigning their health programs to eliminate some covered employees and retirees.

Ultimately, I believe the strategic solution to health-industry reform is twofold. In order to effectively manage the industry, we must apply by state -- or perhaps regionally -- certain medical practice standards and policies. Normative guidelines must be established based on population demographics to control the number of community hospitals, the amount of technically advanced medical equipment such as magnetic resonance imaging (MRIs), and to set limitations on authorized hospital procedures. With respect to the later, specific hospitals should be designated within regions for shock trauma, burn unit, open heart and organ transplant. Individual hospital selection should be based on location to population centers, their staffing and support services, and their morbidity and mortality results, etc. I would recommend that a federal system with correlation to regional cost indexes be established to authorize annual expenditures and cost increases. Since individual states are most familiar with their situation, they are best able to determine how to meet federal cost-containment guidelines. Further, as an incentive, if a state does not comply, then certain federal funding should be reduced. Perhaps overly simplistic, but it should operate much like the reduction in federal highway funds for a state's failure to enforce maximum federal speed limits.

None of this will be effective, however, if we don't tackle the core problem. We must accept health-care rationing based on the likelihood of success. The industry must manage quality by controlling the processes through which health care is delivered. Unfortunately, the scientific data to determine "appropriate" quality care does not exist in a single database. The medical community is not taught that for condition "X," you do "A," rather, they are taught that A, B, C, and D are options based on various patient circumstances. But as a result of litigation fear, they've also learned they'd better do "E" through "L."

In order to give physicians medical practice standards from which health care can be rationed -- based on likelihood of success -- we must first give feedback to the

medical community. We must tell them statistically what works and what doesn't seem to affect outcome. Actually it's the insurance industry that has the most crucial role to play. By reviewing claim history, the industry can help direct the medical community. It can provide the data physicians need to analyze effective care. As an example, claim review of several thousand thyroid conditions will identify the ranges of care. Laboratory tests, treatment patterns, and hospitalizations can be compared for success. By reviewing total expenditures before, during, and following a hospitalization, the insurance industry and the medical community can evaluate "success." If 90% of patients recover equally as well after three days hospitalization for a thyroid gland removal as compared to the standard five days, the ration level becomes two days of hospitalization. As a result, physicians could then be taught in medical school that three days will provide successful care and the insurance industry will then be able to reasonably limit reimbursement.

All of this seems very simplistic and we're all aware of situations where the system seems to be working like this for utilization and review purposes – but the fact of the matter is that there are very few medical practice standards. Care is based on individual physician training, experience, patient demand, and all too often, just trial and error. This is not cost-effective health care.

These recommendations are further predicated on providing tort reform. The medical community will accept rationing based on success of the standards, but only with the legal security of their decisions. As a nation, we can't limit physician authority if we don't also provide general relief from legal liability. Not every medical decision will fit into a mold. There will be errors. There will be situations where if more tests had been performed, a different decision might have been made. But this crisis demands reform. It must be creative and everyone must share the burden . . . not just corporate America.

MR. WILLIAM J. SCHREINER: I was interested in Mr. Breen's observation that the union that he was familiar with had ridden this medical care horse as far as it was going to go and was seeking an outside party to come along and provide new transportation. I was wondering whether Mr. Christenson or Ms. Berry might comment on the attitude within their communities with respect to a third party coming along and lifting these burdens from your shoulders.

MR. BREEN: I think that's a mixed metaphor. Certainly as you said, in countless meetings that I attended with Teamster leaders and professionals at the Fund, it was basically felt by all, and probably attributable to the precarious position politically that they all face, that the only solution would be a governmental intervention, which is, as I said, very ironic, given how they don't want the government to intrude in any other decision that they make or activities that they undertake. I would say if there was one thing that generally every labor leader that I had contact with agreed on, it was that long-term their fund could not continue shouldering that burden. The only entity they look toward with any hope to be able to solve that problem was the government to provide again kind of a base line, all for one, one for all, repositioning of the playing field.

MS. BERRY: I think the comments that have been made, that labor has been looking for someone to relieve the burden, are parallel to the corporate side. None of us like

government intervention. For every issue of willingness to accept assistance on health reform, I'm sure I could give you, as most employers could, a thousand things we don't want to be meddled. But this issue is beyond any of us, and if we take the premise that we as Americans are not going to accept anything less than full and complete access to health care, then it has to be a burden that is shared. But when you are talking about a 50-state community, it's very difficult to permit or even begin to think that there might be 50 solutions to the problems. I think there are a number of key players. I think the insurance industry, the medical community, and labor all play a very important aspect in the discussion. But I also want to see the employer side interjected. I'm not sure we're looking just for relief. I think what I'm suggesting is that there are many players that have to be involved, and it has to be a consensual resolution.

