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Session 36IF
Radical Health Plan Changes Ignited by the Internet

Track: Health

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Summary: The Internet, managed care backlash, and rising costs are causing employers to consider radical changes to their health benefit plans. Topics covered in this session include Internet-based health plan exchanges, defined-contribution health plans, self-directed health plans, personal spending accounts, and episodic-based reimbursement to insureds. Participants learn of current changes to health benefit plans, which changes have a chance of success, and what has to occur for those changes to succeed.

MR. MICHAEL GERARD STURM: Managed care backlash, rising costs, and the Internet are causing employers to consider radical changes to their health plans. This session discusses the changes and key ingredients for their success. Our panelists will discuss Internet-based health plan exchanges, personal spending accounts, episodic-based reimbursement, and defined contribution plans.

I'm hoping to have a lively debate today, and any debate needs both proponents and opponents. We have four proponents that will be presenting and two opponents. In addition, we want you to participate, and we have left time after

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†Mr. Kenneth Jacobsen, not a member of the sponsoring organizations, is senior vice president and national health practice leader with the Segal Company in Atlanta, GA

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

each presentation for you to be heard. Feel free to join either side.

I think we have a spectacular panel of individuals from a variety of organizations. First, we have Ted Prospect is a principal in Hewitt Associates', East Region Health Management Practice. Ted has more than 15 years of experience in health care, the past 13 with Hewitt. Over the past year, Ted was chief actuary at Sageo. Ted will share his thoughts on how Sageo was affecting change by enabling consumer-driven healthcare to create a more efficient market.

Next is David Tuomala, Definity's health actuary. David has more than 10 years of experience, most recently with Blue Cross/Blue Shield of Iowa. He will discuss how Definity Health's personal spending account and consumer tools bring value to employers.

After David, we have Kurt Wrobel, chief actuary at HealthMarket. Kurt joined HealthMarket in May 2000, shortly after its inception. He's primarily responsible for developing and pricing HealthMarket's unique plans. Kurt will share his thoughts on how episodes of care will change how consumers purchase health care.

After Kurt will be Ken Jacobsen, senior vice president and national health practice leader with the Segal Co. Ken has more than 25 years of experience in health care. He'll uncover some of the empty promises of the defined contribution concept.

In the far left corner, we have the opponents. Harry Sutton is an actuary with Reden & Anders Ltd, a health reinsurer. Harry helps customers develop benefit plans, risk-sharing arrangements, and underwriting standards. Harry didn't provide me with how many years experience he has in this business, but I feel safe in saying that it's more than anyone on this panel.

Lastly, we have Mick Diede, a consulting actuary with Milliman USA. Mick works with carriers, providers, and employers on actuarial and strategic issues.

MR. THEODORE A. PROSPECT: I'm going to cover a couple of different topics. I'm going to go through just a quick, high-level overview of defined contribution concept. Then I'm going to walk you through who some of the new players are and what the categories of players are, and then I'm going to walk you through what the Sageo product is and how that fits within the new space.

Defined Contribution

First, let's talk about defined contribution. In terms of the definition of defined contribution health care, there are lots of different definitions out there. I personally like to think of it along a spectrum, in terms of where we might be and what we might grow into (Chart 1).

On the far right side of Chart 1, look at defined contribution as a pure compensation system. If you're thinking about it in terms of its purest form, what we're thinking

about is an employer giving employees cash—go out and spend, go out and purchase individual policies. As most of you know, that's not really, in any practical form, a reality today. So the question is, "Could we ever get there?" Maybe, maybe not. But where are we today?

In today's world, the former defined contribution is thinking around an employer flex benefit-type program. If you think of it in terms of defined credits or a defined dollar subsidy that an employer is providing, the employer allows a very limited set of group choices for the individual employee to choose from. That's getting into the defined contribution concept, in terms of giving choice, giving a set amount of dollars, but that's kind of where we are today.

Most of the focus over the past year has been in the idea of driving consumerism in the consumer-driven plans. There are a lot of things happening, just in that space. Can we get further? Some hurdles are in place today—the individual underwriting markets, the carriers not quite being ready for it, and the tax code.

The Players

Who are the players in this space? If we really think about it, around this driving consumerism and this whole consumerism space, who are the players, and what are the categories of the players?

We break it into four different categories:

The first one is connectivity. And that's really more talking about focusing on connecting directly with the providers. A Web MD might be more of an example of someone who is in that space. Maybe a MedUnite also would be in that type of space or on the connectivity.

Content providers would be the second category, and that would be more along the lines of a Mayo Clinic or Johns Hopkins. That's an individual employee or just an individual who wants to go out and research the treatment conditions, who wants to learn more about diabetes, or who has a certain condition. That person can go on the Internet and try different sites. That's really what the content providers would be.

Our focus today and most of what we're going to be talking about are coverage and the consolidators. The first one, coverage, focuses on the new design, some of the new players that are out there. We talked about Definity Health and HealthMarket. There are also some traditional players, such as Gannet, that have announced recently that they're offering a consumer-type product. A lot of different types are happening in that space, but that's the one that we as actuaries really are going to be focused on, I think.

And the last category, the consolidator piece, that's more focused on bringing together all the players who are out there in that space today; Sageo is an example

of that. It's really more the traditional outsourcers that are somewhere in that space, and they're more focused on things from an employee perspective or from an open-enrollment-type perspective.

The Sageo Product

In terms of Sageo product, what is it? Basically, it's a full-service outsourcing solution. It mainly is focused on our Web site, but users also have access to a benefits exchange and a customer care center.

The main focus of the Sageo product is on enabling consumer-driven health care. It is not a health plan; Sageo is one that works with the health plans to enable them to bring it to an employee so that they in turn can understand some of the choices that they have.

The other piece of the Sageo model is working at creating more efficient markets, and that really is better connectivity with the health plans and driving toward more standardized-type plan designs.

To give you a picture of what the Sageo model looks like, look at the dark blue in Chart 2. This shows what faces the participant. The best way to think about this is through the point of open enrollment.

If you think of someone going through the open enrollment process, there are a lot of new types of plans out there. People are trying to understand what their choices are. What Sageo brings to the table is new plan selection tools to help people make choices between the different products. You can look at it from either from a quality standpoint—what you have access to; or from a cost standpoint and what the out-of-pocket costs are going to start to look like under these new designs. That's really the front end on Sageo.

That's also supported by a customer care center—a call center that's available to help you if you're not comfortable with the Web site and you have additional questions and you want to go through your enrollment. You have questions that come up through the course of the year; perhaps you are looking for patient advocacy through the course of the year. You can go ahead and call into a call center.

Behind all that is what we call our benefits exchange, and that's where we have a lot of the traditional medical plan options, but mostly group offerings. We also have a lot of work with the consumer-driven plans, some of the different plan options that are out there, as well as different welfare coverages.

The site also gives people the ability to purchase individual coverage at the point of open enrollment. If you don't have enough life insurance, here's an opportunity to pick up life insurance or buy some additional benefits.

MR. STURM: At this point I'd like to open it up to the audience or our opponents to ask Ted questions and challenge some of his thoughts.

MR. LAURENCE R.WEISSBROT: Ted, how big is your current market? How many people are using your defined contribution model?

MR. PROSPECT: I wouldn't necessarily call the Sageo model strictly a defined contribution model, but we have about 25 clients.

MR. WEISSBROT: Covering how many people?

MR. PROSPECT: Covering about 400,000 participants.

MR. WEISSBROT: Is that total covered lives?

MR. PROSPECT: Total covered lives.

MR. DAVID J. BAHN: It took me a couple of minutes to figure out how to phrase this question. As I look down through the content and decision support tools, I wonder, how successful have you been in structuring those tools that will go—to use the old idiom—from the janitor all the way up through the CEO, people who have different knowledge, perhaps different fundamental reading skills?

