RECORD, Volume 27, No. 1*

Dallas Spring Meeting
May 30 – June 1, 2001

Session 81IF
Trends in Cost for Health Care—Turbulence Ahead

Track: Health

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Recorder: JUDY L. STRACHAN

Summary: In recent years, there have been a stunning number of technological breakthroughs in health care. These include new drugs for treatment of everything from allergies to AIDS, gene therapies, and non-invasive surgeries.

The managed-care concept has begun to mature and stabilize. And yet, the whole picture could change again with the advent of the Patients' Bill of Rights (or comparable legislation) and the potential for the rights of patients to sue their HMOs.

This session examines how these and other changes are affecting health-care cost trends. The panel presents analyses of cost trends experienced over the last decade and contrasts those with historical trends.

MS. JUDY L. STRACHAN: We have three people on the panel including myself. The speakers are Rick Nelson and Kevin Wooley. Rick Nelson of Tillinghast-Towers Perrin has been a health-insurance actuary since 1978. Rick has been in consulting since 1989.

Kevin Wooley has 25 years of health and welfare experience, 10 years of that in consulting, and he is an account manager in Aon Consulting's New York acquisitions and mergers practice.

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I don't think any one of us has a really good picture of the total issue of trends. Every one of us knows a little piece of it, what we see every day on the job.

MR. RICHARD J. NELSON: The material I want to present is out of a survey that the Towers Perrin part of the company has been putting together for a number of years. It's called "Trends In Cost For Health Care," and it covers the trends on medical and dental plans that our health and welfare consultants do consulting work for.

The survey reports on major trends in employee and retiree health-care costs and covers 221 large companies. The response rate for this survey was approximately 15 percent. We got 221 back, though they were mailed to several thousand companies. It covers 3.4 million employees and retirees, so it's a pretty significant number. The groups are only large-employer groups. Five percent of the groups were over 50,000 lives, and 35 percent of the groups were less than 3,000 lives, but this is not a mixture of large and small groups. This is only large-group health and welfare consulting business. The people that completed this survey were described as senior-level benefit managers within the individual corporations. The survey also, in addition to the cost trends, reports on employee contribution rates. This is the 12th year that it has been run. Generally, it's conducted in the fall of each year.

Table 1

2001 Health Care Cost Survey

Average Cost Increases

Active Employees

1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
14%	11%	12%	6%	2%	4%	3%	4%	7%	10%	12%

Inflation
All Items

1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
4	3	3	3	3	2	2	2	3	3	

Medical Component

1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
9	7	6	5	5	4	3	3	4	4	

Table 1 is a bottom-line summary of the results for active employees over an 11-year span of cost increases for the medical plan for active employees. Remember, there are other things that are covered, but this is for medical plans only. It contrasts that with all items, inflation, and medical component inflation. This table is similar to others I've seen at this meeting, including different graphs and/or tabular

displays of cost increases over a number-of-years period, and this seems to be pretty consistent with the other things I've seen here. In the early '90s, the trends were higher. Then they came down in the mid-'90s to some very low levels, and now they are ratcheting back up again. I think that's consistent with what I've heard other speakers say. Again, this is a survey that's directed at a particular sub-segment of the total insurance population out there, but I think it's pretty representative.

The medical component has started to up-tick, too. At the last meeting I attended, somebody had a statistic there that's even higher than for 2000, so even the medical component of the Consumer Price Index (CPI) is increasing. Of course, there's always been a margin between cost trends that health plans have seen and cost trends that are evident from the CPI. This combines all plans in the top row of table 1. There's a mixture of indemnity, HMO, PPO, and Point of Service (POS), so it's a composite number. In the most recent period, employers and employees have tended to absorb this cost increase in roughly the same proportion as they had in prior years. The employees and employers are keeping more or less the same split of the cost on a percentage basis.

The increases in premium rates are used for insured-type of plans, such as an HMO-type of plan. Increases in premiums are equivalent for self-insured plans. This includes the PPO categories and indemnity categories, given that we're only working with large employers here. It's a mixture of HMO and PPO or POS that mostly would be self-funded, as opposed to insured type of plans.

Those increases are not adjusted for benefit changes. If you have benefit changes that are reducing costs, they would tend to understate those trends, if you wanted to look at them on a benefit-neutral type of comparison. The cost increases vary between the various plan types. Cost increases include administration costs, profit margin, etc., especially in the insured plans.

Each year different companies participate in this survey, so you don't necessarily have the same 200 companies participating each year. There are some "ins and outs" of companies, as they participate or choose not to participate.

In reflection, especially on that top line in terms of premium rates for insured plans and the HMOs in particular, we've seen some run-up of the profit margins on some of the for-profit HMOs in the last year or two, and that would certainly be part of this cost-run-up on HMOs. It's not just more or less a pure claims cost. Profit and administration are going into these comparisons.

Table 2

2001 Health Care Cost Survey

Cost Increases by Plan Type

MEDIAN COST INCREASES - Active Employees

	1999	2000	2001
PPO	4%	10%	11%
POS	5%	7%	10%
HMO	7%	9%	12%

- All plan types have similar magnitude increases
- HMO is not the lowest

Cost increases by plan type. Table 2 shows the last three years for PPO, POS and HMO. Again, this is for active employees only. You can see that the magnitudes of the changes are relatively close, and it's interesting also to note that the HMO is not the lowest. I think that's probably because of the for-profit HMOs getting returning margins and increases in profit. There were PPO plans that would tend to be self-insured, and the necessary profit margins would not be included in there. Again, this is not just for any kind of benefit. The plan changes from year to year, so those would, if you adjusted for benefit plans, tend to raise these numbers at least a little bit. There's also a small percentage of indemnity that is still part of some of these larger-employer plans. Approximately 10 percent of their plan volume is indemnity, 40 percent is in HMO, and the other 50 percent is split approximately equally between POS and PPO sorts of products.

