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Session 59PD
Fundamentals of Defined-Contribution Health Plans

Track: Health

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Summary: As health-care costs are on the rise again, employers are looking for new ways to manage their costs. Defined-contribution plans are gaining attention as one method for managing costs. Panelists discuss product designs and strategies of interest to employees, as well as the impact of defined-contribution plans on the health insurance market and third-part administration business.

MR. ROBERT GORDON COSWAY: Defined-contribution (DC) health plans have gotten a lot of attention lately in part because DC retirement plans have been so successful and people think that a DC health plan would be as successful. DC retirement plans are popular because they're easier for the employee and the employer to understand, they're more portable, and it's easier to define their cost. All of those things are attractive to both employees and employers. But if you cut through a DC health plan, you'll find that they're not quite as simple as a 401(k) retirement plan. A better analogy might be a cash-balance plan where it looks simple from the outside, but to make it work right you need a lot of actuarial adjustments behind the scenes to make it all come together.

Our goal today is to define DC health plans, to talk about some of the issues, and look at what's actually been put in place. Our first speaker is George Wagoner, who is principal and national leader of Mercer's Health Care and Group Benefits Practice. He works with all aspects of employee benefit programs, including managed care issues. George will be talking about how to define DC, what some of the key issues are, and how DC relates to the e-health initiatives.

Our second speaker is Harry Sutton, who is with Allianz Life, where he focuses on point of services and self-insured products for HMOs. He also gets involved in a wide range of legislative and other activities. He will be talking about what's actually been implemented in the DC area.

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

MR. GEORGE B. WAGONER: First I want to give an overview of the DC approach to health plans; second, I'll give some detail about e-health plans. Let's agree on a definition for DC health plans. You might have heard that term, or you might have heard the term self-directed health care or consumer-centric health care. All of those are describing in essence the same topic, so I'll try to go through first what employers think of those terms, and second, I'll offer a structure we can use for the purposes of the discussion today, so we can have a common definition as we go forward. Next, I'll get into some advantages and disadvantages of the DC health plan. Then I'll talk about what's needed to move from where we are now with the concept to reality of a DC health-plan world.

Mercer surveyed the comments of 276 employers for its DC Health Care Study. In addition to surveying the employers, we also had in-depth interviews with senior human resource (HR) people at 60 employers of more than 5,000 lives. The first thing that we found was not surprising at all. Because of increasing cost, employers are becoming more willing to consider changes in their health plans. The employers are also concerned about some growing dissatisfaction with health-plan management. A number of Internet opportunities have encouraged employers to consider this. Employers do have concern, however, about the gap between the anticipated financial rewards that could come from a DC health plan. They also have concern about keeping the employees and the families of the employees from being negatively impacted, which is something that you'll likely find with these plans. Finally, getting to the point of the definition, we found that employers thought of this DC health-plan approach in several different ways.

The first definition that employers had was that DC health plans are just a contribution strategy. The employer's financial commitment is defined as a dollar amount instead of a medical benefit. We've seen this type of approach with flex plans for many years; the e-health plans could fall under this definition also. Another group of employers thought of DC as more of an e-health plan, or an Internet health-based plan.

The third group of employers used DC health plan almost as a buzzword to move away from active management of health care. Because this wasn't their core area of competency, they wanted somebody else to take responsibility.

How can we think of DC health plans? Chart 1 shows how DC health plans fit in the spectrum of employer-contribution approaches. On the left-hand side of the spectrum we have the approach where the employer pays the full cost for the plan. They pay 100%; the employee pays nothing. You'll find this with some union plans and some employers that are competing with union plans, but you won't find it very often today. As you move to the right, probably the most common approach is the percent of cost approach. The employer will pay, for example, 80% of the cost of coverage; the employee will pay 20% of the cost of coverage. Neither one of those is really a defined-dollar contribution approach. If we keep moving to the right, the next thing that we come to is a percent benchmark or percent of premium for benchmark plan; whatever amount that percent defines, that becomes the DC amount for other plans. We've seen this for years in flex plans, where maybe 80% of a company-sponsored PPO plan might be what the company's contribution is or whatever that dollar amount is because it's a defined-

dollar contribution approach to use for all the other plans the employer offers. As you move further to the right, there's what I call a pure DC approach. Some people might call it a voucher approach. The employer pegs an amount of money that it's going to pay. "I'm going to pay $200 per month for a single employee period. You use that to buy whatever you can; you pay the difference." As you move all the way to the right to complete this spectrum, you certainly have some employers that provide no contribution for medical care. It's really wages that they're providing, so that moves all the way on the remuneration spectrum in terms of the way those dollars are provided. That's one way we can think of DC approaches and put them in context.

Chart 2 shows the employer contribution spectrum: the percent of cost, the percent benchmark DC, and the DC-indexed or the voucher approach. We can look at that across the top. As we look down the side, we can look at the spectrum of employer risk. I've broken this into four categories. A lot of employers have a self-funded employer program and that's it. Others have insured plus self-funded, an HMO plus a self-funded, a point of service (POS), or a PPO. Some have only insured group products, and a small number of others have individual insured products.