MR. PROSPECT: It's a good question. About 30 percent of our participants actually have made use of the decision support tools. We've got a variety of people out using the site, some of whom just want to get through it quickly.

I would say most of the companies that have signed on have more of an Internet focus, so we have had a lot of success. In terms of doing our testing, we're pulling people off the street to do testing at all levels to meet their needs. Some people are just not going to touch the Internet, which is one of the reasons that we have the customer care center and an interactive voice response (IVR) system to help people enroll.

But in terms of decision support, we had a lot of learning from last fall's open enrollment. For this fall, we think we've made a lot of enhancements in the tools to address just that concern. And one other point: We do have some unionized and some manufacturing-type organizations that are clients, as well.

MR. DAVID TUOMALA: I'm also going to go through a little bit of background on how the Definity plan design works. I hope that will generate some probing questions on some of the specifics.

Definity Details

There are three basic components of our plan design (Chart 3). None of the components are really all that revolutionary, probably. I think putting them all

together into one kind of product design is kind of a new concept.

Health Coverage. We started out on the top of the page with health coverage, which really is just a high-deductible PPO plan. Typically we're seeing something in the neighborhood of $1,500 to maybe $2,500 employee-only deductible levels. We have a nationwide PPO that we attached to that to give people the advantage of discounted prices for the services.

We don't have any gatekeepers, primary care physicians (PCPs), referrals, or anything like that. We do include preventive care, subject to a schedule, kind of the typical schedule using guidelines from the different medical groups. We do include that as a 100 percent benefit under the health coverage, so that's not something that is included in the personal care account.

Personal Care Account. The second piece is the personal care account, and that's an employer-funded account. Typically the amount that we're looking at there is $1,000—maybe $750 to $1,000 is most typical. And the employer basically sets it up. I always like to think about it like a deductible in reverse, in a sense, that it's not really a cash account; it's really like a benefit provision that you can spend on a first-dollar basis, up to $1,000 a year, let's say. A member has complete control over how those dollars are spent, although the employer does have control on what scope of benefits are provided for that.

Now the limit of benefits that you can include in there, subject to the tax code, is the 213D section, which would cover anything that is deductible on an individual tax form. There's a very broad scope of services that can be covered. The employer obviously can say, "I don't want to cover that entire scope. I want to limit it to just certain services," or "I want to limit the dollar amounts that are attached to certain services."

Probably the unique feature and the most, if we're going to say "revolutionary," thing is that we do allow unused benefit dollars to roll over at the end of the year. That's based on some complexities of the tax code, but under Section 105, our research suggests that rollover of benefit dollars is not something that goes against the deductibility of the employer money, because it's employee money primarily. To me, that's a controversial part.

Health Tools and Resources. The last one is not controversial at all, and that's the health tools and resources. To make all of this stuff work, you can't create consumers in health care, unless they know a little bit more about the cost of services and have a way to really interact with their health plans. So we've created a lot of Web-based tools, as well as phone-based resources, with things such as health care pricing, prescription drug pricing, and those types of things. It's personalized. It's easy to use. But we also have some care advantage or care management features that do all of the usual things. We take advantage of this Web-based resource to do a little bit extra on that, as well.

This is a typical offering for an employer group. We normally like to offer choice among the benefit designs with varying employee contributions. So for this example, we've got an annual deductible on the most costly option, Option 1, of about $1,500, coupled with a $1,000 personal care account (PCA). Employees then could essentially buy down to a lower coverage amount for reduced contribution. That's basically the typical employer group.

Financial Issues

Lastly, I want to talk through a couple of financial issues. We look at the plan designs on an employer-specific basis. It's not really a one-size-fits-all plan.

When we're looking at the cost of the program, we typically assume that 100 percent of the PCA benefits are used in the first year. There are really two reasons for that. Number one, when we first went into this, we didn't know exactly how much of that PCA benefit people might spend on that expanded scope of services, so we thought it was prudent to use a fairly high percentage to start with. Also, the unused portion of that can roll over from year to year, over a long period of time; we think that employees will spend a very high percentage of that. Typically we're using 100 percent for that.

Then we look at what deductible and employee contributions—in light of the other plan offerings a particular group might have—will meet their particular cost goal. Most of the groups that we work with, in fact, are looking at something that costs about the same as their current offerings. Some of the groups that we've looked at have wanted to have a cost savings of 5 percent or 10 percent compared to their current costs, so we really look at the excess of that. So we look at the PCA, subtract that out of the current cost, and say, "What kind of plan design do we need to get to that cost level?"

This does include an element of defined contribution through the PCA, but that's not really the focus of our plan design. We're really looking at trying to create more consumerism within the health care, give them more control of the benefit dollars, and more choice over what kinds of services they get and also help them understand what the different services cost.

The fixed PCA component allows the employer to manage the growth and cost, at least for that component of the benefit. That can be a significant savings. We're doing only self-funded, and we do offer either option or full replacement.

MR. DANIEL R. PLANTE: I have two questions. The first has to do with COBRA continuation. Have you put any thought into whether the PCA benefit is a COBRA-eligible benefit? If so, how you would price for that?

My second question has to do with recent proposals in Washington on allowing flex-plan FSAs to roll over from year to year, and how that would impact the design of your plans, the pricing, and even the take rates. Is it offered as an option?

MR. TUOMALA: Good questions. The answer to the first question is, we've done a lot of research on COBRA, and we do believe that any balances that remain in the PCA at the time of COBRA election, we would have to offer those to COBRA participants. For example, let's just say someone had a $1,000 PCA level and a $2,000 deductible, and he or she was in the plan for six months and during that time had used $500 of the personal care account and had $500 left. Our research suggests that we would have to let that person continue with the $500 PCA, as long as he or she remains on COBRA. We would charge a COBRA premium that's developed in the same way that you develop a COBRA premium otherwise.

I think there are two methods to determine what the expected claims are on a self-funded basis. Basically, they would pay the premium equivalent for the health coverage component for the fully funded PCA, which is really a twelfth of the annual amount plus the 2 percent extra expense limitation.

I hope that answers your first question. As for the second question, I think the FSA proposals that are out there right now actually simplified things in some respect.

It frees up employees to have a very portable benefit, which is one drawback of the personal care account design under the tax code. I guess it's not a portable benefit right now. If they were to leave employment, they would forfeit those balances typically.

Also, I think the other part that's somewhat important is that if the FSA rules were loosened a bit, it also would allow for a little bit more ease in determining how much or how the contribution strategy works between the two plan components.

Right now, we have two separate plans. We have a PCA plan and a health coverage plan. The employee contributions are only going toward the health coverage component. So that does put an upper boundary on how much you can allow them to contribute. It depends on how aggressive the employer wants to be. I think you probably could allow employees to contribute to their personal care accounts, as well. But I think the FSA proposals really just simplify it from tax and administrative perspectives and allow for portability.

MR. ROBERT B. CUMMING: I have a couple of questions for you. First one, if the employer were to cancel the plan next year or the year after that, would the money revert back to the employer, or do the employees have any claim to the funds?

MR. TUOMALA: The employees with respect to the personal care account?

MR. CUMMING: Yes.

MR. TUOMALA: The operation of both components of the plan are identical to any other self-funded benefit, and so the employer really doesn't have any vested interest in the amounts of money—I mean, it's really a pay-as-you-go type of

program. So if the employer cancels the plan, it's like an employee balance really. They have no right to that balance, unless, I suppose, you wrote that into the plan document that said that the plan would continue for some period of time.