MR. CHRISTENSON: I would think it's probably going to be very difficult politically at the local level. There has been an attempt recently to do a regional approach to health insurance, and you're talking about some 50 public agencies, with thousands and thousands of employees and retirees. They were able to get only two jurisdictions who would go together in a single group. You have so many differences at the local government level between the union on the Maryland side, District of Columbia, and Virginia, which is a nonunion state. There are the expectations of the individual employee units wanting their own control over the design, and so I don't know that you could, in the public sector, reach a point where we would have a single regional program.

MR. HARRY L. SUTTON, JR.: I'd like to congratulate you. It's been a very interesting discussion. One comment: wouldn't it be great if we could have Medicare catastrophic back and sharply reduce your retiree liabilities, regardless of who's paying for it?

The Central Conference of Teamsters spent millions trying to get into managed care in the late 1970s. Maybe the only one left is the St. Paul union, which is in share now. It was a really interesting problem -- a really large, spread-out Taft-Hartley trust. At that time the PPOs really didn't exist, and we were trying to get Teamsters enrolled in HMOs. The problem was the Teamsters have a Master Freight Agreement, and every employer contributes exactly the same dollars and cents for health benefits, but health benefits are not equal in different locations, and that causes a problem.

In St. Paul, they enrolled almost all the union members, or a big percentage of them, in share at the time (using a staff model, interestingly enough) and they misguessed the premium. They assumed there were only 2.5 people per employee, and it turned out there were 4.3. If you've ever worked with the demographics of UAW Steel or Teamsters, that's the pattern: They're all males and they all have big families. After they lost lots of money in the first year, they tried to raise the premium rates, but it exceeded the Master Freight Agreement premium rate, so the Teamsters said it cannot pay any more. We tried to explain that the average cost in St. Paul would be higher than many areas, and therefore, the HMO was still cheaper than the prevailing costs if they had stayed on fee for service, but they wouldn't buy that. They couldn't permit variations in contributions by area, because it would disrupt the contributions made by various states where their premium contributions were much higher than costs; in Chicago and Minneapolis, they were lower than cost. The

Teamsters wouldn't permit employee contributions, but they salvaged the HMO in St. Paul when the HMO agreed to bill the members at home $3 a month for each child in excess of one. The members knew that the reason they were losing money was that they had so many kids. They felt it was fair that they would pay for their kids in excess of one.

Recognizing that the costs were so different in different areas -- in a low-cost area, they could have had an expensive HMO and it wouldn't have cost them money -- eventually the enrollment in the HMOs (apart from the philosophical problem of not wanting restrictions of choice, which was a big problem then with the union) went down the tube. Nationwide, with Taft-Hartley trusts, it's almost been impossible to ever get an HMO enrollment. It might sound like they solved the problem with employee contributions, but the Teamster mechanism had no way of collecting contributions from those employees scattered all over the place, so it was impossible for them to do it.

I tend to agree with you, particularly with large nationwide plans. I think we're in very deep trouble.

MR. LAWRENCE R. HAYNES: My question is for Ms. Berry. With the increase in health-care costs for the past few years, have you cut back in other areas, salary increases, savings plan benefits, retirement life insurance or medical insurance, in order to compensate for the increased expense?

MS. BERRY: I'm in an industry that is having some very difficult times. We are about to venture into our fifth Christmas with sales which may be flat, and we've had numerous reductions. Although my industry is not the best to answer from that standpoint, we have had other (nonhealth) cutbacks. Certainly health-care expense has been a factor in the equation, but the fact that sales have been difficult to achieve has really created the basis for our cutbacks. Recently we suspended our company matched 401(k) contribution, -- which wasn't too painful, because I think we'll be making some other changes that will, in the end, enhance the program. We've not had significant salary increases for the last several years, so there's some overriding business issues, which make seeing the trees through the forest difficult.

MS. DOROTHEA D. CARDAMONE: You mentioned a $10,000 deductible. Was that for the employees?

MS. BERRY: We had a $10,000 stop-loss. The deductible before any reimbursement was $1,000. This was high but you have to understand, we're 78% female in our company, which automatically implies that much of the insurance is second coverage. So this plan was to provide catastrophic care. We had a tremendous amount of interest though, because of the nature of our health population. However, most people were targeted at plan B, the core plan, and they accepted it.

MS. CARDAMONE: Another question . . . Do you see any way the employers in the Washington area will be getting together? Do you see any forces coming about to centralize their voices?

MS. BERRY: Washington is a unique city. It's very hard to focus on local issues, because our local issues seem to be federal issues. So interestingly, the very employers that are here are more interested with interfacing with their regional or industry lobbies. For instance, next week I'll be with the national retail federation, so K-Mart and Dayton Hudson's, as an example, will be coming to Washington, my town, to talk about national health-care issues. From a big-picture standpoint, if everybody has that same experience within their industry, it is very hard to get the local companies together. However, we did manage it and we did establish a PPO, HMO. Woodies didn't participate for various reasons, but we also did help establish a hospital PPO that our company participated in. So there have been pockets of coalition. In Washington we have basically a two-tier employment base. We have very large companies and very small companies, and it's hard to find common ground.