As you look at a broadly defined DC approach in Chart 2, it's everything under the percent benchmarked or the DC-indexed approach, regardless of the type of employer risk. As you think through the employer risk, if you have a self-funded plan, it's fine for an employer to say, "I'm going to spend $200," but if the claims come out averaging $220 instead of the $200 you assumed, you really haven't defined your contribution. As we go further along we want to talk about a pure DC. We'll probably be moving away from the self-funded approaches, but that's the first way we can think of the definitions and that's pretty consistent with definition A that the employers used.

The second thing that we could look at is, what happens when the employer wants to completely move away from the management of the health plan? An employer can do that even if they're looking at percent of cost. An employer is saying, "I want a DC plan," while they're thinking, "I just want to get out of providing coverage and get somebody else to take the risk."

If we look at e-health insurance or e-health with insurance coverage in Chart 2, there is a defined-dollar contribution amount with some type of an insured program. Now, as we look at e-health more broadly, it could literally cover the entire spectrum. As we look at that with an insured plan, we get to a smaller area still. As we look at the right-hand side of that, just under the DC index, that would be a pure voucher approach where the dollars are used in an almost non-existent market to buy coverage; that's something that a lot of people are looking at as a possibility down the road.

To complete the spectrum, Chart 2 also features what we've known as traditional flex, which has stayed away from the fully insured group for the total individual. It's had coverage based on a percent of a benchmark plan that would define dollar contribution for others.

As we look at the DC plans, the product possibilities vary considerably. You can have a traditional insured product as something an employer would offer in a DC plan. This could be a Blue Cross/Blue Shield individual product or a Mutual of Omaha or Golden Rule. You could have a virtual e-health plan, a digital health plan as an offering, and that's what a lot of people associate with this type of coverage. Harry will be talking a lot more about that in detail. Typically, you'll have products that have catastrophic coverage with an employee-provided savings vehicle along with that category. You could have employer-sponsored or arranged coverage with an HMO or an insurer, but no subsidy on the premium level. You could have the dollars going to someone as defined dollars; for example, I'm going to give you $200 per month and whatever the carrier offers as the premium, that's the premium you have to pay—or the employer could arrange with an HMO or a carrier to provide coverage, but the rates that the employer uses aren't the exact rates that come from the carrier. The employer has some hidden subsidies. Mostly you see that the cost for dependent coverage is lower than what you would typically find.

The potential contribution levels are quite varied also. You could have a fixed amount per employee regardless of age, gender, or financial status. "I'm going to give you $200 per month, and this is what you've got for getting subsidies for the family." You could have a total remuneration concept where everybody gets the same dollar amount, regardless. Or you could have one amount for an employee and a larger amount for family: "I'll give you $150 a month if you have employee-only coverage; I'll give you $250 a month if you have family coverage." You could have an amount that varies by age: if you're younger you get a lower amount; if you're older, you get a higher amount. You could have an amount which varies by location or division. If you're in Dallas, you get more money than if you're in rural Texas. You could have many other approaches as you go forward.

As we look at these approaches, what are the potential advantages for employees? Why would an employer even want to consider this from the point of view of what its employees will think? You certainly are going to have simpler, more easily understood total compensation. It will be clear what each employee is making. That's certainly a double-edged sword from the employer's point of view.

If we end up with a robust individual insurance market, we could have a very wide array of choices for individuals. If employees switch from one employer to the other, with a very robust individual market it would be a lot easier to keep the same plan as they change. It would be a lot easier to cover part-timers, domestic partners, and dependents if they get dollars and go out on the market to procure coverage. Generally there's more information available on the Web to guide personal decision making, so certainly that can be a help, and they can probably accumulate some funds for retiree health with some of the DC e-health approaches we're talking about.

There are also some advantages to plan sponsors. They spend more time and resources for HR elsewhere. For the employers who say, "This is in our core competency; we want to let somebody else take care of that responsibility so we want to focus on productivity and other issues,"—a mature DC approach would help. Theoretically there are fewer company costs to change health plans, again, if we're down the road with a more mature market.

You can have increased employee responsibility. A lot of employers are wanting to move away from entitlement and move toward responsibility. There would be less risk of unforeseen cost increases for the plan sponsor with a fixed budget, but, as we'll see in a moment, that certainly creates problems and reduced legal liabilities. If the employee rather than the employer chooses the plan, then some of the liability issues that could surface with some new legislation would be minimized, so there are some reasons for employers to take a look at that. But there certainly are some negative effects, particularly today. Right now individuals, if they bought coverage in an individual health market, would lose the tax deductions. There are a number of proposals in front of Congress that would phase in tax deductions for individual coverage to make them the same as group coverage, but those provisions would probably not take place until 2007 or 2008 at the earliest. Also, the individual employee would very much be at risk in a pure DC world. More competition really doesn't mean that they're going to have lower cost. There could be higher risks for insurers and higher costs for the employees as people begin charging the risk margin.

Some plans would undoubtedly individually underwrite, if they could. Some employees would lose coverage or at least lose access to reasonably priced coverage. The individual insurance coverage could actually become a financial sink hole and products could disappear, so there are a lot of potential negative effects for employees, and clearly plenty of negative effects for the employers also. The employer loses the opportunity in a pure DC world for the health plan to be a differentiator in attraction and retention. As you look at the aging of the baby boomers and the shrinking of the labor population, employers are already seeing, in some areas, real challenges in acquiring talent. Anti-selection could definitely increase the cost for employers if their goal is to provide affordable coverage for all of their employees. The healthy employees could get coverage effectively; those who aren't healthy, if you got underwriting, might get it only through the employer plan, which could lead to some cost increases.