FROM THE FLOOR: Have you done any analysis or projections on or do you have any thoughts on what type of savings, if any, this approach might create? I mean the consumerism approach—having the personal care account and some of the incentives involved there. Have you looked at any data so far on some of the groups you've sold related to selection and what type of risks you're attracting?

MR. TUOMALA: Absolutely, on both counts. We have done research, and we've worked with Milliman on some of that. But basically, the cost savings that we assume under our plan design are driven by the deductible levels that you're looking at. It's a common assumption that a plan with higher employee out-of-pocket costs has a reduced utilization, and I think everyone pretty much knows that.

The research that's been done with other clients that we worked with Milliman on is related to these types of benefits and whether putting a first- dollar cash account alongside a high deductible plan creates a large drop-off in that utilization effect. Their experience in research suggests that that's not true. There's a slight drop-off on the order of a couple of percentage points of what you typically would see with a stand-alone high deductible plan. That's the utilization part.

What we've seen with our clients to date—we've got about 6,100 participants right now and started the year at about 5,400—is that as new hires come aboard, these employers were capturing a much higher percentage of new hires than we did of initial enrollees.

What we've seen is that, varying by deductible, the range we're looking at is somewhere around 8 percent to 12 percent for that range of deductibles that I talked about earlier. For the clients that we have on board, they suggest that it's right about there.

We're not seeing our utilization coming in much higher or much lower. It's within a couple of percentage points of that number that we started with.

With respect to selection, we don't have as much data as we'd like to have, but our claim levels are consistent with what we would have expected. We've got at least our fair share of large claims, but diagnoses suggest that we're not getting a super-select risk mix or anything like that.

Twin Cities Case Study

The one case example that we were able to do, because we had comparative data for both plans that they offer, is for a hospital group that we have in the Twin Cities where we actually captured about 82 percent of the enrollment. I'm not sure if

that's the exact number, but it's in that ballpark. And we actually found that on a claims level, we're actually capturing a worse risk than average for our portion of the group, even though the PPO benefit that they have is actually the same one that they had prior to bringing Definity in.

Now, granted, that's a special situation—it's a hospital group. You know they probably are better-than-average consumers to begin with, but I think that suggests at least that the automatic assumption that we would capture the best risk is a faulty one.

MR. KURT JAMES WROBEL: Dave, you might want to clarify that the PCA account covers both the eligible expenses from an IRS standpoint, expenses that are covered by the high-deductible plan, and a number of expenses that are not covered by the high-deductible plan. You can go out and get enough acupunctures to use up all the money, and you'd have $1,000 to pay toward your deductible; or, if you use eligible services such as physician services or hospital outpatients, that would reduce the deductible.

MR. TUOMALA: Right. I guess that probably wasn't clear when I first mentioned that. The 213D is the maximum tax-deductible type item. Things such as cosmetic surgery and over-the-counter drugs and a few other things are not considered eligible expenses by the IRS. It does include, I guess, the typical design. The high-deductible plan covers your usual suspects. It's the typical stuff covered by health plans.

The PCA would include some expanded scope, things such as vision, dental—those are probably the primary items. Things such as massage therapy, acupuncture—those are eligible expenses. What we have seen, though, suggests that one of the things that people were concerned about early on was that if I give you this expanded scope of services, people will go out and get all sorts of odd things, because they now have this money to spend on it.

Real-world PCA Findings

Alternative Medicine. What we found, at least year-to-date, was that very little of the available PCA dollars have been spent on alternative, expanded-scope services—about 4 percent so far. That doesn't suggest, though, that by the end of the year, people might have just been waiting to see, kind of in an FSA-like way, if they have money left. That's still a possibility, but at least you know that it's been about four percent.

People Are Predictable. The other thing we found is that the things people are spending it on really are the things that you would expect them to spend it on. They're buying glasses, they're buying contacts, they're getting root canals and major reconstructive things to supplement their dental plans. You know, about two-thirds of the expenses are for either vision care or dental services. People haven't gone really hog-wild with this money and said, "OK, I'm going to go and get

massage therapy twice a week" or anything like that.

PANELIST: Just so I understand, it sounds like there is a high-deductible plan, which is insurance. Let's say $3,000, anything above that is catastrophic coverage. The first $3,000 may be split, for example—$1,500 is PCA, and $1,500 is the individual's out-of-pocket deductible. The $1,500 in the PCA are employer dollars, because there's a controversy about whether the IRS would allow that to be an employer/employee split on contributions.

MR. TUOMALA: That's correct. The plan, as you mentioned, probably is not the typical one. To readdress that, say it's a $1,000 PCA and a $2,000 deductible, which would produce about the same kind of design there. If you spent the PCA dollars only on the covered health services, the usual types of things, you would spend the first $1,000 if you use all of that.

So let's say you had a catastrophic event of some sort; you use up the full $1,000 of PCA, and you spend another $1,000 out of your own pocket. If it's something you know about, though, such as a maternity or something like that, you can set aside that money in an FSA, as well, to cover up to the deductible. Then anything after the deductible typically would be under a plan design—it's 100 percent in network, although we do sometimes do a co-insurance on that as well.

How Is It Set Up?
We have set it up as two separate plan documents. We are doing only self-funded right now, so it's two separate plans, essentially. It's employer-only money under the PCA, and it's a combination of employer and employee money under the health coverage.

That's more of a conservative legal stance to ensure that there's a distinction between the employee money—that is why we set it up that way. If an employer really wanted to do that, and it was comfortable with the legal risk, I think it could do it. It's just a little bit riskier to do it that way.

MR. STURM: Dave, quick question: Can you talk a little bit about the tools you used to price your product?

MR. TUOMALA: Sure. It would be great if we had a demonstration of how they work.

Basically we've got online tools in which we use a grouper technology that our chief medical officer actually worked to develop. It takes things and it translates the CPT codes and other things into something that's comprehensible by a layperson. We'll take hypertension, for example, and split out into the average cost of an office visit, the lab tests that are associated with it, and the prescription drugs.

We have the ability on our Web site to look up those types of services. Say I have

hypertension. I can find out what the average cost is and what kind of services there are for that.

We also have the ability to look up prescription drugs. We can look those up by kind of therapeutic class—let's say allergy drugs. If you're taking Claritin, you also can find out the cost of Allegra, Zyrtec, or whatever other medications are available. You know if a generic is available, what the cost is, and what the cost is for mail order versus retail. It's hard to do justice to all of this without demonstrating it, but there's a wealth of information available, and all the information that is on the Web site also is accessible by calling the 800 number.

PANELIST: David, do you see this expanding to the fully insured market, and if so, how would a carrier go about making money?

MR. TUOMALA: I think I do see it expanding to the insured market. I don't know if that's something that will happen through a carrier like Definity Health or through a traditional carrier—my guess is probably more through the traditional carriers.

How you would make money on it is, I believe, the same way that you would on any other insured product. You'd want to attach an appropriate margin to the health coverage component.

On the personal care account component, it remains to be seen how you would set that up. I think any kind of margin you try to build into that is going to be very visible. You potentially could get it through some sort of administrative fee. I don't know. I think this is problematic, but I think it is something that is doable.

MR. WROBEL: I'm from HealthMarket. Unlike David's presentation, I'm going to focus more on where HealthMarket intends to go in the future.

Right now we have a product that I would say is somewhat similar to what Definity is offering, and it's really not going to make much sense for me to go over that right now. I think, at least the way we look at it at HealthMarket, there are some exciting alternatives out there that make more sense, especially relating to the savings account and defined contribution plans.

The Ultimate Goal: Behavioral Change

The question I'd ask Dave and probably many of our competitors is, ultimately, what are we trying to achieve? We talk about all this functionality, and we don't spend enough time thinking about what's the ultimate. What do we want to have happen? I would suggest that we really want consumers to truly understand and consider the cost of provider services when they go out and get health care and to consider the quality of services when they get health care.

