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Session 39PD
Driving Factors in the Health-Care Market

Track: Health

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Summary: The panel examines the forces underlying health plans and health carriers profit performance, including:

- *Segment profit performance*
- *Factors driving performance*
- *Successes and failures in the marketplace*
- *Trends in consolidations*
- *Balance between profits and market share*
- *Outlook for change*

MR. CABE W. CHADICK: The managed care companies really improved things in 2000. I've talked to some friends who worked at HMOs, whether they're clients or not, and they seem to have quite a few smiles, at least on what's coming off of 2000. What are the ones who are smiling doing? The profitable plans have placed an emphasis on choice, and have exhibited some pricing discipline. It looks like pricing discipline started some time ago, and it really has borne out in 2000 and I hope it continues in 2001. This performance was largely dominated by their large group enrollment.

On the group commercial side, even the PPO plans and indemnity insurers seem to be doing well. The hot job market and the economy are key factors as to why this is working out in terms of discipline pricing. We're all very blessed by this and I hope that it continues.

Many of the managed care organizations (MCOs) have experienced some one-time conversion charges. That's been a dent in their side, and I have some clients who

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Note: The chart(s) referred to in the text can be found at the end of the manuscript.

are still feeling the lasting effects of some computer conversions and staff reductions. On the individual commercial side, it's been all over the board in terms of results. The pricing discipline is improving, but not as far back as we've seen with the MCOs and the HMOs. This market has even more PPO focus and the competition is just as strong as it is on the group commercial side.

With Medicare Risk/Choice plans, the results also vary, but it seems as if all the HMOs and MCOs have been pulling back and identifying where their resources are best spent. I just noticed in today's *Wall Street Journal* that President George W. Bush has given a few additional weeks for them to make their participation decision for next year. That's going to be a key decision going forward. For the Medicare supplement plans, again the results vary. There are many long-standing players, but we have some new ones on the board. The MCOs are seeing this as an alternative way to spend some resources, at least the ones that have an insurance company license.

As far as the Internet, it is too soon to tell. For all of you who are trying this, I wish you well, but it's just too soon to tell. Maybe a year or two from now we'll be getting back together and telling stories.

In terms of prescription drugs and hospital outpatient costs, which Richard Kipp is going to talk about later, these costs have been hard to contain. The inpatient days utilization seems to be relatively stable, but the average cost has risen. I've seen what I would call provider push-back, and I wouldn't be surprised if that continues.

What are the factors driving future performance? These are some of the effects that we have to deal with in the commercial market:

- Can we continue to soften our cost trends through continued care management?
- Will the drug co-pay and utilization management structure work for us?
- Can our pricing discipline continue or is our job market going to soften, and how will those play off each other?
- Computer conversions have not only cost material dollars, but how have they disrupted claim lag patterns? Did we fail to recognize the rate increases that we needed?
- How do we deal with provider pushback on reimbursement negotiations and the hardening of our excess reinsurers?

The individual and group voluntary association commercial markets have been exciting over the last two years. There have been a lot of innovations. Companies that might have gotten out of the group major medical markets are dabbling in the voluntary market on some of the other lines. Product innovations that I've seen are some inside limits and more services with high co-pays. They're writing out certain coverages that they want to stay away from (i.e. maternity and drugs). The most innovations that I've seen focus on bringing the price down and covering primary insurable events or catastrophic costs.

I'm really interested in seeing the results of one new item that I've seen a couple of players offer. They're providing supplemental plans to group major medical. The cost sharing on these major medical plans is going up, so somebody is saying, "I can cover that (i.e. the cost-sharing), that's insurable to me." It will be interesting to see how well that works out for the players that are trying that. Those who are offering the traditional $500/$1,000 deductible plans, we've seen some of those deductible levels rise, and it's likely they will continue to rise.

In the government markets, and the Medicare Choice/Risk as I mentioned before, we will still examine what's going on. We've seen some managed care organizations (MCOs) and HMOs re-examine what they're going to do with their federal employees' health plan. The competition for this group is going to continue. In Medicare supplement, this market doesn't seem to change a whole lot other than maybe with a new Medicare Select offering. Initial pricing and timely rate increases still are crucial success factors; however, Medicare Select is gaining more carriers and buyers and the competition is heating up, especially from the MCOs that are dabbling in this.

For many years now the PPO has been the focus of dental, whether it's silent or explicitly in the policy form, and the competition here is heating up again from the voluntary plans. You have some players who are getting back into the group A&H business, maybe not major medical, but they're getting into the dental and they're getting into some of the ancillary lines for the good market.

What's driving the Internet? Are people going to shop for their coverage? Are the companies going to realize these efficiencies that are being predicted? Some plans expect that their Web expenses will be a growing and budgeted part of their overall administrative costs. These expenses are just not a one-time cost. Some are saying, and maybe wisely, "Let's anticipate the cost here and let's make sure we get our return on the costs."