Table 3

2001 Health Care Cost Survey

Composite Employee Costs - Active Employees

Average Monthly Costs

	1999	2000	2001
PPO	354	399	440
POS	334	403	422
HMO	316	357	394

- Unadjusted for benefit differences
- In general
  PPO Cost > POS Cost > HMO Cost

Table 3 shows some composite costs across the employers for the various types of plans. In general, the PPO cost is somewhat greater than the POS and POS cost is somewhat greater than the HMO, but for the year 2000, the PPO and the POS changed places. Again, these are unadjusted for any benefit differences between them, so an HMO might have the favorably lower out-of-pocket cost to the employee than the PPO, which is not reflected in these numbers.

Table 4

2001 Health Care Cost Survey

Cost Increases - Active Employees

Range of Increase	Percentage of Employers
<6%	18%
6% to 10%	32%
11% to 15%	28%
16% +	22%

- Wide variation of increase between employers
- Most likely reflects employers aggressiveness in plan modifications

Table 4 gives a statistical display of the size of the cost increases for the most recent period. To give you a little flavor, there are a number of employers that are seeing relatively small increases of less than six percent and still a sizable number that are more in that 6-10 percent range, which would not be considered too terrible. Then, of course, as you get into the double digits, everybody gets very concerned, but about half of the companies are well into the double digits.

Table 5

Average cost increases – Retirees Under Age 65

- For years prior to 2001, cost increases similar to active employees
- For 2001, cost increase is 17% (versus 12% for actives)
- Reflects increased concern over prescription drug coverage

Table 5 shows the average cost increases for retirees under age 65. The data is split between actives and retirees. The retirees under age 65 and over age 65 are contrasted to that. For years prior to 2001, cost increases were similar to the active employees, but for the most recent years, they really jumped up. For 2001 the cost increase is 17 percent versus 12 percent and reflects increased concern over the prescription-drug coverages that are impacting these costs. There's a smaller HMO share for the retirees than for the actives also, which is probably because people move away from where they were working. The cost in general for the retirees less than age 65 on a dollar basis tended to be about 50 percent higher than for the average active employee. Also, the employee cost sharing tended to be somewhat higher on the retiree cost than for the actives. For the actives, the

employee cost sharing was in the neighborhood of 20 percent. It roughly doubled that for the retirees, so the retirees were picking up a larger percentage of their cost.

Table 6

Average Cost Increases – Retirees Age 65+

- Higher cost increases than actives for last few years
  -Medicare HMO premium increases (40% median increase)
  -Non-HMO rose 16% (reflect increased concern over prescription drugs)
  -Overall Increases
    1999 10%
    2000 24%
    2001 18%

The last major sub-segment in the survey is the retirees age 65-plus, who are eligible for Medicare (Table 6). Many of these people are covered by Medicare HMOs and similar plans. Higher cost increases than actives for the last few years and the Medicare HMO increases have been major components of that, reporting a 40 percent median increase in Medicare HMO cost. Non-HMO rose 16 percent with increased concern over prescription drugs. Overall, you can see those fairly high numbers driven by those two impacts, the Medicare HMOs and the prescription drugs. Baseline costs are quite a bit lower than for active employees. Retiree cost sharing here was similar to the less-than-65 retirees—again, about 40 percent of the plan cost.

Prescription drugs are one driver of the recent cost acceleration. Another one is shareholder demands. This has to do with HMOs, especially for-profit HMOs getting additional margins and/or insurance companies. They need to provide economic growth for employers that need to provide attractive plans to retain employees during this growth period. They have not been able to increase deductibles and coinsurances as much as they may have liked to and/or increase employee cost sharing on the contribution as much as they may have liked to. In terms of the overall cost to these large employers, there's been an increase in the retiree percentage of their population. Again, that may be only specific to large employers, because small employers wouldn't necessarily cover a lot of retirees. In this particular marketplace, they're getting the whammy of increased aging; in particular, increased retiree content. There are also enhanced communications, which include TV and the Internet. A move to open-access plans certainly is going to drive up more cost as time progresses.

Table 7

Cost Control Measures – Adopted Within The Last Two Years

- Prescription Drugs
  -65% have made changes
  -43% have instituted 3-tier co-pays
  -25% have introduced deductible and coinsurance
- Health Plan Design and Cost Sharing
  -41% have changed plan design cost sharing
- On-line Benefit Enrollment
  -24% have adopted
  -36% are considering for the future

Table 7 shows some of the cost controls that have been adopted in the last couple of years by large employers in the survey; the most common is prescription drugs moving to three-tier co-pays. Also, a sizeable number of companies have introduced deductible and coinsurance arrangements into their plans. I recently read one of the electronic journals about Humana introducing a four-tier prescription drug design, so that's something I'm sure will start working its way through this large-employer community also.