It shouldn't a surprise to any of you that a very small percentage of employees accounts for the majority of the employer cost for probably the last eight or ten years. As I've looked at employee claims distributions, the sickest or the most expensive 1% of the employees typically have about 30% of the employer's health-care claims in an employer self-funded plan. The sickest 3% would often have about 50% of the claims. The sickest 10% would have 70–75%, maybe even 80%,of the claims. As you look at a small percentage of the employees who have a large percentage of claims, if those employees stay with the employer but the healthy ones end up taking a DC plan maybe even a savings account amount that's larger than the claims the employee incurs, the employer may be spending more money rather than less money with some of these approaches.

What does it take to move from concept to reality? First, we must have a more robust individual market. There's simply not a market to support a lot of the concepts out there now. Some of the e-health plans are beginning to crack that market. You need the same tax advantages for individual as group, and you need some creative approaches to avoid adverse selection such as underwriting, if that's allowed. There are other financial issues. The cost of the DC approach probably will

be greater in terms of marketing than what we have today, resulting in less volume purchasing opportunities.

We also need answers to questions that employers ask. Here are some basic questions that employers have as they entertain whether to move into the DC area: What will it do to attraction and retention? What's it going to do relative to unions? How do I protect my sickest employees? What's the insurance company going to do if they start managing risk? And how should I, as an employer, vary my contribution?

Who's going to educate the employees about the health-care system? Right now the employer or a carrier provides that service, but if you go to individual choice in a DC world, who's responsible for that? No one that I'm aware of has answered all of these questions. The Internet is not the solution, but it could facilitate a market that makes a solution more possible as we go forward.

I'm going to shift gears and talk about emerging e-solutions—not specifically the e-health insurance plans—and provide a quick overview about the e-health insurance plans themselves.

As we look at the e-commerce market as it affects health care and employers, there are five different sets of opportunities for employers: (1) the Web-based administrative solutions, (2) the prepackaged suites, (3) some clinical applications, (4) an insurance procurement exchange, and (5) the e-health plans.

Some employers use Web-based administration programs for enrollment, admin, and health information they might provide over the Web. Some employers use them just for general HR functions—i.e., general forms or employee evaluations.

As you look at the prepackaged administration suites, there are some organizations that have packaged together enrollment, admin, health information, and communication packages. A full end-to-end solution where an employer can just outsource, for the employer that says, "I want to get out of the business; that's not my core competency." You can get an entire package, even including health plans negotiated in advance. SAGEO would be an example of an organization that I'd put in that category, for example.

As you look at health management, there are a number of voice-response opportunities, Internet opportunities, where someone can let the doctor or let the Internet site know his or her blood pressure, weight, and temperature on a daily basis. If there's something that seems to be out of kilter, a doctor can respond.

Best practice guidelines are being developed from some of the research that's out there. There are a number of point-of-care applications that are already available. If you're familiar with the Leapfrog report, it suggested that there should be computer-aided order entry, either through a terminal or through something like a Palm Pilot for doctors, so that somebody doesn't read a decimal as a smudge or vice versa. There are a number of things that you can do at the point of care to make sure you don't have drug allergy reactions, for instance.

As we begin getting more information and focus on outcome information, which will be possible if we aren't stymied because of privacy legislation, we can identify the quality physicians, and that could be a tremendous benefit regardless of the plan.

The next category of coverage is an insurance procurement exchange, similar to any business-to-business (B2B) exchange in any other industry in concept. The platform will be open with a lot of different participants—brokers, carriers, employers, and consultants, but the insurance B2B exchange would be quite different from a chemical or steel exchange. With chemical, steel, and most other B2B exchanges, you have a buyer and a seller, you press the button, and the deal is done. It might take a while for the steel or the chemical to be transported, but you know the cost and what's going to be delivered. When you look at a B2B exchange for insurance, all you've done is start the process when you've decided on the carrier. You still have to enroll the member before the deal is complete. You might have to negotiate plan design and price. The idea has some potential, but it is not going to be something that's achieved the same way it is in a lot of other B2B exchanges. Clearly, I think the automation of the health-plan procurement via the digital marketplace is going to be significant, but there will be some problems out there.

There are a lot of different plans out there. I've put these health plans into three basic categories. The first category is a plan which would let you choose a doctor from a capitated panel. You aren't paying the doctor fee for service; you're choosing a capitated panel. The second category is a discounted provider approach in its purest form. You have a group of doctors and providers out there that have costs that they've listed on the Internet, and you get a chance to access the discounts to those costs by virtue of participating in this plan. The peer model doesn't have insurance with it.

The final category is by far the most common thing that we see—the fee-for-service spending account, the Lumenos or Definity Health type of program where you have to define dollar employer contribution through an employer health-care spending account much like a medical savings account (MSA). The employees would typically buy health care services on a fee-for-service basis and have some catastrophic coverage protection to provide coverage if they had high claims.