I look at it as a savings account. A lot of these other defined contribution approaches are fine, but I think we have to figure out if they are going to get us to

where we want to go. I believe this comes before the consumers consider the cost involved in services, before any purchasing of health care.

I'd like to think about it in the terms of the program's ability to achieve its ultimate goal. If you're able to get this behavioral change, when people then start purchasing health care services on a different sort of set of standards, I think that's where you're succeeding in terms of a new plan design. Without that, it is simple cost shifting or anti-managed care involvement.

How Would This Work?
Look at it under three different types of care. I'm going to look at it in terms of an individual having a large savings account purchasing these services. So I'm trying to figure out, is consumer behavior really going to be changed in these different categories?

Routine Care. For example, look at routine care. Just imagine yourself as a consumer—let's say you have $5,000 to spend over a given year, and you're going to purchase routine care. If you have control of the money, you might have to go out and get the services, which is a behavior change.

There is some behavioral change, at least on the routine care side, in terms of access to the health care delivery system. Once you access the health care delivery system, the real question I'd have is: How are you going to be able to truly shop for services, especially when you consider how you would pay providers. Can you imagine individuals going on a Web site and trying to purchase physician services at the CPT code level? It's simply impossible. They don't know what they're going to be going in for. They don't know what the provider is going to bill out.

Episodic Services. In the same vein, if you look at episodic services, it gets even more complicated. Not only do you have the issue around the CPT codes, but now you're actually going to try to purchase facility services, which as we all know is not something that can be adequately shopped. You're going to be looking at percentages of charges, per diem, and outlier provisions. The different ways in which we pay providers are not going to be understandable to the consumers.

Catastrophic Care. When you get to catastrophic care, that's something that the consumer is not going to have control over in any situation, so there's really no opportunity for behavior change in that case.

Overcoming Inherent Problems
Dave alluded to one potential software solution, and that's bundling services together to give people an idea of what things can cost. But the argument is, there is no similar analog on the provider side. Just because I can say, "Based on historical data, this should cost that," it's still not going to help me when you want to purchase episodic services from providers, because you're not contracted on that same basis. They're going to be contracted differently.

Given these inherent problems, the question is: How can you get a behavioral change with the savings account? Remember the savings account is just a financing mechanism ultimately. It's something that Definity can do, HealthMarket can do, Aetna can do, anyone can do. But it's really not truly going to change behavior unless you change the other side of the fence, and that's the provider's side.

True Consumer Interaction
So what we're doing now at HealthMarket is developing a program in which consumers can now truly interact with a health care delivery system.

Episode Care Basis. The notion is to develop it around episodes of care. When I think of an episode of care, it can be a hip replacement, it can be a maternity episode, and it can be a coronary artery bypass graft (CABG); it can be all sorts of different episodes. Instead of trying to hunt down a CPT code and everything else, the individual, would be to go onto a Web site or use some other mechanism and see a whole host of different provider teams willing to provide services at a fixed rate. Then that individual would purchase services from that provider team for that fixed rate.

Within that, there might be some cost sharing, like a co-pay or something, but ultimately the person would be able to make a definable consideration of cost by all the provider teams. Because it's based on episodes, definable units, definable product will be more meaningful quality measures by which to compare provider teams.

Adjustment for Risk. Now as part of this contractual arrangement that we would be making with the provider teams, we'd adjust it for all the standard risk categories: age, sex, comorbidity, and potential complications beyond the physician's control.

By doing this, at least on the consumer side, we're giving them an opportunity to purchase health care services in a reasonable manner. On the provider side, we're giving them enough risk that they can accept the risk, unlike capitation, which I believe provides too much risk. It's enough risk so that they can handle concerns about the ultimate financial outcome of the episode.

So that's what we're trying to do at HealthMarket. I think we ultimately view a lot of these plan designs, particularly around the MSAs, as something that will happen. But it's not a good idea unless you have a behavior change. And the only way you can get that behavior change is through mechanisms particular to episodes of care.

MR. BAHN: I've been trying to think through how this would work in terms of, say, some of our typical employees at Blue Cross/Blue Shield. They know a little bit about health care, but let's say we were to offer this to some of our employees. We've got, say, a single mother with a child. The child is 5 years old. He's been to the doctor five times and you say, "Well now, this is the package of services. You're

going to need hospital."

"Well, why?" the mother says. "My child has never been to a hospital other than the day he was born."

MR. WROBEL: I don't think we can get around that.

MR. BAHN: OK. How about prescription drugs? And I'm wondering about the education that you're going to have to give to the average consumer, because it looks like the consumer is the one who has to purchase this.

MR. WROBEL: No, we'll be contracting with providers around these episodes. This is the real beauty of the system. By no means is this easy, particularly the contracting element. But in your case, for example, it would be based on a diagnosis. Say the child has some particular condition. That may or may not require a hospital visit, may or may not require a certain amount of physician services. This mother would be able to get online—in an idealized world—and go on and say, "My son has X." Here are all the provider teams willing to take care of that individual person, that child, for a certain amount of money.

MR. BAHN: In other words, unlike the typical PCA deductible program, this purchase would be made when an episode is defined. When she goes into the pediatrician and the pediatrician says, "You have diagnosis X," at that point, somehow they look at a pre-packaged set of options. It strikes me that making the purchase decision at that time could lead to tremendous anti-selection.

MR. WROBEL: OK now, tell me: Why would that lead to anti-selection? They're already in a broader insurance policy; so they've already purchased an insurance policy that has some sort of insurance element attached to it. Now that they're sick, they're going to have an opportunity to realize savings that can be as high as 30 percent to 40 percent. It could be zero percent or 10 percent.

MR. BAHN: Then I think one of the difficulties you run into is someone saying, "My child is sick. Skip the cost; I want the best, whether it's Mayo or someone else, period. And I'll find a way to pay for it."

MR. WROBEL: That's a good point, and I'm glad you brought that up. The provider teams will have different prices. This isn't about having a single price for each provider team.

The notion is that we're going to go out and contract with providers at different rates. Mayo should, and in fact probably would, charge a higher rate. If it's worth it for them to go to the Mayo Clinic and pay an extra $500, or extra $1,000, we think that's a good idea, and they should have the opportunity to do that. If they want to go to a cheaper place and have less cost sharing, that also should be an option. And that's where you get people to consider the underlying cost of the services.

Doing it without a system in which they truly can interact with the health care delivery system, we're not going to get anywhere with a lot of these programs that we have out there right now.

MR. BAHN: I actually like your idea of a fair amount from a conceptual viewpoint, so I guess my question relates to practicality. Wouldn't you really have to get a contract with multiple entities—a physician, the hospital, perhaps a pharmaceutical company—to put forth the risk charge for even one episode?

MR WROBEL: As I stand up here, immediately I'm showing this idealized version of what we're trying to do. I think it makes conceptual and economic sense. Is it hard to do? I'd be the first to say that in terms of an approach to the marketplace, there are a lot of different ways to do it.

The first point is, I think you're going to have a significant contracting effort. The second point is, you could initiate or bring members into the process by saying that if you do get a particular episode, you could go out and tell a physician, if he or she doesn't have an episode contract, he or she might have higher cost sharing. That person could actually go to a provider and say, "Look, here's a way the contract would help market with another entity, around these episodes for a fixed amount." We might give them some kickback or some other cost sharing associated with it.

MR. TUOMALA: I don't know that we're on different sides of the fence regarding that. I guess our viewpoint is that the market can only go so far, so fast. We've created a plan design that really fits with today's market. It's something that can be done under existing tax law, and it has a modicum of consumer-driven components to it. It's not the end all, be all, certainly.