Health plan design and cost sharing—many, or at least a significant percentage, have been able to do something in terms of deductibles and co-pays and that kind of thing, but not everybody. Only 41 percent have changed cost sharing within the last two years. You would, from our perspective, like to change coinsurance and deductibles every year in order to keep them moving upwards in a reasonable fashion, but 59 percent have not been able to do that. Some have been able to go to online benefit enrollment, and hopefully that is a cost savings for these plans. They didn't mention whether it saved any cost or whether it increased cost in the survey, but I would assume that would be an opportunity for cost savings down the road.

Dental plans were the last part of this survey, but not a major part of it. The cost increases have been more moderate than for the medical plans in the five to seven percent range. For dental, they're not seeing an acceleration, so the people that contributed to the survey do not necessarily think that this range will be increased over the next few years. The employee contribution percentage for dental is somewhat higher than for medical. I mentioned 20 percent employee contribution sharing on the medical plan for actives. Here, the contributions were closer to the 40 percent range, so they were significantly higher on the dental plan.

Future expectations of the survey contributors can be scary. The contributors to the survey have pretty modest expectations of abilities to withstand all the cost increases, so it would almost seem this is a pessimistic view by benefit plan

managers for large employers and that we've done what we can do, we're at the mercy of the things that are happening in the economy, we can't do too much, and so double-digit cost increases are going to continue for the next few years. The bottom line of this survey was kind of a pessimistic note from the benefit managers. The year 2002 is projected to be similar to 2001, and after 2002 only nine percent are saying they're expecting lower increases. But, clearly, it's speculative because they're benefit plan managers for large employers. They know no more than what we know, and maybe even less.

Some of the causes have been discussed, but it doesn't hurt to restate them: prescription drugs; provider push-backs as plans are renegotiating with providers; less utilization review; less capitations to hold down costs; slow to increase co-pays; coinsurance; and deductibles. The Patient's Bill of Rights is likely to come into play sometime during the next year or so, and I think all this threat of increased litigation is another major concern. There seem to be a lot of negatives and not a lot of positives in terms of holding down the cost increases going to the next few years. Maybe that's why the benefit managers at these employers are looking at it kind of pessimistically. You don't see a lot of bells and whistles or magic bullets out there.

Table 8

Recent Cost Trends

- Inpatient 5% to 7%
  Outpatient 8% to 10%
  Rx 20% to 25%
  Overall 9% to 12%
- Inpatient utilization has stopped declining
- Outpatient utilization continues to increase
- Rx utilization is up sharply

Table 8 shows recent cost trends. This is outside of the survey and is some data that I've been reviewing on a claims basis, as opposed to a premium basis. Certainly the inpatient utilization decreases seem to have stopped. From other things that I've heard at this meeting, other people have seen that, too. The savings on the utilization dates per thousand and that kind of thing seem to have stopped, and you're not getting that savings from that. Inpatient means a combination of physician and hospital—not just hospital only. Similarly, outpatient is a combination of physician and hospital. Prescription drugs have also been very high. This is based on data, allowable charges after discounts and that kind of thing, but before deductibles and coinsurances.

In closing, the bottom line of this survey seems to be that benefit managers of these large employers seemed to be pretty pessimistic in terms of being able to bring costs down. It's not an insignificant population—three million-plus employees and retirees. The six to seven percent range or so would certainly be a lot more

palatable, but they're not necessarily convinced that we're going to be able to get costs down.

MR. KEVIN WOOLEY: I'm from Aon Consulting, and I work in the mergers and acquisitions group. Here's a little background on what I bring to the table in terms of this discussion. For about 15 years, I worked in the underwriting areas of major insurance carriers and eventually was one of the head underwriters at Equitable Life Insurance Company before they were sold to CIGNA. From there I went to Sedgwick and then eventually to Aon. Basically, my entire career has been associated with the cost of health-care plans. I've gone back to the late '70s, when most of the plans, many of you may remember, were base major plans and comprehensive plans. They were sold on an insured basis, and that's all you had. Then it went to flexible benefits, and then eventually to managed care, as trend factors increased to 15 percent, 20 percent, and even 25 percent.

Now, we're beginning to face the same issues. I want to give you an idea of what happened in the last five years with health-care spending growth, in terms of pure dollars. In 1997 it was 5.4 percent, in 1998 it was 4.8 percent, and starting in 1999 it was 5.6 percent and rose to 8.3 percent in 2000 and to 8.6 percent in 2001. From what I've been seeing very recently, it's been going up even further. From a recent survey of 88 health insurers, these are the trend factors that are being used. It's 14.2 percent for indemnity, 12 percent for PPO, 10.4 percent for POS plans, 9.2 percent for HMO, and prescription drug costs are 19.9 percent. If you look at the health-care spending growth in pure dollars, the portion that's related to drug cost was 11.5 percent in 1998, 15.2 percent in 1999, 17.5 percent in 2000, and 18.1 percent in 2001. As you can see, drug costs are a major portion of why health-care dollars are going up, but there are other reasons.

Some of the reasons are that, back in 1988-89, you had a situation where 27 percent of employers were basically in managed-care plans. By the year 2000, 92 percent of employers had managed-care-type plans. One of the things that was offsetting these rates of increases was employers were going from indemnity plans to managed-care plans. It was as if you were going from a fee-for-service to a discounted fee-for-service, so it was decelerating the cost increases. Now everyone is in a managed-care plan. For example, just recently I was with an employer, and they just received a 48 percent rate increase from their insurer, which happens to be Aetna U.S. Healthcare. Now they have a triple-option plan, a PPO, an indemnity, and an HMO plan, and the bottom line is they decided that they were going to cap salaries at 3 percent, because the business that they're in is slowing down somewhat. Now they're faced with the dilemma that they just get this huge increase from the carriers.