Here are some successes that I've heard about lately:

(1) Direct physician contracting
(2) Continued physician education and protocol sharing
(3) More choice/benefit options
(4) Rate discipline
(5) Tiered network levels, including broader and more well known provider networks that cost more, as opposed to one that is tighter. This puts the decision of quality versus price back into the group's or the individual insured's hands
(6) Active benefit changes, which have been key in the individual market, maybe not the group and major medical commercial market, but on the individual side they have been a key thing for some of the players to get a raise in their co-pays every year
(7) Individual and small group focus on friendly and material markets should re-examine their benefits every six months or every year to see what your benefits are doing, how well are they working out, especially with all the innovations that are going on

I don't like the word failure—I prefer the word mulligan—but these are some reasons for failures nevertheless:

(1) Contracting with some physician management groups
(2) Computer conversions
(3) Missed rate increases (Did you get it when you want it; did you get how much you wanted?)
(4) Adequate claim reserves, that goes hand in hand with your rate increases
(5) Difficulty in dealing with switching from capitation to fee for service

There are a number of consolidation trends. Computer conversions and Y2K concerns may have temporarily put some plans and ideas on hold. Some of the people that spent money on computer conversions would like to try to recoup or spread those costs by buying blocks of business. Block sales or purchases may be a more enticing way to achieve desired scale, distribution, and network negotiation advances. Between 20 and 25 Blue Cross/Blue Shields have been consolidated because of survival concerns and efficiencies in product offerings, compliance, and administration.

In terms of balancing profits and market share, it seems as if we've turned from market share over to profits. Group commercial and Medicare Risk appear to have turned faster than individual commercial. Here are some of the future factors that will affect this balance: (1) risk-based capital (RBC), (2) a desire for stand-alone segment profitability, (3) cost trends and the reasonability of rate increases, and (4) the overall economy and how the job market is doing. Some of our MCOs get in all kinds of different lines. As I said, the market diversification includes Medicare supplement, medical savings accounts (MSAs), PPOs, and possible hospital/surgical, supplemental, or limited benefit plans. Again, we have some network/provider reimbursement alternatives that we're examining these days: (1) fee-for-service rather than risk share, (2) agree-to-disagree contract dissolutions, and (3) resolutions of long-standing contract disputes.

Conservative pricing and trend estimation probably will continue. You're going to see a continued rise in drug costs and hospital outpatient costs. Regulation is always on the forefront. Some states, such as Washington, Oregon, and Kentucky, are readjusting and tweaking their individual and small group programs. There are some potential changes down the road for those of you who play in the group association market. We see some advantages in that, and hopefully those advantages will continue.

There are some outcomes that are still unknown:

(1) The efficacy of alternative distribution methods, particularly the Internet.
(2) The extension of group pre-tax advantages to individual coverages
(3) Defined contribution (DC)
(4) Implications of the final health privacy rule
(5) Medicare reform and prescription drug coverage for seniors

(6) The Patient Bill of Rights
(7) The effect of present and future class-action lawsuits. I'm really interested to see how that will work out a couple years from now.

MR. ROBERT E. BLUHM: I'm going to talk about what's affecting us at Arkansas Blue Cross/Blue Shield. The first thing I thought of was premium deficiency reserves, and the other thing was RBC requirements. The other thing that I get involved with is small group and large group rating. We've actually set up task forces to deal with it, so I'm going to talk about that, too.

Premium deficiency reserves are established when future premiums are not expected to be sufficient to cover future claim payments and expenses for the remainder of the period. This is something that I think others have done before in selected cases, but now we actually have something official that we need to comply with. The contract period we're talking about can mean as long as rates are guaranteed for a group or block of business. It can also mean the period until the block is restored to profitability or lapses completely. There's a Statement of Statutory Accounting Principal Number 54 that comes as part of the codification that Cabe referred to, which is effective on January 1, 2001. At this point, we're now calculating reserves and if it's calculated to be necessary, it must be established beginning with March 31, 2001 in a quarterly financial statement. Of course, whenever you apply some reserves, there's going to be some considerable judgment and some uncertainty.

This is important for our company. Distinct blocks of business must be considered separately when calculating premium deficiency reserves, which means an over sufficiency of premium in one block cannot be used to offset a premium deficiency in another. At Blue Cross, we've had a few products that work well and some that haven't. Overall, they seem to do OK over time. At this point, we need to put up an extra reserve for those products because they are not doing as well. We have individual, Medicare supplement, and dental blocks. We split groups into three sizes. We've split HMO groups into the same three sizes. We have a self-insured group blocking, and we also do our conversions.

We're struggling with the fact that ASO reserves must be established whenever the fees are insufficient to cover expenses. I would imagine there are a lot of ASO carriers out there that have to charge fees that are probably much lower than their actual expenses, and we're struggling with the idea of having to set up an additional reserve for that. We can use investment income on a lot of blocks, but there isn't a whole lot in ASO.