Most of these plans describe themselves as self-directed e-health plans or consumer-centric plans. DC health plans have a slightly negative connotation because of the control. Some people are beginning to think of these plans as general contractors, consolidators, or aggregators. They're virtual health plans, by and large. They pull together the provider networks—the claims payers, the pharmacy benefit managers, and customer service—and offer a virtual health plan to employees.

The major similarities between these plans are that they're new and they're not yet profitable. They may lack unlimited sources of funding, so some of them are already dropping out of the marketplace; however, some of them are headed by management teams with an entrepreneurial background with some significant experience in managed care. Many of them are available on a self-insured basis and a fully insured basis, which has resulted in some problems. Virtually all of them are

based on actuarial models and projections of savings, but virtually nothing is proven. It was not until early this year that these plans had as many as 5,000 employees, so we really don't have much of an idea of what's happening out there.

Many of these plans have a front-end Web site with a personalized home page, research tools, reminders for health-care services, health risk assessments, and detailed provider information. There are some creative things that will make sense down the road, but there are a lot of different things that are swirling in that market.

MR. HARRY L. SUTTON, JR.: George and I were in a group that analyzed the theory of MSAs and their potential savings. If you look at some of the comments of the advocates, they sound exactly like the advocates of MSAs back in 1995 when the AAA did two studies. I have checked with the major sellers of MSAs today to see how their market has changed. I don't represent an insurer in the normal sense. At Allianz, we provide typical stop-loss coverage on self-insured, small- to medium-sized employers. Actually, three of the plans have talked to us about reinsuring them, which we have modestly declined to do at the moment. We couldn't ever decide what they wanted, and they couldn't define what they wanted reinsured. Second, they wanted us to insure high-deductible insurance in the area of $1,000. Our average insurance has a $100,000 deductible. We're not in the first-dollar coverage and we consider $1,000 first dollar.

I'm talking about the future of managed care in Session 133OF. There has been a negative reaction to managed care. HMOs were supposed to control cost, but managed care premium rates have gone up 10–20%. In fact, Definity Care advertised in the paper, "We are an anti-HMO plan." The new entrepreneurs are to some extent the same entrepreneurs who went into the MSA business, which was a dismal flop in terms of expectations. My son is in an MSA plan, but he's 30 and doesn't have anything wrong with him, so he saves money.

I think this is Wall Street hype. They must have something in the health-care business to promote and invest in. The last project they had was medical management companies, all of which went bankrupt within five years.

The employer's concern with patient protection is a serious element. If, in fact, employers think they will be sued or can be sued, they may make major changes. Occasionally, as I'm talking through this, I will broach that question as well. There are nine experimental programs, some of which you may not think of as DC. There are three subsets: (1) Market facilitator, e.g., Sageo and eBenX, which is another Minneapolis company; (2) HMO/Carrier, e.g., Highmark Blue Cross/Blue Shield in Pennsylvania, HealthPartners in Minnesota, and Regence Blue Cross/Blue Shield and MyHealthBank in Oregon; and (3) e-health plans, e.g., Definity Health Care, HealthMarket in ‑Minneapolis health market, Lumenos in Connecticut and Virginia, and Vivius in Kansas City.

Who are some of the market facilitators? Tillinghast-Towers Perrin and Hewitt Associates have been involved in outsourcing and taking over the HR function as far as all the benefits and salaries are concerned. Some of this is merely an extension of that to the Web.

A second facilitator is select/recommend carrier choices. A lot of big consultants work with big employees in deciding which HMOs have the best record, the fewest complaints, and the best service functioning, but they don't get down to picking the actual carriers and telling the employer which one to choose. You can give advice, but the employer makes the decision to outsource. The consultant then takes the risk if something goes wrong.

I want to repeat what George said, because it's not understood. None of the health plans can guarantee cost savings. There's no carrier representative to carry the cost above what the employer is willing to contribute. There's a lot of moving around with funds, but there's no limit to the cost, so if you really want to guarantee cost as George said, you must get a carrier to take the overall risk.

Another facilitator is a heavy use of the Internet. You can download the e-health plans and see all their advertising. I've been looking at this for about a year and essentially it's never changed; that may have something to do with the fact that they haven't sold anything.

Will the employer get out? I don't think the employers want their employees to have a hard time getting coverage. Will carriers really have competing bids and take whatever part of the employer they can get along with four or five other options, even when they take the risk? I don't think they will, or if they do, they have to risk getting the top 20% of the employees or the lower 20% cost employees. If they try it once or twice and they get disenchanted with all the high-cost employees, they are going to stay away from it. They won't take the whole group over if some other carrier is going to bid on it, and this includes the HMOs. Essentially we don't have any indemnity any more.

It is easier for the carriers and HMOs to get into this business. They want the whole single carrier group. We're talking about medium-sized groups. They haven't figured out what to do with a General Motors or somebody like that, that might be single carrier by location. They probably have these groups. In Minnesota, the HMOs have converted over a five-year period to be dominated by ASO business. We used to call this EHO or EMO or whatever. It's a lock-in, it's an HMO, but they pay claims and it's cost plus so the employer is taking the risk back. We have some excessive taxes in Minnesota which say you can get rid of 2+%-of their cost by going self-insured rather than pure risk premium.