The person that I deal with is a human resources manager who is cognizant of the fact that employees making an average of $30,000 with a three percent raise are getting $900 a year. How do I pass on all this cost or make plan-design changes to basically take away any raise that these employees have? It's a decision that I think a lot of employers are going to be struggling with over the next couple of years,

and there is no easy solution. One of the things that I think a lot of people are looking at today is how many employers really have raised co-pays? It has only been recently that the prescription-drug side has raised their co-pays.
One of the objectives for this forum is to have an interaction with the people in the room basically on PPO versus POS—which is the right way to go? Some of these are very hard decisions in terms of cost. But, as I said, by year 2000, 92 percent of the employer plans had managed-care arrangements. Part of the declines in price growth were due to the fact that they were going from indemnity plans to managed-care plans. There are no more discounts to be had. What do you do? There seems to be an emerging trend that's getting back up to the level. Prescription drugs are an example. Trend factor for Aetna, Inc. is 25 percent. Even if you have great experience, you're going to get some sort of increase the following year. Some of the historical factors contributing to the new cost increases are growth in non-price factors such as the technology and service mix. Basically, technology is going to account for 33 percent of the additional cost increases going forward.

I have also seen that a lot of employers have been going away from HMOs and, as a matter of fact, the prevalence of POS plans seems to be decreasing. To be quite honest, I never really understood the methodology of POS plans to begin with. If you had a pain in your knee, and you knew you needed to see a specialist to look at your knee, you'd go to the primary care physician. The physician would say, "Okay, you have a problem with your knee," and then he'd write you a referral. At some point, some of them didn't even ask you to come in. They would just write you the referral and send it to you in the mail. A lot of employers decided not to do this anymore and returned to the PPO-type of plan. But now, costs are beginning to accelerate and employers are finding this is a real problem.

One of the things we'd like to discuss is, what are employers going to do? I've looked at a lot of articles the top people have written in preparation for this, and I'm not sure any of the things that I presented here is a feasible alternative. Another reason for the growth in the PPO is because there's a growth in household income, and they can pay larger out-of-pocket costs. Also, there's a tight labor market. A lot of employers are afraid to change the plans, so a lot of them are just eating the cost. If you take a look at the employers that you work with, how many of them are really on an insured basis anymore? They're really paying the full freight for the cost, except for maybe catastrophic claims. Years ago, you could have had many insured plans where the insurance company would take the risk.

If you're on a minimum-premium basis today, all of that is a budgetable cost from year to year. If you terminate with the carrier, basically the way the term and the liability factors are set, unless it's a substantial loss, they're going to get back their entire loss. I tell employers that terminating with carriers sometimes costs money. Basically, I feel changing carriers should be more service-related than price-related, because you're paying for the claims anyway.

What are we looking at in the near term, in terms of escalating costs? The reasons are rising provider's costs, the insurer's inability to negotiate increases in price discounts, and rising prescription-drug costs. You see a lot of direct consumers, and you see all sorts of drug commercials on TV today. A lot of doctors say that people will come in and ask him about a particular drug because they saw it on TV, and that's part of the reason for the escalation in cost of drugs. The proportion of people who are using medications is growing, and there is a high rate of growth of brand-name drugs. Also, two-fifths of the 2000 drug costs and a quarter of prescription use were accounted for by drugs that were introduced after 1992.

One of the things that will help to slow down drug costs is the fact that quite a number of the popular drugs are coming off of patent. Some examples are Avonex, which is used for multiple sclerosis (patent expires in 2003); Epogen, which is used for treating anemia (patent expires in 2004); Activase, which is used for treating myocardial infarctions (patent expires in 2005); and Neupogen, which is used for treating neuropenia (patent expires in 2006). Let's look at Avonex, for example. It accounts for 79 percent of the sales for Biogen in their company. In order for Biogen to remain a viable company, they have new drugs that they're going to be introducing over time, so this is going to be a continuing chain. I'm not saying that's bad for our personal well-being and quality of life, it's just that it's going to help continue to increase drug costs.

What have employers done to control drug costs? Thirty-eight percent have increased employee-cost sharing, 33 percent used a pharmaceutical benefit manager, 28 percent had a mandatory generic substitution policy, 9 percent are using closed formularies and 8 percent have tried mandatory mail order for maintenance-type drugs.

I see a move back to possibly more restrictive health plans happening after 2003. Between 2003 and 2010, it's estimated that medical-price growth will stabilize at 4.2 percent. With no law changes, though, health-care spending will grow faster than in the 1990s, while gross domestic product increases. The percentage of health-care costs in relationship to gross domestic product is currently at 14.1 percent. By 2008 it's expected to be approximately 16 percent, and that's because the health-care costs are going to grow faster. What's going to happen with prescription-drug costs? The expiration of key patents, obviously, will help decrease cost. There will be an increasing prevalence of tier payment schemes and possibly a move to a percentage-base coinsurance structure.

I've also seen people putting deductibles up front on the prescription-drug plan. For example, an employer had an employee with Gaucher disease. The employee was making approximately $30,000 a year. After eight months, it cost them $90,000 in prescription-drug costs. In response to that, they put in an annual maximum on prescription-drug costs. We did some research to see whether or not this was discriminatory. As of now, nobody has challenged in the courts the annual maximums on prescription-drug costs. That could happen in the future, because generally people with AIDS or some other sort of dread disease are hitting $10,000

or $15,000 maximums per year. But as of this moment, nobody has challenged that.