There are several main points for premium deficiency reserves. If you have good blocks and bad blocks, you can't use the good blocks to offset the bad blocks. This affects us this year, because we have to set up a reserve for the first time, so it's much more important to the profitability this year. After this year, there will be changes in the reserve, but this year, it's been a straight bottom-line hit.

We also use RBC requirements to come up with our profitability goals. Everyone here is probably familiar with RBC requirements, so I'm not going to get into too much detail. There are many reasons why an insurance company needs capital: retention of policyholders, downturns in underwriting, the absorption of additional risk, the funding of special projects, exceeding regulatory capitalization requirements, and meeting expectations of rating agencies. There are five buckets in a complicated covariance-type formula. The NAIC has four thresholds. I don't know how many of you are familiar with Blue Cross thresholds, but the main one we're concerned with is the second one, qualifying for enterprise monitoring 500 percent. We're getting close to that 500 percent, and by using RBC as a means to set profit targets, we generally like to shoot for about 525 percent or 550 percent. When you're a growing company such as Blue Cross Arkansas, you have to have a certain amount of profit. It's not good enough to just make a few dollars here or there. Now we have specific goals that are strictly based on RBC requirements, and so that's been the other main financial thing that drives our profitability.

We have a small group market. It's our largest, fastest growing, and most price-sensitive market. It has mostly independent agents and brokers, and we don't see as many insurance company changes because a lot of companies in Arkansas have gone under recently. There's a lot more potential competition, and so there are special management underwriting skills required to be successful.

A few years ago we created a task force to examine the 2 to 50 market, and we recommended a special Health Insurance Portability and Accountability Act (HIPAA) unit. There was an example at another session in which they talked about having a group of sales reps price higher business under 300 lives; you'd probably break a lot of laws if you did that. We set up a unit to standardize underwriting, streamline profit, and comply with all regulations. We created a smarter marketing position. We're constantly refining the benefit offerings. The main thing now is 10, 30, and 50 drugs. We're even considering a huge deductible for prescription drugs. We'd like to have standardized benefits so that we don't have as much selection. We've modified our commission scales recently, and we're developing a new regional proposal enrollment system.

Of course, since we have a small group task force, we now have a large group task force. We set up seven regions throughout Arkansas. Each region runs its own show, and so there's a lot of variation in how a large group is priced. We established a task force at the_beginning of last year because we were a little concerned that there wasn't enough consistency and we weren't being adequate rating-wise, and so we've now set up our staff to be focused on employee benefits.

There are a lot of competitors in the larger market, especially on self-insured, and so we're trying to deal with that. There's a lot of negotiation in large group and more information analysis time and effort than others. We're trying to find better ways of providing value, delivering services, standardizing benefits, and enhancing reporting and reducing expenses. That's what we've been working on this year and we have been successful so far, but a lot of it has come from increasing premium, which may be enough to cover our claims trend, but it's almost too much to cover

our admin trend. Once employers start realizing that, we'll probably have to deal with that as it comes, but we've tried to set up a decent mechanism for handling large groups in a consistent manner.

THOMAS L. HANDLEY: I'm going to go in a different direction. My firm deals a lot with HMO clients and small health plans. We work a lot with providers and employers. Our clients know how they're performing. They want to know how others are performing and how they compare to the rest of the market. We spent some time researching what other HMOs are doing. What are the differences between HMOs that have been successful? Are there certain factors or certain characteristics that we can identify that might be helpful to us as we work with our clients? Are there some components out there that are common to successful HMOs?

We studied financial statements from HMOs. We had years 1993 through 1999; basically, we had every HMO that was doing business in the U.S. We had different numbers of HMOs for each year. There were a lot of new HMOs that were started in the mid-1990s. Some of them fell off the earth by the end of 1999. I think for every year we had at least 320 HMOs that we included in the study. There are some that we decided not to include. I think as we looked at the data, we found that the Kaisers in northern and southern California distorted the results somewhat. We didn't include them and in each year there were some other HMOs that had some unique and unusual results, so we excluded them from the study as well.

We wanted to look at certain statistics and certain components. We looked at days per thousand. One of the things we noticed right away as we got into our study was the assumption that HMOs had low days per thousand, which has always been one of the key components of the industry we've looked at. It didn't take us long to realize that wasn't the case. What we found out was that those who had the lowest days also had the lowest rates, and they still lost money.

We decided to create another statistic. We started looking at the ratio of the days per thousand to the premium per member per month (PMPM). We did that for both commercial and Medicare and for all of the markets. We thought that may be a better predictor for success or failure because we did see HMOs with very high days that were very successful that just charged for it. We wanted to look at administrative costs as a percent of premium, inpatient expense, physician expenses, and other medical. These are all components that you can pull out of the financial statements of HMOs. They're all clearly identified, not always consistently classified and reported, but they are out there. We looked at underwriting gain and loss, and we looked at physician visits. These are all the things we looked at just to see if there is something in those particular statistics that might tell us whether there is some success or failure.

We wanted to approach it from two different ways. We looked at different ranges in those values to see if there was a pattern, and then we also wanted to look at a range of plans—those who were in the top 30 percent, middle 30 percent, and bottom 40 percent—just to see if there was something.