They offer two to five plan options. The options are very close in cost you don't have a $1,000 deductible at one end and full coverage on the other. It's very much like the rebirth of flexible benefits when you have a $100, $200, $500,or $700 deductible and, of course, the people enrolled. And only a limited number of them in any massive size and result in a lot of anti-selection, but these are close together, so that what they essentially do is estimate. They already have substantial data on the employer because they either have it on a full risk premium or they have it ASO, and they have all the data on the employer, so they can price the total employer out the same way they normally would.

The question is, how does it get divided into two to five options? In fact, the study showed there was no improvement in satisfaction if you had more than two options, which means the employee only wants an option, but doesn't intend to use it. And they guarantee the cost for one year. Most of them are so new they don't have any results on how accurate they are in estimating where the people are going to go, but they think they'll be close. The HMO in Minnesota uses ambulatory care group risk adjusters because of our large employer pool that buries the premiums by looking at risk factors like Medicare does. So it has not only the experience of the employer group, but it has a risk factor representing the average cost of the employees, which may not be identical to the actual cost, but it gives you another element of estimating where the people will go. It's like flex, as it originally started, but because nobody at the beginning tried to estimate the division of risk, it didn't come out exactly as it had been planned.

All the e-health plans use an MSA concept with a high deductible. Currently they're non-risk taking. They may have a carrier partner or essentially almost all their enrollment is self-insured, but that doesn't guarantee a DC. Internet enrollment, choice of benefits, MSA amounts, choice of deductibles, and coinsurance choose providers in advance or at point of service. They may select the fee levels they want to buy, but for some of these the choices can be severe.

The employer sets the contribution and the employee funds the excess. Operations can be poorly defined. None of them, to my knowledge is going to process cash from the employee to the provider. The employee may want to call a doctor to renew a prescription. The doctor will charge $20 for discussing and ordering the prescription, then the employee has to pay his or her co-pay, assuming the employer has co-pays and can push a button and the doctor will get $20. That's about the only thing I've seen where the patient actually pays the money out of his or her own pocket, or creates a transaction.

There has been a big concern that agents and brokers (I don't know about consultants) might be frozen out of the loop. Why do you need a broker and pay him or her commissions if you're doing everything on the Web? But to get any business to start with, you have to keep the agents, the brokers, and the consultants in the loop and convince them that the employer will save money.

I want to talk a little bit about MSAs. The MSA has been historically called the Archer MSA. It's defined under federal law. It was extended for another year at the very end of the last congressional session because nobody could decide whether to increase it, change it, or eliminate it. It only covers employers up to 50 lives and self-employed individuals. I have talked to what I think are the three biggest carriers about their business and essentially, because of the small-group reform, they have stopped selling to small employers, which is one of the big things that was pushed. Maybe that's why Ted Kennedy gave in, because he knew nobody would buy it. Many of them started out in the onerous states like New York, but none of them would write them. In fact, the first request we had from one of the e-health plans was to see if we'd take all of their small group business in Florida, New York, California, and New Jersey. We said, "Sorry, we're not in the first--dollar business." They responded, "You mean, $2000 isn't high enough?" We said, "No," so we haven't negotiated or discussed writing insurance with three of the four. Some of

them say they're using Section 125, which I can't believe; they're probably using 106 because they could still have employee contributions and get a pre-taxed tax deduction. It appears, however, that they're using 105 or 105(b), which essentially is a self-insured medical reimbursement plan. They're not at all like an MSA, although the employer can continue it as if it were an MSA for a while. Typically they're not funded. The employer defines exactly what services are eligible for reimbursement. The employee has to submit a claim, and if he or she doesn't spend it, there's money left at the end of the year. In at least one plan I've seen, the employer gives them the balance. Of course, it would be taxable income and one of them is putting it into their 401(k); I'm not sure if it's legal or not, but they're doing it, or at least they say that they're doing it.

One of the interesting ones is Definity, because it uses the MSA for two purposes at the same time. The MSA amount (none of them call it MSA anymore) can be used to fund the $3,000 deductible; the rest comes out of the employee's pocket. They can bill separate benefits that are not covered under their medical plan such as stress massages, hearing aid batteries, or Viagra to the Section 105 and the employer will reimburse them for their expenses; the balance would go to cover the deductible if they had anything serious. The employer can continue year after year. Normally if the employee terminates, he or she doesn't have any vested interest in it; if he or she's on COBRA the employer could continue it. I'm not sure what would happen if he or she retires. Some of them say everything is funded; the Section 105 typically is not funded. Paying some claims out with limited amounts is one of the advantages to the employee.

According to the MSA study done by the AAA in 1996, the people with claims over $25,000 are 40%of the total claims. Almost 50% of the claimants have total claims of $0–500.

You get an average claim cost say of $2,000 a year, but 50% of the claimants spend less than $500. This is 1996, but it's still roughly the same today. By definition if you give everybody $2,000 to spend out of pocket, 40–50% of the people will earn $1,500. In Golden Rule, 60–70% of the employees have that arrangement, but 70–80% get their money back.

I want you to think of this from the standpoint of the selection and who's going to select one of those options. Almost no one mandates that everyone must have the same benefit plan. It's a choice because it's so new and so different; the employers are not going to replace their plan until they see results.