Decrease cost—I'm not 100 percent certain how you're going to do this. Evaluate the efficiency of hospitals and networks and the value of utilization services. In 1999 under the Medicare Program, according to a study that I reviewed, 53 percent of hospital stays were avoidable. What people are saying is that under Medicare it's very similar under the private sector. We also want to allow employers and payers to focus on managing aggregate performance rather than being accused of managing individual patients. A new approach they're talking about, and I'm not really sure it's new, is a defined-contribution (DC) approach.

I want to cover a brief list of advantages and disadvantages of the employer-based health-care system today. The advantages are:

- It covers individuals who might otherwise not receive coverage.
- It avoids refusal of coverage of high-risk individuals.
- It provides quality assessment and policy development.
- It offers substantial tax savings to employees, including low-income employees who pay only employment taxes.
- It reduces adverse-risk selection for the employer.
- It provides efficient methods of enrollment and payment.

The disadvantages are:

- It does not cover non-workers or workers whose employer refuses to offer health care.
- It is not portable from job to job.
- There is little choice of coverage. You basically have to go with the coverage that your employer has. They might have two or three options.
- It insulates covered employees from recognizing the true cost of health care. Do employees really recognize today that the cost of health coverage, probably, to cover them and their family, is over $10,000 a year?
- Low-wage workers, who are most in need of health coverage, are least likely to be offered coverage.
- Non-insured taxpayers subsidize insured taxpayers.

The primary characteristics of a DC approach include the employer paying a set amount for you to obtain health-insurance coverage. One of the issues being raised is that a lot of people may be able to get their coverage off the Internet. Employers would provide a menu. They might team up with other employers to have a menu of benefits that they could offer. But I've gone around the country and talked to various employers in open-enrollment meetings, and to be honest, the level of education would have to be substantially increased. There is the possibility for confusion because when Aetna might be calling it an Exclusive Provider Organization (EPO), CIGNA might be calling it an HMO. Some of this is whether it's insured versus self-insured in a particular state. It can get very confusing for the professional in this business, and then things change from time to time.

I'll give you an example. Recently a hospital billed me for a couple of hundred dollars, and they billed me because they were having an argument with the managed-care company. They felt they should have been paid a higher rate. I argued and won the point. But, when I go around the country, people will turn around and say, "Well, I'm getting these bills. They're sending me to collection. I'm afraid." They pay, and it's sad because they shouldn't be paying.

Where is the DC approach is basically headed? The employee would make decisions on health care. I'm not sure the education level in this country is at that point to be able to do that.

Another approach is to use health marts, which do third-party screening. They choose and assemble providers for a group of employers. The problem is that a lot of employers have sales offices throughout the country. If you put a health mart in a particular region, what do you do with those employees that are in the outliers? The health mart would negotiate the best rates. To me, it's a regurgitation of all the same things, only putting a different flavor on it. I don't have an answer as far as how to control health-care costs. It is certainly making the quality of life in this country better. And, are we, as a nation, willing to pay that additional amount of money? Another way is direct contracting large employers, concentrating in a single region, but then it's the same issue. What do you do with other employees outside? Very few employers would qualify. There are smaller employers with a concentration of employees in a single area, but then, what do you do with the outliers there also? A possible reengineered flex-benefits approach is where they offer daycare, long-term care, exercise plans, auto, and mortgage insurance. I think we're even doing that right now to a fair degree. There's a certain degree of skepticism on employers, especially flexible-benefit plans on price rates. The employer could be anti-selected against, and then how are employers going to communicate the program?

MS. JOAN P. OGDEN: (Joan Ogden Actuaries) Have you found that employers who offer both insured HMO coverage and self-funded other coverage feel pressured to expand the benefits of their self-funded coverage to match legislative mandates on the fully insured side?

MR. WOOLEY: I personally haven't seen that.

MS. STRACHAN: I have to say that I haven't seen it either. I've seen pressure. I've seen employers trying to move people more to the HMO side or towards various plans, but I haven't seen them trying to enrich their self-insured piece.

MR. SANFORD B. HERMAN: (Guardian Life Insurance Co.) I have a different perspective from the small employer side. What we have seen are trends that are considerably higher than the numbers that were up on the screen—something in the neighborhood of mid-teens to as high as 20 percent during the various time periods. While we did see the migration of a lot of plan holders to HMOs in the mid-'90s, what we're finding now is that our lapse rates, even with large rate increases,

have come down. And contrary to what you've seen in the large case market, employers would prefer to put in higher deductibles, more coinsurance, and tighter limits on the drugs, but keep the indemnity-based PPO-type of plan, as opposed to migrating and making that change to the HMOs. I think those who wanted to make that change made it in the mid-'90s, and those who are left are holding on for dear life. I'm curious as to what you had seen there or what people in the audience have seen in the small case market.

MR. NELSON: The survey that I presented was really directed at the jumbo marketplace—nothing below 1,000 lives. The data seemed to suggest that it's only haltingly increasing deductibles and co-pays and the like, so it's been a tough road to go to increase coinsurance there. On smaller group plans, I have seen that from personal consulting work, where plans are looking at lower option plans. Those are receiving some attention. Certainly, I've also seen that on the prescription drug plans for some small-group programs, they're doing some relatively innovative things with their prescription drugs, in terms of getting deductibles and coinsurance in there, as opposed to just the straight co-pay arrangements. I think that there is a difference between the small-group and large-group marketplaces in terms of the ability to pass on additional co-pay coinsurance.