The other thing that I would differ on is that episodes of care are really one potential future that sort of increases the consumer component of healthcare for certain more catastrophic-type conditions. I don't know that that's the only one, and in the future, we need to extend that consumer component to a larger number of services.

However, the other thing that I would suggest is that limited first-dollar PCA account actually is in sync with today's provider realities, because people access care the same way they always have. They walk into the physician's office, they throw their card down and they take a photocopy of it. It's exactly the same way that you access care today. The only thing that's changed is that we've given them a limited dollar amount for which we've said, "You control that. You don't need the referrals and all that stuff, and it's visible to you. You're going to get an EOB that says you paid $100 for that office visit or that you paid $125 for that drug."

All it does is create an incentive for the consumer to say either, "I'm happy to spend that amount because it makes me well," or, "I may look for a less expensive alternative or just make different kinds of decisions." So it's not everywhere. It's

not 100 percent; we're about maybe 25 percent of the way there. But I think there are many alternatives, and I think the market will decide long-term which ones it will accept and which ones it won't.

MR. WROBEL: Well, maybe I've been a little bit too critical, because my company is offering the same plan. But I still think if you, and the way I was evaluating it, Dave, wasn't to say, "You guys are doing the wrong thing inherently." It's to put it up against the metric—where do you get behavioral change? Given that metric and that design, I think it's going to be really hard to get any behavior change.

The second point is in terms of the future. I would argue that the only way for an individual to interact with the health care delivery system and get this change that I think we all want is through a definable product. And that definable product is an episode of care. I don't see any other way of changing that process. You have to have a way in which they can interact with it; and to be honest, I don't know of any other ways out there to get that definable product with which people can interact with the delivery system.

PANELIST: Somebody in chronic heart failure is going to need frequent care—maybe not hospitalization, but it can extend over a period of years, and you might pay $20,000 to $30,000 for that. Talk about catastrophic types of cases as well as kind of more ordinary ones, like maternity or something.

MR. WROBEL: There are many different types of episodes and procedural episodes, such as maternity episodes, for example.

PANELIST: And the provider's hospitals know how to accumulate the data;, they know how much they should charge for putting it together. Now Johns Hopkins may know how much it costs, and I'm not sure that they do. But with a lot of these things, we're so fractious, when we get our health care, it's pretty hard to figure out what an episode really costs.

MR. WROBEL: You're absolutely right. I'm not saying this is easy by any stretch of the imagination. I do stress that it makes sense economically.

Now if you get a lot of smart actuaries and a lot of smart physicians, and you're looking at a lot of historical data, I believe you can come out with something that would help people to go out and contract with provider groups. By no means is it easy, and it would take time, particularly around the contracting effort, but I think once you get that straight, I think they have a much better model. , and I also think it's the only really true solution to get to this level of consumerism that we all want.

MR. STURM: Let's sneak in one more. There's a rule in the industry, depending on who you talk to, that 20 percent of the people have 80 percent of the cost. And then you hear that maybe 10 percent of the people have 90 percent of the cost. But

in either case, it seems like, absent one of these episode treatment kickers, a lot of the costs in a given year are going to be from patients who are going to blow through any personal spending account. I guess my question then is, what sort of cost control features are inherent in the product design after you reach that point?

MR. WROBEL: We're not asking individuals to go at risk or anything like that. I think the notion is that you can design the insurance product in a variety of different ways, with different cost-sharing approaches. The notion is that you have a fixed episode. It could be a chronic condition or a procedural one, and then you would go online, and you would see different prices for those particular episodes. You would still have a fixed out-of-pocket or a fixed liability associated with that.

There still is exposure to the individual member, but only up to the out-of-pocket, and I think the neat feature is that there is still an element where it's under an intended plan design. So if you want to go to the Mayo Clinic, like the gentleman talked about, that's fine. You just have to pay more. If you want to go to the lower-price facility or lower-price provider group, that's fine as well. In that case, you wouldn't have as much out of pocket.

PANELIST: I'll just add something to that. Call it a corollary to the 80/20 rule—you can argue about what the percentages are. But the other thing that you need to keep in mind is that frequently your very large-dollar claims are not things that you can predict ahead of time. You know your medium-sized claims, such as your disease states and things like that. You know whether you have it or not, but typically the dollar amounts of those are in the single-digit thousands a year, as opposed to $25,000 a year.

I always tell people that to get the $25,000, you have to pass through $1,000, $2,000, and $3,000. So there's still an opportunity for people who have catastrophic conditions to spend better on those early-dollar claims, because they don't necessarily know at the beginning of the year that they're going to use up all of that money with some kind of a catastrophic event.

If you look at the total of all claims less than $1,000 or $2,000, that's often 40 percent to 50 percent of the total claim dollars.

PANELIST: There is one quick point I want to make on the catastrophic side. Again, I keep going back to the metric. How do we get behavioral change? I think that's one area on catastrophic, depending on the condition, in which you're not going to be able to get behavioral change. In that case, we wouldn't have the same sort of shopping experience available; they would just simply be covered. We'd have some other provisions available to them.

MR. WEISSBROT: Kurt, you made a statement before that this type of behavioral change is something we all want, and I don't think there are too many people in this room who would disagree with you, but I'd be careful with that. There are an

awful lot of union groups out there that think that cradle-to-grave free health care is a God-given right. They are not looking to take any personal responsibilities for it; so there is a large segment of your insured population that is not going to go along with this.

MR. WROBEL: I think in my excitement with our own concept here, I might have gone overboard. But that being said, there's a cost benefit associated with anything. On this episode-of-care model, I think we're giving people a considerable amount of choice, and with that choice, some reasonable amount to shop and also some reasonable amount of opportunity to figure out how much they're going to pay.

If someone wants cradle-to–grave, complete coverage, they're likely not going to have a huge network, unless they want to pay for it. What I'm offering—or what HealthMarket is offering around episodes of care—is greater flexibility, greater opportunity to go outside the network and have wider provider choices. In the union case, if they don't want that same choice level, again, that's something that they have to consider on their own.

MR. BAHN: I didn't mean to sound too critical of what you're trying to work through here, because I like and I tried to push the concept within our company of sorting out the routine care as essentially not insurance. My $10 co-pay and HMO benefit are probably equivalent to free parking. That's not really an insurance benefit.

In the case of diabetes, in which a chronic situation is concerned, or maternity, in which you've got nine months, you've got some time before you're actually incur the expenses. However, you do have to sort out what might be called acute intermediate care. If I really want to sound ridiculous, I can say I can envision somebody in an ambulance trying to select the physicians, surgeons, and anesthesiologist for an appendectomy. That's episodic but not catastrophic.

MR. WROBEL: I think that's a good point, and there certainly are some conditions in which it doesn't matter what we do, we're not going to get any behavioral change. There's not going to be any evaluation of price and quality. In that case, there's no way we're going to be able to get anywhere with that. But if I can get 40 percent to 50 percent of customers' dollars for people to have a meaningful shopping experience in which they can make price and quality decisions, I think that's a pretty powerful plan.

The other point I want to make is you talked about an individual choosing different physicians. The intent in our design is to have whole provider teams; so you're not going to go in and say, "Well, I want this physician, this anesthesiologist, and this facility." They would come to you with a fixed bundle set of services.

MR. KENNETH JACOBSEN: When Mike first invited me to be on this panel about four months ago, he asked, "Are you the guy from the Segal Co. who was recently quoted as slamming defined-contribution health plans?" And I said, "No, that wasn't my quote. But I have spoken against them." And he said, "Good, I want you on this panel, because we're meeting in October in New Orleans, and we're going to have three people on the pro side and three people on the con side about DC health plans."