E-health plan eBenX had an IPO about a year and a half ago of $115 million. It went public at about $20 a share and closed two days later at $79; it's now around $3. They have a lot of money in health.

Definity-raised $23 million. HealthMarket was started by Steve Wiggins, but has a different president. Steve Wiggins was the founder of Oxford Health. Oxford went insolvent 3 years ago and wound up with a deficit of about $750 million, so that stock dropped from $80 down to $6 in 1 day. They have restructured it by borrowing from Texas $750 million of venture capital in convertible preferred stocks. They paid off the convertible and given stock to the other, so the $750

million is off their balance sheet; now they're making money again. The stock had been up around $100, but it fell to $5. It sat in the teens until they started making money again with this flush in the spring it got up to $42; now it's back in the low $20s.

Steve Wiggins is a favorite on Wall Street. Steve Shuman formerly ran Prudential, sold it to Aetna—Prudential Health—for a couple of years, and what he did was sell it, raised $34 million which was a second funding venture capital. Value Health was originally all funded by venture capital out of Wall Street;the last amount he raised was $34 million. Vivius has $16 million. They're not unlimited amounts, but they can do a lot of advertising and Web development.

All of them are looking for carriers. Definity is working a lot with Aon. They're buying stop-loss coverage, but all the employers they have are self-insured. Aon's job is to find a carrier to back up the finances of the health plan. So far it hasn't found one. When they talked to me informally way back in the beginning in 1999, they wanted to buy catastrophic coverage with a $1,000 deductible. I said, "Sorry, we're not in the business," and then they didn't talk to me any more. Then when I tried to talk to them again, they found out that our investment department had put venture capital into Lumenos and said, "I won't talk to you without a confidentiality agreement," and I said, "Ah, it's too much trouble." But I've talked to them since then.

Lumenos actually wrote some business and they asked us to be in the small group market where they were going to write legal MSAs; Trustmark was their insurance company. However, they decided that writing ten people at a time was not going to build a big enough business to support their overhead so they got out of the small group market, sold the Trustmark business to N Saver in Kansas City and dropped out of the small group. Now they have self-insured large groups, but they're all MSA, high deductible.

The last one is Vivius. They're looking for a carrier in Minneapolis. Their president is there, but they haven't been able to find one. They have negotiated a working arrangement with an HMO in Kansas City named Coventry, well-financed HMO. You'll see why they would choose to go with an HMO.

What are the provider networks? Where do they get the doctors other than just calling them on the phone and asking, "Will you sign a contract?" The answer 80% of the time is "yes," depending on what the fee is. Vivius tried to sign contracts for capitation.

Definity's network currently is Preferred One in Minneapolis, which is a big network. They have negotiated some good prices. We use them for our company health plan. Preferred One is also a TPA. Of course, these plans say because of the Internet they don't have any claims to process. That was the same thing the MSA people said. They use Beech Street in Chicago. Aon is supposed to be enrolling a large group to get some experience with how this e-health plan is going to work and what makes it attractive.

HealthMarket doesn't claim anything about networks, but in their various ads and articles, they claim they have contracts with 3,000 hospitals and 175,000 physicians. How they got that or whether it's a couple of networks or PPOs, I don't know.

Lumenos originally had a contract with Multi-plan and now has one with PHCS. Multi-plan, which was primarily for emergencies and mostly hospitals, now has expanded into more physicians.

Vivius has Coventry in Kansas City, but they do not have a carrier working with them in Minnesota that I'm aware of.

CCN, which was originally started by an HMO in California, is an affordable network that is part of First Health, which is now becoming a huge company. We just heard in the last few days that CCN was being bought by Affordable, but even if they're nationwide, there are certain areas of the country they don't cover well, so they'd have to expand or buy other PPOs.

In describing their benefits, most of the e-health plans are intended to give the employee or patient a lot of choice. While they may suggest people with low fees or quote a bunch of doctors' fees, they don't really penalize you, except for charging against the health plan the higher fee. In some cases, they say that they're going to impose a limit on that fee, but they don't offer much of an explanation.

In terms of characteristics, eBenX is not an e-health plan. What it did was work for a limited number of large employers, Bell Atlantic being its major account. Bell Atlantic had about 30–40 HMOs in its service areas and other plans. The employer said it's not worth my life and my benefits department to figure out how to pay all these premiums to all these HMOs, so they signed a contract with eBenX to handle all the billing for each HMO. The employer negotiates the deal with the HMO, but eBenX handles all the billing and accounting and keeps track of each employee.

That's the extent of it so far as I know. I don't know if they do this via e-mail or the Web, nor do I know if they are advertising to employees on enrollment. Sageo was talking about getting into the claims processing business, but there's been nothing recently about that and they lost Bell Atlantic. Bell Atlantic merged with Verizon and Verizon canceled out. First they said they were going to grow so rapidly they'd recover that loss; now they're saying the opposite, and the stock is way down at the bottom.

Definity, which is looking for a carrier, has a personal care account and a high deductible coverage. Personal Health Advocate, which is an MSA, is part of a multiple-choice option. In other words, the employers that they have keep their old option. Their enrollment ranges from less than 10% to a high of 85% of the eligibles. One of them has 20,000 employees in the Twin Cities. The one that has 85% enrollment by default includes the employees of a hospital, which has about 800 employees and it's 20 miles outside the metro area or outside downtown. I haven't seen the benefit plan design yet, so I'm unsure what was so attractive about it to all those employees.