MR. HOBSON D. CARROLL: (Vector Risk Analysis) I think that we, as actuaries, find ourselves down fighting forest fires at the ground level without using the benefit of the big picture. I'm not sure that there's much benefit to be drawn from it, but I think that today, more than historically, we are faced with three major enemies that are at the global or macro level that we don't get into when we're down here dealing with how much did the inpatient cost go up, et cetera. One of these enemies is human nature. We want seamless, painless, total health-care provision and financing for that. We'll always be fighting that factor. The second one is the government's refusal to accept responsibility and accountability for their contribution to the problem. Is Medicare a fair payment or not? If it's not, then there's a tax, but they don't want to say it's a tax on the rest of us, etc. And number three, which I think the most important and insidious, with apologies to Dwight Eisenhower, is the medical-industrial complex, which, aside from attorneys, basically controls the world. When you think about it from that standpoint, we have a huge business sector and industry sector worldwide, not just the United States, which has a vested interest in a sick population.

MR. WOOLEY: I think you'd also have to add lawyers to that because when the cost of insurance for the doctors is off the charts, that's also contributing to it.

MR. BRIAN G. SMALL: (BlueCross/BlueShield of Louisiana) From an insurance point of view, I think the best we can do is advise the clients on cost shifting and maybe put more co-pays here and there, but I'm not sure we can really improve things. I think it's got to come from improvements in the delivery of care, and my suggestion would be that there needs to be some funding to make medical practice standardized. There should be some grants where somebody, the government or some health plans, give money to hospitals and doctors and say, "You guys figure

out how to best do this certain surgery, and then everybody can do it that way." There's got to be some savings there. Every doctor does things differently and hospitals have to set up different operating procedures and different equipment for different doctors, and it's very expensive.

My other idea is to do some type of regulation on the drug companies' involvement with physicians. A doctor may see 17 drug reps in a day, and one will take him out to lunch to his favorite restaurant, one will pay him $500 to watch him do a surgery that they don't really care to see, but they just want to give him some money so that the doctor will spend some time with them. Those kinds of things are pretty insidious and it seems like there could be some regulation to curb those abuses.

MR. THOMAS L. HANDLEY: (DeFrain Mayer) I'm going to take it in a little bit different direction, because in our consulting practice, we get to deal with all the parties at the table. We've got provider clients, we've got health-plan clients, and we've got employer clients, so we get to hear all sides of the story, and, typically, nobody's real happy with the way things are going. We find, as we talk to the employers who are starting to get a little frustrated with the increase in cost, and they don't want to decrease benefits necessarily, they still are a little paternalistic. They keep coming to us, looking for that magic bullet, and we've got a gun, but it's not loaded. One of the things we started doing is having a dialogue with both the provider community and the employer community. The employer community is looking at shifting the responsibility back to the employee and, ultimately, the health plans. We can say all we want about managed care, but we still can't get inside that doctor-patient relationship. The doctors don't like us looking over their shoulders, and we have been very effective at pretty much getting them on the rules we set up.

I'd ask the other people in the room if they have you started to look at what we can do to shift some of that responsibility back to the employee? That may be in lower benefits or in different premium contributions. Are we looking at some lifestyle? Health insurance for adults is treatment of lifestyle, and are we getting into a dialogue from that standpoint? That's where we see managed care in the next millennium. We need to begin a dialogue with the employee.

MS. STRACHAN: The speaker at the Health Section Luncheon (18SM) was talking about how, until we solve this shopping problem, we can't contain costs, and the shopping problem is sort of the asymmetry of information. How do we educate the employee to take more care? You also alluded to that. We have the whole issue of the doctor knowing much more than the individual. How do we get to the individual to have more control or have more access to the information he needs to manage his own care?

MR. GEOFFREY C. SANDLER: (Empire HealthChoice) I have a comment that builds on the comment that Brian Small made about standards for delivery of health care. I don't think that's enough. Part of what will help in the delivery of health care

is some of the things that we're seeing now in early detection so that medical conditions can be treated when they're less serious rather than more serious. And in terms of standards of practices, I think that the leading edge now is starting to come out in disease-management programs, and I think there's a lot of potential there. Disease-management programs won't by themselves establish national standards of devoted health care, but they'll set the stage to get people more focused on the potential that there is for truly focused and efficient delivery of those services.

You've already addressed the question about the longer-term picture for health-care cost increases in 2003 and later in general terms of the level of increases. But for those of us who are involved in pricing products, we're not pricing five, seven, or ten years at a time, but pricing them on a year-to-year basis. We have to worry about the ups and downs. The general question I'm going to ask is whether or not there is an underwriting cycle?

MR. HERMAN: I think there will continue to be an underwriting cycle. I think a lot of plans are making profits right now. In the stop-loss marketplace, things have started to turn around, but I think we will continue to have underwriting cycles as people make profits, and then they'll manage to give away the profits several years later.

MS. STRACHAN: I want to comment on the early detection comment, because it seems to me that early detection, while reducing catastrophic coverage somewhere down the road, may actually increase cost in the short term or even in the long term. If you're detecting things earlier, that means you're treating people and buying them drugs for many more years than you would have if you waited, or didn't detect it for four or five years. They would be very sick and use a great deal of health care, and then they might very well die. You might actually have more years of treatment. Instead of the catastrophic treatments in the future, you use drugs now to control the treatment, or to control the condition early. When things are detected early, they throw a whole battery of treatments at them to keep it from ever getting to the more advanced state, so it may not necessarily reduce cost.