I want to clarify a couple things. One of the things we looked at was what we call underwriting gain and loss as opposed to just the gain and loss that was reported from the statement. We defined that underwriting gain and loss as premium minus claims, minus expenses. As actuaries, one of the things we do in our pricing is develop a rate that is sufficient to pay for the claim and expenses. HMOs can be very creative at generating additional revenue from other sources, and we felt that might distort the results. We wanted something that was a little cleaner, so we used this underwriting gain and loss as our measurement of success. There were plans that did make money in a year, but when we defined it as this underwriting component, they lost money. It does change some of the components. We show how we calculated that days per thousand to premium ratio. Generally, we went into that on the assumption that if the days per thousand to premium ratio was below a certain level, the HMO would be profitable. If it was above, there would be a loss. I'll tell you in a moment if that came about.

As I mentioned earlier, we did eliminate some of the plans from our analysis, just because they could distort results. Also, as we looked at this, we used the 50th percentile as a measure for a particular range of values—how they were doing as opposed to the weighted means—because when we did it using the weighted means we found out that a very large plan distorted the results for the range and we wanted to have a result that was representative of plans in that range.

We used different starting points for our data. In 1993–99 we show the commercial premium, which is certainly one of the pieces in which an HMO has some input as to what they actually charge to the market. What the Medicare risks are paid is governed somewhat by what the government is willing to disburse. On the commercial side, the premium actually decreased as we went from 1994 and 1995 through 1997; they started going back up as HMOs started to raise rates. About the time the premium rates went down, we saw loss ratios go up. The loss ratio has been around 88–89 percent for the last four years. Even with the efforts that the HMOs made to raise rates in 1999 and 2000, the loss ratio still hasn't gone down too much.

Inpatient as a percent of premium has been flat since 1994. The other interesting statistic I want to identify is percent of plans with a profit. From 1993 to 1995, the 3 years where as an industry we made money, 50 percent to 66.67 percent of the plans were profitable. This is our underwriting gain loss. If you look at other published sources, you'll probably see that more plans made money once you throw in investment income and those pieces. As you get to 1996 and beyond only about one out of four plans have made money, and that's been consistent for all four years.

Let's start looking at some key statistics. One of the things we wanted to do was say, "Let's take this statistic, this days to premium ratio and let's set up ranges, let's see what the results are for those different ranges." Our assumption going in was that the plans at the lower value could probably be more profitable, and that

plans at the upper end would probably be less profitable. That was what we thought would happen as we proceeded.

In 1993, the days to premium ratio for the 50th percentile of all the plans was 2.522 percent. As we studied this, the premium ratio didn't seem to be a significant factor. We were a little disappointed when we observed that result. It did bounce around. There were some years where those with the lower ratios seemed to do a bit better financially and those with the higher ratios did poorly, but there didn't seem to be any consistent pattern. We were a little disappointed with that.

Administrative costs as a percent of premium was one of the values that we looked at that did seem to be a component. Generally, as the administrative percent of premium went up, the underwriting results got worse. This shouldn't be a surprise, and this principle has been critical to our industry for a long time. I can remember even before managed care got to be such a factor back in the 1970s that there was a paper by Peter Walker called "The Group Insurance Myth." Some of you will probably remember that. One of the key components of their study of insurance company and group results was if you kept your administrative costs down, you had a good chance of being successful and making money in this business. That's still true today, even though we do a more effective job of managing the client piece and controlling those costs. If you don't keep your admin costs down, you're still going to lose money. This was the first factor we came up with which was a clear indicator. If administrative costs were low, you had a much higher probability of being successful financially.

We looked at inpatient as a percent of premium. Again, we picked different ranges just to see as inpatient went up if it was a factor. We thought, as we got into this study, that as the inpatient percent went up, that the underwriting results would worsen. That is true to some extent. It was the case in some years, but in other years it was not. I guess after we saw that result and we talked to some of our clients it became evident that all the plans have gotten pretty good at managing that inpatient dollar and inpatient days so that's not a differentiating factor anymore. There's not much variation in the inpatient or the percent of premium between the different plans and the different categories.

The physician component followed the same pattern when we looked at the different ranges of values. Again, we thought that if that increased the present, that underwriting results would worsen. This has, to some extent, been the case, although probably not as much prior to 1998, but I think since 1998 it's becoming more of a factor, and if you look at 1998 and 1999 as the percent went up, you can see that the average gain of the 50th percentile of the gain and loss definitely got worse in those last 2 years. Currently, physician expense has become a critical factor in determining your financial success.

Let's look at the other medical components. I think "other medical" is a catchall for a number of things. We know that prescription drugs, if accounted for properly, have grown steadily as a percent of premium. Back in 1993 it was 23.5 percent,

and in 1999 it was almost 32 percent. It's becoming a bigger chunk of that health-care dollar, although there doesn't seem to be any consistent pattern.