One of the reasons I give you that as background is that, as you notice today, we're hardly talking about defined-contribution health plans anymore. We've kind of moved to the Internet and consumer-driven health care purchasing, and that is not accidental. It seems to me just in the past four months, all of a sudden there's not that much talk about pure DC health plans.

Anyway, I'm here to present the concept of DC health plans; what that means, and some of the advantages and disadvantages.

Two weeks ago I was at the Employee Benefits Expo and Forum in Atlanta, presenting on this topic there, and the room was about as full as it is here. I asked for a show of hands of, how many people—and this was all plan sponsors and employers—worked for an employer that had a defined-contribution health plan in place. One woman from out of about 80 or 90 people from Minneapolis raised her hand, and then I asked, "How many work for a company that is putting one in in the next open enrollment period, whether it's January 1 or the next fiscal year?" And nobody put a hand up.

So I got to be what I've always wanted to be, which is a futurist, because there is no such thing going on, and as you listen to this discussion, we're talking about the concept of, wouldn't it be neat if we could introduce consumerism and information and arm people with dollars to spend wisely? and all of that. It's a great concept; I agree with all of it.

Defined-contribution Plans

In a DC health plan, the basic concept is simple. Employers give employees a defined dollar amount. The employees then select a health plan they want for the marketplace based on their needs and plan costs. I guess it's important to note that the benefit promised is no longer a benefit but an account—an amount of money.

There are two interpretations of that. One is what was originally looked at as the voucher system. wherein that system an employee is given money on top of his or her compensation or some amount to buy health care. The second would be the employer-directed DC model, which is akin to the idea of a 401(k) plan. Basically the employer still does all the mechanics, lines up the administration, lines up the vendors, and does all the communications and education. The employer oversees the plan rules and fiduciary responsibilities.

Voucher System. On the first of those, which really is hardly talked about anymore, the voucher system and the defined contribution is set. The employer may or may not help from there to identify qualified health care superstores or in purchasing health plans or whatever it may be.

The employee is in charge from there. The employee becomes the direct consumer of health plans or health care. The role of the employee, then, is to seek and compare e-health offerings, and all of this is based on going on the Internet. It really depends almost entirely on E-commerce. The employee uses employer-provided dollars or vouchers to purchase services directly from health plans or suppliers of health care products, services, and devices. Employees might,, depending upon how it's set up, have to select the primary care physician—if they're buying through a managed care type approach—off the free market.

Basically you're responsible now as the employee. We've wiped our hands of it as the plan sponsor or the employer. This is how all this conversation got started—employers were tired of managed-care backlash and tired of paying all the money that they were paying for health care.

But this is just rife with unanswered questions. What is a voucher? Is it actually a slip of paper? Is it another $3,000 in total compensation? Is it encrypted money that I can buy over the Internet and, like my ATM card, it somehow gets back to the account that I was overseeing? Are these plans then sponsored? Are they unsponsored? What are the tax implications?

Are there any regulatory issues, or will there be new regulatory issues, and what might they be? Does the employer or the plan sponsor still have fiduciary responsibility? What about the market? Are 165 million people who get their health care on a group basis are going to have to be reached on an individual basis? How do you administer that? How do you enroll people? How do you collect dollars? None of this stuff was answered, and for the first 12 months that defined contributions were discussed in this country, it became clear that there is no answer, and there's no infrastructure coming into replace what we've got now, so vouchers probably aren't going to make it.

Employer-Employee Strains

Another topic here is the breech of the social contract between the employer and the employee. If I'm suddenly left out on my own to buy health care, and I make a mistake, or I consume a lot of time with it, or I don't like the vendor or the administrator—lots and lots of things are going to go wrong in there—no longer am I so bound to my employer. In fact, I might be so angry with him or her that I'm out of here.

There are a lot of questions about whether it's worth it to disenfranchise your employees just for that alone. I think the number one unanswered question, when you begin to talk to actuaries and underwriters and plan sponsors who are

responsible for a large plan with 10,000 or 15,000 employees, is: What happens with my risk when I begin to segment this off? And unless I do a wholesale replacement, where I put everybody into a DC health plan, if I just begin to offer it as an option, and it looks attractive to those who are young and healthy or have a little extra money, what's going to happen to the rest of my plan? There's nothing new in any of this. It's the same question we've been asking ourselves about flex- or cafeteria plans or any kind of offerings.

Cash Flow Problems
You want to make sure that you don't have a downward spiral on a plan in which you've got the older or the sicker people staying in the richer plan and the cost of that spirals way up while you've got all the good money going into a pool that's not spending.

As Mick said earlier in regard to the 80/20 rule, if you take those dollars out of the total pool, you've got problems. That's not to say that it can't be addressed and tackled. There are lots of actuarial approaches to flex in which we smooth things out. But nobody knows how to do this on DC health plans just yet.

What of Carriers?
We're still talking futuristically. There are some DC plans that can be insured for less than 50 lives. But when you start talking about large plans and breaking that off, it's not so easily answered just yet.

Self-Insureds
And then you have self-insured plans. I've only talked to about four or five clients about this in any earnest. Some of those conversations have gone 10 minutes, and some of them have gone a few hours. But they're pretty much not ready to take on the risks associated with splitting people up like this until they have a lot more information. They have time to wait and see and look what the industry has figured out and what the people who tried it first experienced.

Advantages
The advantages are obvious. The whole point is to encourage consumerism so that people who are responsible for spending the dollars—it's their own dollars now—will begin to make tradeoffs. "Geez, I don't really need the brand drug. I can go with the generic. I don't really need to go to the doctor if my children have the sniffles in the middle of winter. That's natural. I'll just wait seven days, it'll go away, and I don't have to incur that cost."

The more we can get people thinking that way and arm them with other information via search engines and the Web and everything else, the better, whether it's about disease or demand or anything else. People can start to make different decisions. That's the idea behind this. This does, from an employee standpoint in the modern world, enhance choice—it gets them away from some of the managed care hassles. It gives them more accountability, more responsibility.

They like that. Although there's probably an initial increase in administration to get this thing rolling, ultimately it reduces administration. And another thing: If I read 60 articles on the topic of defined-contribution health plans, all 60 of them—some way or another, some emphatically and some passively—mention that one of the main drivers here is that the employer is tired of spiraling costs and wants to just pass that along. So they cap their costs and liabilities. But that's the other side of it, which I think employees will catch onto once they start paying.

Disadvantages

Consumer Learning Curve. Consumers are not ready, I think we know that. There's a band of consumers out there who can probably start this up tomorrow, but as some of the questions here today have pointed out, consumers include unions who are going to fight long and hard to defend their benefits. I mean, they think wage and benefit. They don't think wage and account balance. They're going to fight for benefits.

In De Kalb County, Georgia, where I live, 60 languages are spoken daily. I don't think it's realistic to assume that people who are speaking English as a second language can get onto the Internet and understand the arcane business of purchasing health care. It really has nothing to do with education level.

Communication. Then there's the whole issue of communication. If you really want to start changing enrollment patterns and move people into a DC model, it's going to be very difficult for them to understand. We were able to pick it up today. We're professionals who study health care for a living, but a lot of people are going to have a hard time with the whole concept of what a PCA is. How does it roll over, and how much is contributed? If I spend it all, then what?

Underinsurance. There is also the potential for underinsurance. People will under buy and not even realize it some of the time. Then, when the episode comes around, they realize the fine print says that they're not covered for all of that or some of that. There's also the potential of incenting people to underutilize and get sick rather than take care of themselves. If you follow managed care, there's the whole issue of under utilization versus overutilization.