MR. WOOLEY: With regard to the comment about the underwriting cycle, I feel, yes, there is an underwriting cycle, but much more in the smaller-group market now than the large-group market, because most of these large employers are self-insured. Arguments could be made that some of the PPO plans are keeping a portion of the profits and not passing on the full discount. That's hard to quantify.

MR. STEVEN D. BERNA: (Trustmark Insurance Co.) I have a question for Mr. Wooley. Personally, I am very concerned about the trend in our industry of contemplating and installing annual limits. I feel like we are really missing the point. Claritin, Vioxx, and a lot of other prescription drugs have run successful ad campaigns. An annual limit punishes, in my mind, HIV and other dread-disease people, and I hear the stopwatch of *60 Minutes* ticking in the back of my head

every time that issue comes up. I'm wondering from your client, Mr. Wooley, how they justified putting an annual limit on a drug that was many times this person's salary.

MR. WOOLEY: They justify it because they're looking at the good of all versus the good of one. What happened, though, in that particular situation, was that the employee resigned. But once they weren't able to get it from the employer, they were able to get it from the government, so it washed their conscience to a certain degree. They did know that the employee was able to get the drug, but it wasn't them that wanted to pay for it even though, in a way, we're all paying for it.

MR. BERNA: Further, with a paranoid mind as a health actuary, that is just synonymous. I feel that if we end up with annual limits, we will see legislation on this.

MR. WOOLEY: I would probably tend to agree with you there.

MS. OGDEN: One topic that is never discussed when DC is discussed, is the agent. We do not do a very good job of explaining to those who believe the DC approach might be a panacea, but we will engender the growth of a population that, every time health care costs go up 15 percent, gets a 15 percent raise for no productivity.

MR. EDWARD J. ROWLAND: (Anthem BlueCross/BlueShield) I want to bring up a topic which maybe everyone is trying to avoid, but as Mr. Wooley has said, in 2003 and beyond he sees plans becoming more restrictive, and we all know that trends are extremely high right now, and we're all sitting here trying to figure out what to do about it. Knowing that the national conscience has a very short memory, I was just looking for a general idea or thoughts you have on how likely it might be in another three or four years for national health care to be seriously debated again.

MS. STRACHAN: I think if you see things like annual limits on drug costs, where people are going broke to buy their maintenance drugs, and you see cost sharing increasing rapidly, then national health will probably rear its head again, which means that we need to find better solutions for the problems we have.

MR. WOOLEY: I'm not sure we'd get a solution. It will be debated. There will be lots of opinions, but will we get there? If you go to Canada, you see people coming across the border because they can't get health care, or there's a long wait to get certain procedures. The question becomes, how are you still going to control the cost of doing this, and how much government intervention do you want? And with the present administration in mind, that's probably not likely to happen unless there's a change in administration.

MR. ROY GOLDMAN: (Mercy Health Plans Inc.) I'm not sure that it's that we look to the national government to control the cost. I think what's been pointed out in a number of places in this meeting, as well as other meetings, is that it's the lack of

standardization in the way medical care is practiced, even from one hospital to another in the same city. To piggyback on the last question about national health care, with also a comment that Judy made, in that each health plan is probably going about its own methodology in trying to control costs, say, with early intervention or disease-management programs and things like that, or catastrophic case management—but for who? You're right in the short term in saying that all the plans that do this are increasing their costs in the hope that long term we will have healthier people when they're age 65 and over, but will they actually be insured with that health plan? The answer is no. We'll have each plan doing this individually, hoping that other plans are doing this, so that when they get new enrollees 10 years from now, they're going to be healthier than they were before. It seems to me that you need some kind of national collaboration in order to make this work. If it's not national health care, you need some kind of nationwide collaboration.

The other question I have is how do you break into this cycle? In a way, this is a cycle of, how do you get people out of poverty? Educate them first, and then how do you pay for the education and the jobs and so on? It's a cycle with the medical costs. I think it's pretty clear, and it's becoming clearer now to HMOs that physicians are the ones that are in control and always have been in control. They are the ones that should be in control because they have the most knowledge. While I don't think that each individual employee is going to be sophisticated enough to make decisions, possibly HR or the benefit people could make decisions. What needs to be done is to get the information out as to who are the expensive providers, along with some kind of quality measurement of whether the expense is warranted or not.

There are now various programs that are Internet-based, because that's a technology that makes this feasible. The programs begin to give lists of providers and individuals who can really form their network themselves. At the very end, they say, "Well, here's what it's going to cost to choose these doctors." Right now they're not giving the individual cost for each physician or each provider, but I think that will come. Then if you do that along with some kind of quality measurement, it's like the teachers say, they don't want merit increases because we're doing something special, and nobody can really judge us. But everybody knows who the best teachers are in every school. The administrators know, the other teachers know, the parents know, and the students know. It's not as widely known among consumers regarding physicians, but it is certainly well known within the physician community. All of us have data in our own claim bases that could be used to publish this kind of information.

MS. STRACHAN: One of the more exciting conversations I've had recently was with an insurance carrier who was starting to mine its database extensively for physician-practice patterns and going out to physicians, not to say, "You're doing this wrong—everyone else is doing it this way and you're doing it that way," but just to go out to the physician and say, "Well, we've noticed that your practice pattern is different in this way, and why is that?" They've sometimes found that they've managed to convince the physician to practice differently. They've also

sometimes found that the physician has a very good reason for practicing differently, and they can take this information back to their other providers and say, "This physician has found that if he does this, it reduces cost later on for these reasons." I think that some of what I see is starting to happen, but not enough of it. There doesn't seem to be enough in an organized way.