Let's look at the plans and how they performed and then look at different statistics within those groupings of plans to see if there is some common denominator based on the underwriting gain and loss. The best performer was 100 percent, and the worst performer was zero percent. We looked at a number of different factors. We had some financial measures. We looked at total premium PMPM and commercial premium. We thought that the plans that charged the highest premium were more likely to be successful financially. We looked at some of the things that we looked at earlier, but in a different context. We had several utilization measures that we looked at and tried to analyze. We looked at days per thousand, days per premium ratio, physician visits, and inpatient costs per day to see if there was any common thread running through plans that might be successful or not.

As we looked at these plans, we split them into three groups and we did it each year. We looked at the top 30 percent, the middle 30 percent, and the lowest 40 percent. Any one health plan that might have been in the top 30 percent in 1996 but fell into the middle percent in 1997 could be in a different category in any one of the seven years we looked at. Actually, we only looked at the lowest 35 percent. We kicked out the worst five percent. They definitely were well off the charts from a financial standpoint.

What did we learn? As we looked at the commercial premium PMPM, it didn't seem to be a factor. The top performers did not have the highest rates. In fact, for many of the years, that lower 40 percent typically had the higher average premium on a PMPM basis. As we looked at admin as a percent of premium, which was a factor particularly in the last three years, what we were able to identify was that the best performers averaged less than 12 percent of premium. The worst performers typically were more than 15 percent and sometimes more than 17 percent. There definitely seems to be a component out there in terms of performance and admin expense. We looked at the days to premium ratio. It didn't seem to be a factor. Again, it was generally consistent as we looked at the three different categories of plans. We were hoping that it might be a factor that told us something, but apparently it wasn't. Inpatient as a percent of premium was not a factor whether you were one of the top performers or one of the worst performers. That percent of premiums was pretty consistent. In fact, inpatient generally fell between 23 percent and 27 percent.

As we looked at physician and referral expense as a percent of premium, it appears to have been a factor, although not quite as much in the last three years as the prior years. Generally, the plans that were the better performers ran about two to four percent less than the plans that were on the worst end of the scale, and usually the physician was in-between 33–38 percent of premium range. Other medical as a percent of premium definitely was a factor. The best performers typically were two to seven percent lower than the poorest performers, and this particular component had a broad range of costs. It went anywhere from 20 percent to 35 percent of the premium in terms of where it fell, but this seemed to

be a factor since prescription drugs can fall in this category. Those who have done a better job of holding the prescription drug costs down are certainly going to do better.

The last thing we looked at was physician visits per thousand. This was definitely a factor, and it ties into physician expense being one of the key components of the last couple of years. Because there weren't any definite physician visits per thousand, we developed a physician visits to premium ratio as we did with inpatient days, and it did have some characteristics which were a definite difference between the successful plans and the poor performers. Generally, it was in the 31–46 percent range, but better performers were 5–12 points below the poor performers. There were a lot of other things that we started to look at, and we have quite a bit of data that we analyzed and cut in different ways. When we put some of the preliminary results together, in terms of where is the industry going or what are the component of success, four things jumped out in summary.

Administrative costs are important. If you can keep those down, you're going to be more successful. Inpatient days are not the factor they used to be. We've done such a good job of managing that, it doesn't differentiate anymore. Physician expense and the non-hospital pieces seem to be a more critical differentiating factor. Those plans that are successful in managing the physician-based and the prescription drug costs are more likely to be successful financially.

MR. RICHARD A. KIPP: I'll be your clean-up hitter here today. I'm going to bring you back up to a little bit higher level, looking at the system from the top down. We'll hit some of the same issues, but we will just take a little different approach. As you're thinking about the performance of your organization, this conversation comes to mind. You blow a billion here, you blow a billion there and it all starts to add up after a while. I've broken performance down into two high-level segments—for profits versus not for profits. The Sherlock Company produces a periodic report that shares some of the annual operating incomes from 1997–2000. For the most part, when you look at dollars anyway, things haven't been bad for most of these companies. Aetna, of course, has had a little bit of trouble in 2000 and Oxford had some problems a few years ago. On a percentage basis it's a little bit easier to see the operating income as a percentage of the revenue. It gives us a better feel for what's been happening. Actually, they've had some decent years. WellPoint in particular has done well. I should mention that these percentages and the dollars are all before investment income for these for-profit organizations, so when you add in the investment income, obviously they'd be that much better.

Statistics of a similar sort for the Blue Cross and Blue Shield system, in the more recent periods show that their profits as a percent of income are running between one percent and two percent. This is after-investment income. If you were to look at it without investment income, particularly for the middle 1990s time period, you would see that they actually had some underwriting losses during that time period. Investments helped, and the market definitely brought them up to a certain extent, but they're behaving differently from the for-profit organizations. They're not quite as profitable, particularly in these recent couple of years. The published number for

2000 is out now and it's less than what 1999 shows. I believe it's a little under one percent, so it is dipping down ever so slightly.