Employee Heat. I think that one thing is clear: This is a cost-shifting game. Employers are looking at this as a way to say, "I want to cap my costs and let the consumer or the employee figure it out," but what that's going to translate to is, "Well, last year I might have spent three percent of my paycheck on health care, and this year I'm suddenly spending six percent, and four years from now I'll be up to nine percent." There will be some backlash. People will say, "Oh I get it, all that marketing glitz and all that open enrollment and how cool that looked on the Internet when they showed it to me in the demonstration—that just cost me another $4,000 a year!" They'll figure that out, and they'll talk in the cafeteria. So those are problems here.

Reliance on the Web-savvy. We talked about reliance on Web-savvy employees and the cost burden. The voucher system is really not viable at all. They're not tax–deductible, and there's really nobody addressing the issue of making vouchers tax-deductible.

The market infrastructure is geared for groups, not individuals. The health system is too arcane for the average employee. Risk pools can't be created yet with confidence and accuracy. Now maybe in three or five or seven years, we'll have figured all that out, but not tomorrow. There is no certainty of long-term savings here.

We're assuming that the incentive to consume less health care will result in savings. But again, we're being futurists when we say that, and we can model that out, and I've seen a couple of models. In fact I saw a guy from Aon—they are part of the Definity Group—who said that they have estimated a five to eight percent savings might be available through defined contributions or through the Definity model, but they didn't really know for sure. They had about three percent of their group enroll last year. They had two test sites. So they probably won't have enough data again.

I talked to an actuary who thought it might be worth three or four percent. Is that enough long-term savings for the kind of backlash, the kind of education it provides? I'm not saying yes or no. All of this is untested. It's why I started by saying we're being futurists here.

Negative Vibes. And last but not least, I think there's going to be recurring backlash. Things are going to go wrong. Managed care had its own version of backlash, so too would defined contribution.

I'm not talking about consumer health care. I'm talking about defined contribution health plans in which the employee basically eats more of the cost and makes mistakes along the way in what he or she purchases. There will be a horrendous backlash.

MR. STURM: Thank you, Ken. Is there anybody who would like to ask Ken a question or challenge him and say that DC is the future?

MS. DEBORAH CARYL: Do you expect mainly to see the younger people because of the Web site access to this product? I don't think you're going to see many older people go for this. And I would expect the baby boomers to not want to go for this on the Web site. I think you can market it easier to the younger people. I think an older person wouldn't want to do this at all.

MR. JACOBSEN: I would agree with that. I'm not marketing DC plans. My friends to the right are.

MS. CARYL: I'm one of those baby boomers. I have twin sons who would be happy to get on the Web site and buy this, but I would probably be more reluctant.

MR. JACOBSEN: It's for both reasons. That and you're healthier when you're younger, and you think you're invincible. This plan is cheaper and it looks like you can start accumulating dollars: You've got a PCA of $2,000 or $3,000 dollars that you're only going to spend a few hundred of. The next year you roll it over, and now you're up to $4,000 or $5,000. Over time you think, "Hey I can accumulate $100,000 of health care." Those are the people that are going to enroll.

And now if that employer contribution is going over in that direction and coming out of the pool of the sicker, older people, that's part of the risk pooling problem. But most people seem to think it will be more attractive to the young and the healthy and perhaps the wealthy.

PANELIST: Ken, can I respond to that as well? Our consumer research actually has been exactly the opposite of that to date.

The people who are most attractive to the consumer group and plan don't disagree with a lot that's been said about defined contribution. However, I'm not sure that that's something that will hold true forever. I think it's certainly true of today's market and, you know, there certainly are innovations that have yet to occur. There's no shortage of good ideas out there.

So that said, market research for consumer-driven models suggests that people who are most attracted to this are typically the health care decision-makers in the family who, believe it or not, tend to be women. Probably the 35 to 45-year-old demographic is a lot more attracted to it than the 25-year-olds are.

The reason that they seem to be attracted to this model is because of the hassles and difficulties they've had with the traditional HMO-type managed care systems. They've had things denied for lack of referrals and all that other stuff. And they find it attractive to really be able to do their own research on health care, to know that they can go to whichever doctor they want to, and really to be in control of that. That seems to be the market that it really resonates with.

Age Categories. One other point to make is that the enrollment that we've had on our current clients is a normal distribution of age categories. It has not been disproportionately young. We don't think disproportionately healthy.

FROM THE FLOOR: Has anyone factored into the projections, that each year we all get one year older? As we look out 10 years, in that time the youngest baby boomer is going to be 47. What is the defined contribution level going to have to be then? Has anybody factored that kind of thinking into the potential defined contribution levels that are going to be necessary to provide health care?

PANELIST: We've done a lot of analysis on what we call the Aging of Aquarius in our company, meaning the aging of that baby boom group approaching retirement over the next 10 to 15 years. In fact it consists of about 80 million people, and there are about 50 million or 52 million Gen X-ers coming in behind them. That has a lot of implications, but I haven't looked at it in terms of defined-contribution health plans.

It means that the aging population is getting older. They are generally sicker, health care costs will continue to rise, and retiree coverage is going to be a real strain for the plan sponsors that still provide it. But I haven't pieced together anything on DC health with that. Has anybody? Harry?

MR. HARRY L. SUTTON Jr: I'm convinced inflation trends are going to be even higher over the next year than they were for this year, hospital costs in particular. We're back to the cafeteria benefit plans that gave a choice of six or eight options, varying by small deductibles—$100, $250, $500, even $1,000 was considered outrageously high. And everybody guessed wrong, because the sick people would pick the lowest deductible and the well people would buy the highest deductible.

It's likely that instead of a $1,000 PCA or a $2,000 deductible, we get up to a $3,000 deductible, the employer could save some real money if everybody were in it. But the higher the deductible gets, the fewer people will take it.

The problem is worse in the MSA industry, because the money stays there. The employer gives it to the employees, or they put it in themselves, and they keep it forever. The employee never gets it back. At least in Section 105, if the employee terminates without having expended, there are some ways of continuing the account. When you terminate with that, you lose the benefit—forgetting the COBRA problem and a couple of other things. Until we get everybody into it, I don't think we're going to have a fair view of whether it would save money or not.

MR. WROBEL: It seems, Harry, that we get back to cost shifting. If the employer doesn't pay it, the individual pays it. And to me that doesn't enhance the efficiency of the health care delivery system.

MR. SUTTON: When the Academy worked on the MSA, they calculated various levels of savings. When you pay out of pocket, you're going to resist paying or buying something. There's got to be some modest savings, but the bigger the gap in there between the PCA and where the high-deductible picks up, the less money they will spend.

MR. WROBEL: Let me ask a quick question in regard to that, because you say that there's going to be less utilization if people have their own money. Couldn't you get the same process or that same sort of savings to a slightly higher deductible plan? In other words, rather than going through the MSA and everything else, why not just have a higher deductible plan? I think ultimately it comes into cost shifting.

MR. SUTTON: No, but I happen to buy your point. If it's the 20 percent of the people who spend 80 percent of the money, a $1,000 deductible isn't going to make any difference.

How do you get the people to feed into a system that will control their cost? Theoretically, you have at least a Kaiser model—those physicians can do the same thing you're suggesting and try to negotiate and deal with the providers.

MR. WROBEL: I'd like to say we're much different than the Kaiser model.

MR. SUTTON: Oh yes, I know.

PANELIST: Just coming back on the aging comment: One variation of defined-contribution that employers are looking at really is thinking about it more on the lines of retirees. And a lot of it is put in these FAS 106 caps or subsidy caps, which some of you may be familiar with, which really would just cost shift to the employee.

If you look down the road, it would be really extreme costs. But among some of the more innovative employers, some actually have put something in that is more of a savings account—you can accumulate while you're active. So you can use that to pay premiums or whatever new types of designs might be available when you retire.