MR. HERMAN: I want to comment on Ms. Ogden's comments relative to the agents. There actually is a live situation that has developed in the state of New Jersey, in the small-employer market, where a major carrier has moved its commissions from a percentage of premium to a per-employee basis. There has been a lot of controversy. The agents have tried to argue that this is a violation of the New Jersey Small Employer Act, a violation of Health Insurance Portability and Accountability Act of 1996 (HIPAA). They're arguing that, because it's a flat dollar amount, agents are going to walk away from the higher risk, higher age type of groups. At this point, the board and the insurance department have taken the position that this is not a violation of any of the various rules. But I can tell you, as a member of the board, that this has been a tremendously controversial issue and the battle is still being waged. So the agents are still looking to hook into the essential premium approach.

MR. RICHARD G. MURDOCK: (Watson Wyatt Worldwide) I consult with employers on an ongoing basis in this area, and I guess I would like to share a little bit of frustration with the whole issue. Initially, you were looking for comments as we began this dialogue. Judy, picking up on the thought you raised, which was, "It was interesting that this company, this health plan, is really looking into its data to determine who the good doctors and what the practice patterns are." From our perspective and our business, we would certainly expect the carriers to do exactly that. The managed-care promise was one of managed care, and what we got delivered was discounted fee-for-service, and that was a disappointment on behalf of many of the carriers. They had consolidated to the point where there are few to choose from, aside from small health plans.

The second comment is the fact that, with health-care costs increasing at the rate that we're predicting, forecasting, and probably believing over the next several years, this has got to have an enormous impact on the cost of retiree medical programs and the impact on Financial Accounting Standard (FAS) 106 obligations. I haven't heard that comment suggested here, but it scares me. One of my roles is to sign off on valuations as to the adequacy of these liabilities, and I'm not sure how to deal with that at this point. It's terribly frustrating.

The final comment is one that deals with a personal issue. I had to get my brakes fixed on my car. I looked to see where to get that done, and I got a pretty good deal. And you know what? I paid for it myself. I didn't go to my employer and look to have it reimbursed. I think that this is the cultural issue that we've got to deal with. We're talking about health care as an entitlement to employees, and employers who are supposed to provide it. We're fretting over how we're going to be shifting costs and the $100 deductible, the $10 co-pay. It's peanuts compared

to the cost of these things. I think we have to step back and begin to make employees more responsible for much more of their health care—not all of it, necessarily. I think if we begin to view it that way and consider an educational process where we help them do that, I think some of this can begin to come under control.

MS. STRACHAN: I've done some FAS 106 work, and while I was looking at FAS literature and things like that, one of the things I've noticed is that, in 1994 when FAS became the accounting standard, something like 90 percent of employers offered retiree health, and it's down close to 40 percent now. FAS in itself has affected behavior, and the cost increases have also affected behavior. One of the things we saw earlier was employers trying to drive their retirees to HMO risk contracts, because their cost went from about $1200 to $1500 a year per participant, to $200-$300 a year per participant. Now they're saying, "No, we don't want to put it in Medicare risk contracts, because they're all disappearing, so we force people, or we try to encourage people to go to them, and then next year they're gone." That avenue for controlling retiree cost is disappearing. There's a real problem there, where only 40 percent of employers are offering new hires future retiree health-care coverage. We have an entire generation of people that are going to not have any health-care coverage when they're retired, just as their health-care costs maximize.

MR. WOOLEY: With regards to your comment about it not being an entitlement—yes, I would probably tend to agree with you. But then what happens if it's not an entitlement, and then you increase the cost, the co-pays? Originally, group insurance was for catastrophic coverage for catastrophic illnesses. What happens then to the employee who neglects his health because he doesn't have coverage, and then ultimately gets diagnosed with something when it could have been treated earlier? It's a catch-22, the chicken or the egg-type of scenario, but ultimately it's going to cost.

MR. MURDOCK: Going back to my auto analogy, if you don't maintain your car, it's going to fall apart and maybe many of them do. But we realize what we have to do, and we take care of them. Insurance has evolved over the years. It started out with Blue Cross organizations collecting $10 a month from people in order to keep themselves afloat during an environment when they couldn't collect any money from people who needed health care. It's gotten to a very different point at this time. I think we're going to be revisiting this, and that the DC thought process is going to get us back there. We're headed in that direction. Employers are going to say, "My obligation is X dollars. Here it is. I'll help you try to figure out how to spend it." There are going to be markets that will evolve. I think we're going to get there in that direction.

MR. DOUGLAS R. MCCANN: (Highmark, Inc.) We're taking a look at a lot of different ways of shifting the costs around and trying to cut the costs and everything. But we learned from Kevin Wooley's presentation, 53 percent of hospital stays are avoidable. I'll draw a parallel between two different professions.

You have the physician profession, which is relatively self-governing, but there is a wide variation in practice, and apparently a lot of waste in the system. You have the actuarial profession, which in the last couple of decades has taken some steps to do some self-regulation, self-governance, coming up with actuarial standards of practice, and the Actuarial Board for Counseling and Discipline (ABCD), and other types of things. It almost seems like it's going to have to come from within the medical profession to start exercising some self-interest, too, in excesses.