The factors that are driving the performance of these organizations probably vary between these two segments to some degree with regard to the cost trends and some of the market forces and how they each try to balance their enrollment and financial growth. Managed care push-back has affected these organizations differently, whether you're in the Blue Cross/Blue Shield system or in the not-for profit organizations versus the more aggressive for-profits. I think you might have experienced a slightly different set of circumstances for your blocks of business with regard to managed care push-back in particular.

Prescription drugs have been ailing all of us, and we all have to cope with the technology advances, as well as consolidations. I might add that for Aetna, in the most recent year in particular, they, as you all probably know, have been pulling big blocks of business into their organization. The theory is that some of that has probably contributed to the wealth that they've experienced in this most recent time period. The cost trends actually have been well controlled in some circumstances by some of these organizations, and not as well controlled by others. For individual blocks of business, they perform differently. Some are tightly managed and some have very aggressive contracts applied, so individual results will vary a great deal from the trends. Our belief from the history of trends and the year 2000 is what I would call a backbone trend. In other words, this is the underlying cost of dealing with the providers of the various major components, the prescription drugs, and all the technology advances without recognizing things such as adverse selection or some of the push-backs in individual markets that some of you may have had to deal with.

Friday's *New York Times* talked about the huge increases in hospital costs that they're experiencing in New York. There are 10 percent and 15 percent increases, and 40 percent and 50 percent increases in individual hospital contracts, as they're pushing back from either substantial per diem reductions in their payouts or possibly the spinning out of capitation arrangements. All those things will contribute to pushing trends even higher.

Over the last several years, things have been picking up at a sharpened pace. The first of the four major parts of this underlying trend, hospital inpatient, although still rather modest, is particularly being affected by the fact that the underlying utilization is still negative and there is a lot of movement of cases from an inpatient setting to an outpatient setting. There are still efficiencies and tricks that are being overlayed by MCOs in particular that are being taught to providers, not just for HMOs, in the way that they manage all of their patients. They're contributing to these changes. The forecast is for some continued modest trends. For the year 2000 we forecast a little above zero, but it's still a fairly modest trend. For outpatient hospital trends, we're looking at something that is consistent with what's been happening in the past, but up above 10 percent. The overall hospital trend, when you combine the inpatient and outpatient, is close to five to six percent. The weight that outpatient now has as a portion of the overall hospital cost is getting

close to 50 percent in some markets for some organizations. You'd be weighting that one to two percent trend for inpatient with a 10–11 percent trend for outpatient. You have a substantial trend for hospital, again a lot of that coming from push-back on contracts.

For physicians, trends have been starting to pop up over five percent. If you look at the detailed data, some of it is attributable to utilization and the rest of it to cost. The cost is fairly modest at three to four percent, and utilization is one to two percent. It's picking up considerably and we expect that it will continue to do so for the rest of 2001.

Prescription drugs are probably in the area that's most surprising. How long can trends sustain themselves? In the case of prescription drugs, it's something close to 19–20 percent, without dropping down. Utilization is one of the driving forces to reduce these trends. That is the utilization trend; it's not the utilization scripts per thousand dropping substantially from any particular level. Those things are still raging along and that's due to direct-to-consumer advertising and the effect of individuals walking into their physician's office and more or less demanding, based on information they've received from the Internet or television, particular drugs to be prescribed. We think there's been some push-back on that, so the trend is starting to drop ever so slightly in terms of the utilization.

Cost has been fairly modest. There are a lot of drugs in the pipeline. With future drugs being generated from research, we expect this trend to be a substantial driver of overall costs for some time in the future.

Some of my clients have been complaining about surgery trends for some time now. Managed care pushback has three legs to this stool: provider-related issues, member-related issues, and legislated solutions. The provider-related issues seem to have had the greatest influence as indicated by various surveys that have been done. There seems to be a lack of what they would call clinical autonomy and what they might consider to be the hassle factor. All the paperwork that the organizations deal with and the fact that, for each organization, the paperwork is just a little bit different, so there's no uniform way of responding to the demands of these organizations that the providers have to deal with.

Probably the third one is really the first one, because this is the underlying force that causes the rest of it. The payers that they're dealing with are not paying enough. You hear about the lack of clinical autonomy and the hassle factor and all the rest of it. You don't always hear about the fact that they're not getting paid appropriately, but that is what's really generating most of the hostility with the providers.

Member-related issues are not dissimilar. The plans will abandon them when they're sick, they're tired of dealing with the issues and I fear some of them already have. They have their own hassle factors and issues with the referral processes and the way claims are processed, and the speed in which they're processed. In the back of their minds, at least for those that have employee contributions to deal with, the

cost of the plan has also become an issue for them. The contributions have begun to rise as employers push-back in their own way on the increases that are being given to them by the payers that they have to deal with. They will be dealing with this in the future.