HealthMarket features small, pre-tax, health market savings accounts and episodes of care, which rely a lot on disease management. In other words, if you were diagnosed that you need a coronary bypass, assuming they think it's medically necessary, they will give you a whole range of places and prices. When you set up your health plan with them, you can say, "I want the health plan to pay 90%, 80%, 70%, or 50%." If the prices are too high, they might not get it all reimbursed. They have to get approval beforehand. That's not clearly explained; in other words, this is a large, lump-sum payment as described on HealthMarket's Web site at www.healthmarket.com. They seem to take everything out of the control of the employer. They almost don't mention the employer at all in their advertising. But a different compensation system, and what their target plan is, has massive number of individual big prices. Lumenos started with small groups, in MSA, but they discontinued that. They're starting to enroll their first big group on July 1.

For Vivius, you have to select 16 personal physicians, the hospital, -the emergency room, the outpatient surgery suite, and a few other things. Originally they were going to capitate each one of those. They talked very loosely in their advertising about a section 125, $1,000 deductible premium wrap paid out of their health account.

HealthMarket's pre-tax spending account for routine and preventive care is in the $200-1,000 range; their deductible is $0–3,000 and their coinsurance is 70–90%. Everything else—hospital/institutional care, emergency care, pharmacy, and routine vision care, is vague. That means you can pick any kind of a standard plan you want with them, and I'm not sure what that's going to do.

All the Vivius money is going into one MSA account, so they're going to take the premium for the catastrophic coverage out of the account. They're going to pay for certain things such as an MSA out of the account. The $6,000 per family is partly employer contributions and partly employee. The wrap-around would be about 30%. We've had several meetings with them and the president said, "Well, it's real easy. It only takes 40 minutes to fill one of these out. If you have a family of five, you have to fill out five of them." In terms of the $1,000 deductible coverage rider, anytime you use a provider other than the one they've contracted with, the reinsurer picks up the claims. They can't possibly use those 16 providers. If they get sick, they're going to go to the best hospital in town, which may not be the one near them. They could never define for us what our risk might be and which provider to use. If you pick their emergency room for the hospital next door, how do you know that's where your emergency is going to be? There needs to be further definition.

The employee premium is $140. Vivius would be $125. The carrier administration in the current plan is $24, which is 18–20%. Vivius is only $9 and charges 4% of the provider fee as their income. Because their system is so simple, the provider will save 60% of his or her in-office expenses. Say his or her office expenses are 25%; they subtract 15% from his or her cost. He or she will save 15%, and they'll take credit for that in determining the premium rate. The fact that that's only one provider, carrier, or employer system and they still have Medicare/Medicaid, fee for

service and everything else to deal with, it will add to their cost in my opinion, but that's what makes horse races.

These are some of the advertising claims for DCs. Vivius has said, "An individual can save $700 a year and a family of 4, $2,000 or more annually," that sounds exactly like the MSA people back in 1995. That never happened. Here is another claim: "The HMO administration and profit is 18–22%; physician office costs will be reduced by 60%; e-health fee 4%, no claims to process reduces cost." If I'm writing stop loss, how do I know when they get there if you haven't processed any claims?

"A personal health advocate will guide the employee and his family to improved access in the health care system." I don't know if this will reduce cost. If the employee calls you up and says, "Go over and see this doctor or this specialist," admittedly maybe he or she would fumble around and wait a while. If you're creating more ease to access, I'm not sure whether you reduce cost. Whether you increase early cost and save some of the higher cost cases by intervention sooner remains unknown.

The last claim is one that I want to mention because there's a complete misunderstanding on Wall Street of health care: "Employees would buy only as much health care as they need, as opposed to employers buying the same coverage package for every worker." That means I'm going to leave out mental health, drugs, and pregnancy and strip my plan down so I'm only paying $100 a month. What they don't understand is that each of these items such as mental health is pooled across a huge population. There may be only 15% of the people who need it, but it would cost 6 times as much if they only bought mental health as a single service because that's the only thing they needed. Wall Street seems to think if you're not going to the hospital, why buy hospital coverage? Think of the money you'd save; your premium would go down 40–50%. And that's what they think.

Here is the remainder of that aforementioned claim: "Unfortunately, this means that the sick will pay more and the well will pay less." That's true if the selection is with the MSA. "God controls the medical expense ratio, the claims expense. Management controls the overhead." "Why do we need thousands of people negotiating contracts when the Internet can do it for us?" "The belief that larger employers are moving en masse toward DC is a myth," is from the Washington Business Group on Health "If you believed DC is an industry transforming phenomenon, it is very unlikely that the incumbents will drive the change."

"One of the things that customers want is simplicity." If you look at that Vivius material, you do not see a lot of simplicity. This one I like because it's a local company: "Don't overemphasize the Internet. Giving the employees a Web site to manage benefits is not enough. Seventy five percent of our workers do not have a computer terminal. In one of our institutions our staff speaks 17 different languages." That's a hotel company.