PANELIST: I'll comment on something that Harry said. I think the benefit designs that we're typically modeling for employers are not really designed to increase the overall cost sharing. I think it increases cost sharing for some individuals and reduces it for others, but the overall benefit value is typically about the same as what you'd see under the plan designs that they have today. And let's face it, the predominant plan designs in today's environment are frequently very low cost sharing. It's not uncommon still to see $10 and $15 office co-pays. That's a pretty nominal amount when you look at the 80/20 rule. So people are not spending a lot of money out-of-pocket today for health care.

What we're trying to do with that design is create some incentives for people to care about what things cost. It's not a perfect system by any means, but I think it does involve the consumer more in the health care decisions, at least for those small-dollar expenses.

MR. JACOBSEN: I think what Dave says is right, in that there are going to be some winners and some losers as we shift some of the costs around. I think the big question in all of this is, if you're in the loser category or if you have employees who are in the loser category, how much have they lost and how many of them? Because in the end, this is a sell, you know? Are we going to be able to get consumers or employees to want this? If they move in this direction, and it doesn't hurt them that much, and it gives them all the benefits that we talked about here,

this will continue to evolve.

But if, in the early stages, people start to get stung, even if a lot of people is only 8 percent of your population, they're going to make a lot of noise. I hope we can find a way. I personally am encouraged by all of this. I think it's time to move demand management and consumerism into the equation. There's an end to only managing the supply side and employer trying to eat all the cost increase. How long can that go on?

The final vote belongs to the employees. If they like it, we'll keep moving with this, and if they don't, it'll stop. I'll also say that nothing is predictable in health care. In the last half-dozen years, we thought everybody would be in HMOs by now. Back in 1995 only 23 percent of the employed population was covered by health plans are covered by HMOs. We were supposed to be at 100 percent by the year 2000. Capitation was supposed to have ruled by now. It's dwindling and going away.

You know, health employer data information set (HEDIS) and all the other quality measures were going to reshape how we purchase health care and of course, nobody purchases health care on quality. All this stuff we would have predicted isn't really happening. So if you think we can predict one way or the other on this, we can't. I think we're all encouraged by this, but we just have to keep trying it and finding different ways and seeing what evolves from it.

PANELIST: I think the HMOs and capitation, especially on further review, simply did not make sense to physicians. There are a lot of reasons why it didn't make sense in economic terms. It has to make sense economically, and there is a host of reasons.

Chart 1

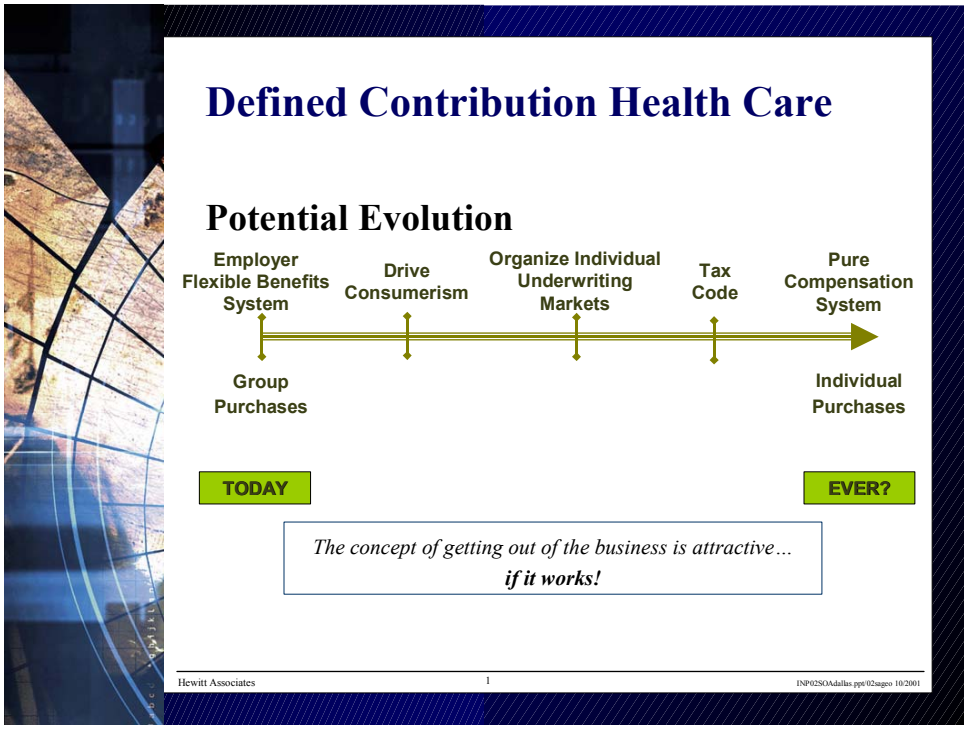

Chart 2

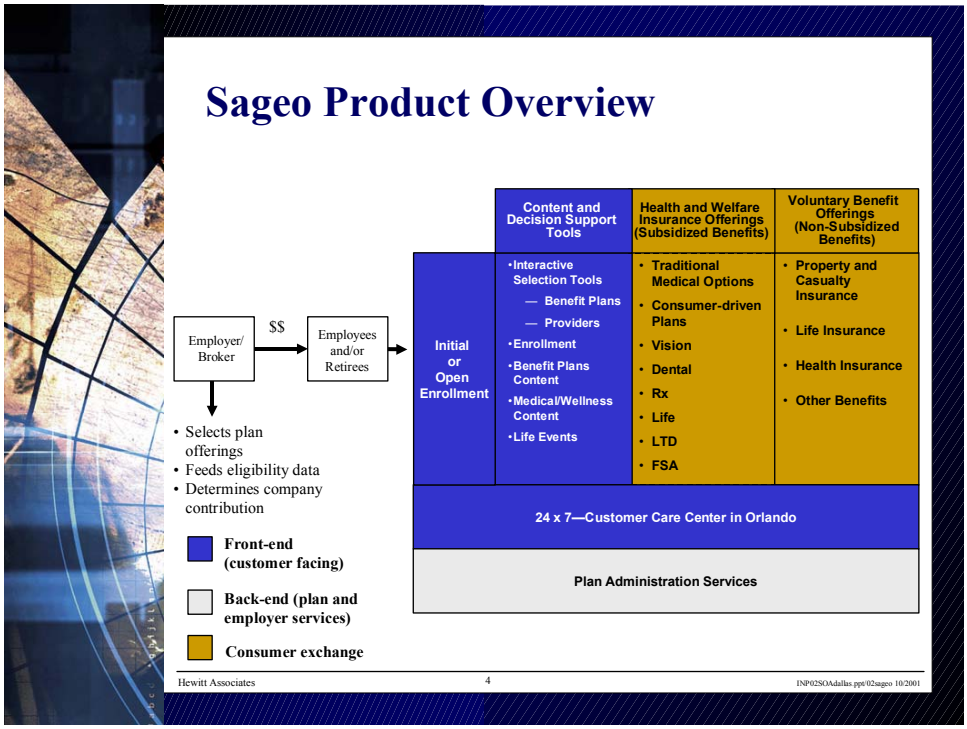

Chart 3

Definity Health Component Details

Health Coverage
- High annual deductible
- Nationwide access to preferred providers
- No referrals required
- Preventive care covered 100% in network

Personal Care Account (PCA)
- Employer allocates benefit dollars
- Member directs benefit dollars
- Section 213(d) "scope"
- Unused benefit dollars roll over at year-end (Section 105) and accumulate for future use

Health Tools and Resources
- Advanced Web- and phone-based resources and tools
- Extensive personalized, reliable and easy-to-use information and services
- Definity Health Care Advantage—individual health management