On the horizon, we have the Patient Bill of Rights as one of the legislative solutions on the horizon. If President Bush is giving the nod to it now, we're probably going to have to deal with one version or another of this in the short term. The ability to sue is built into some of these things. On a different note, there is the notion of physicians being able to get together and do something that the FTC has sort of frowned on the last several years anyway, to really try to help themselves in their bargaining position with the payers. This is something I think all the payers are fearful of to the extent that it becomes like a true union.

I think we talked about the direct-to-consumer advertising. The background cost and use trends have been considerable. I think consumer expectations with regard to drugs and health care in general is one of the things that has been driving health-care costs for some time. The fact that they look at prescription drugs as the magic bullet and feel entitled to the health care that they get almost for free is one of the main drivers of the health-care system now. You can try program design changes, but until you really change the underlying focus and feeling of those who are receiving the benefits, I don't think we'll have any substantial reductions in the cost of health care.

The direct-to-consumer advertising has been growing substantially over the last couple of years. Again, Russell Coile talked a little in the General Session (1GS) about the top 10 drugs. A lot of money is being spent to advertise a very select group of drugs, so it's not unreasonable to expect that a lot of people are showing up in their doctors offices talking about these drugs. They're in front of you all the time.

Background costs and use trends have been in the three to six percent range if you're looking at cost or at utilization, but we've had to deal with mix and technology changes as well. I would say the mix (three to five percent) is being primarily driven by the consumer advertising and technology (two to three percent) for those new products that come into the market for the very first time in any particular year. I guess you could consider that a mix issue, but I consider that to be a new technology issue, where you have a new ingredient that you're having to deal with in terms of determining these costs. These consumer expectations are strong on the system and cause a lot of costs, but some of them aren't really that unreasonable.

In terms of prescription drugs, a lot of people are paying attention to the cost sharing for the drug programs these days and trying desperately to find a way to bring the costs under control. A lot of them are looking at formularies, trying again to find a way to come to grips with all those new and costly products that are coming on line. Some have resorted to additional drug exclusions and the raising of deductibles. Some of these plans have actual front-end deductibles, which are

holdovers from their major medical days. I also struggle at work with the prescription drug programs these days.

Technology is certainly having a bearing on the cost and will continue to have a large bearing on the trends and expected trends that we'll all see. Whether you're talking about computer solutions or medical treatment improvements, we have a lot to come to grips with over the course of the next several years. One thing that might be interesting for actuaries is when claim reserves go away. If they can actually come up with a way to do online processing and real-time calculation of claims, we might have a lot less to do in the way of incurred but not reported (IBNR) work. The other elements of these e-solutions seem to be enhancing communications, whether it's communication between providers and their members, communication with vendors, or DC programs and the way they might end up being facilitated.

As underwriters and actuaries, we will have to deal with the risks of implementing DC health plans. The employers look at this from the perspective that they want to control program costs and freeze their own contributions. Some are saying that it's going to return control of health-care decisions to employees, and I guess that's good news if employees do become a little more involved in their purchasing. This is a way of getting people's attention and having them behave a little differently in the way that they think about and purchase their health care. There are other issues in terms of liability and the transfer of health management activities to a third party and so on. Some of these other reasons are secondary, but certainly the primary reason is cost and this transfer of responsibility.

Physicians and employers are using e-solutions. Physicians use the online services for various things. They resist using it for other things. They have their reasons for wanting to use e-solutions, and they have their reasons for wanting to avoid them. The thing that's really going to motivate them is if they begin to be paid based on the fact that they're using an online activity or whether perhaps an insurer requires them to submit claims in an online fashion. Then things will start to liven up as far as the physicians are concerned, once they're tied to a pocketbook issue.

What physicians say would motivate their practices to use the Internet is a Health Care Finance Administration (HCFA) requirement. A close second is all major health plans requiring adoption of Internet-enabled administrative processes. These are the things that will really get these physicians to change their ways. Employers are using the solution to their advantage by providing employees information, using it for enrollment, and helping employees navigate delivery systems—some obvious communication issues that are going to be addressed by these online solutions that will improve situations for their employees to a certain degree.

Medical treatment improvements may be obvious—biotechnology, bio-informatics, and all the new devices of all the various types. I've read an article where molecular devices will be injected into your system as in the 1966 movie "Fantastic Voyage" There is some pretty remarkable stuff on the horizon. Focusing on these improvements in medical treatment from a health-status or a disease-

management perspective, I don't know if you can call it paradigm shift or not, but I think a lot of people are starting to move in this direction and we see this as a very important, looking at things in a different way and focusing on outcomes. This will give you a way of really looking at the cost-benefit of one treatment versus another and looking at the clinical outcomes, as well as financial outcomes for dealing with diseases in a certain fashion.

We've had to deal with both successes and failures. For those that have done well, many times they have grown to dominate a particular market. They become member friendly or provider friendly in some fashion. They've dealt with their contracting in some reasonable fashion, so they haven't had the terrible push-back that some of the other organizations have had. They've managed their costs and experienced moderate trends either through modest but reasonable contracting or feeding information back to the providers, getting them involved, and collaborating in some fashion. Those are the things that successful organizations have done over the last couple of years.