MS. CARDAMONE: My point was that your comments are very good – getting them more widely distributed among other benefit managers to get them on board would be really excellent.

MR. SUTTON: I couldn't resist responding to one of your recent comments. I enjoyed your remarks, and I agreed with the last comment. However, you point out exactly the nature of cost shifting and the problem with flexible benefits. If you can talk your female employees into being covered by their husbands, you have effectively shifted up to $10,000 of expenses to some other employer.

MS. BERRY: And I'm proud of it. If I can do that before my competitors figure it out, then I'm ahead of the game, because my competition's costs are lower. It's not a solution to the problem, I understand.

MR. SUTTON: But flexible benefits are the-devil-take-the-hindmost and once everybody has done that, everybody's cost will have gone up.

MS. BERRY: Oh, it's like any PPO arrangement, you're right on.

MR. SUTTON: I'm not talking about the PPO. I'm talking about the $10,000 deductible.

MS. BERRY: PPOs are cost shifting too. To the extent that I negotiate a fee with local hospitals and the competition doesn't, that hospital isn't going to lose profit, they're just going to charge my competition's employees more.

MR. SUTTON: I think we have more problems dealing with coordination of benefits and multiple coverages, particularly in situations like you talk about. I think each employer is going to pay for its own employees.

MS. BERRY: That's why, you should make it just my employees. Don't give me the expense from those employers down the street that don't provide coverage.

MR. SUTTON: I agree with you. One of the things I sense from talking to all of you is a strong demand that you must give some choice to your employees. You're spending all kinds of time and money on networks you can still get outside. No one

yet has reached the point where they're saying "I'm going to pick this HMO or this network and that is the only plan you people get." Until we reach that point when the employer is willing to negotiate a deal with a network – put all his employees into it – you haven't reached the desired point.

MR. THOMAS F. WILDSMITH: I have a general question for the panel. In most of our experiments with managed care, it generally involved a restricted access for the insured in one form or another. We have traditionally found it necessary, in exchange for the reduced access, to provide more generous benefits for those who do play by our rules and go with the network. Unfortunately, those more generous benefits are eating up much of the savings that we're gaining from whatever managed-care network we use. Among employers and labor, is there any willingness to accept the managed care and the networks with restricted access without increasing benefits to the extent that it's been done in the past?

MR. BREEN: I'll start that one off and basically say at least at the fund that I was employed by, we at first tried every way we could to come up with something to give the people who already had everything, and found a way to increase their benefits through life insurance, and we gave them additional life insurance, and basically kept the health benefit levels equal regardless of whether you opted into the plan or didn't. This allowed us to measure the effectiveness of the PPO or managed-care strategy, since it was apples to apples. Since I have left, and it has nothing to do with that, they just found that strategy wouldn't work anymore, and in order to control costs on the benefits side, they developed a coinsurance level where there had not been one if you were in the network, and further reduced it if you didn't. So they're still using an incentive basis. You get 10% better benefits if you opt into the PPOs as if you don't, and I would say from the fund standpoint, we were an anomaly, because we chose in the beginning not to even use a true benefit incentive or disincentive on the health side, to try to secure participation.

MR. CHRISTENSON: I'm going to take a little bigger-picture response, because not only do I have responsibility for health care, but we're self-insured on workers' compensation. Costs are going up there as well. I think we're going to have to have multiple strategies that address the issues across the board, and those include many of the measures which have already been mentioned in the presentations. We're going to have to deal with safety issues in the work force. Our analysis has shown that we have serious problems. Supervisors are not being responsible. We're going to be getting into the issue of fraud. We are hiring an investigator to make sure that we deal with those issues. We're beginning to do managed care in a sense on our disability claims with respect to workers' compensation with tremendous success. We have reduced, I think in half, over the last few years, the number of cases that are on workers' compensation. Another major component of our piece when hopefully we get our plan in place is to do education on the health care, which is one of the main points you made, so it's going to require multiple strategies to address the issue.

MS. BERRY: As long as we have the financial luxury of not destroying the good will between us and our employees, we wanted to walk before we ran, and we wanted to be able to give them choices. We truly believe that managed care is the only tool that's viably left to us. We want our employees to believe as we do, that it's good

for them. It provides quality care, and it will be good for all of us as a company, because it will help curtail expenses, and if you want people to buy into that, they have to feel it, and you have to give them that choice. So we had, despite our five tough Christmases as an industry, the luxury of still giving our employees choices. It was important to us to set up the financial incentives to channel them there, and I would like to think that a year from now that we have people in the managed HMO as opposed to the managed network, as opposed to going outside the network. But right now they have those three choices. In fact, most have shifted inside, and I think it's going to continue that way. If it continues that way and all of a sudden we have 90% of the people there, we'll probably make it mandatory, because we won't be aggravating anybody by taking anything away.