What were the most successful marketing results? Our HMO in the Twin Cities that uses 5 options close together in permitting choices has sold 120–140 small groups,

about 25,000 total people. They don't know how the selection is going to affect their estimate. They already had all the groups, so they already had a year of experience and a health-risk adjuster, so they think in the average they'll be adequate, but since these are all relatively new they haven't looked at the experience.

The other HMO in Pennsylvania has started marketing this year. They have four levels of benefits: HMO, POS, PPO, and indemnity. Each one of those has 4 options, so they offer each employer 16 options. Most of the expense is in doing a proposal. They have sold a small number of groups, maybe a dozen, and they're gearing up to make a lot of proposals. Again, this is a middle-sized market, ~~$~~100 at the bottom and $500–1,000,where they have the data. You have a Blue Cross plan that's taking the risk, and if there's an MSA, there's another outfit that's selling it, but they are not MSAs. These are just flexible benefit options offered to this medium-sized employer.

Definity Care has sold three plans in Minneapolis, another one coming aboard January 1, and Aon is supposed to be enrolling its employees in Chicago. They have a PPO in Minneapolis and Chicago. They started in late 1999, and they've kept some business. They're all self-insured, and they all have a spending account and a high-deductible, Section 105-type thing.

Vivius has never sold anything, but it now has a working agreement with an HMO in Kansas City. HealthMarket has said they're filing for a license, and I can understand the state insurance authorities not knowing what it is they're filing. Are they an insurance company or an HMO? Apparently in over a year they haven't been able to get a license in any state. They plan to operate without a license in Texas. Maybe they don't need a license as an insurance company, so it's not clear with them who's taking the risk. Their Web site has been unchanged for the last six months, so they haven't posted any updates on the Web site.

Lumenos has sold two accounts. The first one they're enrolling July 1 and the second one they're enrolling January 1; at least they have something. Their first client is one of the international drug companies that has 25,000 employees, but they're only covering retirees. How many of those there are and why it's only retirees, I have no idea, but they're negotiating to cover the rest of the actives as well. All these seem to be dual choice, so they're getting their foothold, but again, they're all dealing with self-insured employers. None of them, with the exception of Definity, which has a stop-loss insurance for one group, has a carrier involved. They have an HMO involved in Kansas City with Vivius, but they don't know what they're doing.

So far it's a lot of hype and a lot of changing directions in defining how the health plan is going to work. What kind of a structure do they have for their health plan that's going to even enable them to estimate the cost? Vivius was originally going to pay all capitations; the doctors said, "No way," so now they've gone back to fee for service. A few primary-care physicians might take capitation. Hospitals are deaf on capitation. They don't know what's going to happen.

Chart 1

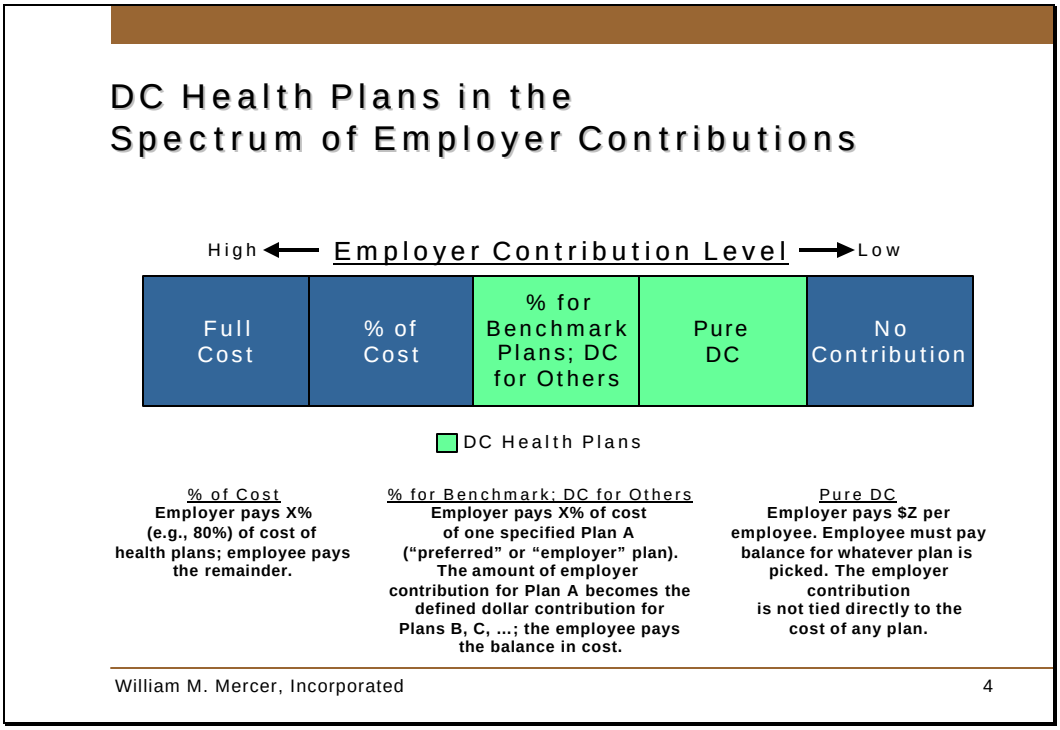

Chart 2