Medicare risk has been a major failure for many people regardless of how well they've managed or contracted things. A number of organizations that have had bad experiences over the last several years have had them in their Medicare risk blocks of business. There have been some consolidation woes, too. Managing drug trends and keeping hospital costs in check are things that will also demonstrate whether someone's a success or a failure. The set of bullets below shows the balance between profit and market share.

- Rate increases were lower than necessary in the mid-'90s—membership was the goal.
- Recent increases (last two to three years) have included a Recoupment Component—stabilization in profits is the goal.
- The "Underwriting Cycle" was, in part, the by-product of the interplay.

Chart 1 shows what's been happening to employees benefit costs. You can see these are employee benefit costs on a per-employee basis. There's a mixture between actives and retirees, so you have to bear that in mind as you're looking at the chart. You can see that the mid-1990s were a time when the premium costs didn't go up all that much; the premiums started to rise in 1998, 1999, 2000, and 2001. You see stories all the time of premiums in the double digits. When I talk to the consultants from Hewitt, they're talking about 10–13 percent average increases for their clients, so we're really starting to see a ramping up of the cost increases for the employer groups in 2001. I think without something dramatic happening, we'll see it again in 2002; then there will be some serious push-backs by the employers. They'll take double-digit increases for just so long.

The outlook for change, at least from our perspective, is that continued pressures on costs will occur because of technology, drugs, and pushback. Legislation is a result of some of that push-back. You'll have cost shifting that might result from a change in outpatient hospital reimbursements, and pharmacy benefits for Medicare recipients will change the profitability of the pharmaceutical companies. They'll end

up cost shifting to the non-government business, or at least they'll attempt to do that. We're going to have cost shifting coming at us from a couple of different directions. Employers and employees are going to resist these increases that are on the horizon; they're already experiencing some of these large increases. Members are becoming and will continue to become more knowledgeable about their benefits and will become more informed purchasers over the course of the next few years. There definitely will be, at least from my perspective, experimentation with this new DC approach. This is a brand new benefit scheme. It may or may not work. The threat of lawsuits is looming larger and will have a major bearing on what will happen to us over the next couple of years, depending on how things are legislated for us.

This is taken from a publication that was produced for the Society of Healthcare Strategy and Market Development of the American Hospital Association and published in *Medical Benefits*. The report that this comes from is called "Future Scan 2001." It gives you a high-level summary of the top ten most important trends in health care:

(1) Aging of the baby boomers will be one of the most important factors driving the future of health care.
(2) Internet-empowered consumers will be much more informed about medicine, health-care choices, and new technology.
(3) Biomedical technology innovations will infuse health care.
(4) Electronic medical records will become widespread in hospitals.
(5) Bankruptcies of hospitals and medical groups will increase.
(6) Health care's share of the GDP could grow to 17 percent.
(7) Medicare and Medicaid HMOs will grow more slowly in the next three years.
(8) Medicare reform to add a pharmacy benefit will be a major election issue.
(9) Staffing shortages will increase despite higher wages and bonuses.
(10) Complementary medicine will be offered by more mainstream providers.

FROM THE FLOOR: If you had normalized or eliminated large claims in your study, do you think that would have made a difference in any of your results?

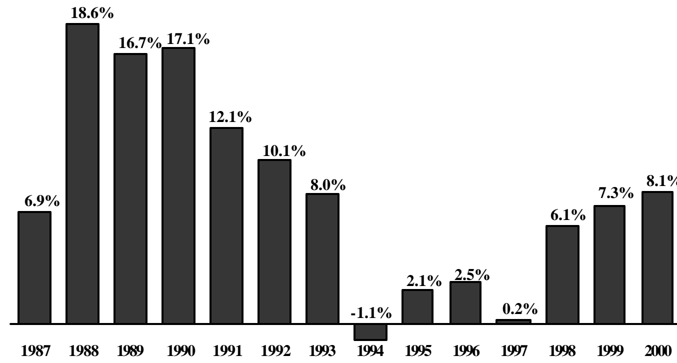
MR. HANDLEY: We used information from HMO financials, so there was no way to identify the large claimants. To the extent that they were a factor, we weren't able to identify it.

MR. DAVID WILLIAM DICKSON: This is also for Tom. Did you try to separate it by major metropolitan areas? Did you just use an eyeball approach or did you use a regression analysis?

MR. HANDLEY: That's in some of the next phases of our project. We're dissecting the information a number of different ways, and that is certainly something we're going to want to look at because we're trying to track the plan performance from 1993 to 1999 to see how one individual plan did. We hope to have the more complete study out maybe sometime in July.

Chart 1

Annual change in average total health benefits cost, 1987-2000



Note: Results for 1987-2000 are based on cost for active and retired employees combined.
The change in cost from 1998- 2000 is based on cost for active employees only.

Source: William M. Mercer, Inc. December 12, 2000, as abridged in Medical Benefits January 30, 2001.

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